REPORT TO:	**Urgent Care Working Group**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Winter beds and capacity planning 2013/14**
REPORT DATE:	**31 OCTOBER 2013**

Purpose

Anecdotal evidence suggests UHL is short of medicine and assessment beds each winter. This paper provides the Urgent Care Working Group with an update on the completed modelling to identify winter 2013 - 14 bed requirements and the actions taken to close the deficit between the beds required and the number of available beds.

Four of the performance challenges UHL faces moving into winter 2013 are:

- Increasing emergency admissions
- Poor performance against the A&E four hour quality measure
- Variable RTT performance
- A high on the day cancellation rate

The four challenges are directly linked to the fragile nature of timely access to beds. UHL has a high nurse vacancy rate which exacerbates the situation.

Modelling

In August 2013, the Chief Operating Officer commissioned a review of the number of beds UHL required in winter 2013 – 14 to treat elective and non-elective patients. The information and performance team worked with divisions and services and updated the bed capacity model to calculate the number of beds needed at a speciality level. Data from 2012-13 was used with assumptions made for:

Elective

- Updated to most recent LOS
- Occupancy set at 95% for a 5 days of the week (which equates to 68% for the week)
- Activity levels as per contracted levels
- Day cases excluded

Emergency/ Non-Elective

- Updated to most recent LOS
- Occupancy set at current occupancy with a ceiling set at 92% for specialties that are 93% and above
- Activity levels as per 2012/13 outturn
- Maternity beds excluded

The outputs of the model were split between adult and children beds and exclude maternity and day-case beds. A number of scenarios were worked through the model and results reviewed before the final planning assumptions were agreed at the Cross Divisional meetings. The model was then shared with members of the TDA and ECIST for external validation. The external findings included:

- 'The tool the team are using in itself is absolutely fine, it's the most complex / sophisticated tool I have seen….it's not just urgent care but planned care, theatres, OPD etc'
- 'The right parameters are accounted for, demography, service changes, LoS, desired occupancy levels etc'

- 'The info team are setting the right / pragmatic boundaries for planning, for example setting a 92% occupancy level, zero impact of demand management etc'

Outcome from tool

Based on current length of stay, occupancy rates and activity forecasts, it is estimated that UHL requires a further 74 medical beds (as detailed below) and 26 assessment spaces this winter to support timely transfer of patients from ED without affecting RTT throughput.

2013/14 WINTER - ADULT INPATIENT BEDS NEEDED AT THE LRI

	BED STOCK AT SEPTEMBER 30th 2013			BED NEEDED OCTOBER 2013 TO MARCH 2014				
	Elective Beds	Non Elective Bed	TOTAL	Elective Beds	Non Elective Bed	AVERAGE TOTAL	Average Difference to bed stock	Actual Maximum Trust Bed Number
Acute Medicine	3	356	359	3	389	392	-33	401
General Surgery	16	48	64	18	54	72	-8	77
Gastroenterology	2	56	58	2	63	65	-7	72
Other Surgical Beds	25	47	72	22	41	63	9	61
Trauma Beds	0	84	84	0	85	85	-1	90
Oncology/Haematology	13	53	66	15	60	75	-9	74
Gynaecology	1	11	12	1	11	12	0	12
ITU/HDU	5	10	15	5	10	15	0	15
Other Beds (BMT/IDU)	6	17	23	6	17	23	0	25
TOTAL	71	682	753	72	730	802	-49	827
EDU/EFU		15	15					

Acute Medicine
Integrated Medicine
Neurology
Dermatology
Rheumatology

Other Surgical
ENT
Max Fax
Ophthalmology
Plastics
Vascular

Length of stay

One of the key ways to reduce the deficit is to reduce length of stay. As a further form of validation, the information team compared the UHL LOS with other peer groups. UHL compares well with the HES peer group (average of all the acute trusts in England) and the BCBV peer (Better Care Better Value six acute trusts). It is likely that Nottingham University Hospitals will have a marginally better LOS, but we are just waiting for their updated numbers. Further work must continue to reduce LOS, but opportunities compared to similar trusts appear to be slim in the short term.

Non Elective Medicine	FY 2012/13	2013/14 (April-June)
UHL	5.7	5.2
HES PEER Average	6.8	5.6
BCBV Average	6.7	6.7
Nottingham	5.5	TBC
Sheffield	7.1	7.7
Newcastle	8.6	7.1
Leeds	7.1	7.7
Birmingham	6.3	7.4
Coventry	7.1	5.8

Actions taken

All possible UHL, community and Independent Sector options for increasing the winter bed base have been explored. The key actions taken to increase the bed numbers are:

Action	Number of beds	Date of opening	Likelihood delivery
Additional community beds	24	Opened	
Additional respiratory beds at the Glenfield	15	01/01/2014	
Conversion of day case facility at LRI into an overnight ward	16*	18/11/2014	
Additional assessment beds from medical bed base	16**	01/11/2013	
Outsourcing of elective work to support RTT work		01/11/2013	
Hiring of modular and Vanguard theatres		N/A	
Reopen Brandon Unit		N/A	

* These beds cannot be used as overnight beds initially because of ward staffing shortages

** Whilst this is a 16 bed increase for the assessment unit, this is a 16 bed reduction for the medical bed base. Clinical opinion has been sought and changing the ratio of beds is supported as a short term measure.

The above changes leave UHL with a 51 bed and 10 assessment unit bed shortage in winter 2013 – 14.

Action	74	26
Additional community beds	24	
Additional respiratory beds at the Glenfield	15	
Conversion of day case facility at LRI into an overnight ward		
Additional assessment beds from medical bed base	-16	16
Gap	**51**	**10**

To close the gap further, it is essential the work to improve discharge, in particular earlier discharge in the day, continues as well as work to reduce admissions.

Recommendation

The Urgent Care Working Group is asked to note the paper and the on-going work to improve access to beds. Access to beds will be the critical factor this winter.

Richard Mitchell
28 October 2013