

Reporting to:	Trust Board - 1 May 2014
Title	Review of The Trust's Winter Plan 2013/14
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Previously considered by	
Executive Summary	<p>The Trust's Winter Plan was phased in from November 2013 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 report describes the process the Trust followed to identify the elements of the 13/14 Winter Plan and how the funding from NHS England was allocated to the schemes and the impact that this had. The report concludes with some recommendations to be taken into consideration in the development of the 2014/15 Winter Plan.</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 checked="" type="checkbox"/> Review <input type="checkbox"/> Note <input type="checkbox"/> Approve	Recommendation <p>The Trust Board is requested to NOTE that discussions are already underway internally and with the local health and social care economy through the Urgent Care Working Board on the development of surge and Winter planning for 2014/15. Updates with regard to progress will be provided within the Integrated Performance Report alongside a first draft of the Winter Plan when this is available. The Board is also requested to NOTE the improvement in performance against the A&E 4 hour standard, across the whole year, but in particular over the Winter period.</p>

1 BACKGROUND

The purpose of this report is to reflect on the effectiveness of the Trust's 2013/14 Winter Plan. The 'Winter Plan' (Surge Plan), was developed on the basis that, as a Trust there was insufficient inpatient capacity to provide assurance to the Board that we would be able to maintain patient safety, timely care and prevent long waits in the Emergency Department [ED]. The bed capacity model for the Trust was split into sites and by month, modelled at 100%, 95%, 90% and 85% capacity, highlighting the size of the challenge facing the site teams with a significant gap in bed capacity.

The Trust's Winter Plan was linked to the Health and Social Economy Winter Plan. This enabled effective vertical planning between provider organisations and ensured that SaTH was supported when attempting to reduce the impact of the capacity gap with the need for a cohesive joined up approach.

The Winter Plan was developed initially with feedback from the trust staff: Operational, Medical and Nursing, and learned outcomes from Winter 2012/13. Also in developing the plan we looked at Winter 9 (a health economy plan from Winter 2011/12) as part of what worked well. This was facilitated through a number of internal Winter Planning meetings.

Bed modelling was a key driver to ensuring that we had sufficient capacity to deliver the required inpatient beds needed, or plans to mitigate against the lack of these. In calculating the bed capacity plan we utilised two calculations: Occupied Bed Days and Contracted Spells. These produced similar results and confirmed the lack of capacity explained in 2.1. The gap identified was 60 beds across both sites.

2 DEVELOPMENT OF THE PLAN

As stated the plan was focused on delivering safe patient flow whilst maintaining quality and delivering national performance targets, e.g. Referral to Treatment [RTT] and Cancer waiting times as well as the 4 hour standard.

The plan consisted of the following areas:

- Workforce
 - Nursing
 - Medical
 - Therapy
 - Clinical Services, e.g. Pharmacy
- Capacity
 - Emergency inpatient capacity
 - Elective planned capacity
- Demand Modelling
 - By site
 - By month
- Site Management
 - New Head of Capacity [HOC] role imbedded during winter period
 - New site team working
- Partnership Working
 - Joined up planning with both Health and Social Care partners
 - Independent sector
 - Powys Local Health Board

2.1 Capacity – 13/14 Bed Model

The bed modelling provided a framework and indicator of the likely capacity requirements. It was based on Occupied Bed Days [OBD]. It identified that there was a gap of 60 beds. The bed gap was split by site and identified the size of the bed requirement challenge by site. The Trust was already utilising every available bed. It was agreed by the health and social care economy that purchasing additional bed capacity outside of the acute Trust would be the best use of resources to bridge the 60 bed gap because:

- 1) It was likely that the acute Trust would be unable to staff another ward given the level of vacancies in nursing staffing at that time;
- 2) Capital costs of a drop-in ward were circa £1M;
- 3) There was a risk that unless models of care were changing, patients would remain in these additional beds when fit to transfer so no additional capacity would be created;
- 4) Purchasing additional capacity from numerous providers spread the risk of alternative providers being unable to staff additional beds;
- 5) It allowed for the development of alternative models of care as part of a longer term strategy;
- 6) 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 whole Health and Social Care plan, 67 beds/bed equivalents that would support admission avoidance or earlier discharge were purchased.

3 THE WINTER PLAN - SATH

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
 - Acute Medical Unit
 - Surgical Assessment Unit
- Flex capacity:
 - Day Surgery Unit at RSH and PRH
 - Ward 28 Annex and 32 E
- Therapy support both sites
- Pharmacy support

Costs for staffing ensured that we could provide additional medical cover for juniors 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.

A full breakdown of spend in each area against identifiable plans can be seen in the financial breakdown on page 5 and 6.

To further support the winter plan we continued with key schemes that had an internal focus and an external focus. These included:

1) Improving Discharge Processes

As part of the ATOS workstreams and the development of the site teams we have continued to develop the discharge plan to ensure we improve discharge processes. This included increasing the number of pre 10 discharges, the development of new paperwork, discharge hub meetings and reviewing our escalation plans. These improvements have supported timely effective discharge ensuring delays are reduced and that we improve pre 10, 12 and 1500 hours 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.

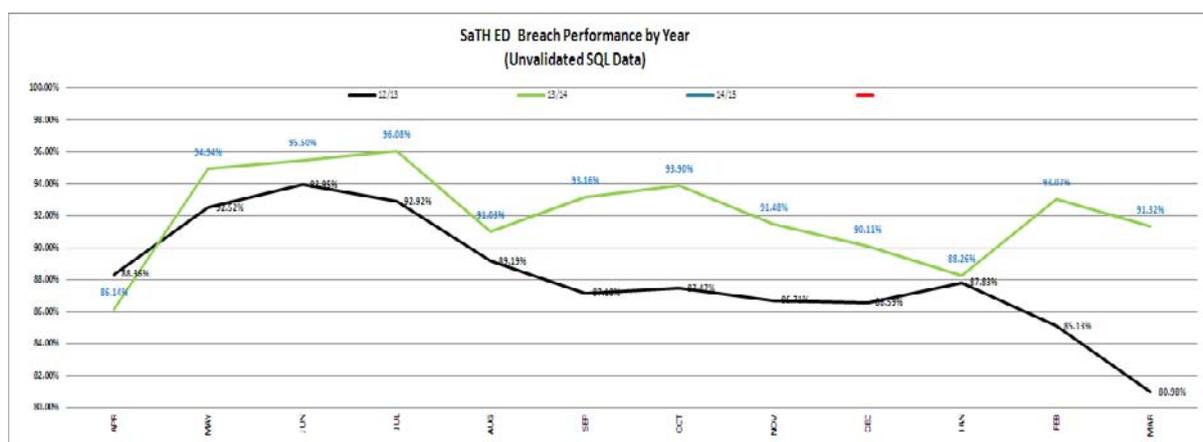
2) Reducing the Number of Patients Fit to Transfer

The Fit To Transfer list rather than Delayed Transfers of Care has been the focus of the site teams, as Fit To Transfer gives a more accurate reflection of those patients who could be supported in a non-acute setting; be this at home or in a bed. We have used the development of the discharge hub to ensure that all patients are discussed twice daily on each site, this is led by the Heads of Capacity who provide supportive challenge and ensures that no patients wait needlessly for their next place of care. A decision at the Senior Winter planning meeting agreed to set a target of 50 patients as a maximum on the Fit to Transfer list. The Trust believes that this

should be in the region of 25 to enable us to effectively manage flow. It has proved extremely difficult to deliver consistently below this target of 50.

3.1 What was the impact?

One of the key achievements' was the increase in performance over the winter months; the following graph highlights this as a comparison to 2012/13 (walk-in centre numbers are excluded):



The Trust may not have delivered the 95% target however:

- Improvement in performance of over 4% on average and in March this was 10%;
- In pure number terms in Quarter 3 there were 696 more patients, and in Quarter 4 1,616 more patients who were seen within 4 hours in comparison to the same Quarters in 2012/13;
- Reduced number of 8 hour escalations;
- Number of 12 hour breaches – Winter 2012/13 we had 17. In 2013/14 only 1, which was due to a delay in mental health provision and outside of the Trust's control;
- Cancellation of TCI's due to capacity problems became the exception within single figures for the whole of the winter. In 2012/13 high levels of cancellations of TCI's led to failure of the 18 Week admitted performance standard;
- Emergency Activity was down from previous year. However for 2012/13 it is difficult to make a direct comparison as all GP admission were directed to the Emergency Department. In 2013/14 this changed to assessment units, reducing the impact on the Emergency Department.
- Patient's complaints for the same period fell from 74 to 67 (Nov – Mar)

3.1.2 Ambulance Turnaround

A further pressure placed on the Trust is the ability of the health economy to fine Trusts who do not adhere to handovers completed within 30 minutes and handovers over 1 hour. We have made a huge improvement over previous winters and it is now the exception to have over 1 hour handover delays in the Emergency Department; although assessment areas are still struggling to manage this week by week. However we have reduced the over 1 hour delays by month to single figures on both sites.

As comparison to February and March 2013 to February to March 2014:

PRH

Feb – 2013 – 14

Mar 2013 - 30

Feb – 2014 – 10

Mar 2014 – 23

RSH

Feb – 2013 – 38

Mar 2013 - 83

Feb – 2014 – 5

Mar 2014 - 25

4 PARTNERSHIP WORKING

The implementation of ‘Year round ‘pressures planning’ was introduced as a concept during this 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.

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:

- **TDA Updates** – Indicating escalation levels, capacity, infection control, previous week’s performance, breach validation, Fit to Transfer list. Twice weekly conference calls took place. This was also followed by two escalation meetings with NHS England and the Trust Development Authority as a whole health economy. The health economy was challenged to deliver a reduction in Fit To Transfer numbers and deliver a target of below 30 on the Fit To Transfer list. This was not achieved.
- **Discharge Hub** – The daily discharge hub was set up on each site and provided support to Local Authorities and Community. Escalation of themes was provided to the Senior Managers Winter Planning Meeting held on a weekly basis.
- **Weekly Senior Winter Pressures Meeting** – Attended by the Chief Operating Officer and 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 at escalation level 3 or above and involved stakeholders from the Trust, the Clinical Commissioning Groups, the Community Trust, the Area Team and the Local Authorities. If during the day de-escalation did not materialise a further escalation conference call took place at Executive level.

4.1 Integrated Care Services (ICS)

As part of the Health and Social Care Economy Plan, Integrated Care Services (ICS) was set up for patients across Shrewsbury and Atcham, as part of the ATOS workstreams and was intended to be a discharge to assess model. A true discharge to assess model would incorporate a risk assessment of the patients to assess their immediate needs, followed by the patients being discharged with temporary support, whilst full assessments are carried out in the patient’s home or temporary residence. The ICS model did not provide this, however it is intended to move closer to this way of working for 2014/15 and provide this across the whole of Shropshire.

5 WINTER PLAN FUNDING

The Health and Social Care Economy received £4M funding for the Winter Plan.

The Winter Funds were split out as follows:

- 39.94% Telford & Wrekin CCG

- 60.06% Shropshire CCG

These percentages were split as follows:

- £1,241,887 from the CCG provided to SaTH as direct funding (31%)
- Improving Health and Social Care £1,270,779 (31.77%)
- Surge Capacity £1,369,320 (34.23%)

5.1 SaTH's Elements of the Winter Plan was split as follows:

- £1.1M RSH site
- £261K PRH site

The disproportionate split can be explained as follows:

- RSH – The money at RSH was predominantly allocated to two major schemes:
 - Staffing (more escalation/flex beds at RSH site);
 - TCI list outsourced to private provider 5 sessions. This did not come to fruition so the money was used to bring in the endoscopy day ward and additional costs for staffing in DSU at RSH.
- PRH
 - Staffing.

Staffing across both sites was split to cover additional capacity within the Emergency Departments, Acute Medical Units and the staffing of Day Surgery Units 7 days a week and overnight on both sites. Additional money was provided for therapies and clinical services to provide additional weekend cover. This proved successful and ensured that all areas had sufficient staffing to provide safe staffing levels and maintain quality throughout.

The current attached financial model for Winter outlines the initial plan for each site and the reductions to the plan to the eventual allocation of funds from the CCG.

Winter Pressures Costing 13/14		Original Submission		Internal Plan		Revised Internal Plan	
PRH							
Period		WTE	£	WTE	£	WTE	£
Opening 6 beds on Ward 11 (Medical)							
Band 5 Nurse to support ward 11	Dec-Mar (4 mths)	4.48	100,160	4.48	48,152	4.48	48,152
Band 2 Nurse to support ward 11	Dec-Mar (4 mths)	4.48	40,013	4.48	31,816	4.48	31,816
Band 2 Nurse (1:1 nursing)	Oct-Mar (6 mths)	1.53	20,945	1.53	16,654		
Subtotal		10.49	161,117	10.49	96,622	8.96	79,968
A&E/AMU - 7 Day Working							
Medics							
RMO 12 hours per day 7 days per week	Oct-Mar (6 mths)	2.10	202,872				
SHO 1400-2200 Hrs	Oct-Mar (6 mths)	1.40	93,242				
SHO 1500 - 2359 Hrs 7 days per week	Oct-Mar (6 mths)	1.58	104,898				
Middle Grade ED 1500-2100 Hrs 7 days per week	Oct-Mar (6 mths)	1.40	135,248				
SHO Weekend Only 1500 - 2359 Hrs	Oct-Mar (6 mths)			0.45	29,971	0.45	29,971
Middle Grade ED Weekend Ends Only 1500-2100 Hrs	Oct-Mar (6 mths)			0.30	28,982	0.30	28,982
Nursing							
Band 5 Nurse 0900-1700 Hrs	Dec-Mar (4 mths)	1.77	39,563				
Band 5 Nurse 1100 - 2300 Hrs	Dec-Mar (4 mths)	2.65	59,345	2.65	37,939	2.65	37,939
Band 5 Plaster Tech	Dec-Mar (4 mths)	1.19	26,493				
Band 2 HCA 1300 - 2200 Hrs	Dec-Mar (4 mths)	1.99	17,781				
Subtotal		14.07	679,441	3.40	96,891	3.40	96,891
Support Services							
Therapy Plan included in RSH costs			0				
Transfer/Flow Team Band 2	Jan-Mar (3 mths)	2.00	13,660				
Discharge Liaison Nursing Band 6	Oct-Mar (6 mths)	2.24	76,593				
Hospital at Weekend Band 7	Oct-Mar (6 mths)	0.76	28,038				
Support Clinical Services	Oct-Mar (6 mths)	2.00	54,500	1.00	24,549		
Pharmacy Band 6	Oct-Mar (6 mths)	1.00	37,352	1.00	25,000	1.00	25,000
Subtotal		8.00	210,143	2.00	49,549	1.00	25,000
Non Pay							
Clinical Supplies	Dec-Mar (4 mths)		16,422		12,000		12,000
Drugs	Dec-Mar (4 mths)		8,300		6,000		6,000
Facilities	Oct-Mar (6 mths)		10,750				
Subtotal			35,472		18,000		18,000
PRHTotal:		32.57	1,086,173	15.90	261,062	13.36	219,859

The original submission was based on an analysis of the resource the Trust needed to deliver safe care over the winter.

Winter Pressures Costing 13/14							
RSH		Original Submission		Internal Plan		Revised Internal Plan	
Period		WTE	£	WTE	£	WTE	£
Opening 10 Medical Beds on Ward 32 (Medical)							
Band 6 Nurse	Oct-Mar (6 mths)	1.40	35,870	1.40	28,324	1.00	20,231
Band 5 Nurse	Oct-Mar (6 mths)	6.23	213,024	6.23	102,412	6.23	102,412
Band 2 Nurse	Oct-Mar (6 mths)	5.09	69,528	5.09	55,285	4.48	48,660
Band 2 Nurse (1:1 nursing)	Oct-Mar (6 mths)	3.07	41,890				
Subtotal		15.79	360,312	12.72	186,021	11.71	171,302
A&E/AMU - 7 Day Working							
Medics							
RMO 12 hours per day 7 days per week	Oct-Mar (6 mths)	2.10	202,872				
SHO 1200 - 2000 Hrs	Oct-Mar (6 mths)	1.40	93,242	1.40	93,242	1.40	93,242
Middle Grade 1400 - 2200 Hrs	Oct-Mar (6 mths)	1.40	135,248				
1 Consultant Session Weekend only	Oct-Mar (6 mths)	0.20	21,674	0.20	15,405	0.20	15,405
Nursing							
1 x Band 5 1100 - 2300 Hrs	Dec-Mar (4 mths)	2.65	59,345	2.65	37,939	2.65	37,939
1 x Band 2 HCA 1100 - 2300 Hrs	Dec-Mar (4 mths)	2.65	23,707				
Subtotal		10.41	536,088	4.25	146,586	4.25	146,586
Surgery - Creation of 10 Inpatient beds in Daycase Ward (current)							
Daycase (Band 6 Nurse)	Oct-Mar (6 mths)			1.00	16,439	1.00	20,231
Daycase (Band 5 Nurse)	Oct-Mar (6 mths)			7.47	122,796	6.23	102,412
Day Case Band 2	Oct-Mar (6 mths)			4.00	43,446	4.48	48,660
Surgery - Conversion of 10 Daycase beds to Inpatient Beds (further 10 beds)							
Daycase (Band 5 Nurse)	Oct-Mar (6 mths)	4.29	146,689	4.29	70,521		
Day Case Band 2	Oct-Mar (6 mths)	4.29	58,600	4.29	46,596		
Outsourcing to Nuffield 5 sessions per week	Oct-Mar (6 mths)	0.00	399,313		349,313		349,313
Trained nurse band 5 required as part of outsourcing agreement	Oct-Mar (6 mths)	1.19	40,519				
Subtotal		9.77	645,121	21.05	649,110	11.71	520,615
Support Services							
Therapy Plan Annex G-3 Band 6	Oct-Mar (6 mths)	8.00	280,800	4.00	100,000	4.00	100,000
Transfer/Flow Team Band 2	Jan-Mar (3 mths)	2.00	13,660				
Discharge Liaison Nursing Band 6	Oct-Mar (6 mths)	2.24	76,593				
Discharge Liaison Nursing Band 6	Dec-Mar (4 mths)			0.50	7,451	0.50	7,451
Hospital at Weekend Band 7	Oct-Mar (6 mths)	0.76	28,038				
Support Clinical Services	Oct-Mar (6 mths)	2.00	54,500	1.00	27,857	0.40	11,074
Pharmacy Band 6	Oct-Mar (6 mths)	1.00	37,352	1.00	25,000	1.00	25,000
Subtotal		16.00	490,943	6.50	160,308	5.90	143,525
Non Pay							
Clinical Supplies	Oct-Mar (6 mths)		41,860		25,000		25,000
Drugs	Oct-Mar (6 mths)		19,600		15,000		15,000
Facilities	Oct-Mar (6 mths)		10,750				
Subtotal			72,210		40,000		40,000
RSH Total:		51.96	2,104,673	44.52	1,182,024	33.57	1,022,028

6 WHAT WORKED WELL AND WHAT DID NOT?

- 1) SaTH's internal plan was predicated on ensuring that all escalation/surge beds were staffed safely. This was the case. However, there was still too much reliance on the use of bank and agency staff. Recruitment to Winter funded posts needs to commence in June 2014 for all staff groups to be in post by October 2014. This will allow time for training and induction. In planning for this there are opportunities to over recruit in the Summer with newly qualified staff as they come out of University.
- 2) Additional clinical support staff (Therapists and Pharmacists) at weekends were valuable but further analysis of their impact needs to be undertaken in relation to return on investment. Simple discharges increased and length of stay reduced in those patients seen by Therapists at weekends. Patient's treatment plans progressed over the weekends potentially leading to earlier discharge e.g. Monday/Tuesday rather than Wednesday/Thursday. However, if a patient's discharge relied on support from social care or community services; then discharge may not have occurred any sooner. For example, having an occupational therapy service over a weekend facilitated home assessment visits, but if a patient needed access to a care package provided by the local authority this was not available. Reported benefits included

being able to mobilise patients over a weekend and undertake medicine's reconciliation, all of which support quality and safety. More sophisticated analysis needs to be undertaken to inform next year's plan. The functions of additional clinical staff at weekends will need to be reviewed in line with 7 day working clinical standards in preparation for 2014/15's Winter Plan.

- 3) Additional medical cover at weekends also helped to support earlier progression of patient management plans but again unless all services involved in a patient's discharge are available 7 days per week then this investment may not have realised sufficient benefit to warrant this. For example, the Trust needs to be able to report an increase in weekend or Monday discharges. Feedback from Consultants is that having more senior decision makers at weekends improved quality and safety of care. The national directive to move towards 7 day working supports this.

7 NEXT STEPS

In managing predictable events, the winter of 2013/14 should be considered within the wider picture of 'year round pressures planning'. SaTH has demonstrated a desire to improve in order to deliver efficiency and quality. In learning from our experiences, the winter of 2012/13 provided us with an opportunity to move from a reactive to a proactive management and planning process in 2013/14. This hinged on clear leadership and responsibility by all team members throughout the patient pathway. Feedback from staff across the Trust was that this winter "it felt much better". This would be expected to show in a reduction in sickness absence associated with workload pressures in 2013/14 Winter period but it is not possible to correlate this.

Discussions are already underway internally and with our local health economy in preparation for winter 2014/15. Feedback has been given to the Trust Development Authority and NHS England regarding the need to release Winter funding in sufficient time to recruit staff on short term contracts rather than having to rely on expensive agency staff.

As a Health and Social Economy the initial discussions have been centred around ensuring that surge planning for winter is a whole year event and not just for winter. Under discussion are 6 System Objectives with 7 schemes identified as the key deliverables.

7.1 System Objectives

- 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.

7.2 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 we will be focusing this year on the following objectives to support Winter 2014/15 and all year long surge planning to enable the trust to deliver 95% and RTT and Cancer standards:

- Analysis of the clinical PA's per consultant to ensure daily ward rounds, 7 days a week to support discharge practice:
 - Demand and Capacity business case to be presented to Executive Directors in Quarter 1 2014/15.
- Support delivery of 4 Hour Performance:
 - Through modelling of recent demand through A&E / AMU, identify likely assessment and bed base for short stay capacity within an Elderly Care Assessment Unit to support Care Of the Elderly patient flow across the Emergency floor.
 - Development of an Urgent Care Centre on both sites.
 - Development of a Chest Pain Assessment Unit [CPAU].
- Clear roles and responsibilities to deliver Trust and site integrity:
 - In-hours team members i.e. Clinical Directors, Consultants, Centre/Care Group Managers, Matrons, Clinical Site Managers, and Ward Managers with agreed actions to maintain and sustain performance.
- Strengthen out-of-hours processes and clarify Off Site Managers role:
 - On-call and Out of Hours team members i.e. Trust and Site lead responsibilities within the Clinical Site Manager role, On-call Manager, Matron, Exec On-call and On-call physicians will be reviewed.
- Standardising practices across both sites, excepting site anomalies:
 - Intelligent information systems:
 - Live IT Capacity Management System Dashboard with a new Emergency Department IT system.
 - Further develop the discharge hub, providing performance support to each ward for daily achievement to support capacity to match predicted demand.
 - Ensure delivery of pre 1000, 1200 and 1500 hours discharge targets across medicine and surgery.
- Review of bed model to incorporate:
 - Occupied Bed Days [OBD] for medicine and surgery.
 - Occupancy level at 85%.
 - Consideration of Infection Control issues by factoring in historical 3 years lost bed days data due to D&V etc. to provide likely / worse and best case scenario.
- Review escalation plans for each site with the Head of Capacity [HOC],
- Infection Control:
 - Management of closed ward areas with 'lock down' practices to reduce visiting and staff movement is enforced.
 - Clear and appropriate communication channels to the local community.
 - Improved cascade of information for timely cleaning and reopening of closed areas.
 - Focus on training to frontline and ward based staff for screening of all admissions prior to placement to prevent risk of cross infection.
- Staffing shortfalls:
 - Maintain focus on early recruitment in quarter 2 to vacancies.
 - Ensure robust application of the Sickness Policy.
- Improved collaborative practices with local partners:
 - Develop with Local Authorities true discharge to assess models of care, Shropshire with Integrated Care Services and T&WW Reablement.
 - Continued support to Senior Management meetings and the conference calls held by the CCG.
 - Development of a single referral document across the whole health economy working towards a single point of access for all services (health and social).
 - Assess the viability of contracting with local independent providers of care to provide early supported discharge.
- Improvement in weekend phlebotomy services:
 - Inconsistency of service between sites.
- Hospital at Night delivered and funded for weekends recurrently.
- Assess the value of contracting with private providers to facilitate recovery at home (sub-acute stepdown).

8 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.

Whilst SaTH promotes a learning culture, the experience of 2013/14 has again proven difficult with reactive management working alongside robust proactive planning to respond to demand, but more managed and controlled than 2012/13. As a learning and “make it happen” culture winter 2014/15 will be based on the learning from this year.

A paradigm gear shift is now essential to develop the processes necessary to respond to the new financial year and deliver sustainable flow. Local Authorities are planning discharge to assess type models and community providers are willing to work with SaTH to achieve some vertical integration.

Through development of knowledge management and transformation of existing processes, the next steps indicated above can underpin 2014/15 thus enabling the Trust to put quality where it belongs – at the forefront of our agenda.

9 RECOMMENDATIONS

The Board is requested to **RECEIVE** the following recommendations:

- 1) A focus on continuous improvement across urgent care pathways all year round must continue;
- 2) Lessons learnt from winter 2013/14 will be used to inform both our own internal plan and the whole health and social care economy plan for winter 2014/15;
- 3) Baseline reports to be in place prior to the winter to better monitor the impact of winter funding and return on investment;
- 4) Recruitment to winter funded posts to commence in June 2014 with staff in post by October 2014;
- 5) Develop integrated working with Shropshire Community Trust Therapy Services to maximise the benefit to patients both as business as usual, and in planning for surge and/or the Winter.

The Board is requested to **NOTE** that discussions are already underway internally and with the local health and social care economy through the Urgent Care Working Board on the development of surge and Winter planning for 2014/15. Updates with regard to progress will be provided within the Integrated Performance Report alongside a first draft of the Winter Plan when this is available. The Board is also requested to **NOTE** the improvement in performance against the A&E 4 hour standard, across the whole year, but in particular over the Winter period.