Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Winter Pressures	**Date:** 18 April 2018	
Prepared By:	Denise Smith, Deputy Chief Operating Officer		
Approved By:	Simon Barton, Chief Operating Officer		
Presented By:	Simon Barton, Chief Operating Officer		
Purpose			
To provide an update on the current winter pressures and actions in place to manage these together with a summary of the winter debrief arrangements		**Approval**	
		Assurance	
		Update	x
		Consider	

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
x				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	x
Patient Impact	x
Staff Impact	x
Services	x
Reputational	x

Committees/groups where this item has been presented before

None

Executive Summary

The Trust, along with the rest of the NHS, has seen significant winter pressures on its hospitals due to increases in the acuity of admissions over the winter. This has had a detrimental impact on performance against the emergency access standards.

Four root causes of underperformance have been identified together with the actions required to bridge the gap between demand and capacity. The root causes are as follows:

(i) Medical assessment capacity – capacity on EAU reduce in May 2017 from 52 beds to 40 beds due to nurse staffing constraints.
(ii) Internal inpatient capacity – due to nurse staffing constraints the winter plan provided for less medical beds than in previous years and was predicated on an outlier plan rather than the creation of an additional medical ward. In addition, there is an imbalance in weekend demand and capacity as admissions do not materially reduce at weekends but the number of discharges drops to 50% - 60% of the weekday rate
(iii) External capacity – there have been a number of bed closures to external capacity since last winter this has led to an increase in delayed transfers of care
(iv) Early discharges - the number of discharges before noon is improving at 25% but is still not at the desired level

Sherwood Forest Hospitals
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WINTER PRESSURES &
IMPROVING ACCESS TO URGENT AND EMERGENCY CARE FOR PATIENTS

MARCH 2018

1. Introduction

This paper provides an update on the current winter pressures and actions being taken to manage these in order to maintain flow and patient safety. It should be read in conjunction with the SOF exception report on Emergency Care that provides an overview of the more general improvement work. In addition, the paper provides an outline of the winter debrief arrangements and a desktop summary of the winter plan to date.

2. Performance

The Trust has seen a marginal deterioration in performance against the four hour standard with total Trust performance at 88.8%% in March 2018 compared to 89% in February 2018. However, the Trust has seen a month on month improvement in performance at Kings Mill Hospital since December 2018.

March 2018 – Emergency Care System performance		
All Type Performance: **88.8% ⇔** (Previous month 89%) (Year to date 92.3%)	% of attends to Majors/Resus **53% ⇔** (Previous month – 54%) (Year to date – 49%)	Bed Occupancy **98%** (Medical beds, all sites)
Discharges pre-noon (KMH) **25%** (Best practice 33%)	Ave Daily Patients with an LOS > 7days (excl MCH & Newark) **213 ⇔** (previous month – 212) (3 month average – 211)	Daily admissions via ED **90 ⇧** (previous month 81) (year to date ave 80)

Figure 1 – March 2018 Emergency Access position

National ranking for March was 30 out of 137 Trusts.

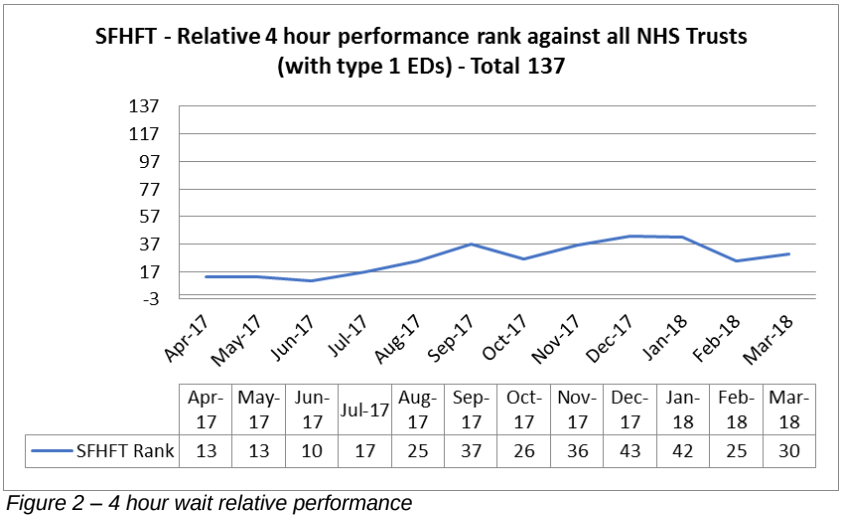

Figure 2 – 4 hour wait relative performance

There were no reportable 12 hour breaches from decision to admit to admissions in March 2018 and the revised escalation process to mitigate against long waits in ED continues to work well.

March 2018 – Ambulance handover performance		
Daily ambulance Arrivals **103** (previous month 93) (YTD average 89)	Handover >30 minutes **21.3%** (Previous month 18.7%)	Handover >60 minutes **4.4%** (Previous month 1.2%)

Figure 3 – March 2018 Ambulance handover position

21.3% of ambulances had a delay over 30 minutes on the EMAS (non-CAD extra) data, this shows a deterioration of 2.6% on February and requires further improvement. An ambulance handover delay is largely due to overcrowding in the ED caused by delays in the admission of medical patients.

3. Root cause of underperformance

A&E attendances at Kings Mill Hospital were broadly similar for the period December 2017 – March 2018 to the same period last year and the majority of breaches continue to be as a result of a wait for a medical bed. The cause root causes of these waits for a medical bed are as follows:

3.1 Growth in emergency medical admissions – figure 4 illustrates this with 138 (6%) more patients over 75 requiring a medical bed from January to March than in the corresponding period in 16/17. Some of this admission growth has been related to a higher acuity of patients this winter due to a higher incidence of flu over a prolonged period. This increase in patients corresponds to 15-20 beds extra medical bed demand for this period.

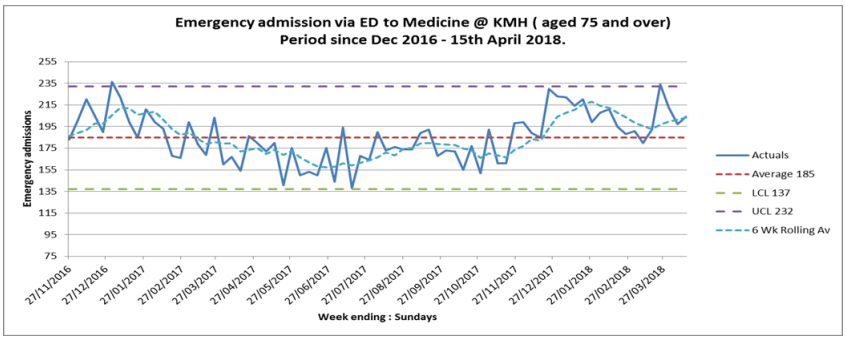

Figure 4 – Emergency Admissions via ED to Medicine (aged 75 and over)

3.2 Constrained EAU bed capacity

The increase admissions described in 3.1 have been trying to get through a smaller EAU bed capacity, with the EAU having 12 (52 beds to 40) less beds than previous winters due to a decision in summer 2017 to reduce the bed base due to nurse staffing levels along with privacy and dignity issues on the unit. Figure 5 shows the impact of this on the waiting times within ED due to the critical position of EAU being the first admission ward for medical patients from ED.

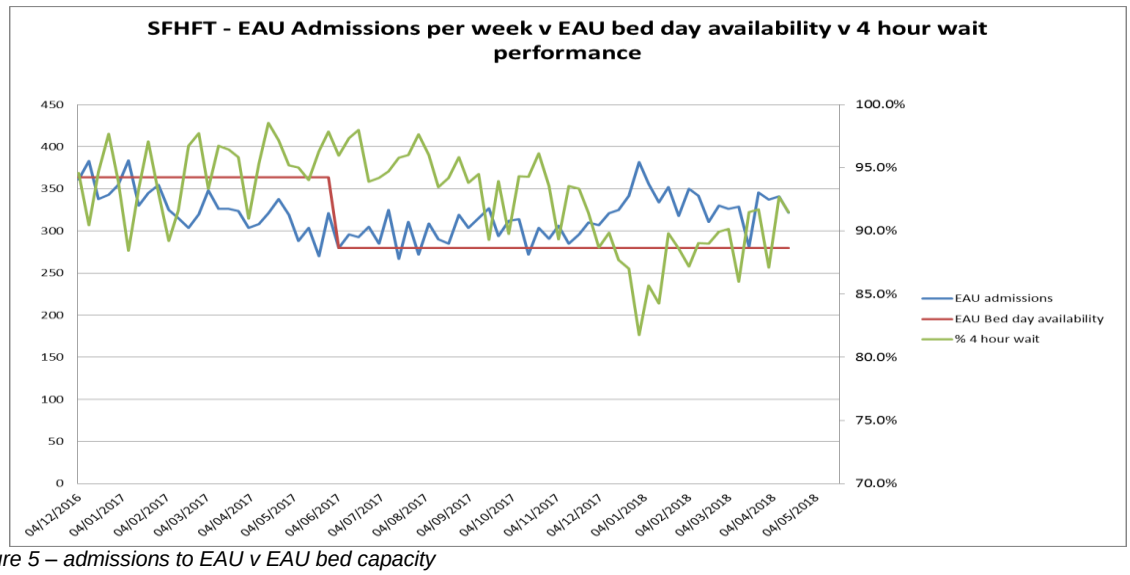

Figure 5 – admissions to EAU v EAU bed capacity

3.3 Flow out of EAU to the base medical wards has been a challenge as at times there have been less acute beds available this winter compared to last. Furthermore, due to nurse staffing constraints, the winter bed plan was an outlier plan, leading to longer lengths of stay. This is even more exacerbated at weekends, when the admission and discharge deficit is larger.

3.4 Reduction in external bed capacity this winter compared to last, with c. 29 less beds overall. This has led to a steady increase in the number of delayed transfers of care from December 2017, reaching a peak of 5.97% in February 2018.

4. Actions to mitigate cause of underperformance

4.1 EAU bed demand and capacity deficit

Mean admissions per day for the period December 2017 – March 2018 were 48 into EAU. With a bed occupancy of 75% EAC has the current capacity for 38 admissions per day, giving a variance of 10 beds per day.

It is proposed that this will be bridged through the following actions – shown on the bridge in figure 6.

- 4 additional patients streamed to Ambulatory Emergency Care (AECU) per day
- Reduced LoS for discharge patients (2 beds)
- Increase in medical base ward discharges leading to reduced LoS on EAU (4 beds)

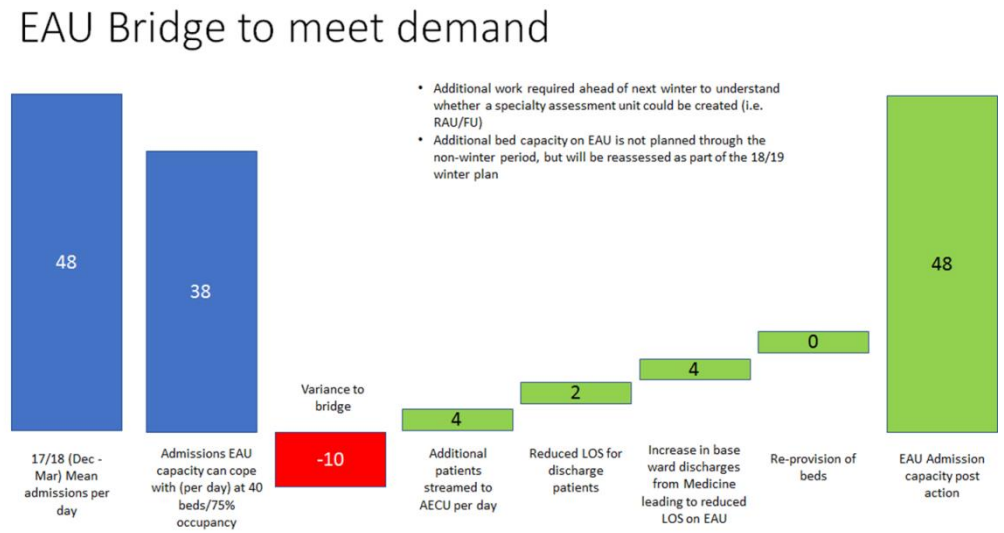

Figure 6 – EAU bridge to meet demand

4.2 Movement out of EAU to medical base ward capacity

Current inpatient capacity, as per the winter plan, is being maintained until 11 May 2018 at least and further work is being undertaken to understand the required inpatient capacity required for 2018/19; this will be complete by July 2018. This capacity work will identify what size the medical bed base is required to be to meet demand at a lower occupancy level than that seen in winter 17/18. Good progress continues to be made on the use of the discharge lounge and early discharge, particularly in medicine with a pre-noon discharge rate of 25% against the standard of 30%.

4.3 Weekend admission and discharge imbalance

The mean number of admissions to medicine on a Saturday and Sunday is 94 and the mean number of discharges from the medical base wards on a Saturday and Sunday is 53, giving an imbalance of 18 beds, which is shown in the bridge in figure 7.

It is proposed that this will be bridged through the following actions:

- 4 additional patients streamed to AECU per day
- Implementation of criteria led discharge (5 beds)
- Creation of a bed surplus each Friday (5 beds)
- Improved discharge planning (5 beds)

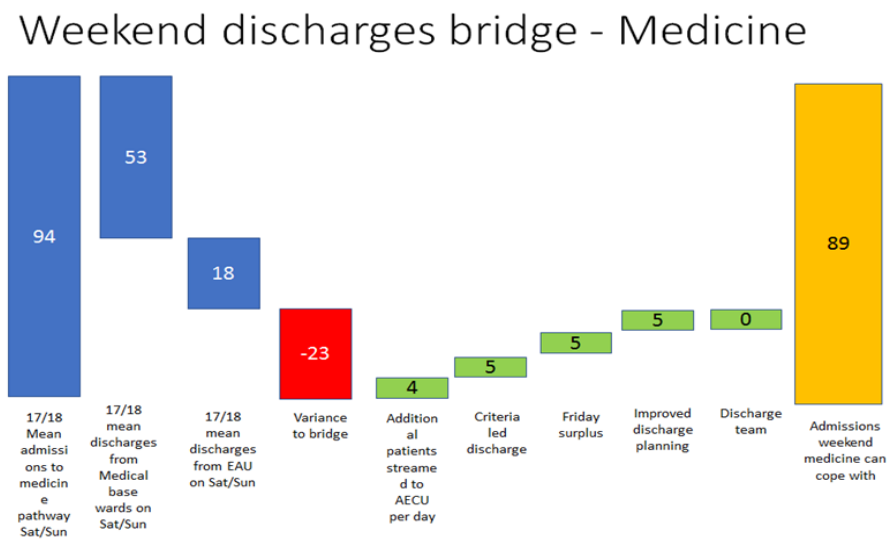

Figure 7 – Weekend discharge bridge – Medicine

4.4 External capacity

During 2017/18 19 transfer to assess beds were closed, leading to an increase in the number of delayed transfers of care (DToC) above the 3.5% target. A summary of the reasons for delay over the last 6 months is shown below:

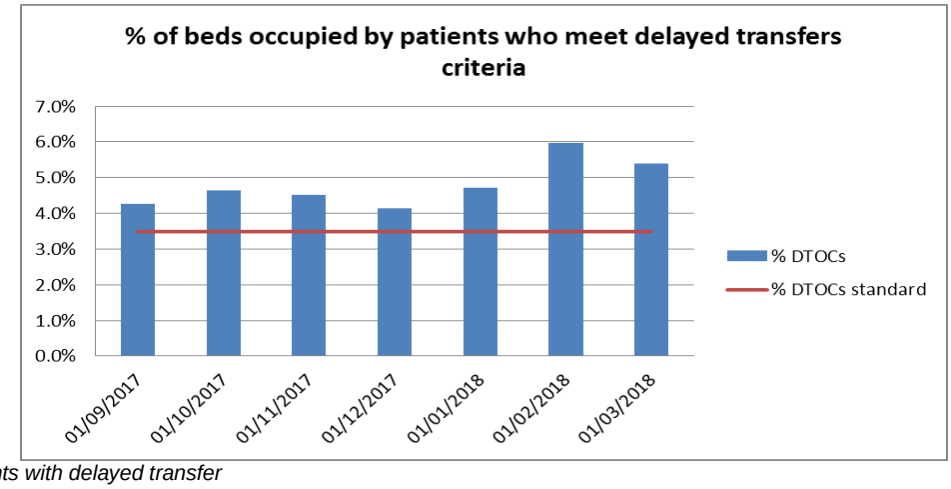

Figure 8 – patients with delayed transfer

In the short term, the CCG has agreed to spot purchase beds to replace some of the transfer to assess capacity, however, further clarity is required on the medium terms plans as this has only been funded for the next 4 weeks.

5. Governance and leadership of improvement programme

The actions are governed through the Patient Flow Group, reporting to the Executive Team, via 3 work streams:

- **'Start right'** (led by Dr Ben Owens) – maximising ambulatory care, EAU demand and capacity

- **'Todays work today'** (led by Dr Anne-Louise Schokker) – 'Red to Green', Board rounds, PDDs, criteria led discharge, discharge transport , TTOs, planning ahead
- **'Length of stay'** (led by Dr Steve Rutter) - >7 day stays reduction, visibility of delays/medically fit, internal delays and escalation. The integrated discharge group will feed into this which will lead on the work associated with the 'Intensive Recovery Roadmap'.

6. Winter debrief / Lessons learned

Demand & Capacity

Much of this is picked up in sections 3 & 4 of this report that shows an increase in the number of admissions but with minimal change in the number of ED attendances at KMH compared to last winter. There has been an increase in the acuity of patients, particularly frail older patients, and in admissions of patients diagnosed with flu.

The winter plan for 2016/17 provided for an additional 24 bed medical ward, over and above the Trust core bed stock; this was also included in the original winter plan for 2017/18. However, the Trust was unable to safely staff the additional medical ward for winter 2017/18 therefore a revised winter plan was agreed. The final winter plan for 2017/18 provided for an increase in medical bed capacity through the expansion of ward 14 (gynaecology) and re-designation of 16 beds across wards 31 and 32 from Surgery to Medicine. This plan delivered a broadly a similar bed number as 16/17 in 17/18 with the exception of in February where there were 23 less beds.

The Trust has in place a 'buddy' ward system and this ensures that all medical patients have a daily senior physician review and management plans are in place. However, the 'outlier' model to increase the medical inpatient capacity is considered sub-optimal as patients are distributed across a number of wards rather than co-located. This can lead to an increase in length of stay as medical staff reviews take place in the afternoon, once patients on base wards have been reviewed, and additional resources, such as therapy staff and discharge teams, have to work across a number of areas.

In addition, in line with national guidance in January, all routine, non-urgent surgery ceased from the New Year in order to maximise inpatient capacity for non-elective medical and surgical demand. This enabled the Trust to utilise ward 21 (elective orthopaedics) for medical patients for a 7 week period.

All decisions to increase or flex the use of inpatient capacity are taken in a planned way by Gold on Call based on the predicted number admissions and daily demand for medical beds. The transfer of patients from a medical base ward to an outlier ward is undertaken in line with the Trust Patient Outlier Policy; this requires that only suitable patients, who meet the criteria agreed in the Patient Outlier Decision Making Tool, are transferred.

The Trusts 'buddy' ward system and this ensures that all medical patients have a daily senior physician review and management plans are in place.

Safe nurse staffing levels this winter

Throughout the year the Trust reviews all nurse staffing levels twice daily to ensure that staffing levels are within the parameters set out in the Safer Staffing Standard Operating Procedure. The Trust Board of Directors receive a monthly report detailing all under and overfill of rotas together with any breaches in minimal staffing levels, this information is also available on the Trust website. A detailed breakdown on the assurance against safe nurse staffing was provided as part of this

report last month and is contained within the monthly report from the Chief Nurse, but as reported the original winter plan was revised to ensure that safe nurse staffing levels could be maintained on all wards throughout the winter period.

Adverse weather over winter

There have been two periods of adverse weather this winter, the first from 28th February to 3rd March, and the second on 17/18th March. The Trust managed these incidents in line with the national adverse weather policy and cold weather plan. However, initial learning and feedback from staff suggests it would be beneficial for the Trust to develop a local cold weather plan, incorporating the management of elective activity and communication during adverse weather.

Staff commitment

It is acknowledged that the 2017/18 winter period has been particularly demanding for the NHS. The Trust has seen sustained peaks in demand over a number of weeks and this has placed huge operational pressures on many groups of staff. In addition, the two periods of adverse weather created further challenges. Despite this, staff have shown exemplary resilience and commitment to maintaining patient safety and flow.

Further debriefs are planned with staff across the Trust to understand how the winter period had felt for them and get their ideas for what could make the plan work better in the coming year.

7. Summary

The Trust has experienced a more sustained increase in admission demand over the winter period, particularly for older people requiring medical beds. This was partly caused by higher patient acuity and the incidence of influenza. A winter plan was put in place which has less medical beds than in 16/17 as the extra winter beds were surgical beds looking after medical patients which is not as optimal. The EAU has proved to not be able to meet demand due to its reduced bed base and there have been some reductions in external bed capacity to the hospital.

The debrief shows that safe staffing was in place during this period; but that the Trust should develop a local plan to manage adverse weather. Further debriefs are planned with staff in the coming weeks.

The winter plan remains in place until the end of 11 May 2018 to ensure the Trust maintains safe patient care and patient flow on a daily basis.

There is a plan in place to mitigate the root causes and this is governed through a clinically led work programme.