Purpose of the Report

To present the first draft of the Trust’s Winter Operational Plan 2014-15 to the Board of Directors for approval. This draft will continue to be developed as internal arrangements are further refined and plans from the System Resilience Groups (SRG), CCGs and other NHS providers become available in September 2014.

Key points for discussion

This plan sets out the actions Airedale NHS Foundation Trust is taking to ensure it is resilient to the pressures placed on health services during winter 2014-15. It is based on the Trusts existing Resource Escalation Action Plan (REAP) thus ensuring that existing, well-understood arrangements are maintained and minimising the additional demands placed on staff.

It is not currently possible to confirm what additional funding will be available via the SRG monies – the Trust has put in bids to Airedale, Wharfedale & Craven CCG, Bradford City CCG and East Lancashire CCG. The outcome of these bids will determine the extent to which this plan can be scaled up and which further developments can be considered and once determined will be included in the final plan due to the Board in September/October 2-14.

The plan has been created with input from Clinical Directors, Senior Matrons and other senior clinical staff and sets out:

- key areas of learning from last year’s winter experience, including
  - staffing mix and spend
  - coordination of patient admission, flow and discharge
  - partnership working
- roles and responsibilities
- operational response and monitoring arrangements

The following risks remain to the implementation of Winter 2014-15

- Higher than anticipated activity given the continued increased in demand during quarter 1 and the national picture across acute providers
- Lack of 7/7 working progress in primary care
- Recruiting additional staff to increase capacity in key areas of scarce human resource – e.g. registered nurses, ED and Acute Physicians

Once the regional arrangements are confirmed (expected September) any extant risks will be given formal review and escalation in line with the Trust’s standard risk assessment process.
Recommendation
Discuss and approve the first draft of the Operational and Capacity Planning Strategy for Winter 2014-15
Final plan will come back to the BOD for approval in September/October 2014.
# Operational and Capacity Planning Strategy for winter 2014-15

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**ASSOCIATED POLICIES & PROCEDURES**
- PANDEMIC FLU PLAN
- MAJOR INCIDENT PLAN
- PAEDIATRIC ESCALATION PLAN
- BUSINESS CONTINUITY PLANS

**SUPPORTING PROCEDURES**
- ADVERSE WEATHER PLAN
- CARER LEAVE POLICY
- COMMUNITY SERVICES BUSINESS CONTINUITY PLANS
- RESOURCE ESCALATION ACTION PLAN
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1.0 Introduction

Following the pressure experienced during the winter of 2012/13, NHS England published the A&E Recovery Plan in May 2013. The plan brought together all partners and triggered the creation of Urgent Care Working Groups (UCWGs).

The recent Operational Resilience and Capacity Planning for 2014/15 guidance has expanded the role of UCWGs to include elective as well as urgent care. This change is reflected in a change of name to System Resilience Groups (SRGs). They will now become the forum where capacity planning and operational delivery across the health and social care system is coordinated.

Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires capacity planning to be on-going and robust. This is managed from an organising and governance perspective using the Resource Escalation Action Plan (REAP) tool which is used by all partners in health and social care in West Yorkshire. This is the methodology that will be deployed during the winter period to deal with the surges in demand.

There is no current forecast available covering the expected nature of winter 2014/15 however, regardless of its severity, there will almost certainly be times when icy conditions increase the risk of fractures; while the effect on different forms of winter weather on chronic health problems is well-known. In addition, increased staff sickness absences and potential transport difficulties will have an impact on the Trust’s ability to deliver a high quality service over the winter months.

This strategy sets out the framework within which the operational processes, during winter 2014/15, will be implemented and any surge in activity managed effectively. It does not contain the detailed contingency plan or the related procedures that will be implemented over the winter period, e.g. the Resource Escalation Action Plan (REAP) or opening a ward as they are already in existence and fit for purpose. If the surge in activity is a result of pandemic flu then the winter plan will work in conjunction with the agreed Trust wide pandemic flu plan.

The experience of previous winters showed that when the site was in escalation, neighbouring Trusts were experiencing similar pressures and therefore any opportunity to consider a diversion to create some temporary capacity was not available. On this basis the REAP does not include any plans to divert patients elsewhere unless a Major Incident is declared.

1.01 Aims of the winter strategy

- To ensure patients receive care in the most appropriate environment
- Enable patients to have a safe journey through the system whilst ensuring that they receive treatment in a timely and appropriate way
• Identify specific initiatives to manage seasonal pressures based on evidence base, best practice guidance and lessons learned from previous years

• Confirm key roles and responsibilities across staff groups

• Work with health and social care partners to maintain services as far as is practicable, and ensure that where a decision may impact on a partner this is taken in consultation with the affected organisation

• Continue to work with CCGs and other partners to map processes against Operational Resilience and Capacity Planning for 2014/15 guidance to ensure the timely release on non-recurrent funding to support winter (due September/October 14)

This plan will contribute to the health economy wide plan developed by the commissioners. It has been reviewed by Airedale, Wharfedale and Craven Clinical Commissioning Group to provide assurance to NHS England. It will also be submitted to the local SRG who are required by NHS England to sign it off as an acceptable plan. The time scale for this is expected to be SRG sign off by the end of September 2014.

2.0 Review of Winter 2013-2014

2013/14 was a mild wet winter, with temperatures well above the long-term average for all three months. By contrast, temperatures in 2012/13 were slightly below the long-term average and this may explain some of the trends noted at ANHSFT.

As you can see from the table below, the number of patients attending the ED in 2013-14 was 6.8% lower than winter 2012-13. This may have been as a result of the warmer temperatures and decreased incidence of influenza in the population, however despite this decrease, admissions into hospital beds increased by 8.7%. Although a definitive cause and effect cannot always be established, it is believed that systems implemented to avoid ED attendances, for example support from the Collaborative Care Team, Advanced Nurse Practitioners in the ED and the development of a Frail Elderly multidisciplinary team based on the Acute Medical Unit worked well. However, there appeared to be a much higher acuity in sick patients requiring a hospital stay rather than community care which led to a rise in admissions.

A significant number of non-elective admissions to Adult Medicine and Surgery throughout the winter period 2013-14 were those from direct GP admissions rather than ED. As the Board of Directors will be aware this is a trend that has continued during the first quarter of 2014-15 and is consistent with the pressures the majority of acute providers across England are facing.

ED breaches decreased by 25% as a result of better management of patient flow, and the provision of additional 12 short-stay beds which changed flow to mean the patients did not need to be admitted to one of the base wards for a more prolonged hospital stay in 30% of patients. This has remained consistent and this not only delivers a better experience for the patients has contributed to an overall reduction in Length of Stay across the Medical Group. This increase in short stay capacity also enabled the Trust to better manage its overall bed base and therefore led to a reduction of 7% in bed
occupancy and an increase to 95.8% in the Trust’s achievement of the Emergency Care Standard (an increase of 1% from 2012-13).

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Also supporting the reduction in bed occupancy was that no bed days were lost to D&V / Norovirus in 2013-14. During 2012-13 there were 729 bed days lost (out of 58,283) or 1.25% over 5 outbreaks from 16/10/2012 to 31/3/2013. This is likely to be because of the low rates of the virus in the community and therefore may not be contained at these levels this winter.

The Trust also achieved the Flu Vaccination target of 75% of patient-facing staff; this will have contributed to better levels of absence rates over winter further easing the pressure on the Trust.

2.01 What went well last year?

- Delivery of the Emergency Care Standard (ECS) for patients throughout each quarter
- Training and development to expand the scope of work the scope of Emergency Nurse Practitioners (ENPs) to cover minor ill health and injury in the ED
- Use of Ambulatory Care Unit (ACU) Ward Manager to assess outliers with respect to movement and flow
- Expansion of short stay ward capacity at the front end of the pathways in Medicine
- Pharmacy representation in Acute Medical Unit (AMU) and Pharmacy opening on a weekend to support discharges
- Expanded psychiatric liaison service in ED from 8am – 4pm service 7/7 to 8am – 2am service 7/7
- Pack up and go team on AMU, ED and Medical base wards
- Focused pro-active management patients with a length of stay of over 14 days by Senior Matron (with a trigger of less than 50 patients over 14 days in the Medical Group bed base at any one time)
- Junior Drs added to weekend nights and late shift
- Community increased daily staffing levels and intermediate care bed base to support demand
- Additional discharge ward rounds on the medical base wards on a Sunday
- Multidisciplinary team led by an Advanced Nurse Practitioner from the Collaborative Care teams for the Frail Elderly pathway based across ED/AMU.
• Telemedicine in local care homes across AWC and Bradford

2.02 Areas for potential further development
• Discharge planning and step up into and out of hospital needs significant improvement
• Locum acute physicians were less efficient than established staff
• On AMU - Short stay, front end and ambulatory care did not expect such a prolonged winter (i.e. until June) and there were resulting difficulties in e.g. bed holds, ACU, PCAL and short stay
• Ensure prompt transport of patients to plain film X-ray between 5-7pm
• On-going work to determine most suitable type of beds for winter 2014/15 e.g. short stay beds, wards beds and intermediate care beds
• The local authority is also working on planning to include additional capacity at Thompson Court to be used as additional rehab and intermediate care beds. This is not yet agreed but a priority we support
• Flow onto ACU from ED and AMU needs to improve/be more efficient e.g. criteria led.
• Implement chest pain pathway from ED to ACU – CD for this area leading this work
• Increase number of clinical support workers, use of phlebotomy and ECG technician support to be considered
• Implementation of daily consultant ward/board rounds Mon – Fri rather than 3 times per week
• Further develop the Frail Elderly MDT model and keep pace with best practice /evidence
• Agreement and implementation of internal professional standards to cover the acute medical pathways
• Focused work to develop the culture of multi-organizational teams to streamline systems and processes and support patient flow
• Improved access to same day diagnostics for the Surgical Assessment Unit – specific priority is Ultrasound.

2.03 Areas for Improvement and Development – New system wide developments

Improved access, and management of intermediate care beds

An Intermediate Care HUB (IC-HUB) is to be developed in conjunction with partner organisations and will be operational from early October 2014. The IC-HUB will act as a shared front door for health, social care and VCS intermediate, rabblemint and rehabilitation services. It will be operated by a dedicated multi-disciplinary team of health, social care and VCS professionals working together to provide a range of services including signposting, screening / triage, assessment and care co-ordination. It will have both a triage and assessment function to ensure that each person referred for intermediate and rehabilitation
care is placed on the most appropriate care pathway. It will provide a single point of entry into intermediate and rehabilitation care services across Airedale, Wharfedale and Craven that enables professionals to arrange the right care for urgent and non-urgent referrals, therefore enabling a seamless transfer out of the acute hospital setting. There is an expectation that a 2 hour response time from the IC-HUB to the referrer is in place.

It has been agreed that the IC-HUB will be based within the Airedale FT Telemedicine Hub and the Director of Operations is chairing the Intermediate Care Board across AWC. This is an important development as the lessons learned from previous years indicate that there is a need to redesign and streamline the processes in place for all staff across health and social care settings in accessing intermediate care. This should improve step up rates resulting in more admissions to hospital being avoided and speed up the process of those patients with complex discharge needs.

There is a significant amount of work to do still to deliver this for this winter, but all partners and the CCG are signed up to this being a priority.

3.0 Capacity Management and Resilience

3.01 Bed Management

Based on modeling by the lead GM plans will be put in place to allow the bed base to be increased by up to 30 additional beds to allow for both winter pressures and any additional surge in demand over the winter period. These will consist of:

- 25 additional short stay beds and general medical beds
- 5 additional intermediate care bed at Castleberg.

Work is ongoing to establish how these beds will be utilised and medically managed over the winter period. There are also ongoing discussions with Airedale, Wharfedale and Craven CCG to increase intermediate care capacity across the patch.

The Local Authority are also developing plans to establish a number of "discharge to assess" beds at Thompson Court, where patients who are medically fit can be transferred whilst they are waiting for care packages.

It should be noted that plans for increasing the physical bed capacity may change subject to further discussions in the Winter Planning group meetings.

There is further work required to detail what response we will put in place when we are experiencing an exceptional surge that is sustained for more than 72 hours. This would be when we have been consistently at REAP levels of 4 and are likely to require further contingencies over and above those currently outlined in the plan. The detail of this is being discussed with the relevant Clinical Directors and will be included in the final plan in September/October 2014.

Daily bed meetings will occur at 1.30pm and 3.30 pm (Mon-Fri) and will establish current activity, demand for admissions, bed availability and any further actions required to meet demand. The 3.30pm meeting will ensure that the Trust has sufficient
capacity to meet demand overnight and, if required, ensure there is an overnight contingency plan, which may include initiation of the bed escalation plans and associated late bed meeting (5.30pm). This meeting will assess whether the plans that have been put in place are sufficient to meet demand and whether any further actions are required overnight. It will also review elective admissions for the following day to determine if there is sufficient capacity available once the numbers of patients with an expected date of discharge is confirmed.

During particularly high levels of activity when the Trust is experiencing bed pressures, the General Manager in Medicine will send a bed alert communication via email to primary care teams to try and avoid hospital admission where appropriate.

On Saturday and Sunday the 1st on-call manager will be in contact with the bed manager at critical times during the day to assess activity in ED, patient flow problems and discharges. The bed manager will convene a 1.00pm patient flow meeting with ED shift leader and an AMU representative, if required. Appropriate escalation of any actions required following this meeting will be to the 1st on-call manager and on-call physician (if appropriate).

3.02 Escalation / De-escalation
Where there are a high number of ED attendances or direct medical admissions to AMU this can create pressure that if not managed proactively can affect the care and management of patients. Trigger points have been created within the REAP and these act as an early warning mechanism to ensure appropriate and timely decisions are quickly made, for example to close and open inpatient beds to maintain patient flow and a safe environment for patients

The escalation plan alerts and advises the Senior Management Team and Executive of the state of the escalation. This will involve the Medical Director and Chief Executive if the site is at maximum capacity for an extended period of time and the safety of patients is at risk.

3.03 Outlier Management
Individual areas are expected to manage their bed base without outlying and should explore all other avenues to create capacity before outlying – primarily this should involve early senior review of newly admitted patients and a focus on discharging patient discharge. However, should it be necessary to outlie patients into non-specialist base wards then the details can be found in the bed management policy.

3.04 Discharge
The clinical teams will focus on discharge, communicating the Expected Day of Discharge (EDD) to the patient and family/carers. The daily board rounds will be used to escalate, via the Matrons, any delays in the system that are impacting on patient experience and flow. Patients being discharged will be made aware of the need for them to have vacated their bed by 1pm wherever this is considered appropriate, and the clinical teams will facilitate this, by ensuring the take home medications have been
arranged the day prior to discharge, transport is arranged and discharge letters are prepared. The senior nurse for transformation has redesigned the discharge information for patients and their families which is currently being tested on one of the wards with a view to roll out to all areas in preparation for winter from October 2014.

When making the decision to admit / discharge patients from ANHSFT, as well as the clinical reason, consideration should be given to the weather, the patient’s personal circumstances and the ability of community services to respond to assessed need.

If discharge of patients to the community is the pressure point within the hospital, it may be beneficial to identify beds as pre-discharge beds. If necessary a discharge lounge function will be opened, where patients who are ready to go home can be transferred from the ward into a safe environment. This should improve patient flow and ensure that beds are available for new admissions.

We are working closely with social care partners to look at the feasibility of opening additional beds outside of hospital for rehab and intermediate care for patients requiring complex continuing healthcare / social care packages although this is dependent upon the CCG commissioning this additional capacity.

3.05 Prioritisation

The clinical priority of patients across all groups and service will be the key determinant of treatment of when, where and how patients are cared for, this may mean that an urgent elective patient is treated before a self-referrrer into the ED.

Where appropriate patients may be directed into less congested services, this will only be done where clinical judgment has identified the alternative as suitable for that patient.

3.06 TTOs

These will be written directly after the completion of every ward round, or the day before discharge for those patients that are planned discharges.

3.07 Communications

Internal communications during winter must be:

- Predictive – staff should be advised of any upcoming capacity requirement and difficulties, and the decisions that will be taken to address them
- Real-time – so that staff are aware of current conditions

Communications will be managed by the Director of Operations and the General Managers in association with the Winter Operations Group and Communications team.
In the event of a period of adverse weather the Trust will cascade communications messages, using normal operational communication flows, to staff and patients as required.

3.08 Admission Avoidance

Admission to hospital should be avoided where possible and clinically justified; work is on-going with our 5 year plans with key partners to avoid admission if there is a suitable alternative service. As the Board will be aware currently this work includes:

- Telemedicine, Telehealth and Telecare
- Collaborative Care Teams focus on step up as well as step down services
- Advanced care planning in primary care with the support of locality based teams – this is in the early stages of development
- Minor illness and injury services at ED and Local Care Direct out of hours as well as in hours delivered from Airedale NHS Foundation Trust
- NHS 111 – developing paramedic practitioners who can see and treat patients – proposal to test this service in Craven that the CCG have been asked to consider – not yet agreed
- Expansion of community pharmacy offering repeat prescription services to all practices based within AWC – not yet agreed
### 3.09 Christmas 2014

In order to ensure that acutely ill patients are safe and discharges are delivered over Christmas period additional arrangements are in place:

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Community services annual leave granted at usual levels to ensure appropriate staffing levels at all time with additional staff on shift pre and post bank holidays in the Collaborative Care teams

### 3.10 Regional and Local Feedback

Currently regional arrangements for winter are under development this section will be updated once the requirements are advised.
4.0 Roles and Responsibilities

To enable the winter plan to work effectively staff must be clear about their roles and responsibilities. Outlined below are the roles and responsibilities of the key people in terms of winter planning. Where the key person is unavailable, e.g. due to annual leave, they are required to ensure appropriate arrangements are in place to ensure continuity of their responsibilities / tasks, for example nomination of a deputy

4.01 Trust Board
The role of the Trust Board is to ensure that the winter plan is produced and is fit for purpose to meet expected demand.

4.02 Chief Executive
The role of the Chief Executive is to ensure that there are robust winter planning arrangements in place, that there is delegated responsibility to a Director for the delivery and monitoring of the plan and to ensure adequate resources are made available to implement it.

4.03 Director of Operations
The Director of Operations has delegated authority from the Chief Executive for the development, implementation and for monitoring the effectiveness of the plan. In addition, the Director of Operations has the responsibility to alert the Chief Executive and other Executive Directors if the plan is not working, and advise what remedial action has been taken and its impact.

The Director of Operations has shared responsibility, along with the Medical Director and the Director of Nursing, to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity during the winter period. The Director of Operations is also responsible for leading the development of communication mechanisms with external bodies.

4.04 Lead Clinical Director (CD)
The CD for Medicine is the lead Clinical Director; along with their responsibilities as a Clinical Director and Consultant (sections 3.09 and 3.10) they will work with the Lead GM and Senior Matrons to develop and deliver the winter plan and provide visible clinical leadership during winter. They will ensure that any risks to patient safety as a result of winter are identified and escalated appropriately.

4.05 Lead General Manager (GM)
The lead GM is General Manager, Integrated Care and Diagnostics. As well as the responsibilities described within section 3.8, they are responsible for ensuring the development and operational management of the winter plan and its related arrangements. They will escalate any concerns which cannot be resolved by them to the Director of Operations
4.06 Director of Nursing
The Director of Nursing has shared responsibility with the Medical Director and Director of Operations to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity during the winter period. The Director of Nursing must ensure that quality and safety risks are quantified and escalated appropriately, and ensure that mitigating actions are identified, implemented and monitored; this includes appointing additional staff and tasking the Senior Matrons as necessary.

The Director of Nursing will provide visible professional leadership to clinical colleagues, most specifically at times of increased pressure, and provide leadership and support during the planned staff flu vaccination programme.

4.07 Medical Director
The Medical Director has shared responsibility with the Director of Nursing and Director of Operations to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity during the winter period. The Medical Director will ensure that in the event that quality and safety risks occur, they are quantified and escalated appropriately, and that mitigating actions are identified, implemented and monitored.

The Medical Director will provide visible professional leadership to medical colleagues, most specifically at times of increased pressure. The Medical Director will appoint additional staff and task the Clinical Directors as necessary.

The Medical Director will play a major role in liaising with the CCG’s, Social Services and GPs and will provide leadership and support during the planned staff flu vaccination programme.

4.08 General Managers, General Manager of the Day and Community Services Manager
The General Managers and Community Services Manager will work with their clinical teams to ensure that beds, patient flow and other services within their areas are managed effectively. The general manager of the day will chair the 1:30pm and 3:30pm bed meetings (Mon-Fri) plus any escalation meetings. The General Managers will make the decision whether to, and where to, open or close wards during winter in normal hours.

General Managers and the Community Services Manager will support the implementation of Internal Professionals Standards for their areas of responsibility.

4.09 Clinical Directors
Clinical Directors will work closely with the General Managers and their clinical teams to ensure that patients are reviewed and discharged in a timely manner. This should ensure that patient flow in their respective areas does not adversely impact on patient
safety. Where appropriate, Clinical Directors will instigate additional ward rounds to ensure patients move quickly and safely through their pathways of care. In addition, Clinical Directors will ensure, as far as practicable, that there are sufficient doctors to meet the increased demand and complexity of patients. The Clinical Directors, supported by the General Managers and Senior Matrons, will ensure that internal professional standards are implemented and remain in place over the winter period.

In diagnostic services, the Clinical Director should ensure services are running effectively to meet the service demands and where necessary expedite tests/procedures to facilitate early diagnosis and possible discharge.

4.10 Consultants
Consultants will work with their clinical teams to ensure that patients are seen in a timely manner and that they are discharged appropriately. They must co-operate with any changes made to deal with a high influx of patients. It is expected that when on-call physicians will ensure the AMU triage and escalation is delivered during times of increased activity.

Consultants will work to the agreed Internal Professional Standards within their area and support delivery across the Trust.

4.11 Senior Matrons
A daily assessment of the bed state, including community beds will be made at 9.00am by a senior matron and provided to the bed meeting

Under the instruction of the General Manager of the Day / 1st or 2nd on-call, the Senior Matrons are responsible for the opening and closing of beds to meet fluctuation in demand and monitor the quality of care and safety of patients. Senior Matrons will escalate to relevant managers any issues relating to the operation of the plan and to attend the daily bed meetings (Mon-Fri), as well as providing leadership for the matrons. They will ensure that any risks to patient safety as a result of winter are identified and escalated appropriately.

The Senior Matrons will review all patients whose length of stay exceeds 30 days.

4.12 Lead Nurse for Transformation
The Lead Nurse for Transformation is responsible for ensuring that wherever possible, pathways of care across the health and social economy are joined up to ensure that there is a seamless transition of care into and out of hospital to and from different care settings.

4.13 Matrons / Community Team Leaders
Matrons / Community Team Leaders will ensure sufficient MDT staff are available to meet the fluctuations of patient activity and to monitor the flow of patients. Where demand exceeds available MDT staff they will prioritise workload appropriately. They will ensure Falls assessments are completed for all relevant patients and where appropriate, additional assistance technologies are in place.
The late Matron will attend daily bed meetings (Mon-Fri and monitor the quality of care and patient safety at ward and community level as reported in the daily capacity and demand reports.

Weekly review of patients in hospital beds over 14 days will be undertaken by the matrons and a report produced for the Director of Nursing and Medical Director.

They should put systems in place to ensure staff can escalate concerns to the Senior Matron, the Community Services Manager or the on-call manager as appropriate:
- With patients relating to cold / winter weather.
- Where patients do not take warm meal and drinks regularly (where permitted by their medical state)
- Do not have suitable warm clothing for their stay in hospital and when being discharged.
- Where patients may have issues with home environment e.g. frozen pipes, broken heating

4.14 Bed Managers and Case Managers
The Bed Managers are the single point of contact for decisions regarding the allocation of beds for all acute and elective admissions (paediatrics and maternity have their own systems). The Bed Manager is responsible for maintaining a current bed state and will attend the daily bed meetings. They are also responsible for liaising with the ED to ascertain their activity throughout the day, and to plan the bed base for anticipated admissions. They will arrange the transfer of patients (in accordance with the transfer policy) between wards and receive transfer requests from external organisations.

The case managers are part of community services and ensure optimum use of intermediate care facilities. During the bed meetings the bed managers will provide data on the number of empty beds, the number of expected discharges and elective admissions for the following day across the Trust. The Case Managers will escalate to the senior matron if there are perceived delays in accessing social services and will work collaboratively to understand service pressures.

4.15 Site Manager
8am-8pm, this role is filled by the Bed Managers. Outside this time the role is discharged by the Hub Sister (band 7) and Acute Care Sister working together.

4.16 1st on-call Senior Manager
1st on-call manager will attend the 3.30pm daily bed meeting (Mon-Fri) to ensure that they are clear about the state of the hospital before they leave the site. They will stay in regular contact with the hospital to enable them to have an up to date position regarding the patient flow and potential problems. The 1st on-call manager will escalate to the 2nd on-call senior manager as appropriate. This level of contact will continue during weekends and over bank holidays.
4.17 2nd on-call Manager
The 2nd on-call manager will attend the 3.30pm bed meeting and provide support and guidance to the 1st on-call manager. They will be responsible for dealing with external communications e.g. press, other providers, Clinical Commissioning Groups, NHS England or other independent providers. They will keep the Director of Operations informed of any material issues as required.

4.18 Compliance Manager
To receive the cold weather alerts on behalf of the Trust and circulate as appropriate (1 November – 31 March).

4.19 Assistant Director of Estates and Facilities
Ensure arrangements are in place to monitor the temperature of clinical areas and take action to ensure safe temperatures are maintained. Ensure that timely repairs are made and contingency plans put in place to address winter issues, for example if a water pipe bursts this is quickly repaired and water supplies are maintained by alternative routes / methods to the affected areas. Ensure that access to the hospital is clear and safe in the event of snow and ice and the site is adequately gritted.

4.20 Head of Employee Health and Wellbeing
Responsible for the implementation annual flu vaccination campaign and making regular reports on its progress to the Winter Operations Group.

4.21 Winter Operations Group
For the winter period a Winter Operations Group will be established to monitor the Trust’s performance against the agreed plan. The group will meet every week, or as required, during November – March.

5.0 Incident Reporting / Complaints
During periods of peak surges in demand normal processes may have to be delayed or suspended to ensure care for critical patients is maintained. This is likely to result in an increased number of complaints from both patients and the public, where this occurs the existing complaints and PALS process will be followed.

In the event of an adverse event the Trust’s existing incident reporting process will be followed regardless of the cause of the incident. If in doubt an AEF should be completed.
6.0 Flu Immunisation

A flu vaccination campaign will be held to encourage staff to have the flu vaccination and the aim this year is to substantively increase that number and ensure vaccination takes place as early as practical in the winter period.

Campaign aims:

- To increase the Seasonal influenza vaccine uptake to meet the target once confirmed by DoH
- Increase awareness and knowledge of the flu vaccination for front line health care workers
- Remind health care workers of the potentially serious nature of flu and dispel myths about the vaccine
- Provide clear information on where and when to get vaccinated
- Encourage early uptake by the end of October 2014

Once DoH targets are confirmed a detailed implementation plan will be created, this will be monitored by the Winter Operational Group, where there is any risk that targets will not be met this will be escalated to the EAG by the Director of Operations.

7.0 Risk Register

Managing patients at a time of increased pressure will expose the Trust to increased risks; due to the requirements for integrated working across the whole health economy these are recorded on the SRG Winter Risk Register as well as our local risk register

8.0 Review and Next Steps

Once approved this strategy will form a basis for the review of the REAP and ED Escalation to produce a winter specific version. The REAP (and any associated documents) will be continually reviewed for effectiveness by the Winter Operations Group and amended as necessary. Revisions will be approved and circulated as required by the Winter Operations Group.

Once formally approved by Trust Board and SRG in September/October 2014, subsequent revisions to this document will be by the Winter Operations Group.