United Lincolnshire Hospitals NHS
NHS Trust

To:	**The Trust Board**
From:	Mark Brassington, Chief Operating Officer
Date:	

Title:	United Lincolnshire Hospitals Winter Plan V1.3

Responsible Director: Mark Brassington, Chief Operating Officer

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Purpose of the Report:

- The purpose of this report is to inform the Trust Board about plans in place to increase our resilience during winter. Despite the additional investment and actions being taken we expect our hospitals to be under significant pressure during the winter months.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	✓

Summary/Key Points:

The purpose of this briefing is to provide:

- A rationale behind the plans
- Analysis of our capacity and demand and assurance of our ability to continue to provide safe, high quality patient care through periods of high pressure
- Information on how the plan will be delivered including new ways of working

Recommendations:

- That the Trust Board note the plan and are aware of the actions being delivered to provide a safe, high quality service to our patients throughout the winter period.

Strategic Risk Register	**Performance KPIs and measures**

Resource Implications (e.g. Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications

Information exempt from Disclosure – No

Requirement for further review? Yes

United Lincolnshire Hospital NHS Trust

Winter Plan

1. Aims of the Plan

The Trust wide Winter Plan sets out the organisations arrangements for the winter period. Winter is not an emergency or considered an unusual event, but we recognise this period reflects increases in pressure due to demand both in the clinical acuity of the patients and the capacity demands on resources within the trust. In addition, the winter period often brings with it untoward events such as widespread infectious diseases including Norovirus and there is the risk of the onset of the unusual such as pandemic flu. Each year, all sites experience increased pressure in patient flow. The Winter Plan prepares the organisation with support from the Health and Care Community in Lincolnshire to:-

- focus on admission avoidance schemes and ambulatory care pathways
- create the capacity to meet increased demand
- link the Trust Winter Plan to the Lincolnshire System Resilience Plan
- robustly performance manage the system to maintain quality, activity, safety and experience

This plan will need to consider how to not only meet the ongoing demands of the winter pressure and managing the sudden peaks in activity, whilst maintaining safe and effective outcomes for patients, along with providing a positive patient experience.

The plan considers the current bed occupancy and our performance against the A&E improvement trajectory. As part of setting this trajectory ULHT and community services proposed a number of schemes, some recurrent, some for winter only. Commissioners then equated this into an A&E performance on the presumption that flow was the main factor relating to underperformance. The schemes are discussed. The plan goes on to discuss the implementation of new ways of working that are improving capacity, not just for winter but ways of working that will change the organisations culture going forward, such as the SAFER patient flow bundle. Phasing of elective capacity through the winter period is considered along with our communications strategy for the public and media and other considerations for the winter period.

2. Capacity and Demand

2.1 A&E Trajectory

A performance trajectory for the 4 hour standard for 2016/17 was submitted on 18th March as part of the Sustainability and Transformation Fund (STF) process and subsequently agreed by the Clinical Commissioning Groups (CCG) and NHS Improvement (NHSI) on the 31st March 2016. To determine the trajectory a calculation was made based on the current performance as at March 2016 less the impact of the winter schemes in force at that time plus the impact of proposed schemes from ULHT, Lincolnshire Community Health Services (LCHS) and Adult Social Care (ASC) for the coming year. Utilising historical data it demonstrated that a target bed occupancy of 93.5% is required to facilitate flow which is a significant contribution to delivering the 4 hour standard. Therefore the proposed schemes would free up beds it was possible to convert the impact of each scheme into a percentage improvement in performance against the 4 hour standard. Some of the schemes are recurrently funded, some will be introduced as "surge schemes" in Q4.

The agreed performance trajectory (with performance to date) is given below

		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Grantham Hospital	Trajectory	94.00%	95.40%	95.60%	96.30%	96.80%	92.30%	95.70%	96.10%	92.80%	90.80%	91.70%	90.40%
	Performance	92.07%	88.02%	86.49%	90.07%	93.46%	96.86%						
	variance	*-1.93%*	*-7.38%*	*-9.11%*	*-6.23%*	*-3.34%*	*4.56%*						
Lincoln County	Trajectory	81.80%	83.10%	81.80%	87.00%	89.70%	88.70%	89.30%	90.80%	86.10%	92.80%	90.80%	88.50%
	Performance	79.06%	85.10%	77.26%	75.22%	76.50%	75.35%						
	variance	*-2.74%*	*2.00%*	*-4.54%*	*-11.78%*	*-13.20%*	*-13.35%*						
Pilgrim Hospital Boston	Trajectory	70.60%	73.00%	79.40%	87.20%	77.60%	83.70%	82.00%	80.00%	88.10%	86.90%	85.00%	88.70%
	Performance	76.05%	78.87%	82.93%	75.76%	70.88%	79.04%						
	variance	*5.45%*	*5.87%*	*3.53%*	*-11.44%*	*-6.72%*	*-4.66%*						
ULHT Total	Trajectory	76.60%	82.00%	82.00%	84.00%	84.00%	84.00%	85.00%	85.00%	85.00%	89.00%	89.00%	89.00%
	Performance	80.54%	83.52%	81.18%	78.45%	77.27%	79.73%						
	variance	*3.94%*	*1.52%*	*-0.82%*	*-5.55%*	*-6.73%*	*-4.27%*						

Performance by quarter:

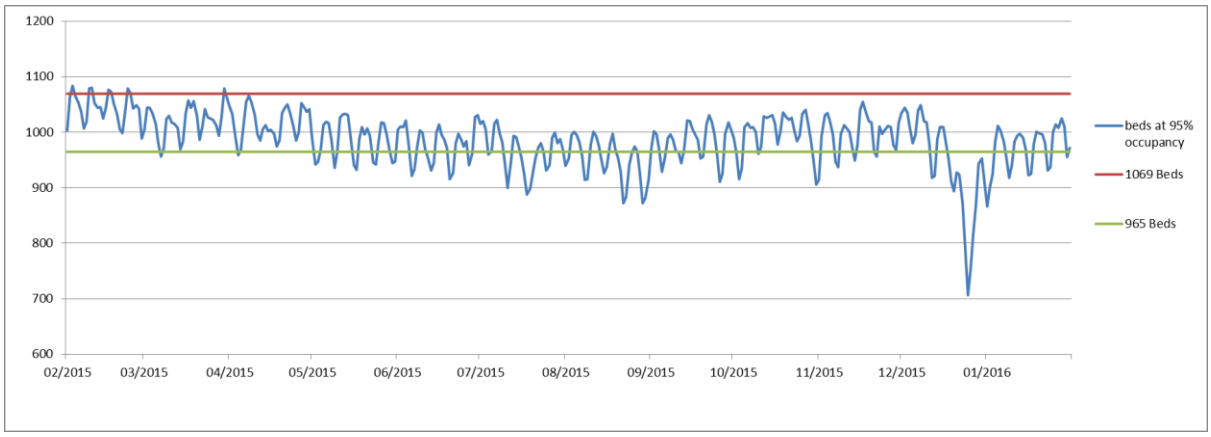
		Q1	Q2 to date	Q3	Q4	Year to Date (from 01 April)
Grantham Hospital	Trajectory	95.00%	95.10%	94.90%	91.00%	94.00%
	Performance	88.72%	92.23%			90.18%
	variance	*-6.28%*	*-2.87%*			*-3.82%*
Lincoln County	Trajectory	82.20%	88.40%	88.80%	90.70%	87.50%
	Performance	80.58%	75.75%			78.43%
	variance	*-1.62%*	*-12.65%*			*-9.07%*
Pilgrim Hospital Boston	Trajectory	74.30%	82.80%	83.40%	86.90%	81.90%
	Performance	79.33%	74.40%			72.29%
	variance	*5.03%*	*-8.40%*			*-9.61%*
ULHT Total	Trajectory	80.20%	84.00%	85.00%	89.00%	84.50%
	Performance	81.80%	78.21%			78.50%
	variance	*1.60%*	*-5.79%*			*-6.00%*

Performance in the first quarter was 1.6% above trajectory. In the second quarter issues around medical workforce predominantly have taken over as the predominant breach reason from bed occupancy hence reduction in bed occupancy from the schemes has not had the predicted effect on performance. Accompanying this Delayed Transfers of Care have remained above our target of 3.2% These two factors have significantly affected our ability to improve.

Plans are in place to mitigate this whilst at the same time we continue to work on the winter schemes to reduce bed occupancy.

2.2 Bed Occupancy

Bed usage fluctuates between around 900 and 1100 beds across the organisation with escalation. The trust currently has 965 funded beds therefore occupancy is often well over 95%. The plans submitted to improve 4 hour performance include plans to increase the number of beds at Lincoln and Pilgrim. This will take the trust to 1069 beds and therefore based on the contracted level of activity occupancy should remain below 95% (see below) N.B. this is bed usage, not demand:



2.3 Schemes

Through budget setting a number of schemes were supported in order to address some of the challenges within urgent care. These included:

- £1million to support additional nurses within emergency departments to more readily meet the levels of demand and enable a new structure to be implemented
- £2.5million to support an expansion of our bed base (further detail can be found below)
-£300,000 to support a programme of work to reduce our length of stay by at least 10% and up to 20%
- Additional medical posts to support urgent care
- Investment to maintain some frailty services at Lincoln and Pilgrim

These will be in place during Q3 and are funded recurrently.

In addition to these schemes non-recurrent funding has been provided to support the 4 hour recovery trajectory through “surge” or winter schemes. These are given, with the trajectory and the anticipated effect on beds and the trajectory in appendix 1. The schemes are grouped into ULHT Schemes and LCHS / ASC Schemes. The predominant scheme in ULHT being additional bed capacity:

2.4 ULH Short Stay Beds

Modelling has confirmed that the number of beds required across ULHT to meet its contractual requirements in 2016/17 is 1063 (general and acute beds), 98 beds higher than the current funded and established bed stock (excluding escalation beds):

	Current bed stock	Required bed stock	Change in bed stock
Grantham	97	112	+ 15
Lincoln	494	529	+ 35
Pilgrim	362	410	+ 48
Louth	12	12	-
	965	1063	98

Commissioners have confirmed their confidence in reducing the bed requirements at Grantham Hospital to the current funded levels by:

- Enhancing community and nursing home capacity to reduce DTOCs; and
- Introduce a community IV pathway.

This would remove the need for any additional bed capacity at Grantham, reducing the additional Trust wide bed capacity by 15 to 83, being 35 beds at Lincoln County Hospital and 48 beds at Pilgrim Hospital.

As part of the contractual process the agreed community schemes, as part of setting the 4 hour A&E recovery trajectory in 2016-17, will release a sufficient number of bed days to equate to 60 beds worth of impact.

ULHT internal actions of 7 day therapy and pharmacy during winter and SAFER will release up to the equivalent of 6.5 beds.

However as activity has increased, DToC / MFFD remains above trajectory there is low confidence that the schemes will mitigate the risk fully. Therefore as explained above the Executive Team approved investment to expand the bed base at Lincoln and Pilgrim as mitigation to the additional demand and high risk to non-delivery of schemes.

The first phase of the plan was to establish a number of the existing escalation beds on the Lincoln and Pilgrim sites. This included:

Lincoln: (16 beds)	Dixon Ward	8 beds
	Neustadt Welton	4 beds
	Digby	4 beds
Pilgrim (22 beds)	Ward 8A	10 beds
	6th floor	8 beds
	Ward 7B	4 beds

The second phase of the plan was to increase the core bed stock. At Lincoln this would involve establishing an additional 27 bed ward. This ward would be used for step down patients and would have the benefit of allowing capacity to relaunch the Short Stay Pathways on the Medical Admissions Unit.

For Pilgrim the initial plan to bring additional wards into use was considered not deliverable due to the staffing constraints faced. To mitigate this several changes are being implemented. Firstly the medical clinic taking place on ward 8A is being moved to vacant accommodation on 8B. Whilst not creating additional bed capacity this would allow the medical ward to be utilised properly for in patient care. Programmes to improve front door streaming will be put in place and a new IT system – QFI – is being rolled out. This system will manage patient admissions by task ensuring timely action planning and resulting in decreased length of stay. The aim to reduce bed occupancy by 10% would release in the region of 30 beds by January 2016.

Therefore the current plans if delivered in full and activity remains within contracted levels should ensure we have sufficient bed capacity. As always there is ongoing risk to delivery based upon the ability to recruit to the expanded bed base.

2.5 Further ULHT Schemes

Internally, as part of the setting of the A&E trajectory the Trust proposed further schemes to improve performance through winter:

7 day Pharmacy – was implemented successfully throughout the winter period last year. This will commence from November with a business case being developed to make this service recurrent, all year round.

7 day Therapies – also commencing from 1st November, utilising bank, overtime and agency to increase capacity to provide therapy service to the wards throughout the winter. It was anticipated based on data from last year that this would improve A&E performance by 0.27%.

A&E Internal Efficiency – a series of Plan Do Study Act (PDSA) style changes to working practises within the A&E department are discussed in 3.1 below. The anticipated effect of these schemes would be an improvement in A&E performance of 0.48%.

Safer Patient Flow Bundle – whilst the safer bundle is in place across ULHT its use is not consistent and work is ongoing to change culture. The bundle relates to a series of common sense practises to improve flow in the hospital such as earlier senior review, clear planning for discharge, early flow out of assessment wards to help clear A&E and early discharge with a target of 33% before noon. The delivery of SAFER is discussed in 3.2 below. By improving the adherence to SAFER a phased improvement in A&E performance was set from 0.18% rising to 0.27% in July and 0.36% from October.

Increase in A&E Medical Staff – to improve performance in A&E additional medical staff will be in place at Pilgrim throughout winter. An additional medical consultant and middle grade from the 1st November and a surgical middle grade from December bringing about an improvement in performance of 1.93%.

Increase Nurse Minors – to help with the minors stream it is planned to have an additional nurse minors stream at Lincoln from 08:00 until midnight from 1st December, bringing a 0.5% improvement in performance.

2.6 Community Schemes

In setting the A&E trajectory community services proposed a number of additional schemes:

Rapid Response – support for people to keep them at home and prevent admissions. Commencing in October this would reduce our bed requirements by 23.56 beds.

Discharge Hub – Although hosted by ULHT the hubs bring together staff from community services and social care. There is ongoing debate around ownership of the hubs, currently ULHT, and we have expressed our concerns around any change to this. However, the CCG are keen to review and feel a model of pulling patients out of the acute trust rather than the acute trust pushing them is the preferred model. Hence the discharge hub was included within the community schemes. The discharge hubs have been a success reducing the length of stay for patients medically fit for discharge from around 10 days to 4.5 days at Lincoln, by way of example. Improvements in the hub from community services are reportedly going to improve capacity in the trust by reducing occupancy by an additional 10.3 beds above the current estimated 2.2.

Transitional Care – New models of working with transitional care included improvements in the community hospitals to reduce their length of stay, reducing delayed transfers of care and increasing bed occupancy to 85% from July and 90% from October, though still well below the trusts occupancy rates. Anticipated effect of this was a 2.6 bed reduction per month rising to 4.9 beds from October.

Trusted Assessor – in partnership with LCC the "trusted assessor" role is already in place, however, it does not work as it should and patients are frequently delayed waiting for assessments. The plan was to improve the role such that it increases incrementally in its effectiveness reducing bed requirements by 3.2 beds per month to 5.2 from July.

Support at Home (HART) – a further admission avoidance scheme to support patients in their own home. Projected admission avoidance would reduce bed requirements by 3.4 beds per month from July to September and 4.8 from October.

LCC Reablement Service – one of the few tangible successes to date, seeing a reduction in ASC delays earlier in the year. Capacity will be increased further from October and the community estimate this will reduce the trusts bed requirement from the current reduction of 6.67 down to 8.33.

CAS – the Clinical Assessment Service is a telephone triage direct from clinicians which, it is stated, will reduce Green 3&4 calls and see a 50% reduction in 111 A&E dispositions.

All the above schemes were converted into an improvement figure in A&E performance; however, it is worth noting that at time of writing, other than the reablement service (a direct purchase of additional capacity) there has been little effect of the community schemes and our confidence in them remains low.

Percentage improvements in A&E performance were calculated as part of the STP planning for the A&E trajectory and assume that the predominant factor underpinning poor performance against the

4 hour target is bed flow. A lack of beds means delays in moving admitted patients out of A&E. Workforce issues – a high proportion of agency staffing, gaps in the rota, the restricted opening times of the Grantham department – will all have an effect that was not considered at the time of setting the trajectory.

2.7 Workforce

The trust has been hindered by a significant number of vacancies both in the nursing and medical workforce. There have been significant efforts to improve both.

The trust had a hundred newly qualified nurses start in September, all of whom will be supported in practice through their 12 week preceptorship by the clinical education team, and all have been allocated ward or clinical areas.

We are also expecting 20 – 25 oversees nurses to start between October and February. These are at various stages of the recruitment process.

At Lincoln, work is underway with external support to look at medical staffing levels to ensure that our staffing is adequate for the demand coming through the front door. This will help to give us a model to future proof our staffing levels. However we must acknowledge the impact currently within the emergency department due to the lack of permanent staff. There is an overreliance on short term agency which is impact upon our ability to staff our rotas and also provide timely access to assessment. A comprehensive recruitment strategy is in place to attract and retain staff.

3. Delivery

3.1 New Models of Care

To improve flow within the A&E department new models of care have been developed. At Lincoln this involved:

- Clinicians being assigned areas to work from, rather than selecting the next patient (improved ownership of work areas)
- A new "majors lounge" where one cubicle was altered to a seating area to accommodate 4 patients who did not need to be on a trolley (creating more capacity within existing space)
- Dedicated RAT cubicles to ensure an area to assess ambulance patients coming in was always available and increasing the number from one to two (RAT processes were always in place but did not always happen when all cubicles were full)
- A revised SOP agreed with EMAS for unloading ambulances and improvements in the data capture for arrival and handover times (LCH was an outlier for delayed handover – this change has helped to improve this situation), see below.

At both Lincoln and Pilgrim Nurse in Charge models and non clinical co-ordinator roles have been implemented working closely with a designated and visible consultant in charge. Both sites have seen the introduction of department "huddles" to discuss issues and set the scene for the day and an internal professional standard has been agreed defining expected principles between staff and departments – the Principles of Emergency Care (appendix 2)

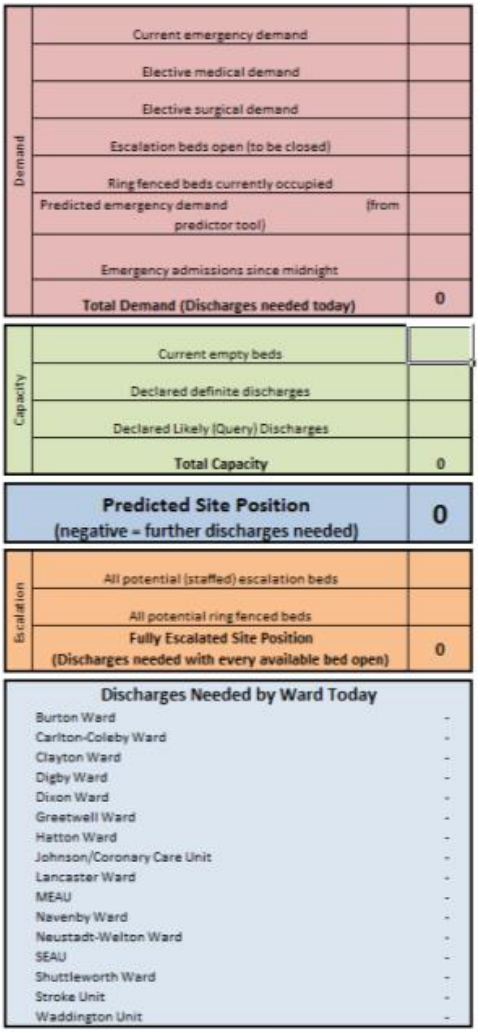
Pilgrim Hospital has also seen the introduction of:

- Zoning to assist with streaming (RAT / Resus / Majors / Minors / Childrens)
- Addressing "frequent fliers" with colleagues in the community and CCG
- Implementing a second triage area
- New See and Treat model
- Nurse requesting of X-rays and PGD's developed
- Fast-track pathways for STEMI, Hip Fracture, Stroke / Bleeding in Pregnancy
- Standard Clerking Procedures

3.2 SAFER patient flow bundle

ULHT has been supported by the Emergency Care Improvement Programme in improving the adoption of the SAFER patient care bundle. The trusts associate medical directors have also been tasked with ensuring clinicians know this is now mandated and work is ongoing to ensure PDD's are in place and ward rounds commence by 08:00.

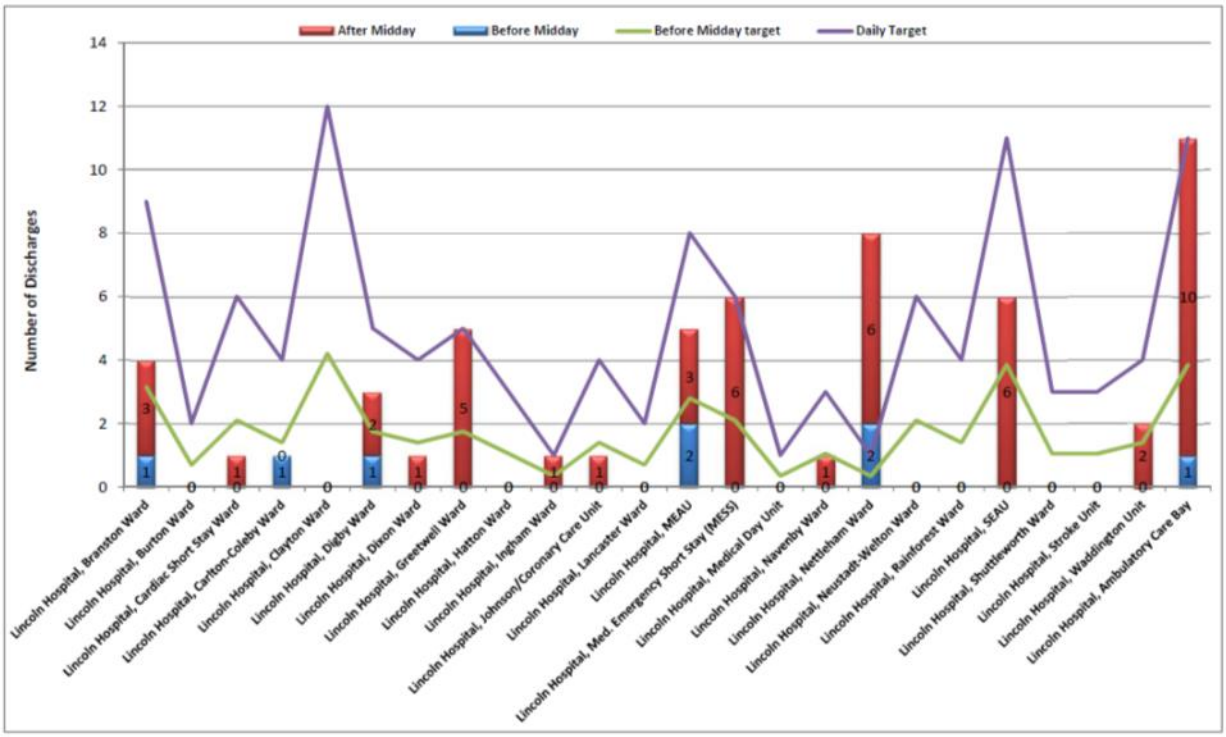
Across all sites we are implanting new methodologies to improve adherence with SAFER. These include an improved flow management concept which counts forecast demand as well as actual and reduces in line with current admissions against this forecast:



Demand	Current emergency demand	
	Elective medical demand	
	Elective surgical demand	
	Escalation beds open (to be closed)	
	Ring fenced beds currently occupied	
	Predicted emergency demand (from predictor tool)	
	Emergency admissions since midnight	
	Total Demand (Discharges needed today)	**0**
Capacity	Current empty beds	
	Declared definite discharges	
	Declared Likely (Query) Discharges	
	Total Capacity	**0**
	Predicted Site Position (negative = further discharges needed)	**0**
Escalation	All potential (staffed) escalation beds	
	All potential ring fenced beds	
	Fully Escalated Site Position (Discharges needed with every available bed open)	**0**

Discharges Needed by Ward Today	
Burton Ward	-
Carlton-Coleby Ward	-
Clayton Ward	-
Digby Ward	-
Dixon Ward	-
Greetwell Ward	-
Hatton Ward	-
Johnson/Coronary Care Unit	-
Lancaster Ward	-
MEAU	-
Navenby Ward	-
Neustadt-Welton Ward	-
SEAU	-
Shuttleworth Ward	-
Stroke Unit	-
Waddington Unit	-

This tool also includes target numbers of discharges per day and this is being backed up by data from informatics showing whether wards are achieving targets both pre and post midday. We are seeing an increase in the number of pre midday discharges (target 33%), Lincoln is depicted below, but note many wards are now achieving higher than this at Pilgrim Hospital:



All sites now have an established "Stranded Patient Review" weekly with the heads of nursing, matrons and ward managers. These meetings identify patients with a long length of stay (>7 days) and work towards unblocking these discharges. At Pilgrim we have successfully closed AEC as escalation on the back of this change, releasing an average of 27 beds per week (The SOP is given in appendix 9).

The QFI system is being rolled out, commencing at Pilgrim on complex elderly wards. This system tracks actions required to progress patient care during board rounds, assigns tasks to staff to complete for a review later in the day and displays the key issues or delays for a ward. As discussed this has the potential to reduce bed occupancy by 35 beds on the site as it embeds the SAFER principles.

SAFER Workshops have been undertaken at Pilgrim and are planned for Lincoln in conjunction with the ECIP team and we are having ECIP clinical support at Lincoln A&E from one of their physicians to look at different ways of working.

3.3 Accident and Emergency Departments

We have worked closely with colleagues in EMAS to develop an improved handover plan in readiness for winter. This has recently been adopted on all sites. A copy is given in appendix 3.

Changes to the departments include having reception centrally located to take direct handover from crews. In times of increased demand EMAS will cohort patients where safe to do so (one crew to look after two patients, freeing up crews).

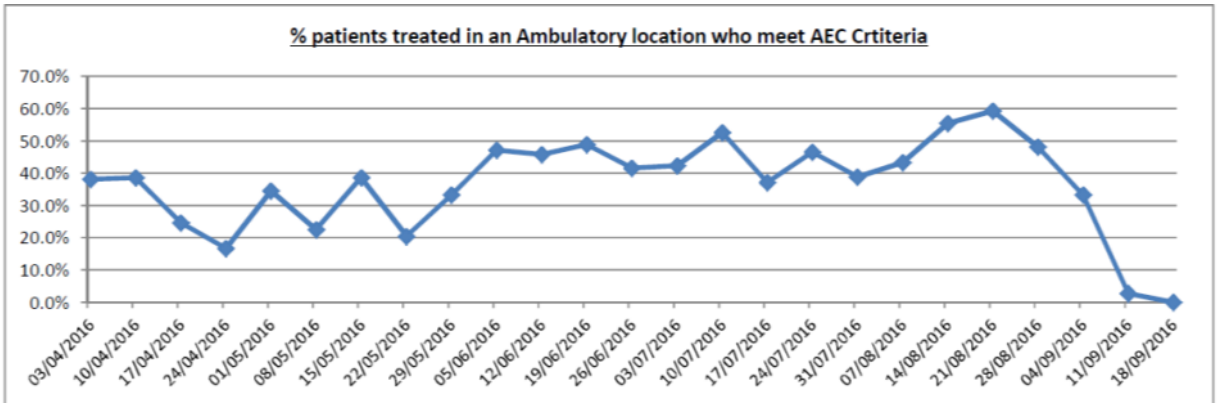
An ED risk tool has also been created, to give an internal escalation level within ED separate to the Site Operational Escalation Level. This new tool, currently rolled out at Lincoln and Pilgrim, with Grantham going live before winter, gives an "at a glance" look at the number of patients in A&E,

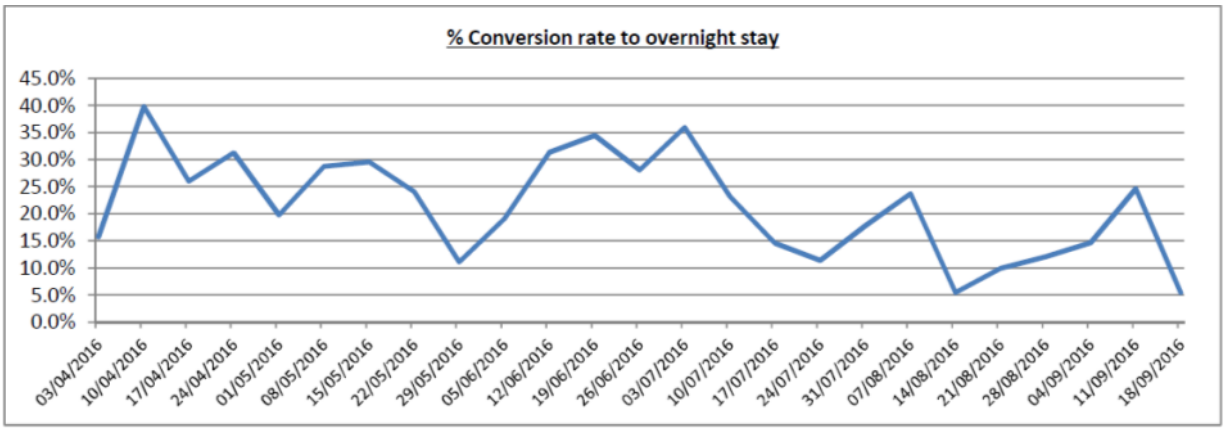
time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait (appendix 4). This gives a focus across the trust on where pressure is building and there are local actions for easing pressure and earlier escalation for the winter period.

3.4 Ambulatory Care

The trust has ambulatory care units at Lincoln, Boston and Grantham. At Lincoln and Grantham these are collocated with A&E. A lot of work has been undertaken over recent months to ensure these units are not used as escalation – this was a major problem at Lincoln and Boston but is now resolved at Boston and is improving at Lincoln, allowing ambulatory care teams to develop their workload.

Our Trust is part of the national Ambulatory Emergency Care Network, hosted by NHS Elect. This network supports the trust in developing its plans to expand and develop ambulatory care. The trust has established an Ambulatory Care Group who attend the network events and develop the plans. Results so far have been largely positive with an increase in the percentage of patients who fit ambulatory pathways going through the units (note the drop in September below is due to incomplete coding, not a fall in AEC %) and a decrease in patients in ambulatory converting to overnight stays.





3.5 Elective Phasing

As with last year we have planned our modelling on reducing our elective activity for the 6 week period from the end of December and throughout January. The Business Units will review surgical caseloads for the week prior to Christmas, scheduling procedures with longer LOS for the early part of the week, and reducing routine inpatient elective activity by approximately 50% on 22nd and 23rd December in order to assist with the aim of achieving 80% bed occupancy on Christmas Eve. This reduction in routine activity will continue between Christmas and New Year.

During the first two weeks of January the Business Units will not schedule any routine inpatient surgery, however they will continue to book cancer, urgent and daycase surgery. During the third week of January routine elective capacity will be re-introduced to a level of 50% of normal activity, increasing to 75% in the last week of January. It is planned that surgical activity will return to standard levels from the beginning of February.

It is anticipated that the combined negative financial impact of the above proposed reduction will be c. £1.3million

3.6 Christmas

This year Christmas Eve, where the sites commonly have increased discharges, falls on a Saturday. It is unlikely we will attract additional staff other than the normal weekend roster to work the 24th so we are planning to ensure discharges on Friday the 23rd are maximised. This will include additional medical and pharmacy staffing to ensure patients are ready to go and we will be talking to transport providers about ensuring their capacity is matched.

After the 4 day holiday we anticipate increased pressure on the system and are therefore planning additional staffing to start from the last day of the holiday – Tuesday 27th – to ease flow back into the normal working week.

3.7 Inclement Weather

The local resilience forum (LRF) produce a multi agency weather plan and ULHT has a Snow and Adverse Weather Plan (appendix 10) that includes advice for staff on preparedness, adverse weather warnings and actions for different levels of escalation. The trust also benefits from the Lincolnshire 4x4 response scheme (www.ln4x4r.org.uk) that can assist in getting staff and resources around the county.

3.8 Communications Plan

We will develop a clear communications plan for the winter period. This will contain key messages for the public to promote “choose well messages” and for staff around areas such as SAFER. The winter communications plan is given in appendix 5.

3.9 IP&C

The trust has a programme of deep cleaning on wards in place. Last winter saw capacity being compromised by an outbreak of norovirus on all sites. Demand was managed with an effective communications plan and the sites instigated outbreak meetings in line with the policy. The Infectious Outbreak / Incident Policy including Major Outbreak will be followed and invoked throughout this winter.

During Flu season Clinical staff who are likely to undertake an **aerosol generating procedure would need to wear a Fit Tested FFP3 mask. Masks have to be fit tested at least annually. The model the trust uses for achieving fit testing is the "train the trainer" approach and the IPC assistants will provide this service. Staff who fall into the above category will need to be fit tested before the beginning of November.

**Aerosol Generating procedures: AGPs can generate an aerosol hazard from an infection that may otherwise only be transmissible via splashes or droplets.

- The following procedures are considered to be AGPs: (Reference:. Guidance on use of Respiratory & facial protection equipment. Journal Hospital Infection 85 (2013) 170-182)

o Intubation, extubation and related procedures (e.g. manual ventilation and open suctioning)

o Cardiopulmonary resuscitation

o Bronchoscopy

o Surgery and post-mortem procedures involving high-speed devices

o Some dental procedures (e.g. drilling)

o Non-invasive ventilation (e.g. bi-level positive airway pressure and continuous positive airway pressure ventilation)

o High-frequency oscillating ventilation; and induction of sputum

3.10 Influenza

The Trust flu plan for 2016/17 is now in place and in the process of being implemented following approval at the Trust infection Prevention committee, the executive team and by NHS England.

Clinics are booked and dates will be released along with promotional information.

NHS England have confirmed that the final date for reporting flu immunisations for frontline health care workers will be the end of December 2016. This is a month earlier than usual as the final date in previous years has been the first week in February.

NHS England have attached a CQUIN to this year's flu campaign, the payment schedule is the full value of the CQUIN for 75% and over and 50% of the CQUIN for 65% and over. The trust has agreed to aim for the 75% and over target.

To increase uptake we plan to take this into the workplace to staff in wards and departments and also provide drop in clinics from Occupational Health.

3.11 Operational Working

Throughout the winter period, as with any other time, operational flow through the sites will be managed by the Operations Centres. This year has seen work on standardising working methods between the sites, accepting some variance due to size and services provided.

We will introduce a new post of Urgent Care Lead / Manager for the Lincoln and Pilgrim sites acting as a link between the SDM's and the Deputy Director for Urgent Care to provide a site operational manager.

Operational Flow (Bed Meeting) times have already been standardised throughout the day so that situation reporting can come out consistently. A 5pm teleconference is in place to brief the silver on call of the situation on each site and a 9 am teleconference takes place with community colleagues to update on issues through the night, discuss where pressures are occurring and provide a county and organisation wide escalation level.

The operational escalation policy is being reviewed in line with the changes to bed numbers reporting outlined above. The new policy will reflect normal working levels to prevent the sites constantly declaring "level 3" and the subsequent apathy this has caused. The escalation policy will take into account the A&E escalation levels and actions are being developed in accordance with the main issues rather than generic actions. We will enforce the actions outlined at each level within the policy.

The sites continue to operate a bronze, silver and gold structure out of hours and during emergency situations. The new Urgent Care Lead will take the role of bronze during normal hours with the SDM taking over out of hours.

The Ops Centre SOP, Bed Meeting SOP and Role of the On Call Managers are all given in appendix 6, 7 and 8 respectively. Note, some of these are currently under review.

4 Conclusion

In summary the winter plan sets out the organisations strategy to manage performance throughout the winter period. Some of the schemes are funded until March 2017, others are recurrent and will help the organisation improve not just through the winter period.

Some of the new ways of working are an ongoing effort to change the culture of the trust along the lines of the SAFER bundle for example, and are becoming more action focussed, having clearer plans for our patients.

Whilst it is anticipated and expected that this period will be a challenge the Trust aims to provide a consistent and seamless approach to this period as if it were any other time of the year and will work in collaboration with the Health and Care Community.

Appendix 1 – A&E Trajectory and Effect on Beds

A& E Trajectory and effect on Beds

	A&E Trajectory												Beds			
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Lincoln	Grantham	Pilgrim	N/S
2015/16 Actuals	**87.30**	**87.60**	**90.67**	**91.37**	**89.17**	**90.17**	**86.41**	**86.52**	**84.88**	**82.73**	**81.07**	**80.32**				
A+E impact (excludes pharmacy impact) of £4.4m	-7.52	-7.52	-7.52	-7.52	-7.52	-7.52	-7.52	-7.52	-7.79	-7.79	-7.79	-7.79				
A&E Activity Growth	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37	-0.37				
Opening Position	**79.41**	**79.71**	**82.78**	**83.48**	**81.28**	**82.28**	**78.52**	**78.63**	**76.72**	**74.57**	**72.91**	**72.16**				
2016/17 Schemes - ULH																
ULH Short stay beds																
- Lincoln From December									1.82	1.82	1.82	1.82	*M9-12*	20.00		
- Pilgrim from January										2.55	2.55	2.55	*Q4*		28.00	
7 Day Pharmacy																
7 Day Therapy				0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27				2.78
A&E Internal Efficiency				0.48	0.48	0.48	0.72	0.72	0.72	0.96	0.96	0.96				
													Q2			1.84
Safer bundle				0.18	0.18	0.18	0.27	0.27	0.27	0.36	0.36	0.36	*Q3*			2.76
													Q4			3.68
Increase in A&E Medical Staff at end Q3							1.00	1.00	1.00	1.93	1.93	1.93				
Increase Nurse Minors at Lincoln										0.50	0.50	0.50				
ULH Total Schemes	**0.00**	**0.00**	**0.00**	**0.93**	**0.93**	**0.93**	**2.26**	**2.26**	**4.08**	**8.40**	**8.40**	**8.40**				
ULH Revised Trajectory (ULH)	**79.41**	**79.71**	**82.78**	**84.41**	**82.21**	**83.21**	**80.78**	**80.89**	**80.80**	**82.97**	**81.31**	**80.56**				
2016/17 Schemes - LCHS																
Rapid response							2.29	2.29	2.29	2.29	2.29	2.29	*Q3-4*			23.56
													Q1			2.20
Discharge Hub	0.22	0.22	0.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	1.22	*Q2-4*			12.50
Transistional Care													*Q2*			2.60
- Community Hospitals				0.25	0.25	0.25	0.48	0.48	0.48	0.48	0.48	0.48	*Q3+4*			4.90
- Trusted Assessor Role	0.31	0.31	0.31	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	0.51	*Q1*			3.20
													Q2-4			5.20
													Q1			2.70
- Support at Home (HART)	0.26	0.26	0.26	0.33	0.33	0.33	0.47	0.47	0.47	0.49	0.49	0.49	*Q2*			3.40
													Q3			4.80
													Q4			5.03
													Q1			1.67
- LCC Reablement Service Capacity Increase above 15/16 levels as per BCF	0.16	0.16	0.16	0.65	0.65	0.65	0.81	0.81	0.81	0.81	0.81	0.81	*Q2*			6.67
													Q3-4			8.33
CAS				1.59	1.59	1.59	1.59	1.59	1.59	1.59	1.59	1.59				
LCHS Total Schemes	**0.95**	**0.95**	**0.95**	**4.55**	**4.55**	**4.55**	**7.37**	**7.37**	**7.37**	**7.39**	**7.39**	**7.39**				
Total revised Trajectory	**80.36**	**80.66**	**83.73**	**88.96**	**86.76**	**87.76**	**88.15**	**88.26**	**88.17**	**90.36**	**88.70**	**87.95**				
Submitted trajectory	**76.6%**	**82%**	**82%**	**84%**	**84%**	**84%**	**85%**	**85%**	**85%**	**89%**	**89%**	**89%**				

Appendix 2

United Lincolnshire Hospitals NHS
NHS Trust

PRINCIPLES OF URGENT & EMERGENCY CARE

The Staff of United Lincolnshire Hospitals NHS Trust agree and commit to the following principles of Urgent & emergency Care.

We Will:-

	ACCESS	FLOW
1.	Stream patients into the most appropriate place for their care considering all patients for AEC pathway until proven otherwise.	Provide all in-patients with a senior review (preferably by a consultant) before midday, 7 days a week.
2.	Agree Internal Professional Standards and expect to hold and be held to account for their delivery.	Ensure all patients have a Predicted Discharge Date (PDD).
3.	Provide designated diagnostic availability for emergency and urgent care patients.	*Undertake* a daily board round on all in-patient wards.
4.	Provide specialist review of urgent and emergency care patients within 30 minutes of referral.	Ensure wards admitting patients from assessment areas "pull" their first patients by 10.00am.
5.	Identify PARIS (Patients at Risk of Increased Stay) on admission.	Ensure the 1st patient for discharge on each ward vacates the bed by 08.30 (tba) using discharge lounge wherever possible.
6.	Provide appropriate care to frail patients.	Ensure all wards know their expected daily discharges and work tirelessly to achieve them.
7.	Accept referral within 2 hours based on clinical decision alone.	Ensure patients are discharged before 12 midday (planned) or 3pm (same day).
8.	Have zero tolerance of outlying patients.	Undertake systematic review of all patients in hospital for 7 days or more (Stranded Patients metric)
9.	Have zero tolerance of escalation into AEC.	Have zero tolerance of Red Days.
10.	Review occasions where these principles are not met in order to learn and prevent recurrence	

Appendix 3

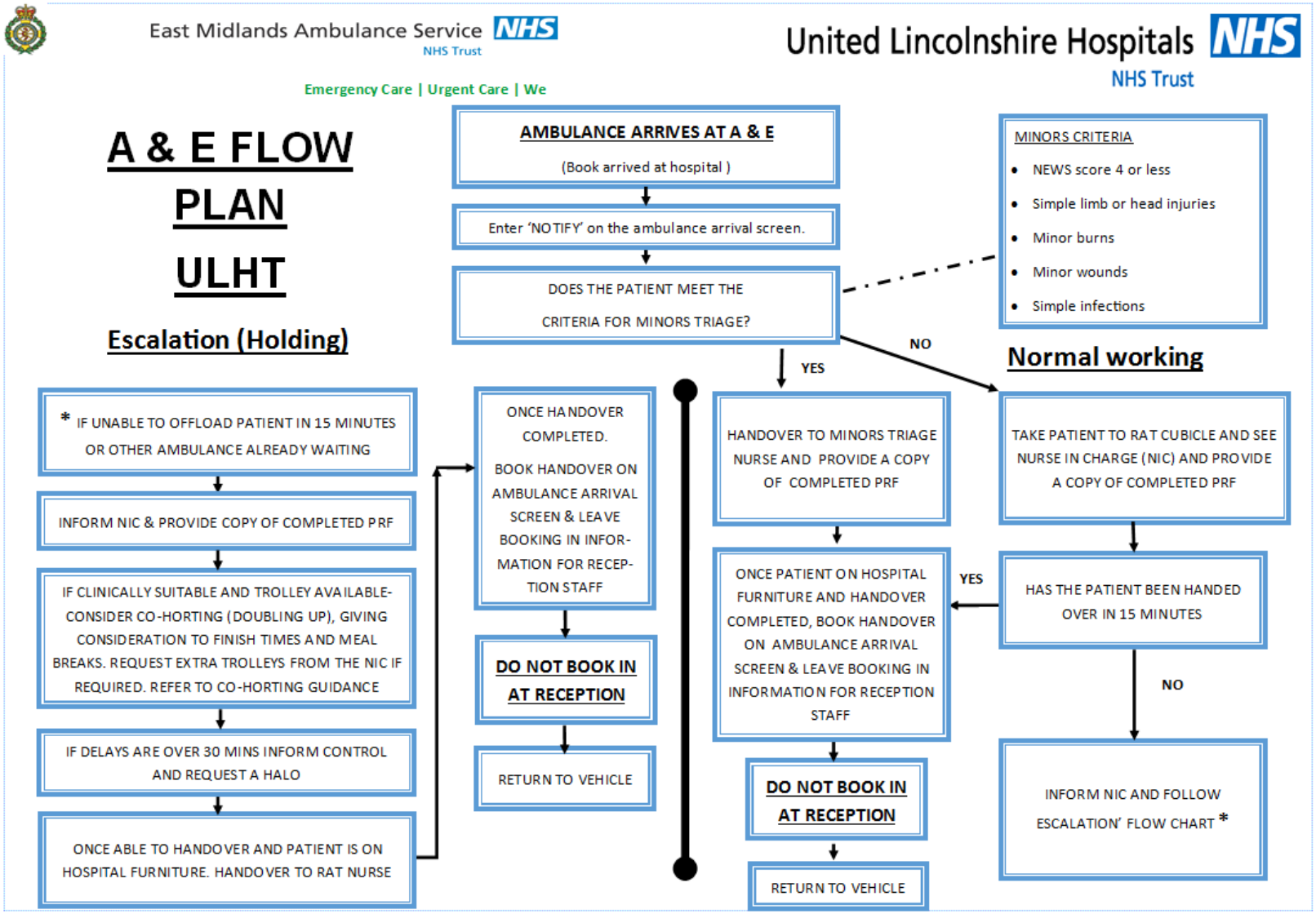
East Midlands Ambulance Service NHS Trust

United Lincolnshire Hospitals NHS Trust

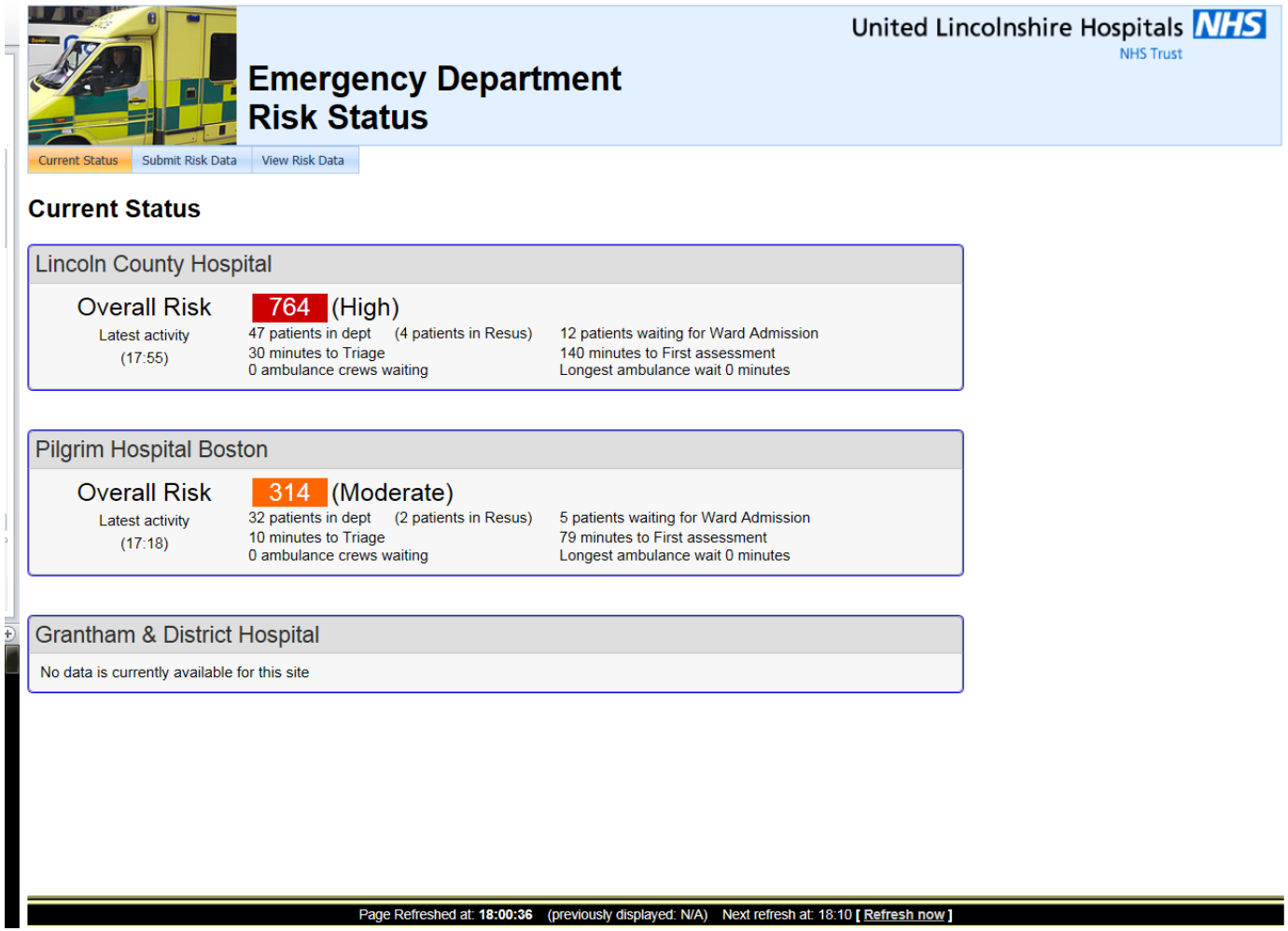
Emergency Care | Urgent Care | We

A & E FLOW PLAN ULHT

Escalation (Holding)



Appendix 4


United Lincolnshire Hospitals NHS
NHS Trust
Emergency Department
Risk Status
Current Status
Submit Risk Data
View Risk Data
Current Status
Lincoln County Hospital
Overall Risk
764 (High)
Latest activity
(17:55)
47 patients in dept (4 patients in Resus)
30 minutes to Triage
0 ambulance crews waiting
12 patients waiting for Ward Admission
140 minutes to First assessment
Longest ambulance wait 0 minutes
Pilgrim Hospital Boston
Overall Risk
314 (Moderate)
Latest activity
(17:18)
32 patients in dept (2 patients in Resus)
10 minutes to Triage
0 ambulance crews waiting
5 patients waiting for Ward Admission
79 minutes to First assessment
Longest ambulance wait 0 minutes
Grantham & District Hospital
No data is currently available for this site
Page Refreshed at: 18:00:36 (previously displayed: N/A) Next refresh at: 18:10 [Refresh now]

Appendix 5 - **Winter plan communications and engagement plan 2016/17**

Introduction

Objectives

- To help deliver the winter plan
- To raise awareness of where is the most suitable place to go for different levels of urgent care (choose well messages)
- To alleviate pressure on A&E by reducing the number of inappropriate visits.
- Raise awareness of alternatives to A&E among GPs
- Publicise ULHT's winter plan-
- Reassure stakeholders and public we have a robust plan including:
    - Increase in beds
    - New models of care
- Promote SAFER to frontline staff and senior managers
- Promote emergency and urgent care principles to staff
- Work together with other providers and commissioners in a joint communications campaign

Key audiences

Staff

- Clinical and frontline staff
- Senior managers
- Clinical directors
- All staff

Stakeholders

- Nursing home and residential home staff
- CCGs
- Providers
- NHS Improvement
- MPs
- HOSC and HWB

Public

- ULHT members
- Hard to reach groups
- Public segmented into the following groups:
    - Confused users – don't know alternatives to A&E
    - Convenient users – people who leave near to A&E
- Attached users (to A&E) - Patients with GP practices who are overrepresented at A&Es
- People with chronic health conditions
- Frequent flyers

Plan

Activity	Start date	Finish date	Lead person	Progress
Messages				
Agree key messages				
Agree plan objectives				
Internal comms				
Raise awareness of winter plan in CEO update & weekly round-up				
Promote emergency and urgent care principles				
Launch phased SAFER campaign in all internal comms channels				
Public campaign				
Bid for funding				
Creatives				
Design on-street posters				
Sign off posters				
Design leaflet				
Sign off leaflet				
Printing leaflets				
Printing A1 posters				
Printing banners/ large collateral				
Create content for websites				
Sign off content				
Get posters translated into Polish, Russian, Latvian and Lithuanian				
Sign off translated materials				
Print translated materials				
Publicity				
Write media and publicity plan				
Agree spokespeople				
Get sign off				
Launch campaign				
Create campaign web pages on ULHT, LCHS and CCG websites				
Launch campaign in media and social media				
PR with staff, members and stakeholders				
Distribute posters/ leaflets to GPs, pharmacies, other public places				
Distribute posters and leaflets to shops in key areas				
Put posters and banners up around ULHT hospitals				
Community engagement				
Identify key groups - biggest users of urgent care services				
Write community engagement plan				
Write semi-structured questions for engagement				
Engage with key groups and hand out leaflets and flyers				
Run sessions with ULHT members				
Evaluation				
Organise debrief session				
Send out survey				
Analyse results				

Appendix 6: Standard Operating procedure for Operations Centres LCH/PHB

This SOP will give an overview of the working of the Operations Centres on both Lincoln and Pilgrim sites, this includes the roles and the functions of the team that work within.

Operations Centre Daily Working:

- The Operations Centre will act as the hub for information regarding the daily management of patient flow.
- Bed meetings will be normally be held at 8:30am, 12:30am and 15:00 daily unless otherwise stipulated at the meetings, further bed meetings may be required if the site is under extreme pressure (level 4). The bed meetings will follow the guidance laid out in the SOP for bed meetings.
- Attendance at the bed meeting will follow that prescribed in the SOP for bed meetings, and ULHT Escalation Policy. It is expected that all attendees to the meetings will actively participate and be able to provide information required to the meeting. Following this attendees will be expected to follow any actions given to them by the chair (Site Duty Manager),and bring back the information requested either to the next bed meeting or at a specified time.

Site Duty Manager: (SDM)

The SDM is the key role in the maintenance of flow through the sites throughout a 24 hour period. They will manage the flow proactively at all times with the bed management team :

- Chair the site bed meeting 3 times daily, more if required, making sure that information in relation to flow is shared and action plans are made for the hours in between meetings.
- Follow the internal escalation plan and document all plans and actions taken on the bed meeting questions.
- Manage the flow of patients both emergency and elective through the site with assistance of the bed management team.
- Work with the Discharge HUB/ External agencies to manage the complex discharges.
- Work with the ward sisters and Matrons to make sure that patients have predicted dates of discharge highlighted and that the next day's predicted discharges are given to the Operations Centre by 2pm daily. Issues should be escalated through the operational matron of the day/week.
- Work with the ward sisters and Matrons to monitor ward length of stay (LOS), and assist in reducing this, as per SOP relating to length of stay.
- Work with the ward sisters and Matrons to ensure high standards of safety are maintained as per policies.
- Work with the wards to address the delays, taking actions to move the patients through their pathway.
- Look at 'risk' associated with decisions and work to the best course of action making sure decisions are clearly documented.
- Liaise with the other sites within ULHT and ensure open sharing of the site situation and patient flow.
- Act as Bronze command. Liaising with Silver as required.
- Follow escalation policy in times of pressure.
- Monitor the 4 hour standard within A&E at all times.

Urgent Care Manager (new post)

The Urgent Care Manager's role is to support the SDM with the maintaining flow across the site. They will:

- Be the link between the SDM and the Deputy Director of Ops (DDOP)
- Work closely with the SDM to maintain standards across the site (eg 4 hour ED, 18/26 weeks, cancer targets)
- Report to the DDOP when there are issues that disrupt flow.
- Work with colleagues to look at solutions to improving flow across the site, looking at PDD's, LOS, bed configuration, ring fencing, outlying.
- Be present on daily systems call raising issues and concerns that are affecting performance to the appropriate partner organisation, and working on a solution to issues
- Supporting the SDM and bed managers in improving ways of working within the Operations Centre.
- Look at trends, analyse and feed this information into meetings, aiming to improve the pathways for the patient through the site.

Bed Manager:

The bed manager supports the SDM in managing the patient flow through the site.

- Proactively manage the bed stock on the site.
- To visit all ward areas and complete Visual Hospital(VH) as per VH standards, using the Plan for every Patient boards.
- Work with the coordinators in ED, on the Assessment units and within the ward areas making sure that beds are allocated as per patient movement standards, and that patients are moved in a timely manner, and that times are provided to ensure accurate times for patient moves to create smooth flow.
- To inform wards of the number of elective and emergency patients that the ward is required to pull through. Each ward will be provided with a list by the bed managers, if there are problems getting patients to allocated wards, they will work with the SDM, the Matron, the medical staff and the ward to reach a solution.
- Follow their escalation card in times of pressure.
- Work with the SDM and Operational matron of the day/week to review LOS over 7 days.

Matrons:

On a daily/weekly basis in hours a Matron will be identified as the Operational Matron for the day. The Operational Matron will:

- Attend the bed meetings as per SOP for bed meetings
- Manage the site staffing, feeding into the bed meetings the issues and actions taken around this. Working alongside the SDM in times of pressure to ensure that escalation areas can be staffed safely.
- Undertake any actions from the bed meeting and report back as required.
- To work with the SDM and Bed Manager to review the LOS above 7 days and action any same day plans.
- Ensure that any actions or information is fed back to colleagues from the bed meetings.
- Ensure that all wards are working proactively to manage patient flow, and are working towards the standards set for making sure beds are ready for the next patient.

- Communicate any issues from their colleagues that could affect flow through the site in a timely, effective and constructive way so that the SDM can work on actions to resolve.
- Assist the SDM in times of pressure to manage 'risk' across the site
- Ensure that all wards have identified 2 outliers and these have been signed off as suitable by the Matron or deputy for that area.
- Ensure that appropriate action is taken and that wards comply at times of pressure and in line with the Escalation Policy.

Heads of Nursing (HON's)

On a weekly basis a HON will be identified as the HON who will support the Operations team with the flow on site. The HON will:

- Attend the bed meetings as per the SOP for bed meetings.
- Discuss and support site staffing both normal and escalation with the Operational Matron and the SDM.
- Communicate any issues from their colleagues that could affect flow through the site in a timely, effective and constructive way so that the SDM can work on actions to resolve.
- Assist the SDM in times of pressure to manage 'risk' across the site
- Ensure that appropriate actions are taken in line with the escalation policy.

Medical and Surgical Business units.

The Medical and Surgical Business units will maintain a rota so that there is attendance at bed meetings through the day in support of the site. The Business units will:

- Attend the bed meetings as per SOP for bed meetings.
- Discuss and aim to resolve any medical staffing issues that may have detriment to flow on the site, making sure that the SDM is kept fully informed.
- Work closely with the Operations Team to make sure that any delays, reviews or outstanding issues are addressed and resolved.
- Communicate site issues with medical colleagues.
- Communicate any issues from their colleagues that could affect flow through the site in a timely, effective and constructive way so that the SDM can work on actions to resolve.
- Ensure that appropriate actions are taken in line with the escalation policy.

On call Consultants/ Speciality Consultants.

In times of pressure, dependent on where that pressure is, it would be prudent for the ED/MEAU/SEAU and any speciality consultant to attend a bed meeting so that they can be aware of that days pressures and feedback to their colleagues with actions that are required to be undertaken to assist the site in achieving flow.

Ward Managers/ Deputies.

The wards need to work closely with the Operational Team to assist them in getting the 'right patient to the right bed' and maintaining safety, managing risk and flow across the site. They will be expected to:

- Make sure that all patients have a PDD documented clearly so that the bed managers are aware of discharges and potential discharges at least 24 hours in advance, and work closely with the clinical team work proactively to achieve this date.

- Ensure that discharges are identified for early movement and that the Discharge Lounge is used except in exceptional circumstances.
- Ensure that the clinical team have identified 2 outliers on a daily basis, and all staff are aware of these, and the patient has been informed. (as per outlying policy)
- Ensure that patients and relatives are aware of all moves and discharge dates.
- Ensure that the PDD form is in the Operations Centre by 230pm daily including weekends.
- Provide accurate information to the Operations centre team around discharges and delays.
- Ensure that once a patient has been discharged the bed space is cleaned and ready in an agreed time as per standards. If there is an issue ensure early escalation.
- Be responsible for ensuring that the ward is aware of the level of escalation across the site, and that all staff are complying with the Escalation policy. Ensure that appropriate actions are taken in line with decisions made at bed meetings.
- Ensure that patients clinical and recovery pathways are monitored and tracked to prevent avoidable delays in discharge, this includes referral and liaison with other services.

Site Sister

The Site Sister will support the SDM on the late part of the shift covering the hours of 1pm-9pm. They will work as guided by the Site Sister SOP, supporting the SDM by:

- Attending the bed meeting at 1500 hours and taking away any actions given to them by the SDM.
- Taking over the staffing from the Operational Matron at 4pm, supported by the SDM.
- Being available to assist the SDM with any issues that arise within their scope of practise.
- Being available to administer drugs/ FP10's from the drug cupboard at set times and on an adhoc basis as required.
- Support wards and departments when they require guidance with issues.
- Help deal with verbal complaints that may arise.
- Undertake viewings in the mortuary if the SDM is not available.
- Follow their escalation card in times of pressure.

Discharge HUB

The Discharge HUB is important in making sure that complex patients are discharged safely and timely, but they also have a major role to play in the flow of patients through the site. They will assist the Operations Centre by:

- Attending the bed meetings, informing the SDM of Medically Fit For Discharge (MFFD) numbers .
- Discussing that days and the next day's discharges.
- Giving information with regard to internal and external delays.
- Escalating to SDM any issue that the Hub are struggling to resolve.
- Working with the Operations Centre to look at patients who are suitable for repatriation to other hospitals within the Trust, and making sure they are referred.
- Ensure that appropriate action is taken in times of escalation.

Appendix 7: Operational Flow Meeting SOP

Bed Meeting Standing operating procedure (SOP).

Scope and purpose

This SOP details the process, expected attendance and information required at LCH Site bed capacity meetings.

Bed capacity meetings will be held routinely in the Ops centre at:

08.30/12.30/15.00

Bed meetings will be led and chaired by the Site Duty Manager

Bed meetings will start promptly and be succinct.

All attendees are expected to fully participate and to ensure that they have all of the information required for their area at the meeting

Any interruptions should be of an essential nature only.

Any matters of an extremely sensitive nature should be discussed outside of the bed meeting on a need to know basis.

The chair will allocate actions, timescales and those responsible.

Further bed meetings to be arranged as per escalation policy, time to be arranged by chair of operations centre.

Any issues outside of the bed meeting template will be raised as any other business.

An agreed written plan will be recorded following each bed meeting detailing action to be taken.

The chair will indicate the end of the meeting and attendees will be expected to exit the operations centre in a timely manner.

During normal working Ops Centre Manager/SDM will liaise with PSM by telephone to keep them appraised of site situation.

The Operational Matron of the day will liasie with the other Speciality Matrons prior to attending the Bed Meeting to confirm any site staffing issues.

At Level 3 the 'On Call Manager' should attend the 3.30 bed meeting if on site. Alternatively they will be contacted by the OCM/SDM regarding the site position at 3.30pm.

Information required for the bed meeting is as per Bed Meeting Proforma

The Bed Manager will provide information on the following:-

A&E Dept performance and any delays
Number of patients on MEAU/SEAU requiring a bed by speciality

Number and location of all 'ring fenced' beds
Number of elective patients expected into Johnson ward/Cardiac Short Stay
Number of Elective admissions expected in the next 24 hours
Number of ITU patients that require 'warding' and which ward they require.
Numkber of emplty beds, known and potential discharges and times.
Number of emergency admissions known about including patients in MEAU ambulatory area.
Number of Predicted Date of Discharge (PDD) for next 24 hours.
Number of outliers per speciality and the location.

Required attendance + additional membership for the subsequent levels of Site alert status.
It is the responsibility of all staff to know what alert status the organisation is on. This information is available from the Operations Centre on 2663.

Mon to Friday	**Weekend**
Normal Working	Normal Working
Bed Manager	Bed Manager
Operations Centre Manager/Site Duty Manager	Site Duty Manager
Operational Matron	
Theatre and ICU representatives	

Monday to Friday

The Ops centre Manager/Site Duty Manager will ensure the Patient Service Manager is appraised of the site position during normal working.

Weekends

The Site Duty Manager will liaise with the Directorate Bleep Holders/trauma co-ordinators and request their attendance at the Bed Meetings as required.

Level 1 (Green)	**Level 1 (Green)**
Attendance as above	As above
Level 2 (Amber)	**Level 2 (Amber**)
As above +	As above+
PSM Emergency, Planned and W&C	Liaise with On call manager
Level 3 (Red)	**Level 3 (Red)**
As Above+	As above+
Business unit managers (EC and PC)	On call Manager
Matrons/deputies for all specialities (as required)	On Call Consultants
On call Consultants`	Liaise with Exec on call
Social Services Representation, (may be by phone)	
AHP representative	
LCHS representative	

Level 4 (Black)(Compulsory Capacity Meeting)

Director of Operations (Executive Board Representation)**(Chair meeting)**
Lincolnshire Health Representation
EMAS/LPT representation
Consultant representative

A Member of the infection control team will be invited when appropriate.
Representation form Facilities will be requested when appropriate.

Appendix 8 - **Standard Operating Procedure – Operational Manager On-Call**

Introduction

This SOP describes the trusts Operational Manager On-Call system and should be read in conjunction with the Operational Escalation Policy and the Major Incident Policy. The SOP is intended to provide clarity on the expectations of those who are on-call and defines their levels of responsibility.

Who this applies to

The Operations Directorate is required to provide an on-call service to manage flow and any incidents within the hospital sites. All operational managers have a duty, defined in their job description, to take part in the on-call system.

Exceptions to this may occur where there is a service specific on-call rota in existence. No member of staff should be expected to take part in two on-call systems where the frequency of duties exceeds that of the normal rota.

Rota Responsibilities

Responsibility for compiling the 2 rotas (Gold and Silver) sits with the Emergency Planning team (EPT). The rota will be produced at least 2 months in advance. The EPT will ask for booked annual leave commitments ahead of the rota being produced and it will be accommodated as part of the planning process. Once the rota has been produced, if staff book further leave or have other reasons why a shift cannot be covered it will be the responsibility of staff to swap these shifts that they cannot work. The swap must then be communicated to the (EPT) who will amend the rota and ensure the rota is updated or if a swap takes place on the day of the duty the member of staff must inform the EPT, switchboard and Site Duty Manager (SDM) on each site.

Where a member of staff who is on-call rings in sick, it is the responsibility of the individual's line manager to inform the EPT. EPT will contact other staff on the rota and will keep a record of who provides cover to ensure all staff are approached equitably and fairly to cover additional shifts. If the shift cannot be covered it will be passed back to the individuals line manager who will be responsible for ensuring appropriate cover from within their or another team.

Training

For those new to the rota, or those requiring support, the EPT will provide training in all aspects of on-call and major incident handling. There will be a bi-annual half day training session for anyone new to or requiring refresher update. In addition there will be on line (E learning) and 1:1 training available throughout the year. All staff new to the rota should expect to receive face to face training and shadowing support as a minimum prior to

undertaking on call alone. The amount of training / support required will vary from one individual to another and will be agreed on a personal basis with the EPT. A self-assessment process will be utilised to identify individual training needs using national skills for Justice Framework (Gold and Silver).

Staff will be covering more than one hospital site. It is essential that the induction period to the rota includes an overview of the site so that those on-call understand the layout and location of escalation areas. It is advisable that staff arrange to spend time in each operations centre and meet with the site Deputy Director of Operations who will be able to give an overview of the site.

Roles and levels of responsibility

There will be two levels of on-call, Gold and Silver with Bronze commanders as site duty managers based on site (standby Nurse at GDH), this is in line with the trusts Major Incident Policy. On-call periods will run from 17:00 to 09:00 (except weekends when it will be 09:00 – 09:00). Staff who are on-call will be expected to keep diary commitments light and although they may attend meetings off site must remain local and any booked meetings must be suitable for short notice cancellation if necessary (i.e. not HR meetings). This will allow for appropriate rest to be taken after on call if necessary.

Bronze command (on site) - will comprise of the Site Duty Managers (Site Sister at GDH supported by LCH – see GDH Escalation SOP later). There will be 3 Bronze Commands; one of these will be on duty at Lincoln and cover Louth, one Grantham (supported by LCH SDM) and the other will be on duty at Boston. They will have an overview of the bed state and status of their A&E departments. Bronze will keep the silver commander updated regarding the site position as and when required.

Bronze Commander has delegated authority from the Silver Commander to:

- Open escalation beds in line with the site plan, provided they can be safely staffed as agreed during the day with Gold Command

- Utilise Ring Fenced Beds where necessary to ensure safety in A&E

- Deal with any incidents that arise and escalate as necessary

- Book transport including taxi's for patients to leave the hospital within a 50 mile radius. Journeys over this will be escalated to silver for approval

The Bronze Commanders will keep Silver Commanders informed of any incidents or problems on their site throughout the shift by whatever means is agreed and at timescales agreed between Silver and Bronze. Bronze will inform Silver of any patients in A&E at 8, 10 and before 12 hours from decision to admit without a plan to avoid 12 hours breaches. Silver will be required to inform Gold so that CCG on call can be informed.

Silver Command (on call) - will be undertaken by a range of senior managers from all sites at band 8C and above. There will be one on call single Silver Commander for the trust. Silver Commander will be briefed by Bronze, as and when required by mutual agreement, as to the position in the trust and will be aware of any patients in A&E with waits in excess of 8 hours without a plan.

Silver Commander has delegated authority from the Gold Commander to:

- Arrange internal ambulance diverts and deflects during times of excessive pressure

- Inform the Gold of any actions taken during times of increased pressure or any potential 12 hour breaches as above

- Deal with any serious incidents that are escalated from the Bronze Commander

- Cancel elective activity based on operational demand as required. The operations centres will receive, from the business unit, a prioritised list of elective cases that could be cancelled if the site deteriorates. This will be escalated to silver for approval.

- Silver Commander is not expected to be on site except in the event of a:

    - Major Incident Declared or Major Incident Standby
    - A serious incident has occurred e.g. fire, IT failure, telecoms failure, any unusual incident that has potential to attract media attention or poses a significant safety risk to patients / visitors or staff – there is no conclusive list and the silver Commander would need to make a judgement in collaboration with the SDM whether their presence is advisable.

Gold - will comprise the trusts executive directors. There will be a single Gold Commander for the trust. These Directors will undertake the most senior level of on call. Gold Command will be automatically activated as part of the Trust Major Incident Plan. It may also be activated following discussion between the Gold and Silver Commanders in the event of an incident which is likely to have a significant impact on the Trust but which does not justify implementation of the Major Incident Plan (for example, serious capacity issues).

Operationally, the actual daily involvement of On Call Gold will be very minimal. The Trust Gold command will provide a high level of strategic guidance and leadership in support of the Silver level on call management tier. Trust Gold should not act at a tactical/operational level unless Silver has requested assistance/advice.

Gold will, however, retain responsibility to approve:

- Increasing staffing via internal bank or external Framework agencies to ensure all patient areas are safe

- Inform the CCG on call of any actions taken during times of increased pressure or any potential 12 hour breaches as above

Major incidents

Please refer to the trusts major incident policy.

In the event of a major incident being declared the Silver and Gold Commanders will attend site and establish their relevant "cells". Runners and loggists will be made available. Ensure communication between the cells is adequate, either via phone or radio handsets. The Bronze Commander will remain in the sites Ops Centre. The cells would normally be located:

Gold: Lincoln Suite, Trust HQ, Lincoln Site
Silver (Lincoln): Matrons office / Ops Centre as required by incident
Silver (Boston): Committee Room 1/ Ops Centre as required by incident
Silver (Grantham): Ops Centre

Any changes to the above must be communicated early in the incident.

Attending site and working time regulations

It is not expected that on-call managers will have to attend site, however, if staff do attend site or if they are called upon to work at home then it is expected that compensatory rest must be taken. The rest provided should make up for the rest missed; and should be taken **immediately** after the end of the on call working period. Employees who are called into work during a period of on call will receive payment for the period they are required to attend, including travel time. Alternatively they may choose to take time off in lieu. However, if operationally this cannot be taken within 3 months, the hours worked must be paid for (section 2.44 AFC handbook). For work (including travel time) as a result of being called in, the employee will receive a payment at time and a half with the exception of work on general or public Bank Holidays which will be at double time. Time off in lieu should be at plain time. There is no disqualification from this payment for bands 8 and 9 as a result of being called out. (section 2.45 AFC handbook)

On-call logs and handover

All on call staff should keep a record of work undertaken, communications, decisions made and times in either a log book or on line. It is possible that such information may be required in the future for legal cases or for learning from incidents that occurred. The EPT may request copies of log books for record and information sharing/lessons learned. Following a period of on call the individual may make contact with the on-coming staff member where there are ongoing issues such as a deflect to handover.

Appendix 9: Directorate of Operations Standard Operating Procedure Reviews of Patients with Long Lengths of Stay (Stranded Patient)

Version Control	
Version Number	1
Author(s)	J Ryan
Date Produced	1/9/2016
Review Due	1/9/2017

Background
It is recognised that reviewing patients' length of stay (LOS) at regular milestones reveals avoidable delays, and can reduce the number of patients with high LOS. Any avoidable delay is associated with increased risk of harm, increased mortality and a poor patient experience. This process is designed to ensure that these risks are minimised. The SAFER care bundle states '*We need to proactively respond to the identified delays through appropriate action planning'*

Process:

- Patients will have their LOS tracked from date of admission. All patients on admission to their host ward should be given a Predicted Date of Discharge (PDD), with a clear plan for their care. This should be monitored daily at the board round and discussed within the Multi-Disciplinary Team (MDT), challenged and amended.

- Patients whose LOS extends beyond a cut-off point of 7 days will be highlighted weekly, on a Monday, to the Ward Sister/ Deputy (a list will be produced from Medway)

- Sister/CN will discuss each patient with the medical team and the Matron for their area, and agree a plan for that patient.

- On Tuesday afternoon (1pm-2:30pm) a 'Stranded Patient' review will be held in the Operations Centre. The Ward Sister/ Deputy of 4 wards with the highest numbers of 7 days and above patients (excluding Ashby, MEAU,SEAU,ICU) will be asked to attend the review to discuss the patients highlighted, 2 other wards at random will also be invited. The review will be chaired by the HON's, Lead SDM or Deputy Director of Ops.

- All Ward leads will reserve a slot in their diaries from 1-2:30 on a Tuesday to focus on stranded patients, and discharge delays. Even if not called to the challenge meeting, all areas will be expected to use this time to resolve delays.

- At the end of the challenge meeting all patients who require further work to resolve delays will be highlighted to the Ward Sister & Matron along with any suggested actions. The matron will lead a thorough review, involving medical teams as necessary, and provide the Ops team with a plan through to discharge by 1pm the following day.

Stranded Patient Review Form

Ward: Date

Please return this completed form to the Ops Centre by 1pm on the following day.

Name	LOS	Action Required
Action Taken (include PDD)		

Name	LOS	Action Required
Action Taken (include PDD)		

Name	LOS	Action Required
Action Taken (include PDD)		

Name	LOS	Action Required
Action Taken (include PDD)		

Name	LOS	Action Required
Action Taken (include PDD)		

Name	LOS	Action Required
Action Taken (include PDD)		

Completed by (Name & Signature):

Appendix 10: Snow and Adverse Weather Plan 2016/17

	Action Site level to be decided Trust wide through emergency planning lead	By whom	Timeline
Level 1 Preparedness	• Within the wards and patient areas review windows/doors and ensure as draft free as possible. • Useful advice from http://www.theaa.com/motoring_advice/seasonal/winter_motoring.html • Staff who have a long distance to travel may like to consider keeping a small supply of essential items in personal locker for use in the event they are unable to get home e.g. toiletries, underwear. • Staff be aware of colleagues living near by and consider car sharing • Ward Sisters to ensure all staff personal details of address are current. • Wards to have lists of own staff with 4x4 who may consider help with transport of colleagues. • Facilities to consider loan of 4X4 • Ensure plan is available in all areas • Make sure that any alerts re weather are shared with the ward teams. • Escalate any estates issues to the facilities team	Matron/ Ward Managers	End November
Level 2 Adverse weather warnings	**As level 1** **STAFF** • Matrons to maintain good levels of communication with the operations centre/site sister, 4X4 vehicles/staff accommodation may be available from Progress Housing (booking information available in site sister folder) • Be aware of weather forecasts. http://www.bbc.co.uk/weather/2655138 • Be aware of local travel advice. http://www.bbc.co.uk/travelnews/lincolnshire/ • Review ward staffing levels to ensure sufficient staff , consider where members of staff live, availability, plan ahead to make sure that staffing levels are sufficient to cover the anticipated period of severe weather. • Operational staff have access to the met office web page for accurate updates **PATIENTS** • Ensure patients have access to extra blankets/hot drinks. Consider those who need assistance. • High risk groups to be provided with additional heating available via facilities. • Locations and numbers of all Bair Huggers to be identified • Consider if any assistance available from local Voluntary agencies (Red Cross etc) • Operations Centre to make sure that Met office alerts covering the next 24hrs are shared with ward teams. • Business units to be ready to implement elective business continuity plans as required. • Consider bed capacity within acute setting and community and discuss with PCT and SW colleagues stepping patients down whom no longer need acute hospital care. • Consider cancelling routine elective surgery.	Matron/Ward Manager/ Business managers/ SDM/ DDOP Ward Managers/ Matrons/ SDM	As required

Level 3 Adverse weather in progress	**As level 1 & 2 plus.** **Wards** • Staff to ensure patients have adequate blankets and are warm enough. • Identify particularly high risk individuals and ensure area suitably heated. • Hot water bottles and electric blankets if brought in by family are **not** to be used. • Operational teams to contact EMAS and NSL to discuss their contingency plans and activity **Facilities** • Consider restricting visitors to site. • Ensure access to the site maintained to key entrance points. **Elective Work** • Consider cancelling outpatients' clinics. • NSL to contact sites if unable to support non emergency work • Work with partner agencies to identify where pressures will be greatest, so as remedial action can be taken. **Staffing** • If staff are unable to work please see ULHTguidance : http://ulhintranet/human-resources-policies/ • Utilise other professions within the Trust to assist in caring for the patients, • It is important that we continue to present a professional appearance to patients and visitors, so staff are to wear uniform correctly throughout the cold period.	Ward Manager/ Matron/SDM/ Facilities Lead/ Deputy Director of Operations	As required

Plan Links with:

Trust Wide Escalation Plan
Lincolnshire Escalation Plan
Winter Preparedness Plan
Flu plan
Industrial Action Plan
Major Incident Plan
Evacuation Plan