SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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EXECUTIVE SUMMARY

REPORT TO THE COUNCIL OF GOVERNORS

HELD ON TUESDAY 22ND OCTOBER 2013

Subject:	WINTER PLANNING
Supporting Director:	Director of Strategy and Operations
Author:	Chief Operating Officer
Status (see footnote):	N

PURPOSE OF THE REPORT:

This paper provides the Council of Governors with the final agreed actions to mitigate the impact of winter pressures on the quality of services and the delivery of the Trust's key operational objectives.

KEY POINTS:

This paper provides final detail on the key issues which have been identified during the TEG discussions on sustaining the delivery of high levels of patient experience during winter planning for winter 2013/ 2014:

1. Winter Bed Capacity:
    - In Patient
    - Primary and Community Services
2. Professional Services
3. Recruitment

To ensure robust arrangements are in place to mitigate the Trust wide impact of increases in Accident and Emergency attendances, non elective admissions and special cause events during the 2013/ 2014 winter period.

IMPLICATIONS:

		TICK AS APPROPORIATE
1	Deliver the best clinical outcomes	√
2	Provide patient centred services	√
3	Employ caring and cared for staff	√
4	Spend public money wisely	√
5	Deliver excellent research, education & innovation	

APPROVAL PROCESS:

Meeting	Presented	Approved	Date
TEG	CN/COO	X	7th August 2013
TEG	CN/COO	X	28th August 2013
TEG	DSO		2nd October 2013

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the five aims of the STHFT Corporate Strategy 2012-2017

1.0 Introduction

Following discussions on the key issues related to the expected increase in admissions to Acute and Elderly Medicine at Trust Executive Group (TEG) meetings and with Care Groups, final plans have now been developed to conclude the Trust's internal winter planning process.

2.0 Demand and Capacity

2.1 Demand

Although the demand for admission, and subsequently discharge from Acute and Elderly Medicine is an unknown quantity, an assessment of the potential demand and subsequent bed requirements has been undertaken based upon a 10% increase in admissions on winter 2012/ 2013, combined with a 1 day reduction in average length of stay at discharge compared to 2012/ 2013. The results of this assessment are identified in appendix 1. The 1 day reduction in length of stay at discharge reflects a reasonable expectation that the additional investment in Primary and Community services should translate into improvements in patient flow through winter 2013/ 14.

This work illustrates that maintaining flow and appropriate length of stay in the Community Capacity and Acute and Elderly Care wards is crucial to the success of the winter plan and the quality of care and performance through winter.

2.2 Capacity

2.2.1 Primary and Community Care

Primary and Community Services have had a number of service improvement projects underway which are focussed on ensuring pathways are as efficient as possible in readiness for this winter. Some services have also received investment through the Right First Time Programme. To try to ensure high quality services, a mixture of community packages, community beds and inpatient beds have been agreed:

- District Nursing; investment to increase capacity during core hours 0800 – 2200 seven days per week.
- Provision of the ability to care for up to 6 people a week receiving 24 hour care at home for up to 3 days (whilst assessments and packages of care are put into place).
- Active recovery programme; the redesign of CICS and STIT services.
- Increased Community Intermediate Care packages – 10 per week.
- Introduction of the Early Supported Discharge for stroke patients.
- Development of the Single Point of Access (SPA) function 24/7 including the merger of SPA and Bed Bureau.
- Expanded FDRT will support A+E and the Frailty Unit through winter.
- Increased resilience of provision of care in the community at night.

To manage the presentation of the likely demands additional community beds will be phased in through winter:

- 15 additional recurrent Intermediate Care Beds with wrap around services will begin to be introduced in October to complete the overall 31 bed expansion agreed through *Right First Time (RFT).*
- 46 off site winter beds will be phased in between November and December to deliver transitional care to patients who are medically fit and no longer have an acute or intermediate care need.
- Revised long term care system (Home of Choice replacement) was introduced in September.

At the point all of the beds open there will be 61 additional beds available. This would be a 45% increase upon the community bed base which was available at 1 October 2013.

Financial Implications

Following discussions with Sheffield CCG, funding has been made available via the Right First Time Programme and the Trust's internal financial arrangements to support the recurrent investments.

Non recurrent investments will be supported from the slippage on recurrent programmes in Primary and Community Care and within Sheffield CCG:

27 re-ablement beds	£466.3K
19 respite beds	£213.7k
Total	£680k

2.2.2 NGH Inpatient Capacity:

To manage the likely demand for inpatient medical beds, existing and unstaffed capacity will be made available to Acute and Elderly Medicine subject to appropriate staffing levels being available through recruitment, NHS Professional and Overtime payments:

Acute and Elderly Medicine

- Huntsman 5 will remain open throughout the winter period providing 32 beds (already in use).

- 13 beds on Vickers 1 will be available to Acute and Emergency Medicine from 6 January 2014.

Surgical Specialties

- 18 beds on Huntsman 2 will transfer to Acute and Elderly Medicine from 2 December 2013.

- Gastroenterology admissions to NGH will be assessed in the Surgical Assessment Centre.

South Yorkshire Regional Services

- 6 beds on Firth 2 will transfer to Acute and Elderly Medicine from the 2 December 2013.

Unallocated/ Unstaffed Beds

- Unallocated/ Unstaffed beds will be available on:
    - Chesterman 2 8 beds
    - Chesterman 3 3 beds
    - Chesterman 4 4 beds
    - Renal F 4 beds
- Once the orthopaedic arthroplasty service transfers to RHH on 4 November 2013 a further 16 beds will be released to maintain elective activity, or at the peaks of winter pressures to manage the demand for outlying beds.

Financial Principles for STH in patient Beds

Following discussion with General Managers the financial principles underpinning the use of the inpatient beds will be:

- Acute and elderly Medicine will receive the full tariff (i.e. make good the 70% MRET loss) for activity.
- With full tariff income Acute and Elderly Medicine will be expected to meet the ward, medical staff and other costs required to treat the admitted patients.
- There will be no change to outlier charges.
- Where a transfer of beds is planned, e.g. Firth 2 or Huntsman 2, the beds will be charged to Acute and elderly Medicine via a budget transfer at cost rather than outlier charges.

2.2.3 Capacity v Demand

At the point at which all of the beds are in use by Acute and Elderly Medicine this would be:

- 69 additional beds above the expected 2013/ 2014 baseline.
- 37 beds designated as Acute and Elderly Medicine beds above the September baseline;

  Vickers 1, Huntsman 2, Firth 2

- 35 additional beds to manage any demand for outlying beds (it should be noted that 22 unstaffed beds have been in use at times during 2013/ 2014):

C2, C3, C4, RUF and Orthopaedics post transfer.

To mitigate against the risks of outlying, all Directorates in Acute and Elderly Medicine have agreed to take specific actions:

- Board rounds and morning ward rounds
- Increase rapid access services
- Maximise the benefits of the new bed management systems
- Maximise the use of estimated date of discharge and increased use of patient centre
- Focus on delayed transfers of care
- Develop seven day working to improve weekend cover and increased weekend discharges with proposals to Sheffield CCG by 4 October 2013
- Develop nurse led discharges with proposals requiring financial support to Sheffield CCG by 4 October 2013
- Develop a proposal for presentation to Sheffield CCG by 4 October 2013 for the utilisation of patient flow nurses to support the proactive management of length of stay
- Ensure robust arrangements are in place to proactively manage and utilise RHH capacity

Following the Emergency Care Intensive Support Team (ECIST) visit to the Trust on Wednesday 18 September 2013, specific work is required to:

- Establish a proposal for the management of the Medical Assessment Units
- Expand the use of CDU to maximise ambulatory care services
- Develop comprehensive plans to manage a 1 day reduction in the monthly Length of Stay at Discharge when compared to 2012/ 2013
- Develop specific plans to manage admissions and discharges during the half term periods.

3.0 Winter Viruses

The lessons learnt from winter 2012/ 2013 have been used to inform winter planning for 2013/ 2014 and actions via the Trust Winter Planning group are well underway. Specific actions are required:

- Achieve a 75% uptake of the flu vaccination programme to front line staff
- Finalise the flu capacity plan utilising ward J2 at RHH. This requires the work on the centralisation of the pre assessment programme to be completed by 2 December 2013

- Specific action is required through Sheffield Clinical Commissioning Groups (SCCGs) winter planning groups to ensure Infection Control Procedures are in place in Community Services, particularly the Intermediate Care and Transitional beds

- Specific action is required through SCCGs winter planning groups to ensure an appropriate flu campaign is in place in Nursing and Residential Care facilities.

4.0 Professional Services

During winter 2012/ 2013 professional services utilised agency staff to cover a number of areas supporting inpatient services; primarily physiotherapy, occupational therapy, pharmacy and imaging. These services have little or no opportunity to avoid additional staffing costs being incurred at agency rates which adds a non added value cost and as a result a number of proposals have been presented to Business Planning Team for consideration. As a result it is proposed to forward specific proposals to SCCG for winter funding to support:

- Pharmacy services to winter beds £ 98,443

- Therapy Services to FDRT £ 87,877

With further proposals around additional pharmacy and imaging support to be forwarded to SCCG by the 4 October 2013.

5.0 Recruitment

To support the level of recruitment needed to ensure a reasonably robust staffing model, specific actions need to be taken to deal with any remaining issues from the vacancy control process and from the additional winter investments. Additional HR support will be in place to support recruitment:

		Mid point	Total £ (4 months)
Band 5	2wte	£30,050	£20,333
Band 3	4wte	£21,335	£28,447
Band 2	1wte	£18,918	£4,730
Total	7wte		£53,510

6.0 Sheffield Clinical Commissioning Group

Following initial discussions with Sheffield Clinical Commissioning Group it has become apparent that some non recurrent winter monies may be available for specific programmes of work which will impact upon quality and performance through winter. As a result Care Groups have been asked to develop short proposals to support:

- Patient flow nurses – Acute and Elderly Medicine
- Pharmacy Support to Huntsman 5
- Seven day cover in Geriatric and Stroke Medicine
- Additional Therapy support to FDRT
- Additional weekend pharmacy cover
- Additional Therapy Services
- Band 7 Radiographer
- Targeted work on frequent admissions (more than 6 admissions in 12 months – currently 750 patients)
- Targeted work on frequent attenders at A+E (more than 2 attendances in a month – currently)

7.0 Meeting Structure

In order to effectively manage the key issues which will have the greatest impact upon winter performance key meetings are in place:

- Nurse Directors Length of Stay meeting - Monday
  Purpose – to manage the delivery of the planned Estimated Dates of Delivery and Length of Stay exceptions

- Health Community Delayed Transfers of Care meeting - Tuesday
  Purpose - to manage the delivery of reductions in delayed transfers of care and the delivery of relevant key performance indicators

- Right First Time Programme Delivery - Wednesday
  Purpose – To manage the delivery of the key performance indicators relating to patient flow through the new re-ablement pathways

- STH Winter Planning meeting - Monthly
  Purpose – To manage the issues associated to the delivery of all aspects of the winter plan.

- Urgent Care Board – Bi monthly
  Purpose – To support the Health Communities delivery of winter performance

- Health Community Winter Planning Meeting - Monthly
  Purpose – To manage the co-ordination of the Health Communities Winter Plans.

8.0 Risks

The most significant risks associated to the commissioning of the described additional capacity are:

- Inability to maintain safe staffing levels*
- Inability to recruit key staff *
- Prolonged periods of winter viruses
- Prolonged periods of adverse weather
- Inability to establish a model for the medical assessment centres.
- Admissions exceeding projected demand >10% on 2012/ 2013
- Admissions at much lower levels than expected <2012/ 2013
- Demand within the new reablement pathway (replacement of HOC) is unknown and may exceed intermediate care beds available
- Demand in primary and community services exceeds capacity available and waiting times increase
- Infection control policies and procedures in community services
- Variations in average length of stay producing variations in bed occupancy

Specific actions to mitigate each risk are in place within this plan, and as part of the normal winter planning arrangements.

*Further papers will be presented to Trust Executive Group on Safer Nursing Care within Acute and Elderly Medicine.

9.0 Benefits

The most significant benefits of committing to the capacity plans described in this paper are the impact of the proposals on Acute and elderly Medicine's ability to better manage flow and lower lengths of stay.

If successful, the impact upon other specialties and the Trust's overall performance through winter and into 2014/ 2015 is likely to be significantly improved.

10.0 Conclusions

The success of the winter plan and the foundations that a successful winter period would have for the Trust cannot be underestimated, but the greatest impact will be upon

- Quality of patient care
- Staff engagement

- Regulatory status – CQC and Monitor compliance
- Overall performance against national and local contract standards; 18 weeks, A+E, Cancer, Infection Prevention and Control, CQUINs.
- Financial performance; direct and indirect costs associated to correcting underperformance.

The actions identified in this paper should lead to significant improvements upon the quality of care and performance levels achieved during winter 2012/ 2013.

11.0 Recommendations

The Council of Governors is asked to note the implementation of the actions necessary to complete preparations for winter 2013/ 2014.

APPENDIX 1

2012/ 2013 Discharges + 10% Increase at 2012/ 2013 Length of Stay minus 1 day to reflect increased community capacity and new re-ablement pathways. Gastroenterology is model at 10% and Dr Fosters or less.

	GERIATRIC AND STROKE MEDICINE				
MONTH	**AVLOS (-1 DAY OR Dr Fosters AV)**	**BED BASE**	**DISCHARGES (+10%)**	**REQ BEDS**	**OUTLIERS**
OCT	12.8	282	608	251	
NOV	12.1	282	517	202	
DEC	12.8	282	560	231	
JAN	15.6	282	556	280	
FEB	16.5	282	535	285	-3
MAR	14.3	282	546	252	
APR	16.7	282	601	324	-42
AVE					

	RESPIRATORY				
MONTH	**AVLOS (-1 DAY OR Dr Fosters AV)**	**BED BASE**	**DISCHARGES (+10%)**	**REQ BEDS**	**OUTLIERS**
OCT	7.7	131	513	127	
NOV	7.8	131	523	132	-1
DEC	6.8	131	600	132	-1
JAN	7.3	131	673	158	-27
FEB	9.4	131	616	187	-56
MAR	6.9	131	691	154	-23
APR	7.8	131	624	157	-26
AVE					

	DIABETES AND ENDOCINOLOGY				
MONTH	**AVLOS (-1 DAY OR Dr Fosters AV)**	**BED BASE**	**DISCHARGES (+10%)**	**REQ BEDS**	**OUTLIERS**
OCT	8.5	71	270	74	-3
NOV	10.3	71	259	86	-15
DEC	8.9	71	338	97	-26
JAN	9.7	71	317	99	-28
FEB	11	71	292	104	-33
MAR	9.4	71	305	92	-21
APR	9.2	71	307	91	-20
AVE					

	GASTROENTEROLOGY				
MONTH	**AVLOS (-1 DAY OR Dr Fosters AV)**	**BED BASE**	**DISCHARGES (+10%)**	**REQ BEDS**	**OUTLIERS**
OCT	6.3	64	409	83	-19
NOV	7.1	64	366	84	-20
DEC	6.4	64	331	68	-4
JAN	6.8	64	317	70	-6
FEB	7.2	64	290	67	-3
MAR	7.2	64	312	72	-8
APR	7.2	64	322	75	-11
AVE					

	WINTER CAPACITY PLAN				
MONTH	**TOTAL OUTLIERS**	**COMMUNITY CAPACITY**	**INPATIENT CAPACITY**	**REALLOCATED BEDS**	**PLUS/MINUS BEDS**
OCT	-22	15			-7
NOV	-35	42			7
DEC	-31	61		24	54
JAN	-61	61	13	24	24
FEB	-95	61	13	24	-10
MAR	-53	61	13	24	32
APR	-99	61	13	24	-14
					*minus = outliers