The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 11 July 2024

Agenda item		113/24		
Report Title		Formal Review of Winter Plan 2023/24		
Executive Lead		Acting Chief Operating Officer		
Report Author		Deputy Chief Operating Officer		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF5, BAF9, BAF10
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	-
Well Led	√	Our partners	√	
Consultation Communication		N/A		
Executive summary:		1. The Board's attention is drawn to the improvements made in length of stay and number of patients with No Criteria to Reside in acute beds. 2. Whilst the interventions undertaken throughout winter reduced the bed gap, we continued to see long waits in the Emergency Departments over the winter although March started to see marginal improvements. 3. We have developed an Urgent & Emergency Care (UEC) improvement programme with the support of KPMG.		
Recommendations for the Board:		The Board is asked to note this report.		
Appendices:		None		

1 Introduction

1.1 Managing UEC demand across the NHS and locally for SaTH and the wider Shropshire, Telford and Wrekin Integrated Care System (STW ICS) has continued to be challenging over the winter of 2023/24.

1.2 There were continued peaks in Covid infections, an increase in suspected measles and norovirus which required isolation.

1.3 As a system there was also a need to continue to balance the requirements of elective recovery with the pressures winter brings to urgent and emergency care.

1.4 The financial pressures within SaTH and the wider system limited the winter schemes that could potentially have been delivered.

2 Background

2.1 The NHS core objectives and actions were introduced this year to address the issues that are consistently faced during winter.

These were as follows: -

- Increase capacity outside acute trusts.
- Increase resilience in NHS111 and 999 services.
- Target Category 2 response times and ambulance handover delays
- Reduce crowding in ED and target the longest waits in ED.
- Reduce hospital bed occupancy through increasing capacity of sub-acute beds, virtual wards, and pathway improvements.
- Provide better support for people at home.
- Prepare for variants of Covid 19 and respiratory challenges.

2.2 Further focus on the following interventions were identified to be part of the system winter plan: -

- Frailty and dementia pathway
- Operational rhythm
- Delivery of 7 day working
- Admission avoidance

2.3 The modelling that was undertaken indicated that there would be more demand on urgent and emergency care services than the available capacity. There was a bed gap identified within the acute hospital throughout the winter months.

	Nov-23	Dec-23	Jan-24	Feb-24	Mar -24	Average bed gap
Predicted shortfall	-233	-236	-256	-273	-225	-245

2.4 Interventions were identified to mitigate the bed gap both within SaTH and across the system. These were as follows: -

SaTH interventions

- Reduction of Length of Stay (LoS) by 0.5 days by focusing on the long length of stay patients, increasing pre-5pm discharges, improving weekend discharges.

- Improving the flow through SDEC
- Introducing the OPAT service
- Developing the frailty model

The ICB awarded winter monies to schemes to support the system through the winter period:

- 2 additional discharge vehicles Monday – Friday
- Mental Health: targeted rapid intervention to patients over 65 (MPFT) – 2 additional staff to support the current hospital avoidance service.
- Communications support
- British Red Cross: 72 hour and 6-week home support programme including a focus link with aging well.
- Voluntary Sector; staying well this winter, supporting social prescribing.
- Falls (hospital avoidance): combined SCHT Social Care and Fire Service.
- Single Point of Access (SPA) and Clinical Co-ordination

3 What happened in winter?

The Flow Improvement Programme meetings and the Emergency Care Transformation Assurance Committee monitored the improvement actions in relation to UEC. Two weekly performance monitoring meetings took place, chaired by the Acting Chief Operating Officer (COO) – one focused on hospital flow and one on ED performance.

3.1 Command and Control

We have been improving our command-and-control processes throughout the winter period, following feedback and support from NHSE colleagues. We have reviewed the site management meetings, the rhythm of the day, the touchpoints throughout the day, set clearer expectations and captured and followed up actions with a focus on improving patient flow.

3.2 Frailty

The first stage of a new frailty model commenced utilising ward 10 at PRH and ward 28 at RSH as dedicated frailty wards. Planning is underway for stage 2 which is to create frailty assessment areas on both sites – these will be in place from the beginning of July and will create 6 assessment beds at PRH and 9 assessment beds at RSH. Patients attending the ED who meet the frailty criteria will be transferred to these areas for assessment. Any additional care requirements will be arranged to ensure patients can return home safely. This will reduce long waits in ED for this group of patients and prevent unnecessary admission.

3.3 Improving ward processes

There has been continued focus on ward flow and length of stay throughout winter months. The medicine division undertook a *'test of change' week* in February 2024 and because of the learning from this, have set up the Medicine Transformation Programme. With the leadership support from the Associate Medical Director and clinical colleagues from the GIRFT team they are engaging medical colleagues in improving ward and board round processes.

3.4 Hospital Full Protocol and Escalation beds within SaTH

The Hospital Full protocol was updated, and additional patient spaces were identified on wards and ED corridors. These were risk assessed, with clear triggers for when and how these areas could be utilised. The main hospital street at PRH had to be used throughout the winter months, however, alternative corridor space (DSU corridor) was approved as escalation space following completion of estates work, thus enabling us to remove the main hospital street as an escalation area.

Additional bed spaces were also created on several wards, following risk assessments, as "*next patient areas*". The purpose of these spaces was to create a space for patients who were identified as definite discharges on the same day, so that the bed space could be used for a new in-patient admission to enable earlier movement out of a busy ED.

3.5 SDEC

Support was received from KPMG over the winter months to develop SDEC pathways and processes. A '*test of change'* week was held in October on the RSH site and in February on the PRH site. This enabled an increase in the "pull" of patients from ED into SDEC and a reduction in follow-up patients being seen in an SDEC setting, creating the capacity to support patients that would otherwise have attended ED.

3.6 Transfer Team

Additional porters and healthcare assistants were rostered to support patient moves and bed cleaning so that the time between patients moving out of bed spaces and new patients moving into bed spaces was reduced. This enabled all bed spaces to be used as efficiently as possible. The transfer team are available on Teletrack, and a business case is being developed to support the sustainability of this important service.

3.7 Multi-Agency Discharge Events (MaDE)

MADE events took place throughout the winter period to support the creation of capacity over the long bank holiday weekends or over periods of industrial action. The focus of the MADE events was to ensure all actions were being undertaken effectively by all partners to support patient discharge. The events were supported by the System Control Centre and an additional system wide MADE event took place prior to the Easter Bank Holiday with a focus on discharge from community hospitals, which created significant capacity going into the 4-day bank holiday.

3.8 Community Rehabilitation and Recovery wards (formally known as sub-acute wards)

Two Community Rehabilitation and Recovery wards opened on SaTH sites in January 2024, run and managed by Shropshire Community health Trust (SCHT) – one on ward 18 at RSH and one on ward 36 at PRH.

The original intention of these wards was to enhance the rehabilitation pathways for frailty, orthopedic and stroke patients; however in the first phase, due to the skill mix of the staff available to open the wards, the main group of patients have been those patients who have '*No Criteria to Reside'* (NCTR) in an acute hospital setting and are requiring ongoing care and support post-acute hospital stay. Work is progressing with clinical teams as the skill mix on the rehab and recovery wards improves to create the appropriate pathways for patients as they were initially described.

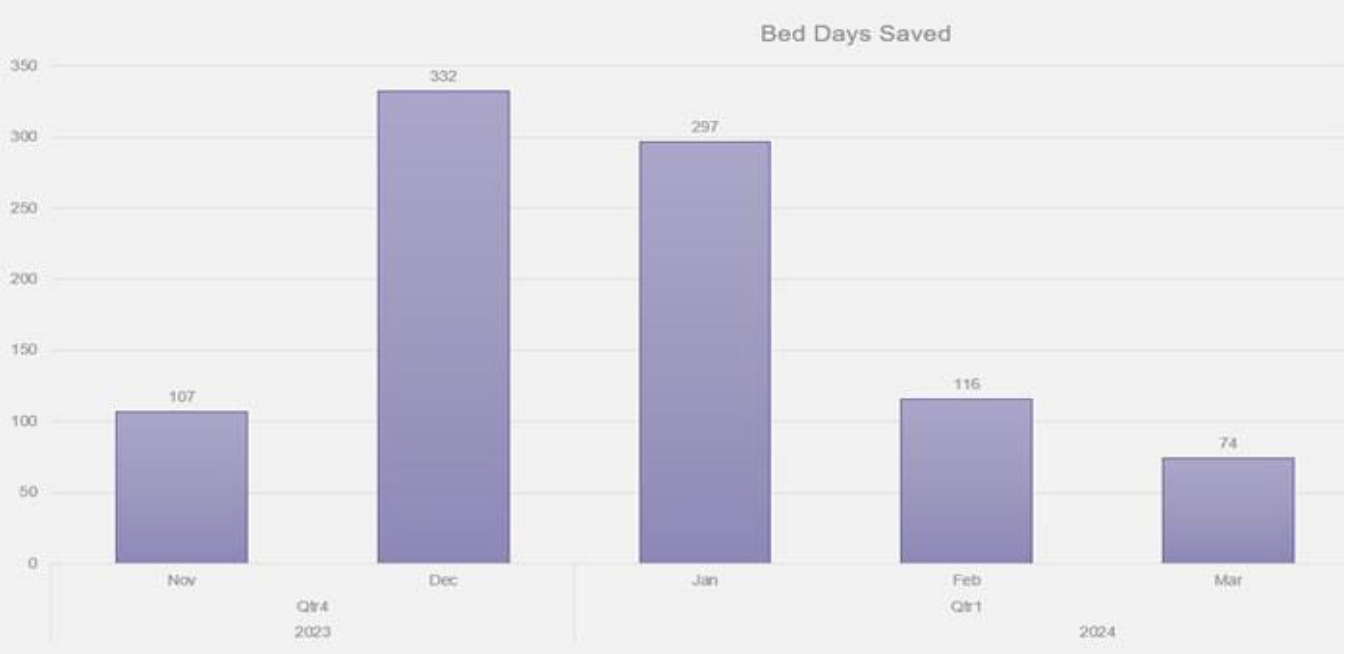
Planning permission has been granted and groundwork preparation has commenced for the two modular wards at the entrance to the RSH site – once completed, this will house the Rehabilitation and Recovery ward at the RSH site and also create a replacement (decant) ward for the essential estates work that is required on the ward block at RSH. The expected handover to SaTH from the company is November 2024.

3.9 Virtual Ward and OPAT

We have continued to promote the Virtual ward as an alternative to lengthy stays in acute hospital wards. The referral rates have been variable despite the significant promotion of the service to ward-based clinicians.

Monthly Step up / step down	May	June	July	August	September	October	November	December	January	February
Step up A&E PRH	29	30	29	23	29	45	33	32	37	29
Step up A&E RSH	28	25	34	14	16	32	35	20	26	39
Step Down SaTH PRH	12	48	63	27	40	58	31	38	35	22
Step Down SaTH RSH	13	36	43	22	23	43	36	39	36	33
SaTH TOTAL	**82**	**139**	**169**	**86**	**108**	**178**	**135**	**129**	**134**	**123**

The Outpatient Parenteral Antibiotic Therapy (OPAT) commenced in November 2023 and has enabled a cohort of patients to be discharged to receive their IV antibiotics either in a clinical environment or at home with the support of the Virtual Ward team. A total of 868 bed days were saved from Nov-March by using this new service. Further work is ongoing to develop a business case as there is greater opportunity to increase bed day savings with an enhanced offer.



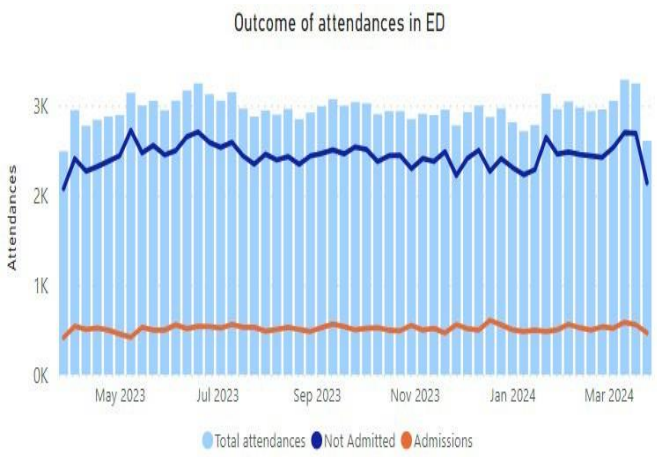
4 Winter infections

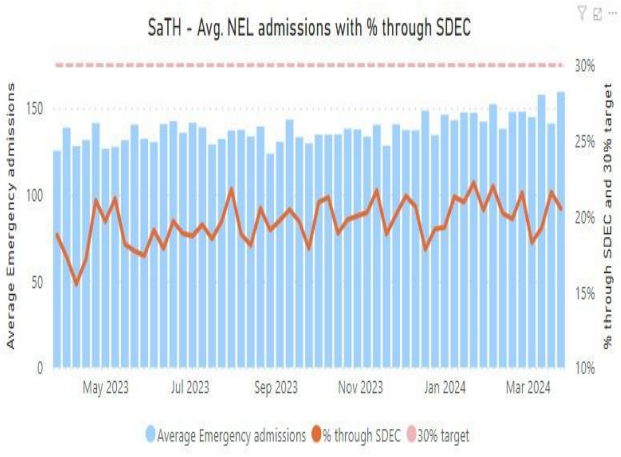
We continued to see a seasonal rise in respiratory infections, including flu and COVID19 which resulted in increased demand for single rooms and isolation spaces.

Over the winter there was also an increase in suspected and actual measles infections. Most patients with measles infections did not require admission, but any patient with suspected measles required isolation to prevent any potential cross infection This had a specific impact on the ED, Children's Assessment Unit and paediatric bed capacity.

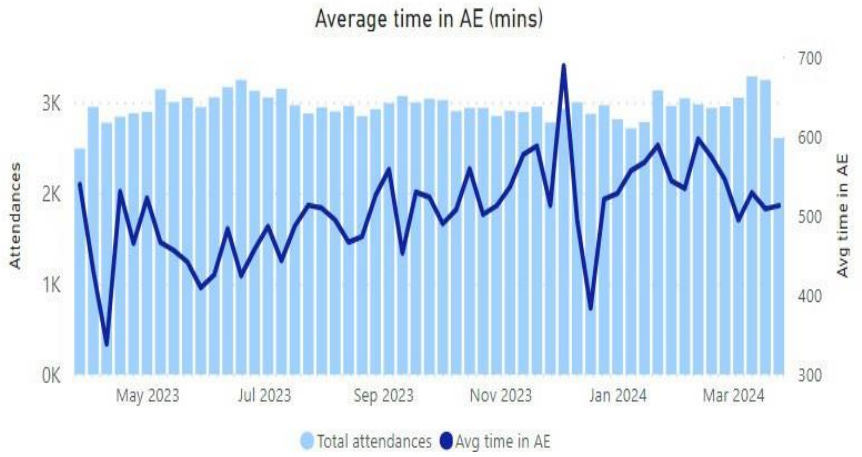
5 The data

5.1 Attendances to our emergency departments rose in the middle of January and remained high to the end of March 2024. Admissions via ED remained relatively static, however with the increase in direct admission pathways, overall emergency admissions increased in January and remained higher throughout the winter than we had seen between April and January 2023.

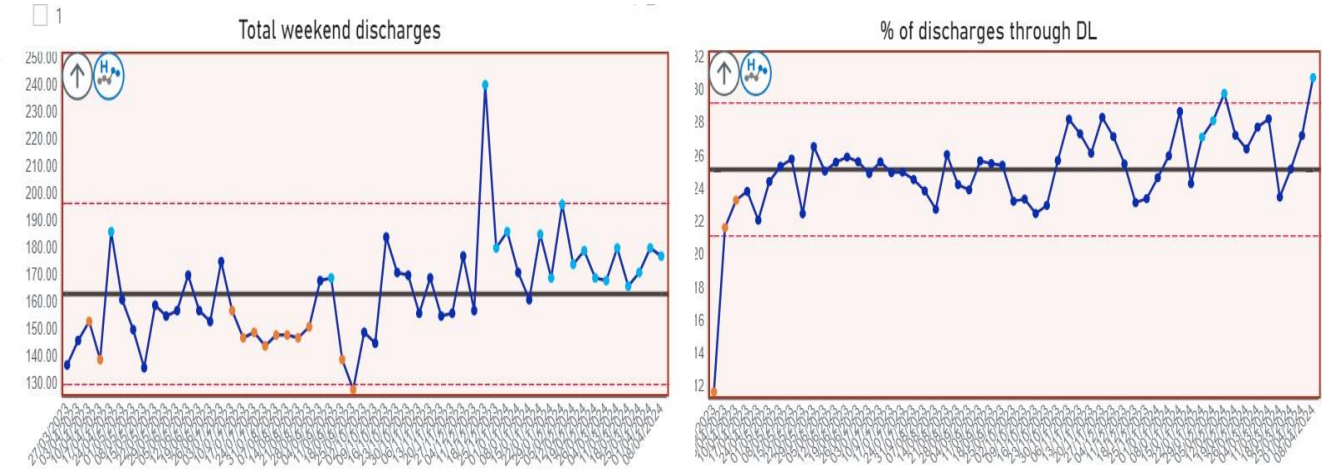




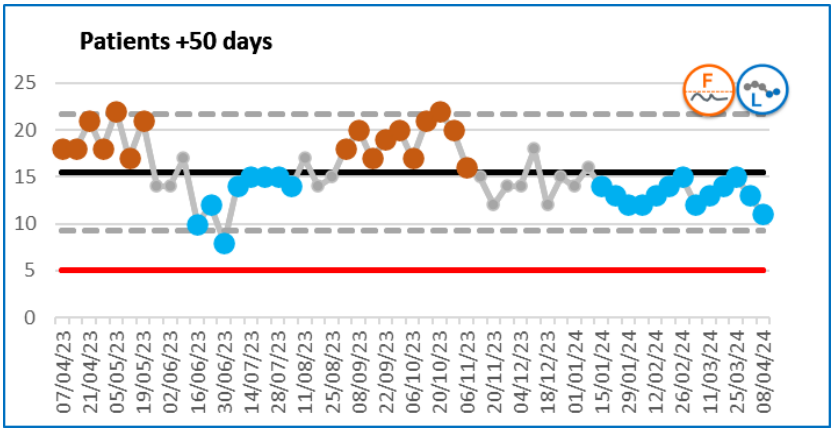
5.2 With the increased attendances in ED, the average time for a patient to be seen, treated, and discharged from ED has remained high throughout the winter period although there were signs of this starting to reduce in March.



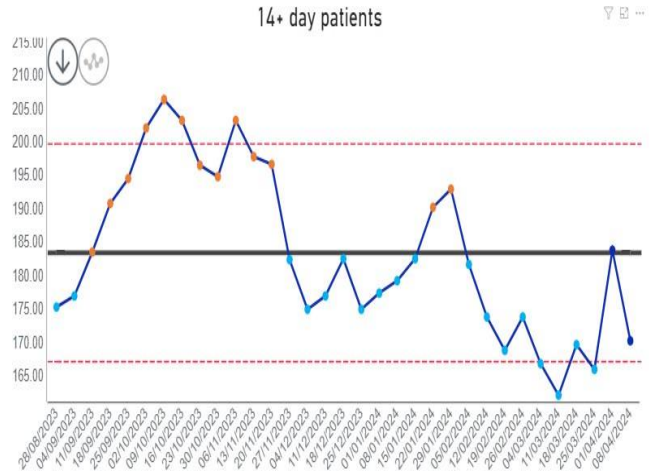
5.3 The discharge-focussed activities have resulted in a positive impact on the number of weekend discharges and continued utilisation of the discharge lounges on both sites.

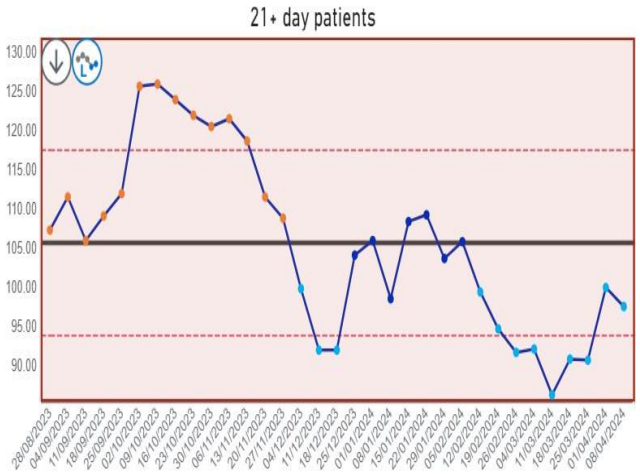


5.4 There has been a reduction in very long-stay patients, with a sustained improvement in the number of patients over 50 days and to date, we have had no patients over 100 days in the bed base for over 60 days.

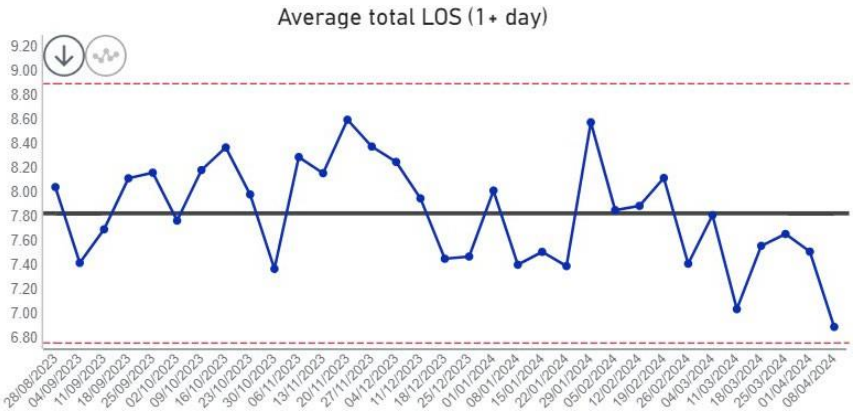


5.5 There is also a consistent improvement in the number of in-patients staying over 14 day and over 21 days:

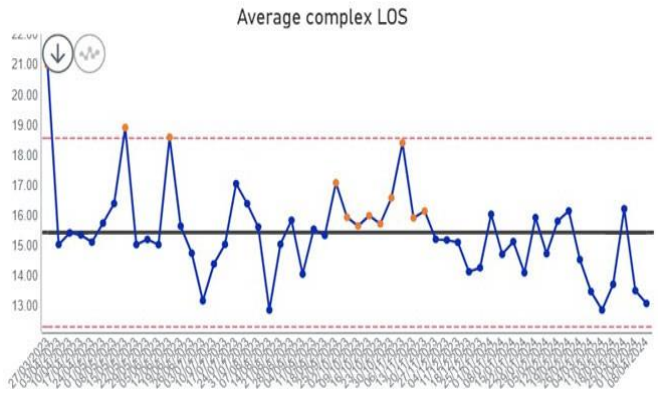


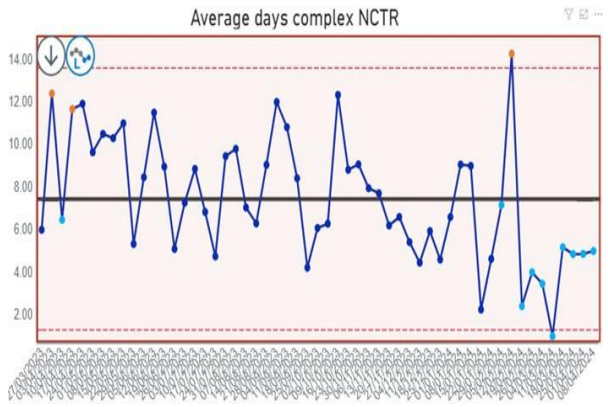


5.6 This improvement is having a positive reduction in total length of stay:

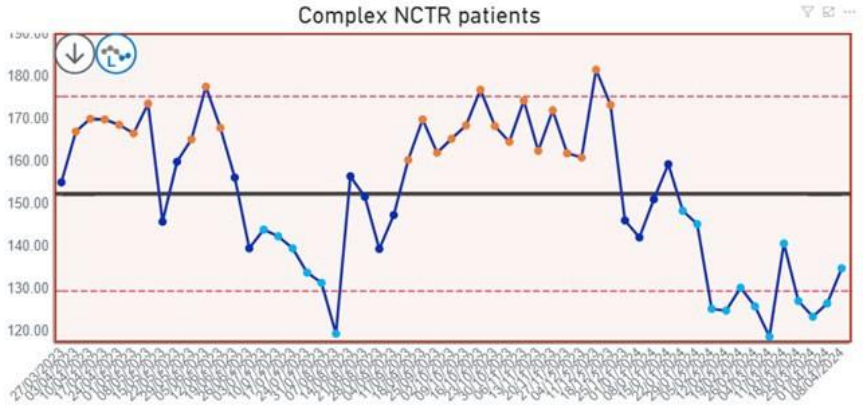


The biggest gain in the reduction of length of stay has been in those patients that require additional support on discharge – either care in their own home (Pathway1), additional rehabilitation and recovery (Pathway2) or long term residential or nursing care (Pathway3). This is due to the reduction in elapsed time between a patient being identified as fit to leave the hospital (No Criteria to Reside) and discharge.





5.7 As a result of the improved length of stay and the Rehabilitation and Recovery wards that are managed by SCHT we have also seen a reduction in the number of patients with no criteria to reside in our bed base.



5.8 As a result of the improvement actions taken our actual bed gap over the winter period was as follows.

	Nov-23	Dec-23	Jan-24	Feb-24	Mar -24	Average bed gap
Predicted shortfall	-233	-236	-256	-273	-225	-245
Predicted shortfall following interventions and R&R wards	-140	-134	-94	-90	-59	-104
Actual shortfall	**-71**	**-63**	**-76**	**-77**	**-71**	**-72**

Our focus over the next few months will be on the timeliness of discharges and increasing the number of pre-12pm and pre-5pm discharges to create the early flow required to reduce long ambulance waits and long waits in ED for patients waiting admission.

6 Summary and Conclusion

The 23/24 winter period was extremely challenging for SaTH and the wider system and whilst there was an improvement in length of stay and discharge profile, this has not translated into reduced escalation capacity or in long waits for patients in our emergency portals.

The STW system are now in Tier 1 for monitoring UEC performance and receiving support from NHSE. We are also working closely with GIRFT colleagues who are supporting us to make the improvements they have suggested will make the biggest difference to our patients.

To ensure effective governance, we have created a single UEC Improvement Assurance Committee, bringing together reporting against the Emergency Care Transformation Programme, Medicine Transformation Programme, capacity and flow improvements and the continued implementation of internal professional standards. The combined impact of all these activities is designed to improve 4-hour performance, earlier in the day discharges and further reduced length of stay.