Winter Review paper July 2017

<table>
<thead>
<tr>
<th>Trust Board</th>
<th>Item: 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: 26th July 2017</td>
<td>Enclosure: F</td>
</tr>
<tr>
<td><strong>Purpose of the Report:</strong></td>
<td></td>
</tr>
<tr>
<td>The report provides information about the management of winter of 2016/17 and the lessons learnt for consideration for 2017/18.</td>
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</tr>
</tbody>
</table>

**For:** Information ☑ Assurance ☐ Discussion and input ☐ Decision/approval ☑

**Sponsor (Executive Lead):** Tracey Moore  
Acting Chief Operating Officer

**Author:** Tracey Moore  
Acting Chief Operating Officer

**Author Contact Details:**

**Risk Implications – Link to Assurance Framework or Corporate Risk Register:**

**Link to Relevant CQC Domain:** Safe ☑ Effective ☑ Caring ☐ Responsive ☑ Well Led ☑

**Link to Relevant Corporate Objective:**

**Document Previously Considered By:** Executive Management Committee 19th July 2017

**Recommendations:**
The Trust Board is asked to note the report and that the Trust is actively planning for winter 2017/18 and will also ensure that the plans for KHFT form an integral part of the plan for the A&E delivery board which has to be submitted to NHSE by 8th September.
Winter Review paper July 2017

1. Introduction
The purpose of this paper is to:

- Provide information about the management of winter of 2016/17 and the context within which services operated.
- Describe the management of activity in winter 2016/17 and consider lessons learnt
- Set out assumptions regarding activity in 2017/18
- Set out expectations from recently published national guidance for winter 2017/18
- Set out emerging views on the management of winter in 2017/18
- Set out conclusions from the paper and to
- Set out Next Steps.

The focus of this paper is on adult services, with further information on paediatric services to follow.

2. Context within which the service operated over the winter period 2016/2017

2.1 KHFT contractual assumptions
- The contract for ED attendances in 2016/17 was based on an assumption that through a series of initiatives in community and primary care, attendances to ED would reduce by 0.8% against actual attendances in 2015/16.
- No change to admission rates were anticipated.
- A trajectory for the emergency standard was agreed with the CCG, which is set out in table 1 below:

<table>
<thead>
<tr>
<th>Period</th>
<th>Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>95.03%</td>
</tr>
<tr>
<td>May 2016</td>
<td>92.44%</td>
</tr>
<tr>
<td>June 2016</td>
<td>90.30%</td>
</tr>
<tr>
<td>July 2016</td>
<td>95.00%</td>
</tr>
<tr>
<td>August 2016</td>
<td>95.20%</td>
</tr>
<tr>
<td>September 2016</td>
<td>94.30%</td>
</tr>
<tr>
<td>October 2016</td>
<td>95.00%</td>
</tr>
<tr>
<td>November 2016</td>
<td>95.00%</td>
</tr>
<tr>
<td>December 2016</td>
<td>95.00%</td>
</tr>
<tr>
<td>January 2017</td>
<td>93.43%</td>
</tr>
<tr>
<td>February 2017</td>
<td>94.00%</td>
</tr>
<tr>
<td>March 2017</td>
<td>95.15%</td>
</tr>
</tbody>
</table>

Table 1: Agreed trajectory for 2016/17

2.2 Performance - national and local context
The achievement of the emergency standard deteriorated nationally and regionally over the winter period as demonstrated in table 2 below.
Table 2: National and regional performance

- In January 2017, 18 of 22 London Trusts did not achieve the emergency standard with the average performance nationally being 85.9%. KHFT performance in January was 82.55%.
- In April 2017, 17 out of 22 Trusts did not meet the emergency standard, although performance improved nationally to 89.8%. KHFT performance in April 2017 was 90.39%.
- The trajectory agreed by KHFT and Kingston CCG was only met in 2 months (April 2016 and June 2016) out of the last 12.

2.3 Activity analysis: national and local context ((NHS providers – on the day briefing 14.7.17))

- Growth nationally for the period December 2016 – March 2017, was lower than the 5 year average growth on all measures as shown in table 3 below:

<table>
<thead>
<tr>
<th></th>
<th>Year on year growth 2016 vs 2015</th>
<th>5 year average growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non – elective admissions</td>
<td>1.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>-1.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Ambulance calls</td>
<td>1.1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>NHS 111</td>
<td>-4.2%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

Table 3: Demand growth metrics (On the day Briefing NHS Providers 14 July 2017)

- Despite this, acute providers had more acute hospital beds open in winter 16/17 than the previous winter with bed occupancy being 1.5% higher, caused by the difficulties in discharging patients.
- Whilst there was little winter demand growth nationally, there were significant peaks in growth, particularly after bank holidays.
- Over the course of the year, type 1 attendances for KHFT went up overall by 2.10%, attendances in the over 80s went up more significantly by 6.83% comparatively to 2015/16.
- Ambulance attendances also increased comparatively to 2015/16 by 2.73%. However, during the first three quarters of 2016/17 the number of Type 1 attendances went up more significantly by 4.28% and ambulance arrivals by 3.31%.
- The admission rate over the financial year remained relatively consistent at 20%.
- Attendances and admissions by borough remained consistent from 2015/16.

2.4 Bed Occupancy

- Bed occupancy across the Trust, including adult services, paediatrics and neonatal unit, was 88.87% for 2016/17
- Bed occupancy for adults only was 92.77% for 2016/17. In quarters 3 and 4, this increased to 94.65% and 94.66% respectively. This % is based on the total number of beds used, including escalation beds, at any one time.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All inpatients</td>
<td>87.96%</td>
<td>85.33%</td>
<td>91.16%</td>
<td>90.77%</td>
<td>88.87%</td>
</tr>
<tr>
<td>Adult Only</td>
<td>91.91%</td>
<td>89.59%</td>
<td>94.65%</td>
<td>94.66%</td>
<td>92.77%</td>
</tr>
</tbody>
</table>

Table 4: Bed occupancy for 2016/17 by quarter

- In addition to the opening of Claremont ward, KHFT saw a significant increase in the number of beds in surgery and gynaecology occupied by medical patients.

### 2.4 Activity analysis: Delayed Transfers of Care (DTOCs)

#### Number of Beddays Lost through Delayed Transfers Of Care

![Graph](image1.png)

#### DTOC & Percentage of Bed days lost to DTOC

![Graph](image2.png)

Table 5: Delayed Transfers of Care (DTOC) – bed days lost and percentage of bed days lost

Nationally DTOC levels reached their highest recorded level in January with DTOC levels over winter an average 22% higher than the year before. In November 2016, 5.2% of available beds in the system were occupied by DTOC patients.

Delayed Transfers of Care at KHFT fluctuated during the winter period in 2016/17 as shown in table 5 above. In November DTOC was at 7% with this reducing to 6.1% in January 2017. DTOC rose again significantly during April (6.5%) and into May (7.8%).
Summary

- Nationally and regionally performance did not meet the emergency standard over the winter period with a year on year growth 1.4%.
- Attendances at KHFT exceeded national growth.
- There was an increase for KHFT in ambulance attendances of 2.73% and an increase in ED attendances of over 2.10% (against a contracted reduction of 0.8%).
- There was a significant increase in the number of attendances in ED of patients of 80 years and above. This led to an increase in the number of admissions of patients over 80 years of age.
- Despite this, the admission rate for KHFT remained relatively constant from 2015/16 to 2016/17 of around 20%.

3 Management of activity in winter 2016/17

3.1 Key challenges identified prior to winter 2016/17

In preparation for winter 2016/17, the operational team reviewed the activity and learning from the previous year and identified key challenges. These were as follows:

- The need to plan effectively for the post-Christmas surge, ensuring that empty beds were available on Christmas Eve.
- To mitigate the expected post-Christmas surge by creating additional capacity for medical patients on Claremont ward.
- To secure additional staff – all professionals to support the additional capacity.
- To ensure consistency of staff in the escalation areas.
- To maintain an elective programme.
- To assess, diagnose and treat patients early in the pathway, thereby avoiding the need for an overnight length of stay.
- To manage increased numbers in ED.
- To manage 0.8% less attendances than in the previous year.

3.2 Initiatives implemented to manage demand on service

The Trust implemented the following initiatives in response to the above challenges.

- Claremont Ward opened as a medical escalation ward from January 2017.
- Beds for Isabella ward were identified for surgical elective escalation, allowing Astor Ward to accept all surgical emergencies. This left AAU available for medical emergencies only.
- A block booking of beds in the private patient wing was made to protect the elective programme.
- A focused effort was made in advance of Christmas to identify patients waiting to go home, the actions required to support their discharge and the monitoring of these daily to ensure that patients were home for Christmas.
- Permanent staff were rostered to work on the escalation wards and were backfilled with bank and agency staff on their host wards.
- Additional staff were recruited - bank, agency and fixed term contracts to support the need for additional therapists, pharmacists, nurses and medical staff.
- A member of the surgical administrative team was designated to coordinate the elective programme - assessing those patients who were urgent, had been cancelled before, those who could be recovered in the day surgery unit and those who could be
accommodated in the private patient unit. This ensured that the maximum number of elective cases were admitted and that cancellations remained low.

- A bid for a frailty and community health/social care in reach project was submitted to the A&E delivery board and was approved. This involved the provision of seven day social worker, community therapy and nurse support to Kingston patients in AAU and ED. It also included the recruitment of a consultant geriatrician to lead the frailty team. This team operated from October.
- The clinical decisions unit in the ED was commissioned and was operational in November.
- A phased winter plan was developed which included activities such as maximising use of DSU theatres and reviewing the feasibility of providing recovery to main theatre patients in DSU where appropriate.
- In addition, there were a number of projects initiated as part of the Emergency Care Programme which were developed to support flow throughout the hospital, for example, trialling new roles in ED, developing a more robust AEC service, better management of our delays process and implementing the SAFER bundle.
- A medically optimised ward was set up in February 2017 to facilitate a safe and appropriate environment for 16-20 patients from the medical wards who were deemed clinically optimised, had a robust discharge plan in place and were awaiting packages of care, nursing home placement, residential placement or inpatient rehabilitation.

4 Initiatives and actions taken which impacted positively on the service and performance and lessons learnt

4.1 Initiatives and actions taken which had a positive impact on the service

Clinical Decisions Unit (CDU)
- The CDU was opened in November and between November 2016 and March 2017, 975 patients were admitted. Table 6 below shows the breakdown of how many patients were admitted to CDU per month.

<table>
<thead>
<tr>
<th>CDU Admissions</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>March-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>68</td>
<td>181</td>
<td>242</td>
<td>236</td>
<td>248</td>
<td>975</td>
</tr>
</tbody>
</table>

Table 6: Number of patients admitted to CDU per month

- The expectations of the CDU, as described in the operational policy were met. The average length of stay (LOS) for a patient in CDU from November 2016 – March 2017 was 9 hours against a baseline of 12 hours.
- These are patients who would have otherwise remained in ED or would have been admitted to an AAU bed.
Urgent Care Stream

- The urgent care stream was developed. The stream was supported by 18 hours of GP cover, plus a team of nurses, doctors, physiotherapist and emergency practitioner. The ED standard was met in this stream.

New roles in ED

- New roles in ED e.g. Physiotherapy practitioner and emergency practitioner were developed.
- A revised ED manpower model was developed and subsequently agreed.
- Key medical roles which have proved to be successful in the ED – such as Consultant In Charge, Doctor in RAP, and Doctor in Streaming were introduced.

Managing delays

- The Inpatient patient tracking list and improved delays management were developed.
- The choice and discharge policies and information for patients on simple and complex discharges were delivered.
- The delays meetings and escalation process were developed.
- The discharge coordinator team was increased.

Frailty team

- The Frailty and in-reach teams identified, assessed and discharged patients quickly and safely within key areas of patient flow, in particular in A&E and CDU.
- Had the frailty team not been operational, more escalation beds would have been required to manage the increased number of admissions for this age band (as described in section 2.3).
- There was an increase in patients being discharged to their usual place of residence, particularly for those with short stays, increasing from 70.95% to 77.48%.
- The proportion of patients discharged home from Hounslow, Richmond and Kingston was higher than the proportion discharged home for boroughs not supported by the frailty team.
- Re-attendances and readmission rates for patients over 75s reduced.

Discharge Ward and escalation

- The purpose of the Discharge Ward was to provide a suitable environment for patients who are clinically optimised and the support the admission of acute patients to the most appropriate speciality ward.
- The plan to open Claremont and other escalation areas were successful, although there was still reliance on bank and agency staff to support the wards.
- The analysis of the impact of the Discharge ward demonstrates a reduction in Length of Stay on two of the three specialist wards compared with last year’s data, as shown in table 7 below:

<table>
<thead>
<tr>
<th>Inpatient ward</th>
<th>Feb/Mar 2016</th>
<th>Feb/Mar 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronte</td>
<td>8.9</td>
<td>9.6</td>
</tr>
<tr>
<td>Hardy</td>
<td>12.6</td>
<td>11.0</td>
</tr>
<tr>
<td>Hamble</td>
<td>13.5</td>
<td>12.1</td>
</tr>
</tbody>
</table>

Table 7: Length of Stay on inpatient wards
Managing the elective workload

- The pre planning of elective patients was successful, although in the future additional beds through the private patient wing would be secured in advance. The number of elective cases cancelled was low.

4.2 Lessons learnt

Workforce

The ED workforce continued to be challenging, with a number of leadership changes.

There remain difficulties in recruiting to posts in ED, including middle grade doctors. A robust recruitment and retention strategy has been implemented and some improvement in recruitment of senior medical posts has now been identified.

The resourcing of staff through agency/bank/fixed term contracts was challenging as there was a shortage of bank and agency doctors available to fill vacancies/short term sickness etc.

Nursing gaps were mitigated through the robust implementation of the escort policy, thereby reducing the need for nurse escorts, the redirection of resource from the practice development resource, the increased use of HCAs to take bloods etc.

Development of Ambulatory Emergency Care (AEC)

The hospital manages approximately 20% of its medical emergency admissions through AEC but has not been successful in developing this further in 2016/17. The opportunity to extend the work of the AEC has now been agreed. Although this number of patients is relatively small, it will help to free up beds on AAU for those patients requiring inpatient admission. The model for service delivery and workforce model will be implemented in 2017/18.

Discharge to assess and DTOC

Little improvement has been seen in DTOC. Kingston Hospital is now participating in a project led by HRCH to develop a discharge to assess model.

ED space

ECIP noted that there is a consensus amongst staff that ED is too small for the increasing number of attendances and that the current layout of the Department did not allow for enough flex between majors and minors. At busy times, the limited capacity in resus means that resus patients have to be managed in majors as ‘step down’ and that majors patients need to be managed in minors.

Setting up of the Discharge Ward

The transition of Claremont from escalation to Discharge Ward happened late in the winter period – didn’t open until February 2017. This had a number of impacts, for example, organising substantive staff to work on the ward and planning and setting baseline metrics to enable us to measure the impact of the ward. The ward also had challenges discharging some long stay patients – who stayed on the ward for significant periods of time.

Escalation

We didn’t anticipate that growth in the first three quarters of the year would be as high – and that these would be predominantly high acuity patients. As a result we did not plan for medical escalation on the surgical and gynaecology wards which meant that medical staff across the Trust were very stretched. There was a high level of flexibility from surgical nurses and support from medical matrons which mitigated.
The pace of response from all partners in the event of a surge needs to be rapid and resources available need to be managed more flexibly to support the surge.

5 National guidance for 2017/18
NHSI issued details of their priorities for the next few months in order to build resilience ahead of winter. This was documented in a letter to Chief Executives, and Accountable Officers on 14th July. This included a good practice guide focused on improving patient flow in 10 key areas.

NHS providers also issued a review of winter 2016/17 on 14th July and they made 10 recommendations to be considered/implemented ahead of winter 2017/18. These include reducing occupancy to 92%

The Department of Health and Department for Communities and Local Government - in its joint letter of 14th July requested that DTOC be reduced to 3.5% in order to reduce discharge delays and free up bed capacity.

These priorities have been factored into the Trust’s proposed winter plan for 2017/18.

6 Assumptions regarding activity in 2017/18
- The Trust has physical capacity for 415 adult patients.
- In quarter 3 of 2016/17, an average of 365 adult beds were in use in the Trust.
- If the Trust is to achieve 92% occupancy for adults only in quarter 3, a further 15 beds – i.e. a total of 380 beds will be required – i.e. escalation will need to be activated earlier than it was in 2016/17
- If the Trust is to achieve 92% occupancy for adults in quarter 4, an average of 405 adult beds have to be open at all times. At peak times the number of beds required will exceed the number of physical adult beds in the Trust – i.e. 415.
- Based on STP anticipated growth of 3.62% per annum, the Trust will require a further 15 additional beds in winter 2017/18 to manage demand. This is 15 over and above the adult physical capacity which is currently available in the Trust
- The additional beds required therefore to support growth and the requirement to achieve 92% at all times are between 15 and 30 beds. As this physical capacity is not available mitigating actions are needed.
- KHFT A&E attendances have increased by around 3% a year over the last two years, it is anticipated that this trend will continue and our A&E attendances will increase by approximately 3% in 2017/18.
- KHFT has agreed an emergency standard trajectory which the Trust must meet for 2017/18; the agreed trajectory is set out in table 8 below:

<table>
<thead>
<tr>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>90</td>
<td>92</td>
<td>90</td>
<td>88</td>
<td>92</td>
<td>92</td>
<td>90</td>
<td>88</td>
<td>90</td>
<td>92</td>
<td>95</td>
</tr>
</tbody>
</table>

Q1 90%
Q2 90%
Q3 90%
Q4 92.3%

Table 8: KHFT emergency standard trajectory 2017/18
7 Planned activities in preparation for 2017/18 and impact on the management of demand.

The planned activities for 2017/18 reflect the learning from 2017/18 and the requirements of the SWL UEC programme and A&E Delivery board. The A&E Delivery Board is charged with focusing solely on delivering UEC services. Board membership now consists of senior representatives from across each local health system to facilitate collaborative system-wide change. This board is chaired by the Chief Executive of KHFT.

The planned activities for 2017/18 for KHFT include internal and external initiatives. The external initiatives require KHFT to work together with our partners through the A&E Delivery Board. The internal initiatives are managed through the Trust’s Emergency Care Programme Board. The Emergency Care Programme Board is chaired by the Chief Operating Officer.

The A&E delivery board winter plan must be submitted to NHSE by 8th September 2017.

In proposing a number of actions to support the winter plan, the following have been considered:

- The need to mitigate the requirement for a further 15 beds and to manage bed occupancy at 92%. This includes external and internal projects.
- The need to consider how the elective programme will be managed – i.e. will it be reduced in order to support medical escalation, or will it be maintained.
- The need to open medical escalation - i.e. Claremont Ward. Peaks in activity are better managed.
- The need to meet the emergency trajectory
- The requirement to staff adequately in advance any escalation capacity.
- The requirement to increase the physical capacity in ED.
6.1 **External programme of work**

The external programme of work is focussed on reducing delayed transfers of care, reducing variation in best practice and ensuring good practice in patient flow is embedded across all parts of the emergency patient pathway.

The specific initiatives that KHFT will support through the A&E Delivery Board are:

- Anticipated to result in increased bed capacity
- Potential to result in reduced ED attendances
- Other impacts – e.g. ED performance, patient experience

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Timescale</th>
<th>Impact - description</th>
<th>Impact on beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a frailty team based on robust Trusted Assessor model where the frailty process is embedded in ED, AEC, CDU, AMU and the wards with patients actively involved in their care</td>
<td>October 2017</td>
<td>Reduce admissions and length of stay where an admission is required.</td>
<td></td>
</tr>
<tr>
<td>Initiative</td>
<td>Status</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Care Homes – supporting the implementation of the Red Bag initiative, enhanced GP cover and greater support to care homes are all initiatives being rolled out</td>
<td>Ongoing</td>
<td>There may be a small impact of these on our admissions but it is not anticipated to be significant, although with improved sharing of information length of stay may reduce</td>
<td></td>
</tr>
<tr>
<td>Pillar 7 of the A&amp;E delivery board – supporting hospital to home.</td>
<td>TBC</td>
<td>It is recognised that Discharge to Assess will be critical to managing winter successfully as shown by the recent bed audit which shows that a significant proportion of our patients could be discharged from our inpatient wards, if the right packages of care and support or additional rehab/neuro rehab beds were available. The trusted assessor model will ensure that resource is used more effectively irrespective of employer and borough</td>
<td></td>
</tr>
</tbody>
</table>
### 6.2 Internal programme of work planned to manage demand

Internal actions/initiatives the Trust will deliver as part of the Emergency Care Programme are:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Implementation date</th>
<th>Impact – description</th>
<th>Impact – beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a Medically Fit for Discharge (MFFD) Ward with up to 30 beds to facilitate efficient discharge, patient rehabilitation, improved staff development and improve capacity and admission flow</td>
<td>Pilot – with 16 beds from August 2017 Full implementation – October 2017</td>
<td>Better flow through the hospital, ensuring the right patients are in the right inpatient beds earlier in the pathway, improve patient experience, increase discharges to usual place of residence and to reduce Length of Stay on inpatient wards.</td>
<td>![Up]</td>
</tr>
<tr>
<td>Implement an enhanced AEC service to increase current numbers going through the service from 20% to 30%. This includes primary care referrals</td>
<td>Phase 1 August 2017 for weekdays only Phase 2 October 7 day service</td>
<td>Improve flow in A&amp;E, reduce 0 length of stay on AAU and improve patient experience.</td>
<td>![Up]</td>
</tr>
<tr>
<td>Implement an Urgent Care stream within a new build to manage at least 35% of ED attendances through the UCS.</td>
<td>November 2017</td>
<td>Improve ED performance Improve patient experience Improve staff experience including recruitment and retention</td>
<td>![Green]</td>
</tr>
<tr>
<td>Focus on A&amp;E processes and Improve Primary Care streaming including redirection</td>
<td>October 2017</td>
<td>To improve flow in the A&amp;E department and prevent avoidable breaches To ensure prompt response of the specialities to demand in ED</td>
<td>![Green]</td>
</tr>
<tr>
<td>Implement an extension to Majors and Resus to increase capacity within the A&amp;E Department</td>
<td>Mid December 2017</td>
<td>To increase capacity and better manage flow within the A&amp;E department to meet the increased number of attendances.</td>
<td>![Green]</td>
</tr>
<tr>
<td>Implement increased senior decision making at weekends in medicine</td>
<td>September 2017</td>
<td>To provide a 2 man on call rota, to better manage the take and enable faster identification and management of sick patients.</td>
<td>![Up]</td>
</tr>
<tr>
<td>Initiative</td>
<td>Implementatio n date</td>
<td>Impact – description</td>
<td>Impact – beds</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Introduction of plan for each patient and Red/Green days plus implementation of SAFER as part of discharge and flow programme. This includes clinical criteria for discharge, home for lunch and management of delays.</td>
<td>Phase 1 July 2017 to implement all medical wards by October 2017</td>
<td>To ensure patients are discharged as soon as they no longer receive benefit from acute care – discharges ensuring that the SAFER bundle and Red2Green days is implemented on every ward Reduce the number of 'stranded' patients</td>
<td>![Green Arrow]</td>
</tr>
<tr>
<td>Implement A&amp;E workforce strategy to recruit substantively into the Department</td>
<td>Ongoing</td>
<td>To reduce reliance on agency and bank – and to improve consistency</td>
<td>![Green Arrow]</td>
</tr>
<tr>
<td>Recruit staff to support the opening of Claremont Ward from December 2017</td>
<td>Ongoing</td>
<td>To ensure a consistent team with leadership run this ward and that agency/bank costs are reduced.</td>
<td>![Green Arrow]</td>
</tr>
<tr>
<td>Calculate elective bed requirement and consider options for the management of the elective programme. To include: Reduce elective programme and use elective bed capacity for medical emergency admissions, thereby removing the need for Claremont Ward. Or: Commission Claremont Ward and continue to run full elective programme. Implement decision arising from the above review.</td>
<td>August 2017</td>
<td>The use of elective beds for emergency capacity will impact on 18 week performance, will place pressure on the medical teams to manage this number of beds and potentially increase the number of ‘stranded’ patients. The opportunity to reduce the elective programme may be limited in order to support urgent and cancer pathways.</td>
<td>![Green Arrow]</td>
</tr>
<tr>
<td>Document week by week winter programme from December 1st 2017 – March 2018</td>
<td>November 2017</td>
<td>To track specific actions and manage demand and capacity</td>
<td>![Orange Square]</td>
</tr>
<tr>
<td>Agree operational management of winter</td>
<td>September 2017</td>
<td>To ensure a consistent approach to the daily management of winter pressures</td>
<td>![Orange Square]</td>
</tr>
</tbody>
</table>
7. **Conclusions**
The evaluation of the management of winter 2016/17 has provided the organisation with useful information on which to base the plan for 2017/18.

The pressures sustained by the NHS in 2016/17 have resulted in the publication of a number of guidance notes to support the implementation of key changes in order to provide greater resilience in 2017/18. These include stretch targets for DTOC and occupancy.

The Trust is actively planning for winter 2017/18 and will also ensure that the plans for KHFT form an integral part of the plan for the A&E delivery board which has to be submitted to NHSE by 8th September.

It is anticipated that without any mitigating actions, the requirement for escalation beds in 2017/18 will exceed that provided in 2016/17 by 15. In order to sustain 92% occupancy throughout this period, further beds are required.

It is anticipated that the successful implementation of the internal and external plans will reduce the need for the additional 15 beds. The successful implementation of all schemes will mitigate the need for escalation beds. However it is recognised that this work programme is challenging, and is dependent on a range of factors, some of which are not in the Trusts control. It is therefore recommended that the Trust plan for 16 escalation beds on Claremont Ward.

This will ensure that the elective programme continue as it did in 2016/17 and that patient experience and 18 week and cancer performance are not compromised. It is important however that the financial implications of either opening Claremont Ward or reducing elective activity are explored.

8. **Next Steps**
- To provide financial analysis to the above proposals.
- To seek approval via EMC for the agreed internal plan, once financial analysis has been applied
- To participate fully in the development of the A&E delivery board plan for submission in September.
- To action plan and measure impact
- To develop a specific plan for paediatrics and incorporate into the hospital’s plan.