The Shrewsbury and Telford Hospital NHS Trust

Paper 9

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| **Recommendation**<br>☐ **DECISION**<br>☑ **NOTE** | **Trust Board is asked to note the content of this report** |
| **Reporting to:** | **Trust Board** |
| **Date** | 27th September |
| **Paper Title** | Winter Plan 2018/19 |
| **Brief Description** | This paper provides a summary of the winter planning process, and the main actions for SATH. There has been a weekly winter planning group at SATH, in order to ensure a whole Trust agreement on priorities, risk and objectives. The broader process has been managed system-wide, through the A&E Delivery Group (AEDG) and System A&E Delivery Board (SAEDB). |
| **Sponsoring Director** | Nigel Lee, Chief Operating Officer |
| **Author(s)** | Sara Biffen, Deputy Chief Operating Officer |
| **Recommended / escalated by** | n/a |
| **Previously considered by** | n/a |
| **Link to strategic objectives** | SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm<br>VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce |
| **Link to Board Assurance Framework** | RR1134 |
| **Equality Impact Assessment** | ◉ **Stage 1 only (no negative impacts identified)**<br>○ **Stage 2 recommended (negative impacts identified)**<br>○ negative impacts have been mitigated<br>○ negative impacts balanced against overall positive impacts |
| **Freedom of Information Act (2000) status** | ◉ **This document is for full publication**<br>○ **This document includes FOIA exempt information**<br>○ **This whole document is exempt under the FOIA** |

The Shrewsbury and Telford Hospital NHS Trust

# Winter Plan
# September 2018

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## 1.0 Introduction

The aim of the Shrewsbury and Telford Hospital (SATH) winter plan is to ensure internal processes, systems and capacity (workforce and beds) are fit for purpose and resilient to meet the anticipated level of demand and maintain and optimise patient safety.

This paper provides a summary of the winter planning process, and the main actions for SATH. There has been a weekly winter planning group at SATH, in order to ensure a whole Trust agreement on priorities, risk and objectives. The broader process has been managed system-wide, through the A&E Delivery Group (AEDG) and System A&E Delivery Board (SAEDB).

National Winter Planning 2018/19 Guidance was issued on 22nd March setting out the requirements for preparing for winter 2018 including information on winter funding 2018/19 and the requirement to produce a winter demand and capacity plan.

Key points from the guidance:

- There will be no additional winter funding in 2018/19 over and above the £2.3 million allocated.
- Systems need to demonstrate that winter plans are embedded in both system and individual organisation operating plans.
- There is a requirement to produce a separate winter demand and capacity plan.
- Winter Plans to include appropriate phasing profiles to reflect seasonal changes in demand, especially related to winter.
- There is a system-wide approach to the winter plans that aligns key assumptions between providers and commissioners which are credible in the round.

SATH attended an NHSE Winter Planning Workshop in April 2018 and there have been two local system wide planning workshops held in July.

An internal winter planning group has been established with representation from all four Care Groups. The aim of the winter planning group is to look at ways we could improve patient flow 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.

## 2.0 Review of winter 2017/18

A review of the winter schemes implemented in 2017/18 was undertaken and Winter Planning – Lessons Learnt (Appendix. 1) was presented to Trust Board in May 2018.

## 3.0 System Winter Plan 2018/19

The A&E Delivery Group (AEDG) has been tasked by the A&E Delivery Board to produce the system winter plan for 2018/19. This year there has been a greater focus on a whole system plan together with working on the six high impact changes which will improve patient flow and ED performance.

The following schemes will be in place to support the system through winter and also to manage surges in demand, which was experienced in winter 2017/18:

Admission avoidance:

- Increase community step up resources
- Carers in a car
- Care home Multi-disciplinary Team

Improve complex discharges:

- Optimise pathway 2 & 3 beds
- Additional pathway 2& 3 beds including EMI
- Appointment of Trusted Assessors in Care homes
- Additional Social work capacity at weekends
- Additional domiciliary care packages.

## 4.0 SATH Operational Plan 2018/19

In order to maintain high quality, kind and safe care within the context of:

- national targets and standards
- workforce constraints
- the financial control total and
- infrastructure challenges

The operational plan for 2018/19 addresses three key ambitions which will support winter resilience:

- Improving patient care and experience
- Reducing our reliance on temporary staffing
- Improving efficiencies and reducing waste

Within these ambitions there are 3 high impact changes which are monitored through the AEDG:

- SAFER
- Stranded patient programme
- ED systems and processes

### 4.1 Implementation of the SAFER programme including Red2Green and Criteria Led Discharge

The management of patient flow is an ongoing and consistent challenge for the Trust, and the majority of acute Trusts in England. During 2017/18 the Trust has made some progress with embedding the Red2Green initiative. The Clinical Programme Lead for SAFER, along with the team of Red2Green Trackers, focuses solely on the delivery of the SAFER Patient Flow Bundle and works with clinicians and managers to reduce non-value added time for patients and work to get them home sooner.

The work to deliver the SAFER programme continues as a priority into 2018/19 with a key focus on setting the clinical criteria for discharge and setting an expected date for discharge (EDD). This is

recognised as a key enabler to reducing the number of beds consumed by the 'stranded patient' cohort.

4.2 Stranded Patient Programme

We already know that the greatest opportunity to reduce bed days is by focusing on the 'stranded patients'. Since January 2018 a programme of work has been undertaken to reduce the number of patients within our hospitals that have a length of stay greater than 7 days. The programme of work focuses upon both prevention of stranded patients via early identification and case management of patients using tools developed by the Emergency Care Intensive Support Team (ECIST). Reducing length of stay for 'stranded patients' will reduce the number of bed days consumed. The work that has been undertaken since January 2018 has demonstrated a reduction in the number of bed days consumed by stranded patients and has resulted in the reduction in the number of beds open. Addressing the 'stranded' patient cohort will also enable a reduction in the bed occupancy rate. The aim is to reduce this to 92%, enabling capacity to match variation in demand and improve the flow of patients to wards and assessment areas from ED. There are two months where historically there has been a peak in the number of stranded patients October and January. The plan to manage this surge in demand is as follows

- Frailty Phase 2 focusing metrics on early goal setting
- setting clinical criteria for discharge at the front door
- Review stroke LOS (Ward 15 + 16) – national guidance
- Implement findings from 6 As audit
- Redesign discharge hub around pathways

Additional capacity has been sourced over the winter period for independent sector step down beds which will support the earlier transfer of patients.

4.3 ED systems and processes

Over the past 12 months there have been several external reviews of the systems and processes within both of our EDs. This has resulted in several key actions needing to be undertaken; e.g. the use of both Clinical Decisions Units (CDU), the streaming process at the front door of each ED and the role of the ED coordinator.

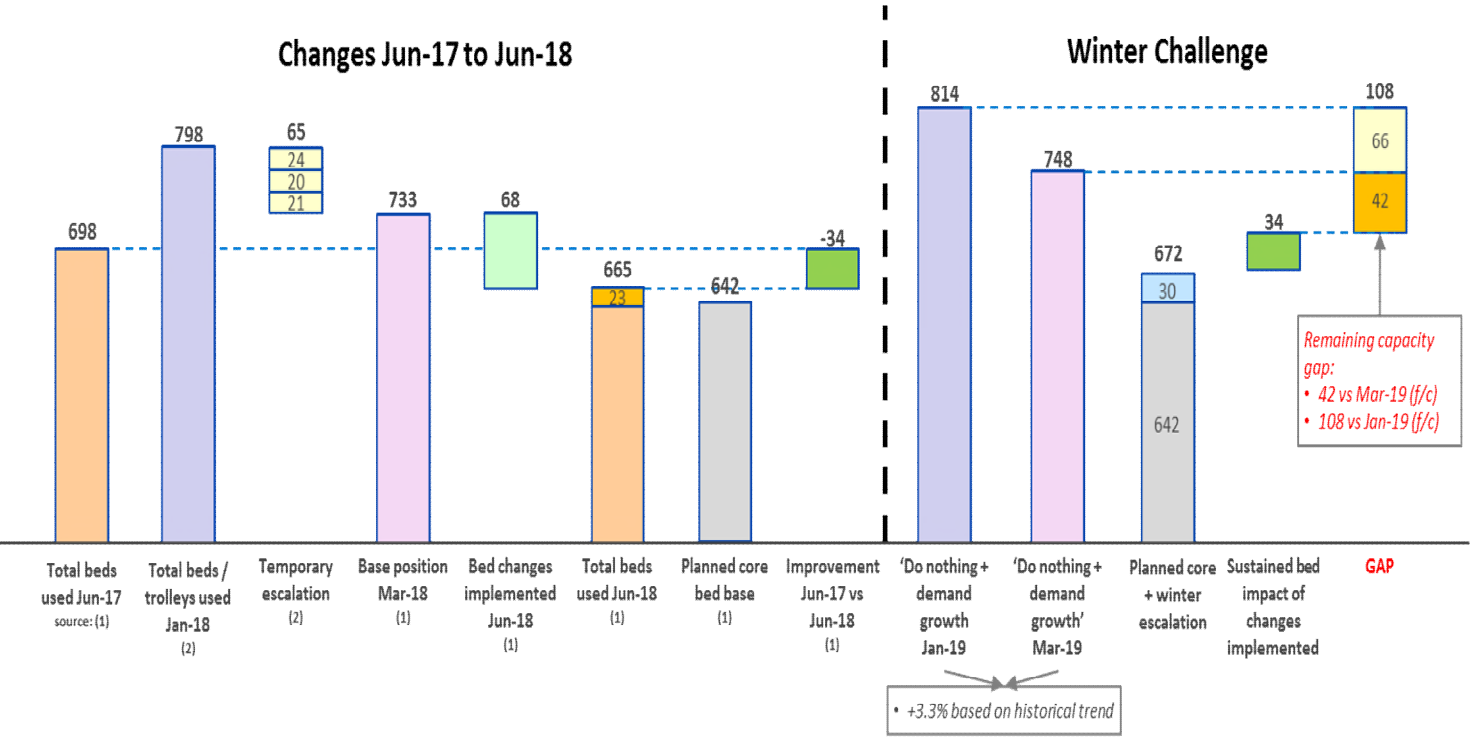
All of the above objectives are monitored at the weekly Urgent Care Programme group and the A&E Delivery Group.

## 5.0 Bed capacity required for winter

The diagram below aims to describe the basis on which a bed capacity requirement has been calculated. The left hand side of the diagram provides the actual number of beds reported in use at key points in the year. The right hand side of the diagram describes forecast demand scenarios (including growth) and the associated bed gap which the winter plan needs to address.

The winter forecast shows the total additional capacity required:

- To meet the peak (January 2019) of 814 requires an additional 172 beds against the core bed base of 642 beds. The 'peak' represents the maximum declared number of beds and includes additional patients on wards and other pressures However, the number of stranded patients has reduced by 100 and therefore the March demand would seem to be the most reasonable assumption.
- To meet the March 2019 demand of 748 requires an additional 105 beds against the core bed base of 642
- The March level represents the 'average' winter position. Forecast growth has been added to these figures. In addition, the June 2018 bed position was compared to June 2017 to calculate the impact (benefit) of the stranded patient reduction.
- At its peak the number of stranded patients was circa 350.



The table below details the schemes and interventions which will be in place to close the bed gap through winter 2018/19:

| Intervention | Acute bed impact | | Example intervention |
|---|---|---|---|
| | RSH | PRH | |
| | Plan for peak | Plan for peak | |
| **1. Avoid acute admissions** | 13.8 | 13.6 | • Increase community step up resources<br>• Frailty front door<br>• More effective ED streaming to UCC<br>• Carers in a Car<br>• Care Home MDT |
| **2. Improve / maintain acute flow** | 52.4 | 14.6 | • Stranded patient reduction trajectory<br>• Twilight capacity in AMU/SAU/AEC<br>• Discharge lounges/discharge before midday<br>• Community IV antibiotics service |
| **3. Complex discharges**<br>Maintain the MFFD list at the current c67 patients to avoid winter peak c112 | 5.2 | 4.3 | • Optimise community P2 and P3 bed usage and reduce LOS to av. 17 days<br>• System wide new Choice Policy<br>• Additional P2 and P3 capacity (vs. winter 17/18) inc EMI<br>• Releasing domiciliary care capacity to support P1 discharges<br>• Additional social work capacity (weekends, CHC assessments)<br>• Trusted Assessor Care Homes |
| **4. Increase acute capacity** | 46 | 38 | • Planned winter capacity (RSH ward 21, PRH ward 8)<br>• 30 escalation beds (funded from NHSI capital)<br>• DSU Escalation beds |
| **Total** | 117.4 | 70.5 | |
| **Forecast capacity requirements** | 82 | 83 | |
| **Remaining gap** | **35.4** | **-12.5** | |

As indicated in the table above there is still a gap of 12.5 beds during peak demand (January) on the PRH site. The escalation ward which is funded through NHSI capital monies will be on line in January and therefore will bridge the gap. However this will be subject to staffing availability and funding confirmed.

There are a number of key risks which have been identified which will impact on winter:

- Workforce availablity (including sickness increase);
- Activity exceeding planned capacity;
- Unprecedented impact from Flu;
- Higher levels of infection resulting in closed wards
- Adverse Weather
- Failure to deliver the complex discharge target on each site
- Lack of Frailty scheme at PRH.
- Stranded patients exceed current levels

All of the above risks have been added to the A&EDB risk register and SATH risk register.

## 6.0 Winter Funding

The winter funding for 2018/19 is £2.3m. The following areas/schemes will be funded within this allocation and the detailed costs are listed at Appendix 2

| Scheme | Number of beds |
|---|---|
| Ward 8 | 14 |
| Ward 27 | 16 |
| Escalation ward (NHSI capital funding) | 30 |
| DSU @ PRH | 24 |
| **Subtotal beds** | **84** |
| Ambulatory care – GPs | To avoid admissions |
| Weekend discharge doctors | Increase level of discharges |
| Ambulatory care twilight shifts | To support ambulatory clinic |

## 7.0 Next Steps

- Finalise and endorse the list of system schemes based on available funding at the (SAEDB)
- Identify a contingency set of schemes in the event of additional national funding
- Focus on recruitment of key staff both substantive and bank in order to support winter capacity
- Implement the additional the ward capacity supported by the national capital funding

The Quality and Safety Committee is asked to note the contents of the winter plan paper, and the key risks associated with the plan and the interrelationships/interdependencies of the system schemes.

The Shrewsbury and Telford Hospital NHS Trust

**Appendix 1**

# Review of SATH Winter plan 2017/18

Proud To Care
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## 1.0 Introduction

This paper provides an update to the Trust Board on the success of Shrewsbury and Telford Hospitals NHS Trust (SATH) Winter Plan 2017/18, during a very challenging winter within the NHS. The paper details the schemes and key enablers that were put in place; the impact that the schemes realised and the next steps to plan for Winter 2018/19.

## 2.0 Background

As part of SaTH's operational plan in 2017/18 there were a set of key internal actions and programmes of work that needed to be in place, in order to maintain high quality and safe care and support winter resilience from November 2017 to March 2018.

The key actions were as follows;

- Reconfiguration of the bed base
- Implementation of SAFER (Red2Green)
- SaTH2Home
- Clinical Decisions Unit (CDU) at PRH

In addition to the above schemes, key enablers were required in order to release bed capacity and facilitate timely discharge;

- Discharge Lounge
- Ambulance handover nursing support
- Weekend discharge teams
- Frailty front door service

As part of the system wide plan, external schemes were put in place to avoid admission to an acute bed base and support patients in their own homes.

- GP Primary Care Streaming at PRH
- 10 admission avoidance beds
- 20 discharge to assess beds
- 7 day brokerage service
- 4 extra care beds in Shrewsbury
- Hospital Activity Liaisons Officer (HALO) to avoid unnecessary handover delays

## 3.0 Internal Schemes and key enablers

### Bed reconfiguration

The reconfiguration of the bed base between scheduled care and unscheduled care was to ensure the right number of beds were available within medicine to support the increased demand throughout winter. Although there was an increase in the core bed stock for medicine this did not stop further outlying of patients on the surgical wards due to demand exceeding capacity.

**SAFER (Red2Green)**

There have been significant challenges in embedding the SAFER principle and therefore achieve the pre 10am and 12 midday discharges that were required to maintain patient flow. Significant workforce constraints has restricted the roll out progress, however going forward the SAFER methodology will form part of the respiratory value stream roll out programme. During winter, performance against this metric was 17% of discharges before midday against a standard of 33%.

**SATH2Home**

The above scheme has been successful in working with our local authorities to ensure that patients are returning home with packages of care much quicker than in previous years. The key constraint with the scheme is the geographical coverage across Shropshire and Telford and Wrekin as it restricted to certain postcodes, however further work is being undertaken with a view to expanding the service. On average between November and March 22 patients per week went home with SATH2Home provision. An analysis is detailed below.

- **655** total discharges facilitated
- **22** on average per week
    - **12** with SaTH2Home care
    - **10** with SaTH2Home intervention (care not req.)
- **2** days average care for bridging patients
- **5** days average care for enhanced discharge patients

**Clinical Decisions Unit**

The Clinical Decisions Unit (CDU) opened on 4th April 2018, due to unforeseen delays with the building works. Therefore we were unable to stream patients from the emergency department to avoid admission and create cubicle capacity.

**3.1 Key enablers**

**Discharge lounge**

There is a well-established and utilised discharge lounge on the PRH which supports wards to improve patient flow. On a daily basis approximately 20 patients are transferred to the discharge lounge before midday thus creating flow form the emergency department. To support winter a discharge lounge was established on the RSH site adjacent to ward 32. The discharge lounge was open 7 days per week between 9am and 9pm and could accommodate up to 30 patients per day. Utilisation of this area was between 45% and 50% per day and therefore did not realise its full potential. Further options are being scoped to look at alternative settings for the discharge in preparation for winter 2018/19. A discharge lounge is fundamental to support the pre 10 am and pre midday discharges.

**Ambulance handover nursing support**

Both sites had additional nurses within the Emergency Departments (EDs) to support the timely handover of ambulances. This ensured that offload times were within the standard and demonstrated a reduction in ambulance handover delays from the previous year.

The table below demonstrates the improvement from the previous winter.

| | Nov 16 to Mar 17 | Nov 17 to Mar 18 | Variance | % Improvement |
|---|---|---|---|---|
| SATH Ambulance handover 15 minutes | 10078 | 8922 | -1156 | 11.5% |

**Weekend Discharge team**

Weekend discharge teams comprised of additional doctors, supported by therapies, pharmacy and phlebotomy. The purpose of the team was to increase the number of discharges over the weekend, in order to improve flow from the emergency departments and create additional bed capacity to manage surges in activity. The full benefit of the weekend discharge teams was not realised, because frequently they were covering medical vacancies and sickness within the acute medical team. However, if they had not been in place then discharges at the weekend would have not been at the level that was achieved.

**Frailty service**

A frailty service was implemented in November 2017 on the RSH site, working within a multi-disciplinary team to prevent admissions and to reduce the length of stay for those patients. Since its implementation there have been 92 fewer admissions per month and a reduction in length of stay in the >75 age group.

**Stranded patient metric**

The Emergency Care Improvement Programme (ECIP) defines stranded patients as those with a length of stay of seven days or more. In December 2017, there were 350 patients in SaTH with a length of stay greater than 7 days. A review of these patients was undertaken to understand what they were waiting in hospital for, and could we expedite their medical plan and reduce their length of stay and ultimately get them back home. This work was undertaken with our system partners and the table below identifies the significant improvement that has been made to reduce the number of patients in hospital with a length of stay of 7 days or more.

| Hospital | Base Position Dec 17 | 02/04/2018 | 09/04/2018 | 16/04/2018 | 23/04/2018 | 30/04/2018 | 07/05/2018 | 14/05/2018 | 21/05/2018 | 28/05/2018 |
|---|---|---|---|---|---|---|---|---|---|---|
| RSH | 185 | 180 | 175 | 170 | 165 | 155 | 145 | 140 | 135 | 125 |
| PRH | 165 | 145 | 140 | 135 | 130 | 125 | 120 | 110 | 105 | 100 |
| Total Target | 350 | **325** | **315** | **305** | **295** | **280** | **265** | **250** | **240** | **225** |
| Actual Number of patients >7 days | | **317** | **306** | **290** | **283** | **274** | **248** | **244** | | |

## 4.0 Key Challenges

Emergency admissions at both hospitals over the winter period 2017/18, exceeded capacity within the core bed base and therefore additional capacity was opened within our day surgery units. Additional patients were placed on wards in accordance with the Hospital Full Protocol (HFP) to reduce the pressure within the Emergency Departments (ED). There were 57 12 hour trolley waits between

November 2017 and March 2018, 30 of which happened in January 2018. Further challenges were faced with the adverse weather conditions in December and January which had an impact on staffing levels across wards and departments.

The Trust received a national directive from the Emergency planning team to cancel all routine elective activity (inpatients, daycases and outpatients) to free up workforce resource to support patient flow and create bed capacity to accommodate admissions. This impacted on the year end 18 week Referral to Treatment (RTT) performance and the Trust ended the year with performance at 91.3% against a national target of 92%.

## 5.0 Next steps

The Trust together with system partners has undertaken a review of winter 2017/18 in April 2018. It was a very challenging winter and whilst some of the schemes provided benefits, the impact was limited. The next steps are to take the learning from 2017/18 and work with our system partners to produce a fully integrated system plan. Further workshops are planned in June and July 2018 and the System Winter plan will be presented to the A&E Delivery Board in September 2018.

## 6.0 Recommendation

The Trust Board is asked to note the contents of the update paper, and the further actions that are being undertaken in preparation for winter 2018

The Shrewsbury and Telford Hospital NHS Trust

**Appendix 2**

# SaTH Prioritised Winter Schemes 2018/19 @ 23rd July 2018

| | | Start | End | £,000 Pay | Non-Pay | Income | Total | Capital | |
|---|---|---|---|---|---|---|---|---|---|
| **Already Committed by Commissioners / Costs Being Incurred** | | | | | | | | | |
| USC | Handover Nurses - A&E | 01/04/2018 | 31/03/2019 | 528 | | | 528 | | |
| **Proposed Additional Future Costs** | | | | | | | | | |
| **Priority 1** | | | | | | | | | |
| USC | Ward 8 - 14 beds | 01/12/2018 | 31/03/2019 | 508 | 24 | | 532 | | £2.8m |
| USC | Ward 21 - 16 beds | 01/12/2018 | 31/03/2019 | 505 | 24 | | 529 | | |
| USC | AMU Twilight Shift Nursing | 01/12/2018 | 31/03/2019 | 111 | 0 | | 111 | | |
| USC | Ambulatory Care GPs | 01/10/2018 | 31/03/2019 | 133 | 0 | | 133 | | |
| USC | Twilight Shift in SAU | 01/12/2018 | 31/03/2019 | 121 | 0 | | 121 | | |
| SC | DSU escalation at RSH - 20 beds | 26/12/2018 | 31/03/2019 | 450 | 13 | | 463 | | |
| SC | DSU escalation at PRH - 24 beds | 26/12/2018 | 31/03/2019 | 381 | 13 | | 394 | | |
| SC | Additional Beds and Mattresses | 01/12/2018 | 31/03/2019 | | 25 | | 25 | | |
| | | | | 2,209 | 99 | 0 | 2,307 | 0 | |

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|---|---|---|---|---|---|---|---|---|
| **Priority 2** | | | | | | | | |
| USC | Weekend Consultant & Junior Medic Cover | 01/10/2018 | 31/03/2019 | 83 | | | 83 | |
| | | | | 83 | 0 | 0 | 83 | 0 |
| **Priority 3** | | | | | | | | |
| USC | Frailty service at PRH | 01/10/2018 | 31/03/2019 | 321 | | | 321 | |
| Corp | Additional CSM / DLN | 01/10/2018 | 31/03/2019 | 152 | | | 152 | |
| | | | | 473 | 0 | 0 | 473 | 0 |
| **Priority 4** | | | | | | | | |
| USC | CDU -extension of current area | 01/10/2018 | 31/03/2019 | 123 | 18 | | 141 | 50 |
| USC | Ambulatory Care - shortfall in current workforce requirements | 01/10/2018 | 31/03/2019 | 235 | | | 235 | |
| USC | Twilight Registrar | 01/10/2018 | 31/03/2019 | 83 | | | 83 | |
| USC/SC | Discharge Lounge RSH | 01/10/2018 | 31/03/2019 | 91 | | | 91 | |
| USC/SC | Discharge Lounge PRH | 01/10/2018 | 31/03/2019 | 65 | | | 65 | |
| | | | | 598 | 18 | 0 | 616 | 50 |
| P1-4 | Total | | | 3,362 | 117 | 0 | 3,479 | 50 |