Executive team meeting

Subject:	H2 Capacity Plan	**Date**: 25th October 2021	
Prepared By:	Simon Barton, Chief Operating Officer		
Approved By:	Simon Barton, Chief Operating Officer		
Presented By:	Simon Barton, Chief Operating Officer		
This paper sets out the Trust's draft H2 capacity plan for 2021/22.This has been developed by the Clinical teams and Divisions following a consultation and winter debrief.		**Approval**	X
		Assurance	X
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X			X	X

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -		X		

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

Committees/groups where this item has been presented before

Trust Management Team 29/9/21
Executive team 29/9/21
Executive team 6/10/21
Update to Trust Board on 7/10/21
Trust Management Team 27/10/21
Executive team 27/10/21

Executive Summary

Due to the Covid-19 pandemic, planning for the year 21/22 for the NHS has been split into two halves (Half 1 Apr to Aug (H1) and Half 2 Sept to Mar (H2). Given the pressures that have been evident in H1, with emergency activity higher in summer months than it was in winter 19/20, a different approach to winter 21/22 has been adopted and this paper outlines the plans and costs of capacity to meet a forecast level of demand from October 2021 to March 2022 (and beyond) rather than purely the traditional winter period.

National guidance has been received with regard to H2. Planning guidance describes that systems should plan on 0% growth on the baseline year (19/20). There is some doubt that this will happen given how busy the system has been and so 3 scenarios have been modelled 0% growth, 2% and 4%. The latter is the most likely scenario given the growth in non-elective admissions (excluding lockdown months) is 3% higher than 19/20.

This 4% modelling when unmitigated creates bed deficits for the adult medical and surgical pathways with a variance to 92% occupancy of between 33 and 66 beds during H2.

The **overarching priority** this winter as always will be to support our colleagues and their well-being through such a challenging period. The plan to support colleagues during what is likely to be a challenging winter period was presented to the Trust Board in October. Following discussions at the October Board meeting it is planned for this to be updated and come back to the Board in December.

The **capacity priorities** identified for this winter via discussion with the Clinical Chairs are:

Priority 1 – decompress critical care to mitigate the risk of the service interruption and support to the well-being of colleagues currently working within that service
Priority 2 – meet non-elective demand in a timely way to supress ED crowding and support safe ambulance turnaround, whilst continuing to treat cancer/Priority 2 patients
Priority 3 – treatment and diagnosis of priority 3 & 4 patients

NHS England/Improvement has identified expectations for H2 within the planning guidance and this is outlined within the paper, along with the Trusts position against such expectations.

At this stage this plan requires the recruitment or cover from 157 WTE, at a cost of £6.4m, £4.3m of which would be new non-recurrent investment. 66% of these WTE are either shifts being filled now or have been secured.

Update on H2 Capacity Plan 2021/22

Introduction

This paper sets out the proposed SFH H2 capacity plan for 2021/22. This plan is later than in previous years due to the complexity of the planning cycle and priorities, along with uncertainty associated with the financial envelopes available for H2.

The plan has been developed by the clinical teams and divisions following a collaborative winter debrief with 29 respondents from wards, services, and departments to gain their views on what worked, what didn't, and what can be improved for the coming winter. This has then been developed further with the clinical chairs.

Over recent years SFH has a positive track record in ensuring safe and effective patient access over winter. There has been a tried and tested approach that has, on the whole, worked well. However, the expected varying levels of demand in winter 21/22 and the increase in non-elective demand over the summer, along with the continued surge of critical care, makes this winter a different proposition

Background

The overarching aim of the H2 capacity plan is to ensure there is sufficient capacity to meet demand in the safest way possible. This year the added complexities of preparing for potential infection increases are paramount to the planning. The key principles are:

- Patient access is as safe as possible, notably that no area of the Trust is over its designed capacity, particularly reducing the surge level of critical care and crowding in ED

- CARE values ensuring staff wellbeing is paramount
- Patients are at the centre of our decision making
- Reduce the risk of cross infection
- Lead and support colleagues in line with H+S Guidelines
- Learn from our experiences of previous winters and from COVID

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National Expectations in H2

In the relationship with this capacity plan NHS England/Improvements expectations for H2 are as follows:

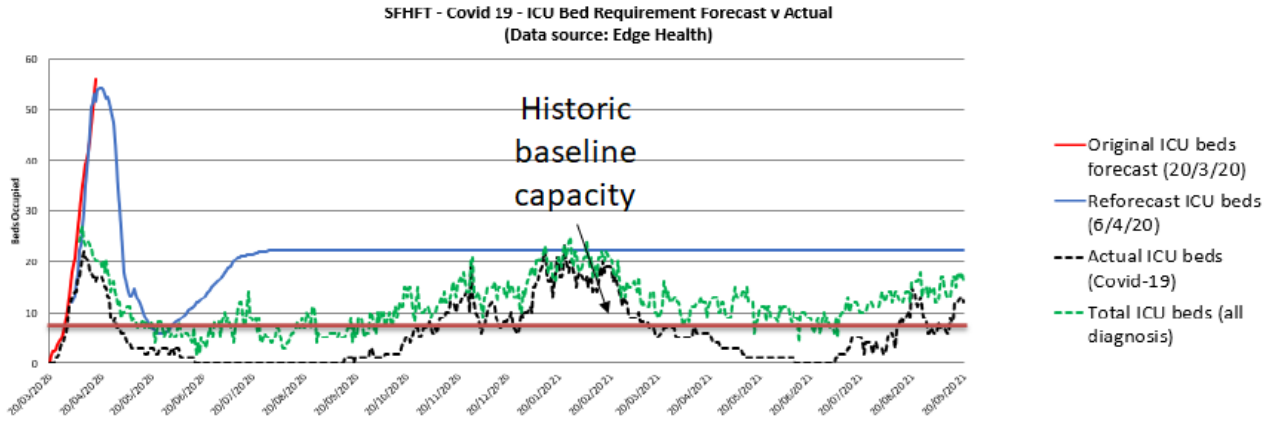
- Reduce the number and duration of ambulance to hospital handover delays within the system
- Eliminate 12-hour waits in Emergency Departments
- Return the number of people waiting for longer than 62 days to the level we saw in February 2020 (based on the overall national average) by March 2022
- Meet the Faster Diagnosis Standard (FDS) from Q3, ensuring at least 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing
- Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer
- Hold or where possible reduce the number of patients waiting over 52 weeks
- Stabilise waiting lists around the level seen at the end of September 2021

These national expectations will all be reported to the Board in the SOF from December (for October reporting, the first month in H2).

Priorities

Priority 1 – decompress critical care to mitigate the risk of the service interruption and support to the well-being of colleagues currently working within that service

The critical care unit (ITU) at KMH has been surged throughout the pandemic. The funded baseline capacity of the unit is 9 Level 3 equivalent patients. The unit has consistently had more than this level of patients since March 2020. The ITU pandemic surge plan provides an additional physical space (in Theatres) to the unit and additional staffing to support the safe care of critically ill patients.



The surged position is not sustainable and indeed there is a risk that the adverse effects on colleagues who work with the sickest patients could lead to a risk of a comprised service. In the model of how SFH runs critical care there are a number of patients, who in other NHS organisations, are looked after by other specialties in non-critical care specialist units. This is most true of Respiratory Support Units (RSU) which are units run by respiratory medicine who look after Level 2 patients who are receiving Continuous positive airway pressure (CPAP) treatment. Such units are often linked with patients who receiving non-invasive ventilation (NIV), such as patients who are currently looked after ward 43 at KMH.

There are often 4-6 patients on ITU who could be treated within an RSU and this would reduce pressure on the unit and return them closer to levels of baseline capacity, reducing the pressure on colleagues who work in the service and providing them with more sustainable workload, whilst ensuring patients get the treatment they need. It will also allow more P2 elective patients, many who have cancer, who need post-operative ITU to receive their elective treatment.

The preferred current location is surgical short stay unit. Work is underway with Skanska to increase the oxygen supply to levels required for this unit on the surgical short stay unit.

Given the status of the Respiratory Support Unit (RSU) being a new service (albeit bringing to together current services) it will go through a separate quality assurance process and be approved by the Executive team in its own right although the finances will be initially approved through this capacity plans approval.

There is some significant collateral impacts of this move, particularly:

- The displacement of short stay surgery from the location
- The closure of Ward 43 (24 beds) to allow colleagues from that unit to work on the RSU
- The removal of the respiratory team from an ability to cover any winter ward capacity as they have in previous winters given the on call/on site consultant led rotas required to run such a unit

Priority 2 – meet non-elective demand in a timely way to supress ED crowding and support safe ambulance turnaround, whilst continuing to treat cancer/priority 2 patients

This is the priority more historically dealt with through previous winter plans.

This will be achieved through the delivery of the following key objectives, delivered within the outlined principles.

- Safely avoiding admissions

- Safely creating more capacity
- Safely reducing length of stay

What level of emergency demand is expected?

Planning guidance was received in early October. The national guidance is to plan for 0% growth in non-elective demand against a 19/20 baseline year. SFH's current growth in 21/22 non-elective admissions (adjusted for lockdown month of April 21 where demand is artificially supressed) against 2019/20 is 3%. SFH therefore feel that planning on 0% would present too high a risk for patients and are planning on a 4% growth, particularly noting the likelihood of surges in Covid admissions during the winter. NUH are planning 3.5% growth.

The below shows the bed deficits against baseline (476 adult acute beds) at 0%, 2%, and 4% growth at 92% occupancy. This analysis is produced by Edge Health, the Trusts bed analytics partners since 2018.

	01/10/2021	01/11/2021	01/12/2021	01/01/2022	01/02/2022	01/03/2022
Beds required @0% growth on 19/20	500	509	496	524	526	485
Deficit/surplus	-24	-33	-20	-48	-50	-9
Beds required @2% growth on 19/20	503	518	503	536	534	496
Deficit/surplus	-27	-42	-27	-60	-58	-20
Beds required @4% growth on 19/20	509	524	508	540	542	501
Deficit/surplus	-33	-48	-32	-64	-66	-25

As in previous years, the aim of the plan is to deliver 92% occupancy for 75% of the daily hours, acknowledging that occupancy can be tolerated a little higher overnight. The trust has shown in past winters that at certain times it can cope with occupancy slightly higher than 92% and still provide safe access to care for patients, but the planning ambition needs to remain at 92%. This level of occupancy will not deliver levels of perfect access that 85% would. 85% is not seen as achievable from a workforce perspective. No LOS improvement is factored into the unmitigated model of the case as the Trusts LOS on this pathway is at some of the lowest levels seen in recent years.

At 4%, this modelling therefore creates the following bed deficits for the adult medical and surgical pathways with a variance to 92% occupancy of between 33 and 66 beds during H2. The March modelling is skewed by Covid-19 effecting admissions in March 2020 (the baseline year).

	Baseline capacity	Requirement by month					
		01/10/2021	01/11/2021	01/12/2021	01/01/2022	01/02/2022	01/03/2022
Medical & Surgical Pathway requirement	476	509	524	508	540	542	501
Variance to baseline capacity		-33	-48	-32	-64	-66	-25

Planned H2 bed capacity (at this stage)

H2 capacity plan will focus on meeting the shortfall in demand via the following methods:

- Safely avoiding admissions
- Safely creating more capacity
- Safely reducing length of stay

Safely avoiding admissions

Admission avoidance will mainly be via the extension of the Same Day Emergency Care service (SDEC). Due to its expansion, during 21/22 to date the service has doubled the number of patients

(1923 patients) treated via SDEC than in the corresponding period in 19/20. Some of these patients would have been admitted to a bed and therefore this off sets a proportion of bed demand, although this is a small impact on bed capacity as it essentially removes a 24 hour stay. The patient experience benefits are significant.

Further focus will be to safely avoid admissions by expanding the consultant cover, notably in ED later into the night and at weekends. It is planned to have longer opening hours of SDEC to increase the level of throughput for same day care. Bolstering staff in ED and EAU to peak time of demand will also support flow and patient safety.

Safely creating more capacity

The table below shows the plan for bed capacity opening only for H2.

Area	Additional Beds/Equivalents	Timeline	Cumulative	Comments
Acute Adult beds				
Respiratory Support Unit (RSU)	10		**10**	
Ward 43 (closes)	-24		**-14**	
Ward 41	16	Dec 21 - Mar 22	**2**	Open as acute ward following Oakham moving onto Chatsworth (16 beds)
Ward 14	10	Open	**12**	Surgical patients
Ward 21	8	Open	**20**	24 beds to medicine (Jan-Feb 2021)
Non-Acute Adult beds				
Sconce	8	Open	**8**	Open in H1
Ashmere	3	Open	**11**	Open in H1, only 3 beds extra v MCH
Virtual hospital	12	Oct 21 - Mar 22	**12**	Respiratory/cardiology
Acute non-adult beds				
Ward 25 (Paediatrics)	10	As required	**10**	Via Paediatric surge plan

The ability to safely open more beds may be constrained by the levels of workforce and given the forecast increase in flu, RSV and the continuation of covid it would be reasonable to assume there will be an increase in workforce loss due to sickness and carers/ parental leave as been seen in H1.

The winter ward (Ward 41) will be facilitated by the movement of rehabilitation patients off that unit to Chatsworth ward at Mansfield Community Hospital. Ashmere homes will continue to be used to supplement the rehabilitation bed base due to the delays in the completion of the estate works at MCH that means these wards will not be available this winter.

In partnership with primary care, SFH will build on the success of the Covid-19 virtual ward and create a wider model that will support admission avoidance and early supported discharge for covid and non covid patients. This will include adult respiratory, cardiology, frailty and RSV in children.

The plan intends, as in previous winters, for Ward 21 to be a medical ward in January and February 2022, although agreement is not yet in place on its purpose (it has been an end of life ward in previous winters). This will be settled over the coming weeks with the ward teams involvement in the plan.

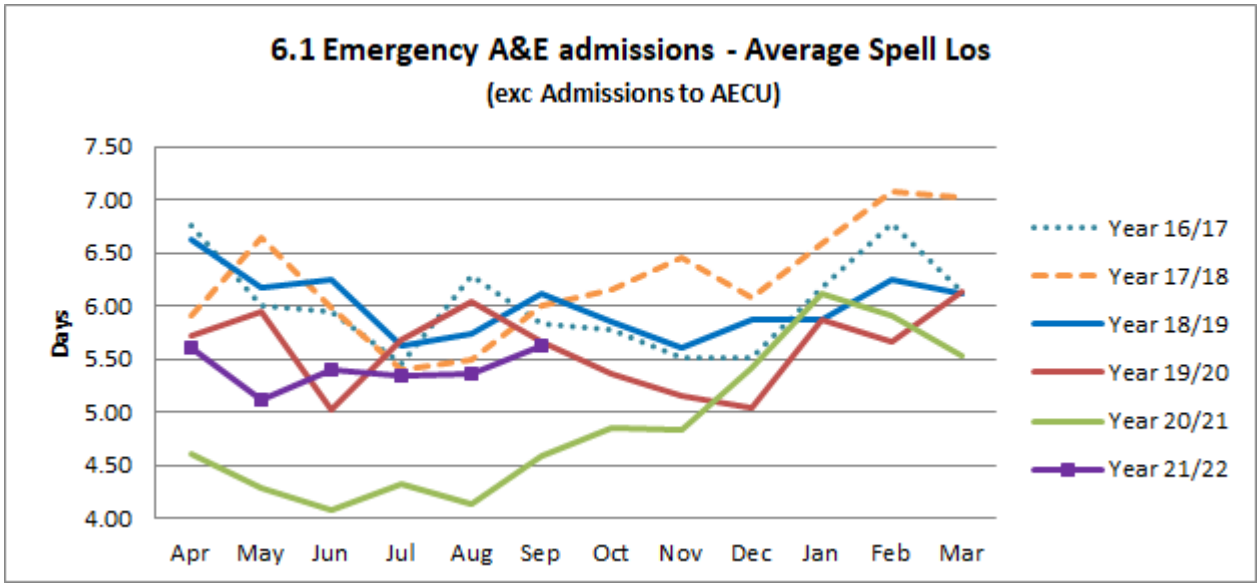
During this period elective orthopaedic patients will continue to be treated via the surgical short stay unit and within the established service at Newark.

For children's services there is a pandemic plan in place. Ward 25 operates on a baseline with 30 beds in the day and 26 at night. There is also a Children's assessment unit (CAU), a successful and innovative service with a capacity for 6 children at any one time that operates 1300-2200 Monday to Friday. The surge plan has 3 escalation levels with incremental levels and triggers

dependant on the levels of RSV, which at maximum would take the service to 40 beds overnight although at this levels elective care for lower priority children would not be able to take place.

Safely reducing length of stay

To end of September 2021, the average LOS (excluding SDEC admissions) at SFH has been lower than most other comparable years (not including the pandemic period when demand fell in 20/21).



There remains internal improvements that can be made in SFH to manage LOS in H2, but the most fundamental improvement relates to the improvement in the discharge of 'Medically Safe for Transfer' (MSF) patients into their on-going care destinations in a timely manner.

The agreed ICS threshold for MSFT patients at SFH is 22, yet levels are regularly over double this threshold. Patients wait a range of days for accessing their on-going care in a timely manner and this needs to be a very high priority for H2 in the ICS capacity plan if hospitals are to safely cope with demand. The ICS is working on the plans to mitigate the risks of the growing number of MSFT patients occupying acute beds within SFH and this plan is expected but is not yet finalised. SFH will work closely with Nottinghamshire County Council to support the financial and workforce requirements of the provision of home care.

Internally, there will be two other areas of focus on LOS, the discharge of patients at weekends and the second is escalation when services are crowded.

Priority 3 – treatment of priority 3 & 4 patients

The decompression of critical care may reduce the risk of excessive use of Theatres at KMH as a surged critical care facility and may mean that inpatient operating (and particularly cancer care) can be maintained if beds are made available. The Division of Surgery are also working up proposals to increase the levels of operating at Newark, on an extended procedure list and potentially at weekends for day cases. It is planned that even if the short stay surgical unit is used as an RSU then the 'trolley side' of day case unit can continue to take patients from Theatres, thereby continuing the treatment for a large number of day case surgical patients.

The plan at present would be to continue to run outpatients as per the past year, however, at times it may be required to prioritise senior medical staffing to inpatient areas, sometimes diverting them from outpatient work.

What does this mean for capacity?

The table below shows the cumulative impact on capacity of opening and closures in this H2 period. This includes the impact of the creation of an RSU.

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22*
Projected @4% growth in demand	509	524	508	540	542	501
Deficit/surplus against baseline beds	-33	-48	-32	-64	-66	-25
Bridge (Acute adult beds)						
Respiratory Support Unit			10	10	10	10
Ward 43			-24	-24	-24	-24
Surgical Short stay (on Ward 43)			0	0	0	0
Ward 41 (created by Chatsworth)		16	16	16	16	16
Ward 14	10	10	10	10	10	10
Ward 21	8	8	8	8	8	8
Deep clean decant	-5	-5				
Total (adults)	**13**	**29**	**20**	**20**	**20**	**20**
Deficit/Surplus with acute mitigations only	**-20**	**-19**	**-12**	**-44**	**-46**	**-5**
Bridge (adults - not acute, so not included)						
Chatsworth (counted above as creates acute beds)						
Sconce	8	8	8	8	8	8
Ashmere**	2	2	2	2	2	2
Virtual				12	12	12
Paediatrics	10	10	10	10	10	10
Total (adults)	**10**	**10**	**10**	**22**	**22**	**22**
Deficit/Surplus with ALL mitigations	**-10**	**-9**	**-2**	**-22**	**-24**	**17**
Forecast Occupancy (%)	**94**	**94**	**92**	**96**	**97**	**89**
* Mar 22 baseline skewed by Covid lockdown in March 2020						
** Ashmere homes have capacity of 26 beds - 24 of which offset MCH						

The table demonstrates that at 4% growth, SFH would have a bed deficit at 92% occupancy for acute adult beds of between -12 and -46. When non-acute beds are factored into this plan, it delivers a deficit of between -2 and -24 beds. With all beds factored in this would lead to the forecast occupancies identified.

In practice this will lead to some delays as patients, notably who are medically safe for transfer will need to be moved into non-acute capacity to free up acute capacity. Even at 0% and 2% growth SFH will have an acute bed deficit (0% growth deficit of -4 to -30, 2% growth deficit of -7 to -40). Given the required closure of 24 acute beds within this programme to facilitate the creation of the RSU then there is a direct link between the priority of decompressing critical care and going into H2 with an acute bed deficit.

In January and February, when occupancy will be high this may lead to a reduction in day case surgery and the conversion of some of that capacity. The Trusts full capacity plan and escalation processes are currently being reviewed to be able to ensure patients safety during these periods.

Workforce requirement

At a high level, the workforce requirement of the plan at this stage is shown below. Detailed plans are required for the implementation of these critical workforce elements.

Summary per WTE	UEC	Medicine	D&O	W&C	Corporate	Total
Nursing	33.59	39.29	3.00	13.91	12.00	101.79
Medical	4.00	17.90	-	0.40	0.30	22.60
Non clinical	8.88	6.80	-	-	-	15.68
Other clinical	-	-	17.43	-	-	17.43
TOTAL	**46.47**	**63.99**	**20.43**	**14.31**	**12.30**	**157.50**

In future iterations of the plan there will be the usual RAG rating of each scheme is based on the following:

Recruited to plan < 75%	Recruited to plan between 75% - 90%	Recruited to plan > 90%

The progress on these plans will be reported weekly on the plan to the Divisional teams, Executive team and to Non-Executives.

104 WTE (66%) within this plan is either already operational supporting capacity that has been open in H1 or has already been secured for H2 schemes so despite how challenging the workforce environment is progress is being made in this area. Contracts are being secured with agency workforce, along with rolling recruitment and international recruitment to support the plan further.

Costs

At this stage, this plan would require £6.4m investment into H2. Approximately £2.1m of this (at PYE for 6 months) cost is for schemes that have been operational in H1. Therefore, new investment would be £4.3m.

This costing has not yet been through a detailed executive challenge process by the COO & CFO and this is scheduled to take place at the Divisional Performance Reviews on 29/10/21.

There is normally an attrition rate from the forecast to the actual which is driven by a lack of fill rates for some schemes as well as shift price changes and recruitment assumptions. Given workforce challenges this is likely to be higher in 21/22, but with that cost savings comes scheme risk delivery.

Quality assurance and approval

There are three schemes within the plan that would require a quality assurance and approval process, along with QIAs to be undertaken as they are new services:

- Respiratory Support Unit
- The movement of additional elective operating to Newark, potentially with a more complex cohort of patients
- An expanded virtual ward which supports non-Covid patients

This will be led by the Medical Director & Chief Nurse.

What does success look like?

The success of this plan is linked to the priorities described and would be as follows:

- A sustained critical care service delivered by SFH, ensuring that patients who need critical care receive it when they need it
- The suppression of crowding within ED and maintenance of the current ambulance turnaround times

- A safe reduction in the number of patients spending over 12 hours in ED from arrival to departure
- The delivery of the re-forecast cancer backlog over 62 days along with assurance by the quality committee on the systems and processes for ensuring delays above 62 days do not lead to adverse outcomes
- The delivery of the FDS standard for cancer diagnosis
- The delivery of 0 patients waiting over 2 years for their elective treatment

Risks

There continues to be a number of risks to the delivery of the plan and will require mitigation where possible

- **Workforce supply** – it is forecast that workforce supply will be constrained this winter, mainly due to infection in general, and carers leave. Absence in winter 2020/21 was around 7-7.5% in winter 20/21 and a similar position is anticipated.
- **Demand assumption** – the plan is based on 4% NEL growth, any increase to this will adversely impact flow and may contribute to overcrowding in ED
- **Infection surge**- we are anticipating RSV, flu and covid alongside other infection e.g. noro virus which will inadvertently impact of capacity and risk bed closures
- **Partners winter plans/number of MSFT patients in acute beds** – these will be shared at A+E delivery board but are not clear at this point. Plans across all system partners will be critical for the reduction in the number of MSFT patients in acute beds and if this continues at current levels creates a high risk of this plan not achieving its aims.
- **Elective recovery**- the recovery of elective work may be at risk where NEL activity supersedes the bed availability

The Trust Management Team, Executive team, and Trust Board are asked to:

- Approve the H2 capacity plan and the success outcomes identified
- Acknowledge the risks in delivery
- Agree a fortnightly progress report on the implementation of the capacity plans identified

Simon Barton
Chief Operating Officer
October 2021