Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	29 October 2014				
Report Title:	**Operational and Capacity Planning Strategy for Winter 2014-15**				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X			X	X	
Prepared by:	Shaun Milburn, General Manager, Medicine, Diagnostics & Therapy Services and Stacey Hunter, Director of Operations				
Executive Sponsor (presenting):	Stacey Hunter, Director of Operations				
Appendices (list if applicable):	Operational and Capacity Planning Strategy for winter 2014-15				

Purpose of the Report

To present the final draft of the Trust's Operational and Capacity Planning Strategy for winter 2014-15 to the Board of Directors for approval.

This document will be reviewed as long range weather forecasts become available and plans from the System Resilience Groups (SRG), CCGs and other NHS providers become available.

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.

The plan has been created with input from General Managers, Clinical Directors, Senior Matrons, Matrons and other 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
- surge capacity arrangements for winter pressures and for dealing with any additional surges in demand occurring during this period, for example from a MAJAX.

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

- Higher than anticipated activity given the continued increase 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

It is anticipated that the AWC CCG will coordinate a regional winter planning exercise to test system resilience in the near future (dates have yet to be confirmed) any issues identified as a result of this will be incorporated into a further revision of the plan.

Recommendation

Discuss and approve the final version of the Operational and Capacity Planning Strategy for Winter 2014-15. Subsequent amendments to the plan will be approved by the Winter Planning Group chaired by the

Director of Operations.

Airedale NHS
NHS Foundation Trust

Operational and Capacity Planning Strategy for winter 2014-15

UNIQUE IDENTIFIER	ASSIGNED BY SHAREPOINT
VERSION NO.	6.1
LEAD AUTHOR NAME	SHAUN MILBURN / STACEY HUNTER
LEAD AUTHOR JOB TITLE	GENERAL MANAGER MEDICINE
ACCOUNTABLE DIRECTOR	DIRECTOR OF OPERATIONS
CONSIDERED BY	WINTER OPERATIONS GROUP
RATIFIED BY	TRUST BOARD
DATE APPROVED	
EFFECTIVE FROM	OCTOBER 2014
REVIEW DATE	JANUARY 2015
LOCATION OF COPIES	SHAREPOINT
ASSOCIATED POLICIES & PROCEDURES	PANDEMIC FLU PLAN MAJOR INCIDENT PLAN RESOURCE ESCALATION ACTION PLAN PAEDIATRIC ADMISSION POLICY MATERNITY ESCALATION PROCEDURE CONTINGENCY PLANS
SUPPORTING PROCEDURES	ADVERSE WEATHER PLAN CARER LEAVE POLICY COMMUNITY SERVICES BUSINESS

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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 long-term weather 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 of 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 these plans 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 there was no opportunity to consider a diversion to create some temporary capacity. 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

- 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 based, 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 of non-recurrent funding to support winter (due September/October 14). Currently the release of system resilience money is still waiting for confirmation from NHS England, with the consent of the Systems Resilience Group (SRG) Bradford, Airedale, Wharfedale and Craven plans have been approved and organisations are proceeding on this basis. The SRG has formally advised NHS England.

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 October 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 (December 2013-February 2014). 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 in Table 1 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 of sick patients therefore requiring admission to hospital rather than community care.
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 2 quarters 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 ad meant patients did not need to be admitted to one of the base wards for a more prolonged hospital stay for 30% of patients. This has remained consistent, and not only delivers a better experience for the patients but 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).

	Dec-12	Dec-13	% diff	Jan-13	Jan-14	% diff	Feb-13	Feb-14	% diff	Mar-13	Mar-14	% diff	Total 12/13	Total 13/14	% diff
ED attendances	5001	4396	-12.098	4474	4153	-7.1748	4172	3880	-6.999	4633	4594	-0.8418	18280	17023	-6.8764
Admissions	1465	1512	3.20819	1424	1544	8.42697	1250	1486	18.88	1394	1473	5.66714	5533	6015	8.71137
Breaches	320	193	-39.688	327	254	-22.324	162	155	-4.321	142	111	-21.831	951	713	-25.026
ECS	93.6013	95.6096	2.14566	92.6911	93.8839	1.28689	96.117	96.0052	-0.1163	96.935	97.5838	0.66929	94.79759	95.811549	1.0696
Bed occupancy	98.25	91.26	-7.1145	98.55	94.26	-4.3531	98.1	93.87	-4.3119	98	95	-3.0612	98.225	93.5975	-4.7111

Also supporting the reduction in bed occupancy was the loss of no bed days 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 31/3/2103. 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 decreased 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 an 8am – 4pm service seven days a week to a 8am – 2am service seven days a week.
- "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 Doctors added to weekend nights and late shift
- Community increased daily staffing levels and intermediate care bed base to support demand, e.g. Holmewood for patients with Dementia
- Additional discharge ward rounds on the medical base wards on a Sunday
- Multidisciplinary team led by an Advanced Nurse Practitioner (ANP) from the Collaborative Care teams for the Frail Elderly pathway based across ED/AMU.
- Small pilot of ANP from Collaborative Care Team working in ED / AMU which has informed further service development

- Telemedicine in local care homes across Airedale, Wharfedale and Craven (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, led by the Clinical Director for this area
- 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
- Improved access to same day diagnostics for the Surgical Assessment Unit – specific priority is Ultrasound.
- ANP in ED/AMU over 5 days per week implemented March 2014

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 which is planned to be operational in November 2014. The IC-HUB will act as a shared front door for health, social care and Voluntary Care Services (VCS) intermediate, re-ablement 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 stream line 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.

- **Developing Community Capacity and Capability**
  Non-recurrent funding from North Yorkshire County Council and AWC CCG has been provided to expand a range of community services, including
  - Dementia Crisis Response and Prevention Services
  - Expansion of the Collaborative Care Teams
  - Expansion of Specialist Nursing Services, including heart failure and cardiac rehabilitation and respiratory
  - Expansion of telemedicine service into Craven Care Homes and East Lancashire

3.0 Capacity Management and Resilience

3.01 Bed Management

Based on modeling by the lead GM (detail in Appendix C), plans will be put in place to allow the bed base to be increased to allow for both winter pressures and any additional surge in demand over the winter period. These will be available from the 1st December and consist of:

- 30 additional short stay beds and general medical beds based on Ward 10 (Appendix A)
- 5 additional intermediate care beds at Castleberg (Appendix B).
- 15 beds at Thompson Court, including "discharge to assess" beds where patients who are medically fit can be transferred whilst they are waiting for care packages.
- 10 additional short stay beds on Ward 1 that will be flexed as required.
- 14 beds available on Ward 3 annex that could be opened during peak surge periods. This will be contingent upon adequate nurse and doctor availability which will be determined by the Clinical Directors, General Manager and Senior Matron for the Integrated Medical Group on a day to day basis
- There are also ongoing discussions with Airedale, Wharfedale and Craven CCG to increase intermediate care capacity across the patch but, there is a risk as nothing has yet been confirmed

Based on activity assumptions (see Appendix C) and continued reduction in length of stay over this winter, modelling shows an additional 50 beds will be required at peak times (Jan/Feb). There are 12 local authority beds (as below) available meaning 38 acute beds are required at peak times. The arrangements outlined above should enable sufficient provision on this basis. Clearly there remains some risk as the trends in demand remain unpredictable and volatile.

AWC CCG advise there are currently no changes to existing service provision and **subject to NHSE releasing system resilience funding** additional capacity will be provided at Thompson Court and Holmewood. The CCG are also in dialogue with North Yorkshire CCG regarding the additional beds at Ashfield and Neville House and Currergate and will keep the Trust informed if the situation changes. Currently there are the following bed numbers

- Currergate - 16 beds
- Castleburg -10 beds
- Holmewood – 4 beds

Subject to system resilience funding (expected to be confirmed by Oct 31st 2014

- Thompson Court - 8 beds (shared use with BTHFT). There is a possibility to commission additional beds, however funding for this is not identified, the CCG will keep this under review
- Ashfield- 6 beds

NB: Please note as of 17th October, 2014 we have received notification that we are likely to get a second tranche of SRG monies, estimate £782,000. This is yet to be confirmed but is positive news.

During winter access to these beds will be managed using the management arrangements described within the REAP, when all the escalation beds (Ward 10, 1 and 3) are legitimately full the Trust will move to formal Command and Control arrangements to ensure adequate management and oversight (as described in the Corporate Contingency Plan). This will remain in place until the surge and any resulting issues are resolved (estimated 2-3 weeks for a 5-6 day surge).

The plan for opening the additional beds will need to remain flexible given the unpredictable nature of some of the critical factors. It is anticipated this will be in December however a specific date cannot be given as the trigger point will depend upon the nature and type of weather and patients admitted. This will be managed in the Winter Planning group meetings which are chaired by the Director of Operations

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 decide 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 will be sufficient capacity available once the numbers of patients with an expected date of discharge is confirmed.

During particularly high levels of activity, for example when the Trust is experiencing bed pressures, the General Manager in Medicine (or their designated deputy) 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 during times of escalation 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.

Escalation plans also exist for maternity services (Implementation of Maternity Services Escalation Plan) and children's services (included in the Children's Unit Admissions Policy) which will be invoked when the defined triggers are met within these areas.

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 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 pinch point within the hospital, it may be beneficial to identify beds as pre-discharge beds. If necessary a discharge lounge 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. These will be for patients requiring complex continuing healthcare / social care packages, however 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-referrer 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 key partners on our 5 year plans 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
- Expansion of community services and development of new pathways, e.g. delivery of IV / subcutaneous therapies.

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:

Month	Date	Extra ward rounds				
December 2014	**24**					
	25					
	26					
	27					
	28					
	29					
	30					
	31					
January 2015	**01**					
	02					
	03					
	04					

	05					
	06					
	07					
	08					
	09					
	10					
	11					

Community services annual leave requests managed 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 clear and 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 throughout the winter period. The Director of Operations is also responsible for leading the development of communication mechanisms with external bodies.

To ensure that medical staff with the correct skills are appropriately located to provide the best support for discharge and flow the Director of Operations will work with the Lead Clinical Director to identify a cohort of Senior Physicians and other relevant staff to form the basis of a rapid response team to work across AMU/ACU/ED. Once identified, the Consultants will identify appropriate Junior Doctors to join the team. HCSW from OPD will provide required support.

4.04 Lead Clinical Director (CD)

The CD for Medicine is the lead Clinical Director; in addition to 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.
- Ensure that any risks to patient safety as a result of winter are identified and escalated appropriately.
- Work with the Director of Operations to identify physicians to form part of the rapid response team

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, including SITREP reporting. 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 at 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 allocate 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 beds / 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 an increased 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 (in hours) or 1st / 2nd on-call (out of hours), 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. One / both Senior Matrons will escalate to relevant managers any issues relating to the implementation of the plan and 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 and that minimum safe staffing levels are met.

The Matrons for Medicine and Surgery will review all patients with a length of stay over 14 days and both 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 staff are available to meet the fluctuations of patient activity and to monitor the flow of patients. Where demand exceeds available staff they will prioritise workload appropriately and utilise additional assistance technologies where necessary.
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 ensure staff 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 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 normally filled by the Bed Managers. Outside this time the role is discharged by the Acute Care Team Sister (band 7).

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 uptake and ensure vaccination takes place as early as practical in the winter period. Community Services are integral to the delivery of the national flu campaign for patients.

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.

Appendix A – Winter Ward and Surge Capacity Details

To provide suitable and safe patient care during winter the following arrangements have been put in place – these will be in place from the 1st December, but implementation will be delayed as long as circumstances permit (estimated 18th December)

- Specific patients will be identified for these beds. Discussions are ongoing with Clinical Directors to confirm the criteria for admission and any impact on other wards to ensure logical grouping of patients by medical team.
- Short stay patients will not be admitted.
- Staffing for ward 10 will be essential to ensure safe patient care and maintain patient flow;
    - Nurses will be pulled from base wards (recruitment of nurses is ongoing, to ensure adequate ratios can be maintained). Any resulting gaps in nursing rotas on base wards will be backfilled by bank / agency staffing
    - An additional ANP will be provided
    - Consultant rounds will depend on the nature of patients admitted (see above) these will be supported by Registrar and Junior Doctors, as appropriate.
    - Discussions are ongoing to provide pharmacy & therapies support.

Appendix B - Castleberg Hospital, Harden Ward - Action plan for Increase in patient bed numbers

Requirement	Action	Lead person responsible	Time scale	Interim arrangements
Increased registered and non-registered staffing levels required	Staffing to be asked to work flexibly, bank shifts Bank staff from community bank, agency nurses to be 2nd RN	M Greenwood F Durham	Minimum of 48hrs	If nurses not available from bank, discuss release of nurses from AGH with Senior Matron if still not adequate, then utilise agency nurses.
Increased supply and stock of bed linen, bed side curtains, towels etc.	Housekeeper to order extra supplies	T Lambert	48hrs	
Increased need for meal provision on ward	Catering staff will order increased foodstuffs to be delivered to unit	Sodexo	48hrs	
Increased stock of medications	Order extra stock of ward stock medicines	M Greenwood F Durham	24hrs (working days)	
Review of oxygen cylinders, ensure adequate stock	Review ward stock and order increased supply if necessary	M Greenwood F Durham	24hrs (working days)	
Increased stock of dressings, catheters, equipment etc.	Review of ward stock and order increased supply if necessary	M Greenwood F Durham	7 days	Will increase ward stock levels in anticipation of increased bed base
Increased stock of equipment such as water jugs, drinking cups etc.	Order extra equipment	M Greenwood F Durham	7 days	Will increase ward stock levels in anticipation of increased bed base

Requirement	Action	Lead person responsible	Time scale	Interim arrangements
Increased domestic staffing levels to maintain cleanliness standards	Review of staffing rotas and allocation of domestic staff	R Oddy	48hrs	
Increased clinical waste	May need to increase clinical waste collection to weekly (currently 2 weekly)	A Wooler	To review agreement	
Increased ward administrator hours to maintain clerical duties	Review available admin hours across community services to offer support, staff may need to work flexibly	A Wooler M Greenwood		
Extra dining room furniture will compromise sitting area in dayroom	Other furniture available across site to be used if suitable in short term	M Greenwood F Durham R Walton	24hrs	Will review other available furniture and label in readiness
Spare patient lockers and bedside tables stored in empty bay on ward	Ned to review and dispose of shabby/ excess equipment to free up bay for inpatient beds	M Greenwood F Durham		Will review in next 2 weeks and arrange for disposal of any unfit equipment
Test outdated nurse call system and ensure operational in ward bay not currently used	Ward has been allocated new nurse call system from capital funding – need to confirm date of fitting	M Greenwood F Durham	4/7/14	
Extra easy chair furniture required for bedsides and dayroom	Costings to be sought for new furniture, liaise with AGH re spare furniture	M Greenwood F Durham		
Bedside lights In spare bay require checking to be in working order by estates dept.	Refer to works dept. for review	M Greenwood	Reported to works dept. July 2014	

Requirement	Action	Lead person responsible	Time scale	Interim arrangements
Increased need for pressure relieving equipment on ward	Costings for new pressure relieving cushions required Air mattresses may be needed from ANHST mattress store	M Greenwood	July 2014 ordered 4/7/14	

Appendix C Bed Modeling for Winter 2014-15

Assumptions

- Ward 15 is now closed with loss of 21 beds.
- Activity is running 7% higher than last year
- Predictive model is based on higher winter activity than last year
- Length of stay (LoS) is between 0.5 and 0.8 days less than last year
- Patients with LoS>14 days will increase to similar levels to last year
- 25% of these patients are medically fit for discharge and could be elsewhere
- 8-12 additional local authority beds are available from November
- During peak months (Jan-Feb) bed occupancy will be 325
- Bed occupancy rates must not exceed 95% (failure of ECS)
- Maximum additional beds = 50 made up of 40 acute and 10 local authority
- Plan - open up ward 10 (30 beds) during 2nd half of December
- Flex up ward 1 and AMU during peak times (10-15 beds)

	Month	Average daily admissions	Beds occupied	Bed occupancy	LoS	Beds Required (89-95% occupancy)	Total Additional escalation beds required	Patients >14 days	Estimated pts. >14 days that could be transferred to step down bed	Additional Local authority step down beds	Acute escalation beds required
2013	June	42.97	275	86.2	6.40	319	1	61	15		
	Jul	46.45	277	88.2	5.96	314	-4	63	16		
	Aug	44.71	270	86.2	6.04	313	-5	68	17		
	Sept	43.53	281	89.3	6.46	315	-3	73	18		
	Oct	46.23	287	91.4	6.21	314	-4	69	17		
	Nov	43.83	289	88.2	6.59	328	10	78	20		
	Dec	48.77	306	91.26	6.27	335	17	70	18		
2014	Jan	49.81	327	94.26	6.56	347	29	100	25		
	Feb	53.07	326	93.87	6.14	347	29	86	22		
	Mar	47.52	332	95	6.99	349	31	98	25		
	Apr	49.86	320	95.06	6.42	337	19	98	25		
	May	49.58	311	95.11	6.27	327	9	95	24		

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	Month	Average daily admissions	Beds occupied	Bed occupancy	LoS	Beds Required (89-95% occupancy)	Total Additional escalation beds required	Pts >14 days	Estimated pts >14 days that could be transferred to step down bed	Additional Local authority step down beds	Acute escalation beds required
	June	49.7	300	91.75	6.04	327	9	89	22		
	Jul	48.55	284	94.04	5.85	302	11	69	17		
	Aug	46.32	264	89.31	5.70	296	5	70	18		
	Sept	49.3	268	90.38	5.44	297	6	64	16		
	Oct	50.29	274	92	5.44	295	4	69	17		
	Nov	50	278	92	5.55	300	9	75	19		
	Dec	53.06	294	92	5.55	318	27	80	20	12	15
2015	Jan	54.16	325	95	6.00	341	50	100	25	12	38
	Feb	55.72	323	95	5.80	339	48	95	24	12	36
	Mar	51.68	300	92	5.80	324	33	95	24	12	21

Ward	Established beds	Escalation beds available
1	18	10
2	30	
3	0	14
4	30	
5	27	
6	30	
7	30	
9	25	4
10	0	30
13	29	1
14	28	2
19	11	
ICU	16	
18	15	
Total	289	61

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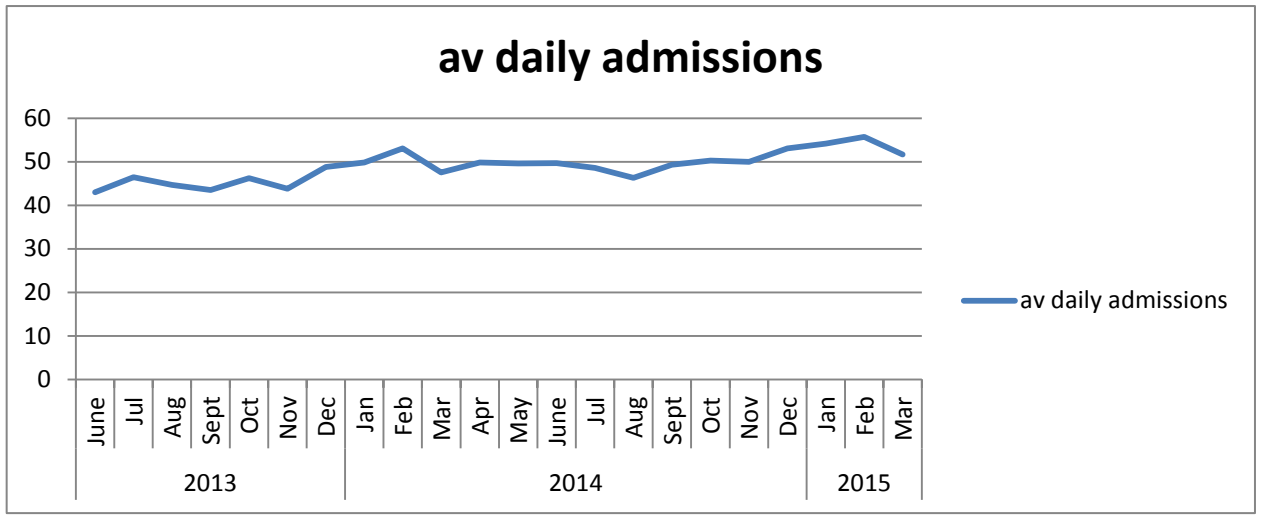

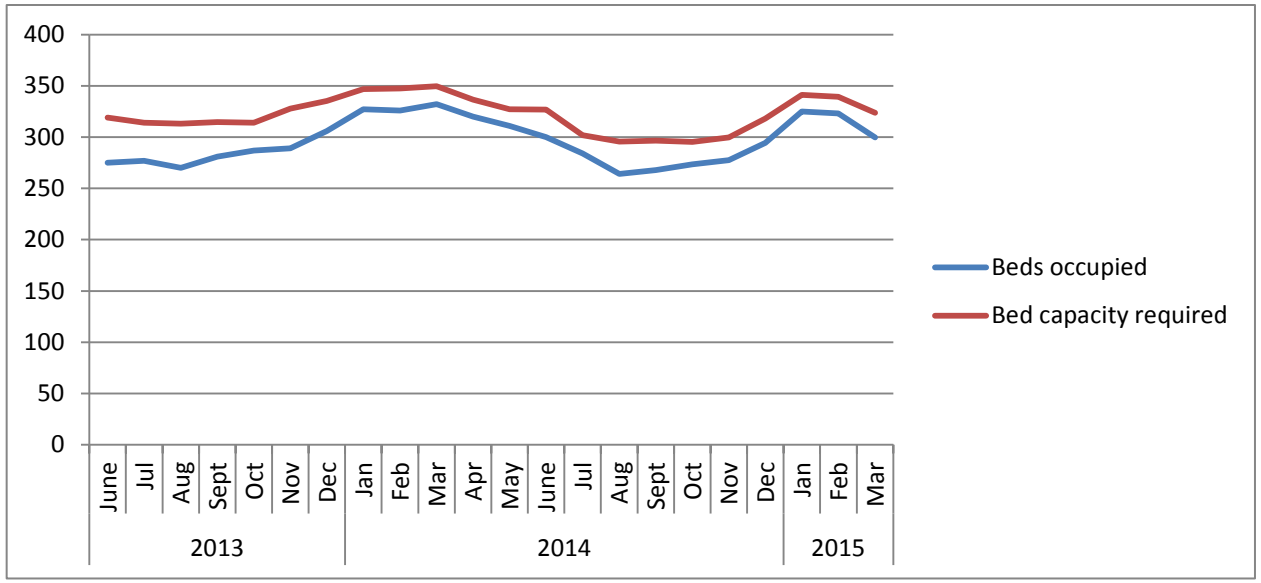

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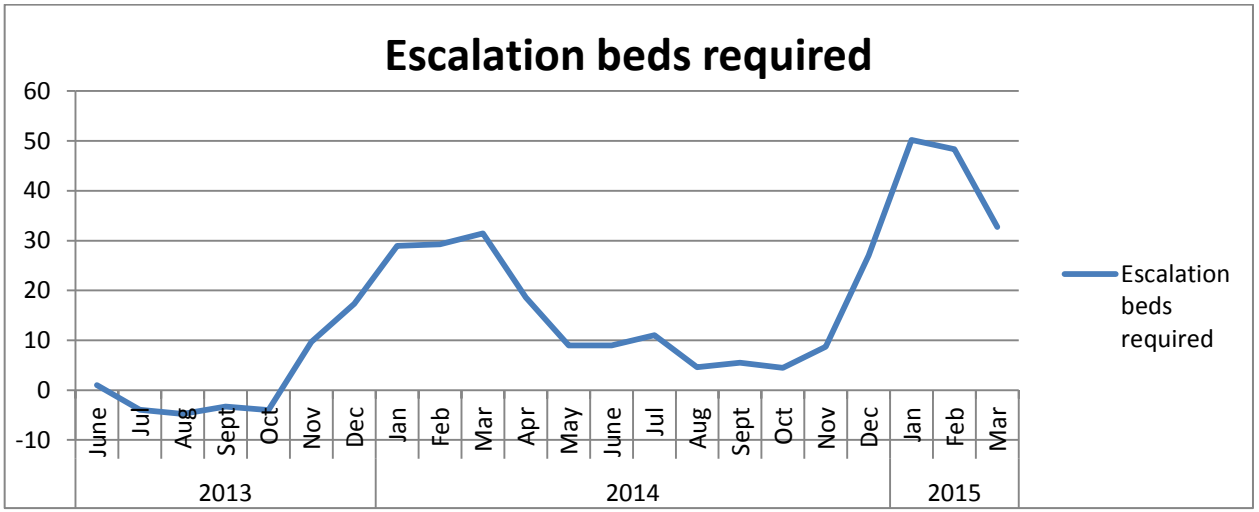
Escalation beds required
60
50
40
30
20
10
0
-10
June
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2013
2014
2015
Escalation beds required