United Lincolnshire Hospitals NHS Trust

United Lincolnshire Hospital NHS Trust

Draft Winter Plan 2018/19

V0.9 22/8/2018

1. Contents

Appendices 1-9 will be updated as new plans are released

2. Plan 2018 -19

The Trust wide Winter Plan sets out the organisations arrangements for the winter period. The plan sits as part of the wider Lincolnshire system plan and as such may reference other provider plans (such as LCHS) where direct links are made.

Winter is not an emergency or considered an unusual event, but recognised as a period of increased 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

Much of this plan echoes the urgent care improvement plan being worked on throughout Q1-Q2 (*also referencing elements of the ULHT Capacity and Delivery plan*).

The winter period 2018-19 will see an increase in bed capacity across the system, with an additional 99 bed impact (through increased beds and reduction in demand for beds) created in total by the end of quarter 4. The other solutions described in this plan will focus on demand management, efficiency and improvement of flow and throughput, which will enable the system to deal with the increased pressure that winter brings.

The top 4 interventions within this report are:

- The reduction of overcrowding in ED through the increase of streaming patients to services outside of the department (Primary care streaming, AEC and other department pathways)
- The reduction of DTOCs from 2017/18 level of 4.71% to 3.0% reducing occupancy and the need for increase bed capacity
- The reduction of LOS through schemes such as the reconfiguration of Pilgrim Hospital Inpatient Services, reduction in super-stranded patients together with the use of Red2Green market place
- The reduction and avoidance of admissions through services within the community, the CAS service and other ambulatory management of patients

3. Context

There are a number of assumptions that underpin the 2018/19 plan for urgent care and subsequent Winter Plan. Activity levels in ED and admissions were reviewed in 2017/18 and associated improvement schemes, together with growth were then added into the forecast and plan for 2018/19.

At month 4 when the first version of this Winter Plan was compiled the reality of actual versus plan were in some cases far apart from one another, and that some assumptions about attendance and admission avoidance had to date been unsuccessful.

Specifically challenging elements of this difference in plan versus experienced activity are:

- 5.5% more Medical Admissions than plan, (5.7% more than previous year)
- This translates into 3295 more bed day demand or the equivalent of 27 additional medical beds being required during M1-4
- 8% more A&E attendances than 2017/18 and 18% more than planned for in 2018/19. This equates to more than 72 patients per day being seen across the Trust that were not planned.
- Delayed Transfers of Care (DTOC) plans were assumed to be operating at no more than previous year's level of 4.2%. M1-3 in 2-18/19 had risen to 5.04% creating increased length of stay for patients ready to transfer/discharge. (Inclusive of 0 day stay LoS)
- Primary Care Streaming would reduce the number of A&E attendances in the department by 25% at each of PHB and LCH EDs. M1-4 shows only 9.3% of attendances were diverted to streaming thus understating the actual demand on acute teams in ED.
- Length of stay has increased from previous years of 4.6 NEL LOS to in excess of 5.0; increasing bed occupancy

The impact of this increase in activity to date means that planning on staffing, ward and physical departmental capacity are all short of that required. Improvement plans from 2017/18 do not accommodate this growth sufficiently and therefore combinations of internal and external improvements need to be made to offset the impact of winter and keep urgent care pathways safe and responsive.

4. A&E Trajectory

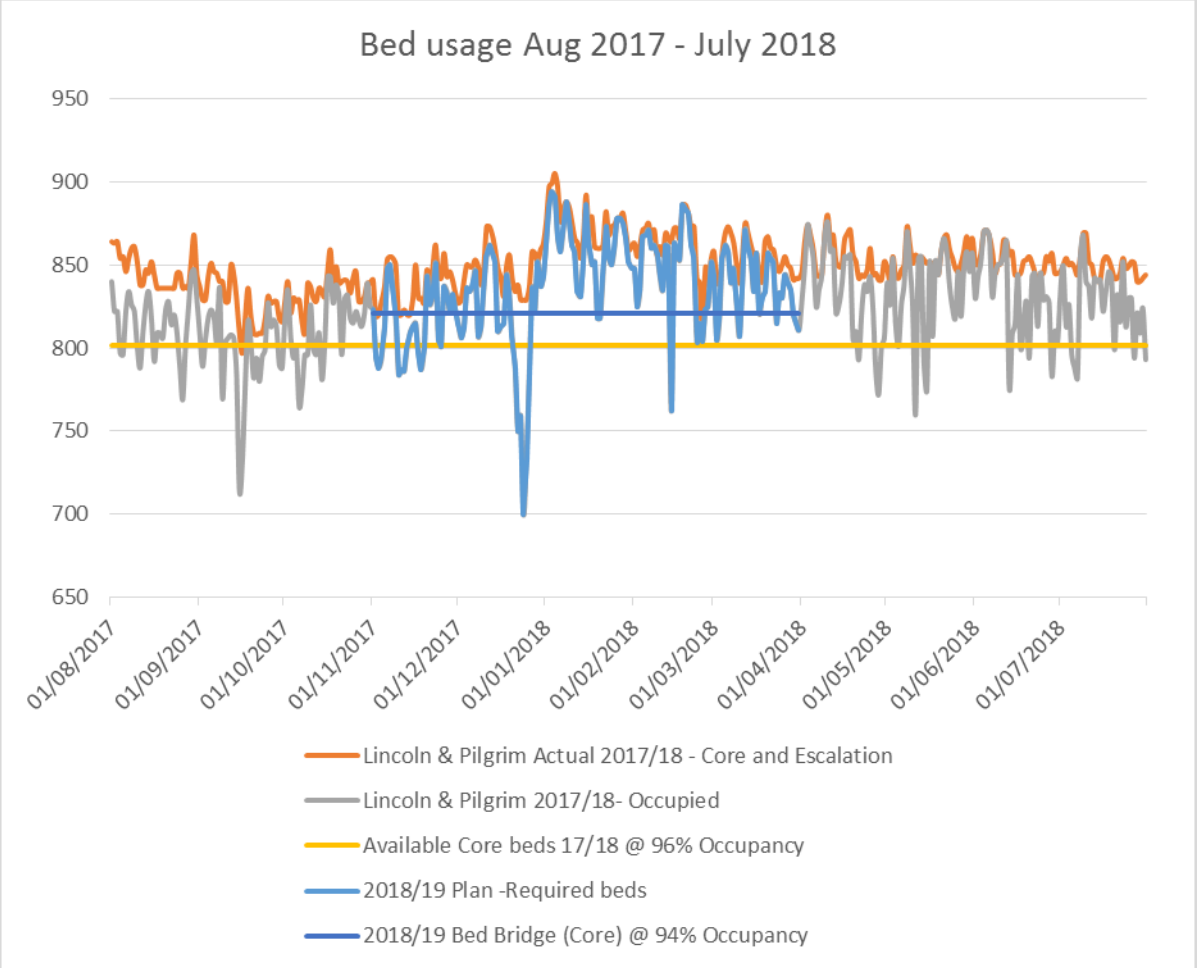
A performance trajectory for the 4 hour standard for 2018/19 considers improvements in process, staffing, physical capacity and aligns with anticipated demand changes over the winter period.

Lincolnshire 4 hour standard trajectory 2018/19

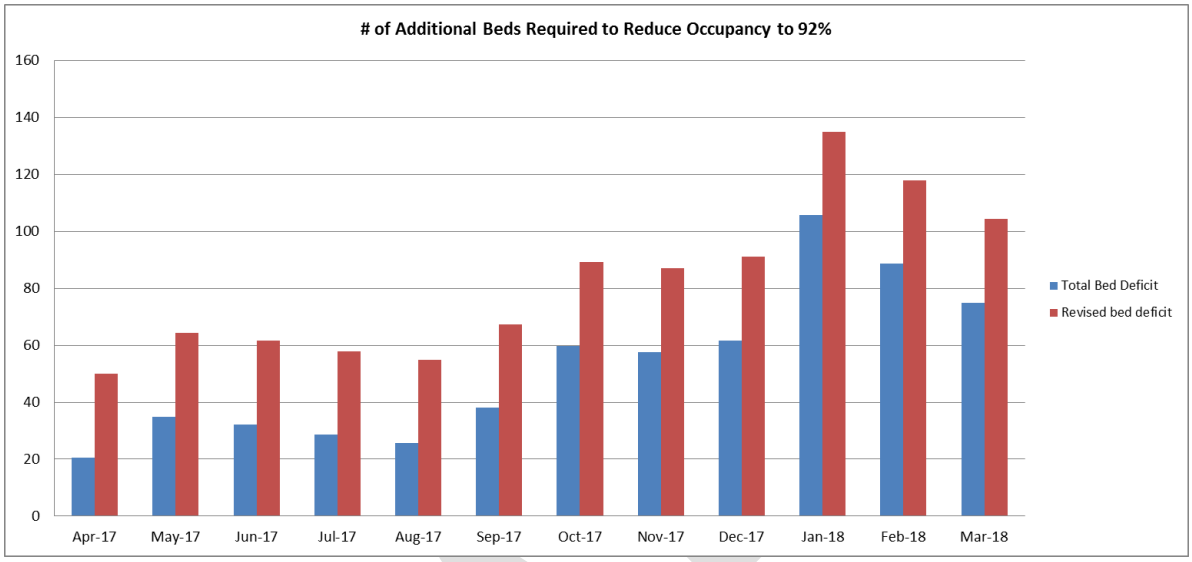
	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
ULHT Type I	69.69%	72.03%	74.38%	76.72%	79.07%	81.41%	82.22%	83.02%	79.07%	76.72%	77.53%	86.24%
ULHT + Streaming	72.04%	74.33%	76.63%	78.92%	81.22%	83.51%	84.39%	85.26%	81.22%	78.92%	79.79%	88.74%
ULHT + Streaming & Type 3	82.07%	83.68%	85.30%	86.91%	88.52%	90.13%	90.94%	91.75%	88.52%	86.91%	87.72%	95.00%

5. Bed Occupancy Approach

Bed usage fluctuates between around 775 and 1000 beds across the organisation with escalation. An increase on the previous year by 25 and 50 beds respectively.



Forecast demand had been modelled based on anticipated adult bed requirement throughout 2018/19. At a Trust-level the model forecasts a bed shortfall of circa 105 beds, however with the most up to date information available this is now estimated at circa 135 beds shortfall. Whilst at an aggregated level the pressure is seasonal, the model is forecasting the bed-base to be insufficient throughout 2018/19. This will be particularly pertinent over winter months.



Winter 2018/19 will see an increase in bed capacity within the trust of 44 beds although these will be based on the acute site it is proposed that they will not be acute beds managed by the Trust. This is due to the inability to safely staff these areas. Agency usage for nursing (required for bed capacity) is already extremely high and supply of agency staff is already at times insufficient to meet the needs of the existing bed stock.

Winter 2018/19 plans to address the shortfall in bed occupancy are integrated into the overall system improvement plan.

This will involve –

- Admissions avoidance; community beds will be used as an alternative to acute
- Frailty at the front door model
- Home Intervention Team Model (target improvements in weekend discharge)
- Effective streaming to divert patients from the acute setting
- Continued use of the Red2Green and Pride and Joy approaches at each hospital, reducing acute LOS
- Introduction of enhanced discharge lounge team
- Introduction of weekend pharmacy service
- Expediting transfer from hospital of medically safe patients (Discharge to Assess, investment in community, British Red Cross scheme and home care capacity via the BCF)
- Elective care pathway redesign
- Elective inpatient reduction in scheduling and programming, together with the reallocation of elective capacity to support emergency care pathway patients.

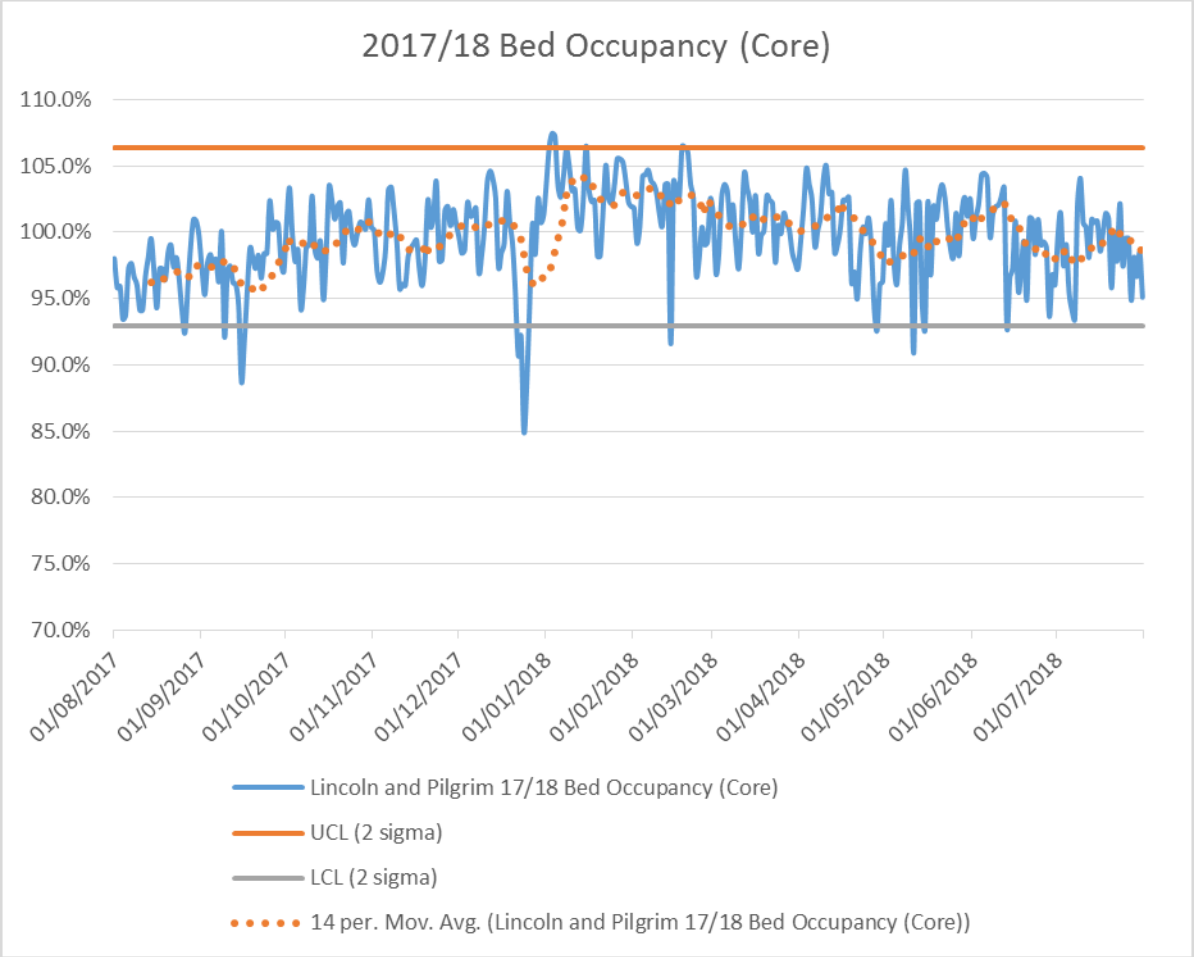
Specifically the reduction in demand through admission avoidance, together with LOS and earlier discharges will reduce occupancy across Q3 and Q4 in line with submissions earlier in the year as per below.

	17/18 position	18/19 position	Commentary
Bed Capacity	No change	Increase in medical beds and small reduction in surgical. Surge capacity available in Q4.	Total of 99 additional beds in system = 28 Digby, 18 Bostonian, 10 Grantham, 9 reconfiguration 34 achieved through LOS reductions
Reduction in NEL LOS (Excluding 0 day stay)	6.24	6.07	
Reduction in NEL admissions	56210	*TBC dependant on system urgent care plans*	NEL admission avoidance in primary care and the introduction of AAU will reduce admissions
Reduction in DTOC	4.7%	3.0%	DTOC programme to continue
Reduction in Super stranded patients		Reduction by 26%	Introduction of multiagency review will impact on number of SSP

6. Bed Occupancy Schemes

Red2Green

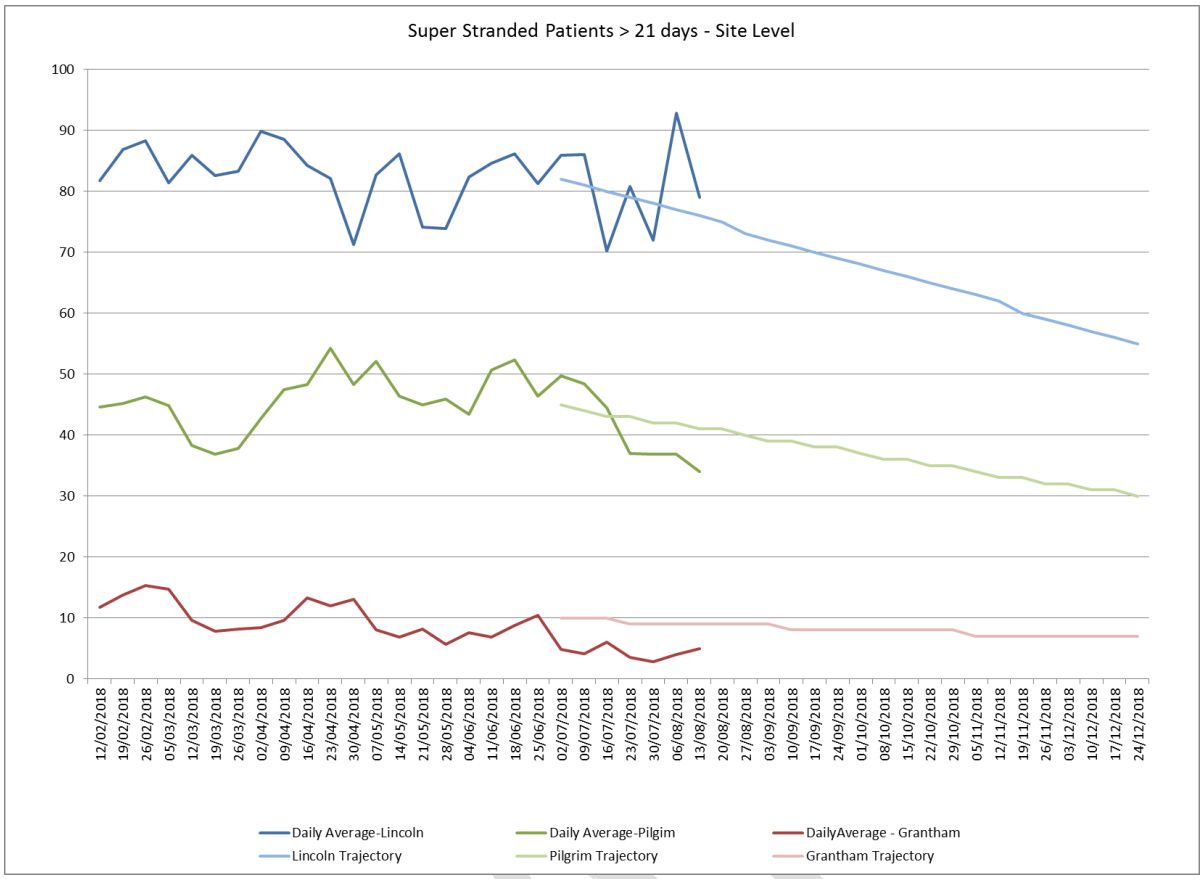
Early success in Red2Green implementation at the beginning of 2017/18 is forecast to continue and will strengthen over the winter period. Senior manager (head of nursing, general managers, deputy director) silver led Red2Green meetings will enable increased escalation, resolution and authority to resolve issues for patients with delays in care. *(See appendix 7 for an example of the Red2Green capture of delays)*



**N.B. Excludes Grantham*

Super Stranded Patients

Super Stranded patient reviews chaired by directors will increase visibility and escalate issues for longest stay patients in order to reduce the effect of PJ Paralysis, and both DTOCs and excessive health delay patients in each hospital.



LOS and occupancy improvements in Q1 and Q2 2018/19 have been small with increased focus on the Red2Green schemes, SAFER principles, Pride & Joy and Executive lead at the weekly meetings and improvement is expected.

<u>DTOC reduction to 3.0%</u>

Reduction in and sustainability of 3.0% or below will be supported by the urgent care system. Performance for 18/19 is worse than 17/18, necessitating executive input.

As part of this there is an ongoing drive to:

Ongoing drive for;

- Effective decision making for patients (safe care)
- Ensure staff are well led and motivated
- Ensure patient has a clear and agreed reason for admission to bed based care – Home First
- Clear pathways of care with milestones and accountabilities – Acute and Transitional care
- Red/Green day operating framework to manage the day and the stay for every patient
- Measurement one version of the truth
- Active in-reach for discharge planning and decision making
- Well led, engaged and motivated workforce
- Individual and team accountability

Elective Care Pathway Redesign

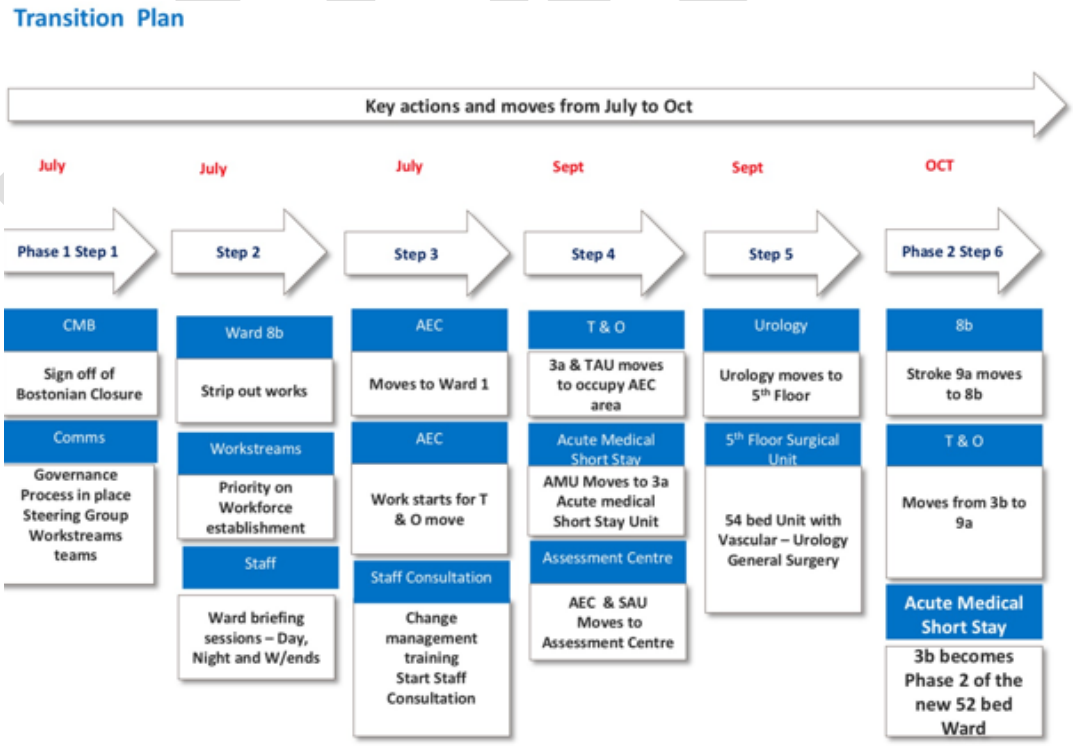
Work continues on the consistently increased levels of enhanced recovery after surgery (ERAS) across specialties. Starting with Orthopaedic patients and building on the Getting it Right First Time (GiRFT) opportunities of LOS efficiencies and bed reductions are expected on each of PHB and LCH hospital sites. Identified groups of patients with variation between 1.8 days LOS and 5.4 LOS are priorities and have excellent clinical buy in to pathway improvements.

Ward moves PHB

The reallocation and reconfiguration of wards at PHB will take place throughout the winter of 2018-19. The Re-configuration project will address the following requirements;

- Appropriate sized assessment units for all urgent care patients to improve urgent care flow and performance
- Short stay facilities to manage the majority of patients with a 72hrs timeframe
- Appropriate sized elective area to protect elective activity and deliver against the GIRFT programme
- A protected Ambulatory Emergency Care unit
- Right sized areas for Specialities

Considerable progress has been made on the project, which is currently going through the staff consultation phase prior to the key moves shown below.



The above transition plan shows the timelines and the extent of the following ward moves;

a. Trolleys based Assessment Centre with AEC & SAU increasing 0 day LOS discharges

b. 12 bed unit & 29 bed ward in support of the GIRFT programme

c. New 3rd Floor 52 bed acute medical short stay unit

d. 5th Floor 54 bed Surgical Unit for vascular, urology and general surgery

e. Refurbished discharge ward

7. Emergency Department Approach

Each of the Trusts' three emergency departments will experience increased pressures over winter. Using themes that are recurrent in recent years, these are likely to manifest as:

- Increased case mix of frail patients who experience difficulties in winter months (increased demand)
- Increased demand at times of holidays when patients delay receipt of treatment and/or expose themselves to increased risk of injury/illness (increased demand)
- Decreased support and availability in primary care GP through during winter holidays and patients that decide not to use alternative services (increased demand)
- Reduced flow and inpatient bed availability increasing exit block (reduced capacity)

The response to this increased pressures are incorporated into the urgent care improvement programme already underway. The main themes of these improvements will be:

- Reduced demand on EDs through bypassing of ED and straight to ambulatory/assessment units
- Reduced demand on EDs through increased streaming of patients to other services; internally within the hospitals, newly built primary care service areas, and externally to community based services
- Increased capacity through greater number of medical staff in each of the two main EDs at LCH and PHB – Utilising the new model of specialty (medicine, surgery and T&O) doctors working within the teams directly
  Frailty at the front door (Pilot at Lincoln site – from September)

8. Emergency Department Schemes

<u>Ambulatory Emergency Care Unit Direct GP Referrals</u>

The trust has ambulatory care units at LCH, PHB and GDH. LCH AEC moved in 2017 to an area that could not be used for inpatient beds, thus protecting the facility from becoming surge capacity overnight. This improvement together with the pathway of direct GP referrals reduces the burden on both ED and the admission wards. This model will also be introduced at Pilgrim prior to quarter 4 2018/19.

AEC unit at PHB will become a 7 day unit from October 2018, forming part of the 24 hour Acute Assessment Centre thus increasing the number of patients that can be streamed to AEC and

reducing the burden on ED and admission units. This does require recruitment; however as a part of the urgent care improvement plan is a key priority for the Trust. The anticipated impact will see 99% of GP referred patients bypassing EDs by Q4.

The combined effect of AEC improvements will positively impact on exit block, as well as reduction of overall ED attends.

9. Additional ULHT Schemes

Internally, to support the Red2Green, reduction in waits, and to improve responsiveness in each ED the following increase and improvements in services will be put in place:

7 day Pharmacy –Pharmacy provides supply and discharge facility every weekend all year round. Clinical pharmacy cover, medicine reconciliation prescription review could be provided at the weekend if funding was available *(Funding requested)*

Safer Patient Flow Bundle –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. The delivery of SAFER has greatly improved over the last 12 months however two significant areas of improvement will be incorporated into both the urgent care improvement plan and this winter plan.

- Board rounds at weekends – is an area of weakness currently within the trust. The combination of increased medical cover at weekend together with this operating process is anticipated to greatly improve the ratio of weekday:weekend discharges
- Pull from base wards from admissions by 10:00 am is another area of weakness that will be implemented in preparation for winter. The target of pulling a patient for each ward by 10:00 will be incorporated into each wards accreditation and safety checklists. Displayed on every ward it will be a key measure of flow and safety across the trust.

Increase Reception capacity in ED – to support increased streaming and the increased resilience of the reception team, additional staff will be recruited to work overnights ensuring that nursing teams can focus on nursing duties and that administrative coordination between parts of the department and primary care streaming are robust. *(Funded)*

Increased Medical Capacity at weekends – At both PHB, and LCH core ward and outlier review capacity will be in place with additional specialist registrar and CT2 doctor team to ensure that weekday plans our carried out and new patients are seen and given plans for treatment through to discharge. *(Funding requested)*

Home Intervention Team Model – At LCH team comprised of Band 7 nurse and junior doctor FY2 to facilitate discharge of patients identified in weekend plan as fit for discharge. *(Funding requested)*

Enhanced Discharge Lounge Team – Comprised of Pharmacy Technicians and Porters to facilitate flow of patients throughout the organisation. *(Funding requested)*

Increased nursing, medical and managerial teams- Will be in place across Q3 into Q4 building on capacity and delivery improvement plans created earlier in the year. These teams will likely increase the number of agency nurses and doctors in each of the ED departments at PHB and LCH with a possible small increase in substantive staff. Additional managerial posts will be substantive team members and will help strengthen the grip and control of the urgent care pathway throughout the winter months. *(Funded)*

10. 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.

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.

Support at Home (HART) – a further admission avoidance scheme to support patients in their own home. This service also supports discharge of patients with a planned date of package of care commencement. This ability to "bridge" package of care enables a more rapid discharge and reduction in LOS

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

Red Cross – Winter Pressure service, a 72hour service which aims to support patients in returning to their home and supports them in the first 72 hours (funding currently being sought).

Additional Beds – Additional sub-acute beds will be created. These 44 beds will be in the Acute Trust based on Digby ward, and the Bostonian unit but this is proposed to be managed by a combination of system partners including but not definitively community and social care trusts. Nine bed reduction in demand will be created as a result of the Pilgrim reconfiguration programme. Additional inpatient beds will become available due to efficiencies in Length of Stay as previously described.

11. Ambulance Handover

The Trust works closely with EMAS to improve handover times and the impact that ED overcrowding and pressure can have on released ambulance crews in a timely way.

The use of Rapid Assessment and Initial Triage (RAIT) across the EDs has greatly improved handover times over the past year 12 months. This process is maturing and will continue to improve, with support from ECIP and SSG. A series of change cycles from Quarter 1 through to Quarter 3 in 2018/19 detailed in the overall improvement plan as well as this winter plan and will seek to deliver a sustained improvement across the winter months.

The ED risk tool is now firmly embedded into daily practice giving an internal escalation level within ED separate to the Site Operational Escalation Level. This tool, 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.

(See joint handover protocol Appendix 1 for more detail on process)

12. Elective Phasing

Reducing elective activity plans will follow previous years plans for the 8 week period from the end of December and throughout January and part of February. The week prior to Christmas will incorporate scheduling procedures with longer LOS for the early part of the week, and reducing routine inpatient elective activity by approximately 50% on 21st - 24th 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 January Clinical Directorates will not schedule any routine inpatient surgery at PHB and LCH hospitals however they will continue to book cancer, urgent and day case surgery. Louth and Grantham Hospitals will continue to offer full operating schedules throughout the holiday period. During the second week of February routine elective capacity will be re-introduced. It is planned that surgical activity will return to standard levels from the beginning of March 2019.

13. Christmas

This year Christmas Eve, where the sites commonly have increased discharges, falls on a Monday, usually a low discharge day. It is unlikely that additional staff other than the normal roster will work the 24th. The planning of discharges from Friday the 21st will need to be maximised. This will include additional medical, nursing and pharmacies staffing to ensure patients are ready to go as well as securing increased capacity from transport providers to ensure that demand is matched at this important time.

After the prolonged holiday period (5 days including the weekend) we anticipate increased pressure on the system and are therefore planning additional staffing to start from the Thursday 27th – to ease flow and prepare the organisation for the New Year period.

14. Inclement Weather

The local resilience forum (LRF) produce a multi-agency weather plan and ULHT has a Snow and Adverse Weather 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. *(For more information see appendix 8)*

15. Communications Plan

This will contain key messages for the public to promote "choose well messages" and for staff around areas such as SAFER. Ways of communicating the status of the organisation across the organisation will be improved.

16. IP&C

Norovirus can have a major impact on the capacity of the site and its ability to deal with additional pressure. Increased demand will be managed with a cohesive communications plan and the sites operating outbreak meetings in line with the policy. The Infectious Outbreak / Incident Policy including Major Outbreak will be followed and invoked throughout this winter.

The medical admissions ward has a door system that can support the compartmentalisation of the ward in the event of infectious outbreak. This would reduce the likelihood of spread and enable the ward to remain open for longer.

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.

17. Influenza

The Trust flu plan is enclosed in Appendix 9. (Plan as of 2017/18)

In 2017/18 the Trust vaccinated 82% of staff one of the highest vaccination rates of hospital staff in England.

The plan describes a similarly robust approach and is to be delivered in conjunction with the ULHT Flu Charter. Vaccinations will commence in October. Incentives and a wider media campaign are in the plan which is built on best practice taken from other Trusts and national guidance.

18. Operating Frameworks for Bronze-Silver-Gold and escalation

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.

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 an 11 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 (UCL) will take the role of bronze during normal hours with the SDM taking over out of hours. During the winter period an Operational Matron of the day will work alongside the UCL providing additional clinical support as needed. *More detail on operational standard operating procedures is enclosed in Appendices 4-6.* Twilight bed mangers will also work at both Pilgrim and Lincoln sites.

19. Governance

A robust and integrated governance structure for the winter period will be established. A fortnightly Winter Planning Group, comprising relevant services, will be responsible for the operational delivery of the plan. An Integrated Winter Planning
Board, chaired by Director of Operations, who has operational responsibility for, will oversee delivery and effective implementation of the Winter Plan. The plan will be reviewed and signed off by both the Acute Trust Board and partner agencies through appropriate governance processes.

Locally the plan will be delivered under the operational management of the DDO for Urgent care. A winter room will be located at the Lincoln site to coordinate the Trust response

Escalation processes will be as described in the Trust Operational Escalation Policy; this will continue to be developed over the coming months.

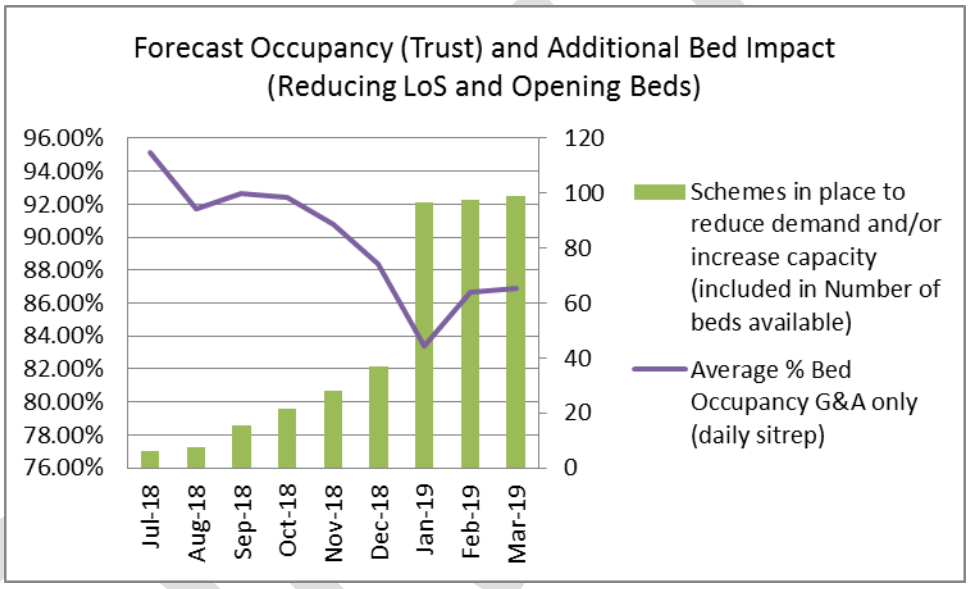
20. Summary

Winter 2018/19 will undoubtedly see increase demand for patient services throughout Lincolnshire. The table below detail the total number of beds available on the acute sites from July 2018 – March 2019.

Occupancy levels are predicted to be at their lowest in January 2019, as all of the winter schemes would be in place delivering the greatest impact.

UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A	Number of emergency admissions per day (daily sitrep)	155.2	154.4	153.8	166.2	171.8	135.2	160.4	164.4	160.4
B	Number of G&A beds available per day (daily sitrep)	1007	982	1007	1007	1007	1019	1050	1050	1050
C	Average LoS G&A beds only exc Zero LoS (SUS)	6.29	6.29	6.27	6.25	6.22	6.18	6.15	6.11	6.07
D	Average % Bed Occupancy G&A only (daily sitrep)	95%	92%	93%	92%	91%	88%	83%	87%	87%
E	Number of days in month	31	31	30	31	30	31	31	28	31
P	**Schemes in place to reduce demand and/or increase capacity (included in Number of beds available)**	6	8	16	22	28	37	97	97	99
P 1.1	LOS and 21 day stranded improvement schemes	6	8	16	18	22	28	32	32	34
P 1.2	Additional Winter Lincoln Beds	0	0	0	0	0	0	28	28	28
P 1.3	Additional Winter Grantham Beds	0	0	0	0	0	0	10	10	10
P 1.4	Additional Winter Pilgrim Beds	0	0	0	0	0	0	18	18	18
P 1.5	PHB Reconfiguration LOS Improvements	0	0	0	4	6	9	9	9	9



The plan will continue to be monitored by the system resillence group throughout the winter period and further alterations made as necessary.

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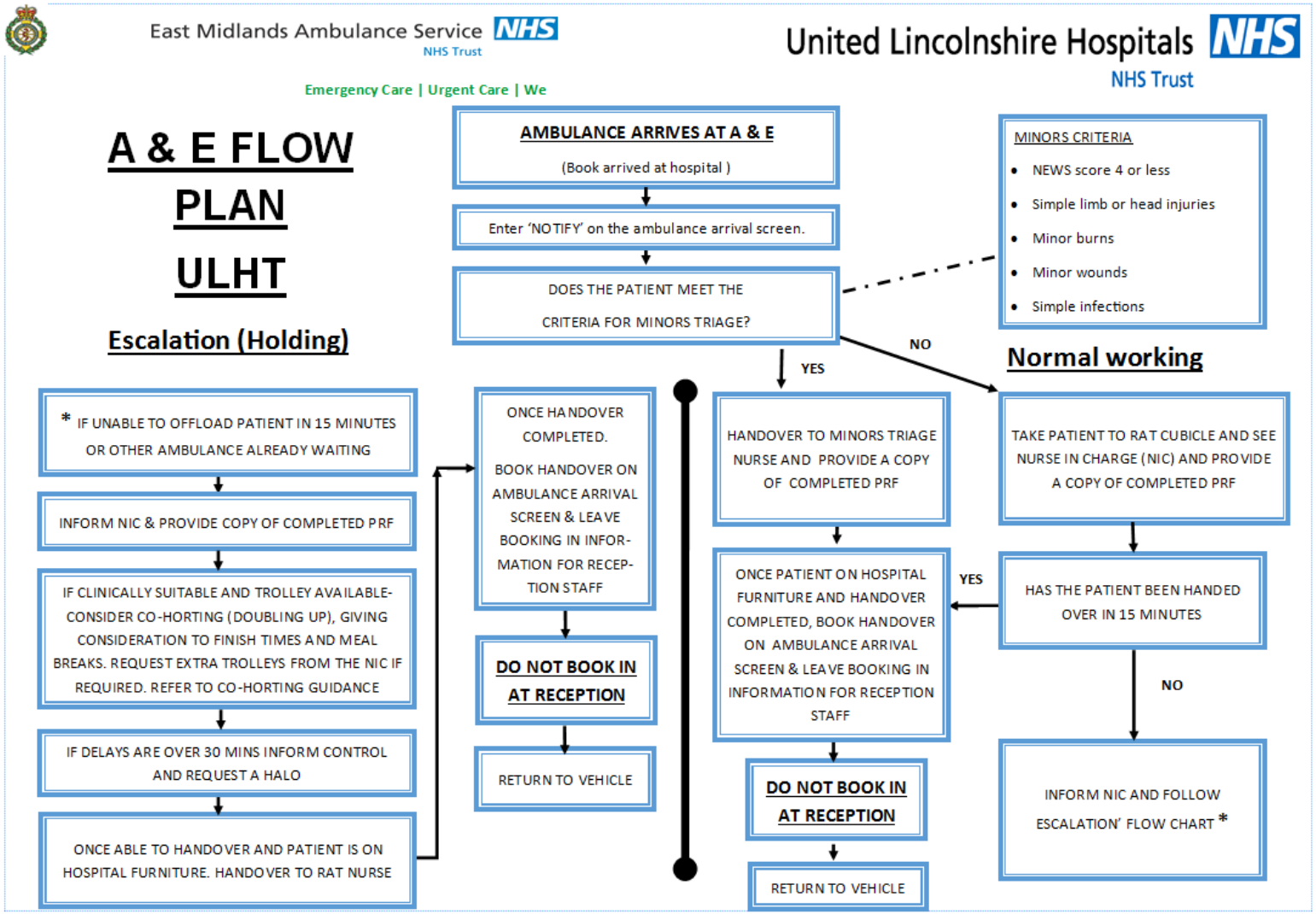
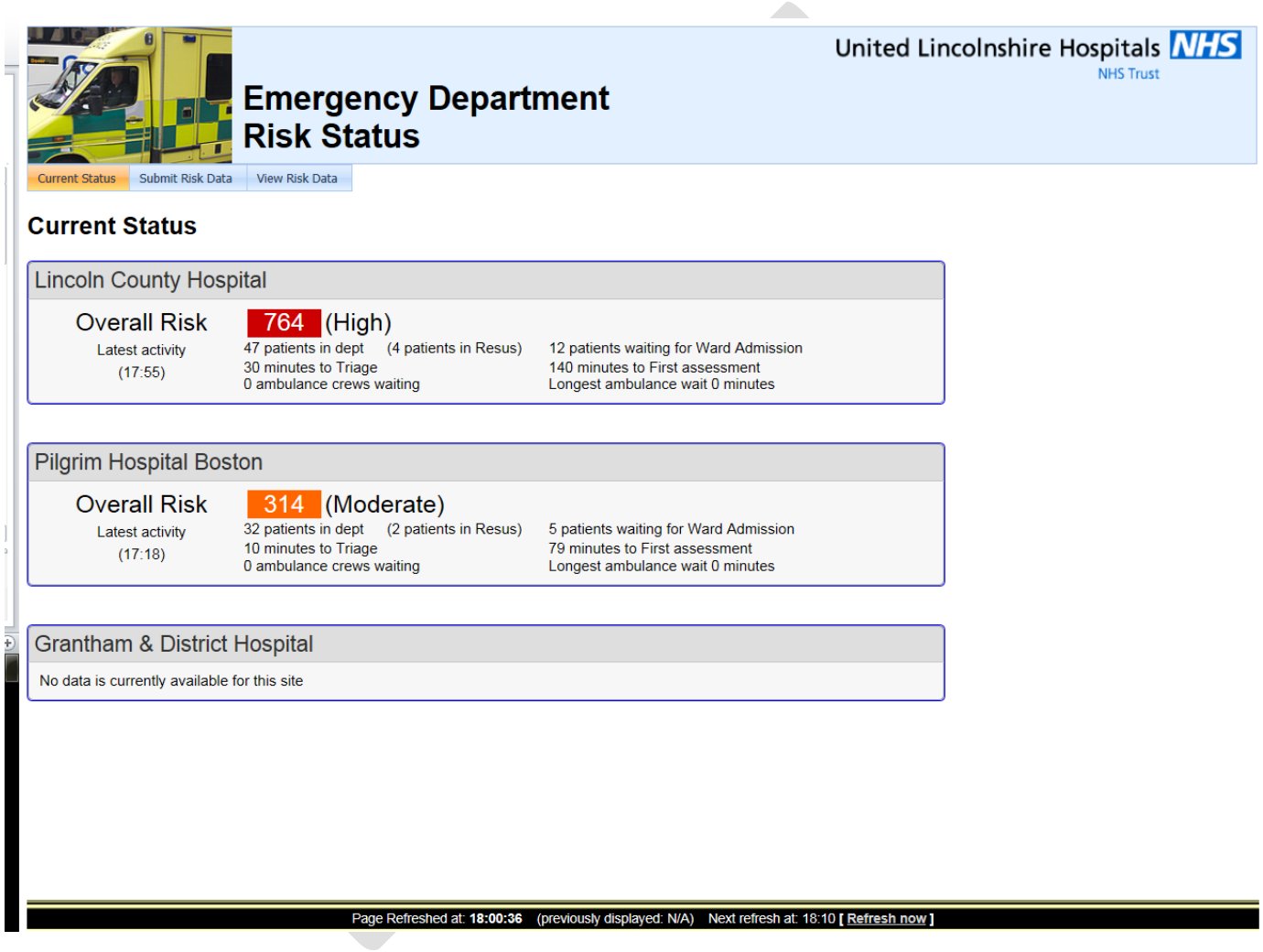
21. Appendix 1 EMAS & ULHT Ambulance Handover



22. Appendix 2 Risk Status System Screen Shot (RAGB = L1-4)



23. Appendix 3 - 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 (national Stay Well message starting with flu in October and local 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 and practice staff
- Publicise ULHT's winter plan-
- Reassure stakeholders and public we have a robust plan including:
    - Urgent care streaming
    - New models of care
- Promote SAFER to frontline staff and senior managers
- Raise awareness of Red to Green and Pride and Joy with staff
- Promote emergency and urgent care principles to staff
- Work together with other providers and commissioners in Lincolnshire on 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				

24. Appendix 4: 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 these 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 is 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 (e.g. 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 Clinical Directorates.

The Medical and Surgical Clinical Directorates will maintain a rota so that there is attendance at bed meetings through the day in support of the site. The Clinical Directorates 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 day's 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 the 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.

25. Appendix 5: 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 liaise 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.
Number of empty 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.

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

26. Appendix 6 - Standard Operating Procedure – Operational Manager On-Call (Silver)

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 Clinical Directorate, 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 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 loggist's 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.

27. Appendix 7 – Red to Green Capture and Escalation Template

CARING FOR YOU

United Lincolnshire Hospitals NHS Trust

R2G template in here and process etc.

CARING FOR YOU **Red 2 Green** ,

United Lincolnshire Hospitals NHS Trust

Ward	Surname	NHS Number	Red Day Delay	Int or Ext	Agency	14:00 Update	Resolved?
				Internal	Ward		Yes
				External	ASC		No

Captured twice a day for all wards the template above is sent to all associated agencies with relevant escalation and actions taken reported back at the following review.

United Lincolnshire Hospitals NHS
NHS Trust

28. Appendix 8: Snow and Adverse Weather Plan 2017/18

	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 nearby 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. • Clinical Directorates 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.	Matron/Ward Manager/ Business managers/ SDM/ DDOP Ward Managers/ Matrons/ SDM	As required

	• Consider cancelling routine elective surgery.		
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 ULHT guidance : 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

Lincolnshire NHS Occupational Health Service Outline Flu Programme 2017/2018

Introduction

For 2017/18, it is the ambition of the Department of Health and NHS England that trusts must ensure that a 100% offer of flu vaccination is made available for all frontline staff, reaching **a minimum uptake of 70%.**

Frontline health and social care workers have a duty of care to protect their patients and service users from infection. Therefore, as in previous years, flu immunisation should be offered by NHS organisations to all employees directly involved in delivering care.

ULHT Occupational health Services have completed orders for the 2017/2018 flu season to be delivered in three drops in September/October 2017.There are 9.000 vaccines on order with the option to purchase more if required. The vaccines on order are Sanofi Split Viron flu vaccine.

Vaccination of healthcare workers with direct patient contact against flu has been shown to significantly lower rates of flu-like illness; hospitalisation and mortality in the elderly in long-term healthcare settings, vaccination of staff in acute care settings may provide similar benefits. Flu immunisation of frontline health and social care staff may reduce the transmission of infection to vulnerable patients, some of whom may have impaired immunity increasing their risks of flu and who may not respond well to immunisation.

Vaccination of frontline workers also helps reduce the level of sickness absences and can help ensure that the NHS and care services are able to continue operating over the winter period. This is particularly important when responding to winter pressures, and winter planning should seek to take account of the importance of staff vaccination across the NHS and care services.

United Lincolnshire Hospitals NHS Trust (ULHT) are responsible for ensuring that arrangements are in place for the vaccination of their healthcare workers with direct patient contact. Flu outbreaks can arise in health and social care settings with both staff and their patients/clients can be affected when flu is circulating in the community. It is important that health and social care professionals protect themselves by having the flu vaccine, in doing so; they reduce the risk of spreading flu to their patients, clients, colleagues and family members.

NHS England have attached CQUIN to this year's flu campaign, the payment schedule is outlined below. NHS England have indicated in this document the final measurement for delivery flu vaccines frontline staff will be **the end of February 2018**. The information from NHS England on the value of the CQUIN to the trust is that it is worth **£235.000 for delivery of 70% and over.**

The main objectives of this year's campaign are:

To identify and reflect key success factors of the previous staff flu vaccination programmes in the delivery plan for the 2016/2017 programme to improve the efficiency and effectiveness of our approach.

To continue to improve the uptake rate from 2016/17 season onwards beyond the 70.13 % level achieved last year.

To promote a local ward or department senior figure acting as an advocate and champion and promoting the flu vaccine to staff to act as a "Peer vaccinator" in ULHT, where clinical (nursing/medical) staff can arrange to vaccinate colleagues in the same team/department/ward.

To continue to work with communications, and be innovative in marketing & awareness approaches.

To build on the successes of attending training events to capture staff such as induction and core training.

Central points on the two main sites where drop in clinics can be set up on a regular and consistent basis

Communications

Use a communications strategy to raise awareness amongst staff of how to access the flu vaccine and challenge the myths surrounding flu vaccination through "myth busters". Information was shared via established internal communication**.**

Starting in late August early September when we have confirmed deliver dates we will commence the publicity in ULHT and across the whole Health Community.

The key elements of communication to the Trust staff are:

Introduction from, Trust board, Chief Executive, Medical Director, Chief Nurse, Occupational Health and Infection Control.

We need a clear, regular, consistent message from The Trust Board supporting the immunisation programme with letters to staff from the Chief Executives, Medical Directors and Chief Nurses and repeated in all forms of trust communication. As well as being seen to have the vaccine themselves and delivering the same message at briefings, meetings and on hospital walkabouts.

Timely availability of vaccine clinics, visits to work areas with pre-arranged dates and times.

Myth busting and answering common questions.

Information available to staff on the vaccine the OH service will be using

Dynamic responding to changes in the press, Department of Health and Trust's needs.

Flu Charter

Methods of Communication to get our message to trust staff

Weekly screen savers: in Aug/Sept/Oct/Nov/Dec
Trust wide Launch event first week in October
The use of the Wire, Trust magazine and weekly news
Websites, Intranet, Face Book and twitter encourage them to post pictures of when they have had their jab
Direct e-mail to selected groups of staff
Team briefing, The CEOs Blog
Information and News story in trusts publications
1st Agenda item at all meetings in the trust
Vaccination rates by service group published monthly
Posters, Stickers, Business cards
Information leaflets and information packs for each ward or department and peer vaccinator
Visits/walkabouts by senior staff encouraging staff to have the flu vaccine repeating the trust message
Use of DOH, NHS Employers and Suppliers information.

ULHT Flu Programme Approach, Vaccination Strategy

As per the 2016/2017 programme, there will be 4 modes of vaccination delivery to staff in ULHT and LCHS.

Peer Immunisation to agree a peer immunisation policy and teams with clinical (nursing/medical) staff located in the community and Acute sites. Promote Peer Immunisation the as the primary route to flu vaccination

On site Vaccination Clinics, vaccination clinic stations will be set up across the 4 Acute hospital sites over 6-8 weeks. The staffing resource Occupational Health and Bank Nurses, this is the best way to target the majority of “front line staff”. Clinics are of course open to Acute and Community staff alike. Central points on the two main sites where drop in clinics can be set up on a regular and consistent basis

Roving Teams, As well as staffed vaccination stations, OH roving teams will be covering hospital sites on scheduled vaccination clinic days throughout the roll out, visiting wards and units to offer the vaccine to those staff that cannot make it to the vaccination clinic station on their site.

The existence of these teams will be publicised to staff before the main roll out programme to allow staff to stay in their units awaiting roving teams. Team members can carry around 30 vaccines per 1-2 hour round; clearly, there is limited capacity for these teams to vaccinate large numbers of staff.

By appointment at the Occupational Health Service within normal Occupational Health clinics by appointment only at our site and Satellite clinics.

To build on the successes of attending training events to capture staff such as induction and core training.

Increase in Nurse staffing. the number of outreach clinics into the wards and departments in and out of hours Establish To increase regular central drop in clinics above what is already in place would need and

Time tables for clinics published well in advance, with time date and sites where clinics are held
Prearranged clinics in ward areas agreed with staff and managers. Publicised in advance and in agreement with the ward or department manager.
Peer Immunisation to agree a peer immunisation policy and teams with clinical (nursing/medical). Promote Peer Immunisation the as the primary route to flu vaccination
Establish suitable central drop in venues on the main hospital sites and locations with large numbers of staff for 20016-2017 where regular clinics can be held
Bespoke outreach clinics where the nurse calls in to hospitals wards, departments, clinics surgeries, health centres and work places across the county without prior arrangement clinics. Prearranged, around meetings and study days, at break and lunch time.
Prearranged Clinics in Occupational Health are still a core way of delivering vaccines to staff. These can be by appointment and drop in.
Flu clinics arranged for early morning, evening twilight and weekends to cover the full range of shifts when staff are at work
Attending meetings to access staff, such as Drs lunch time meetings. Mandatory training and other meetings
Occupational health teams changing shift patterns to work late shifts, twilight and weekends to increase access to the flu vaccine for staff
A dynamic approach to enable the OH service to be flexible and respond to changes in demand across the Trust, Health Community and DOH/NHS England guidance.

Vaccine virus strains and ULHT vaccine *(Information in italics will change as it is released)*

Flu viruses change continuously and the World Health Organization (WHO) monitors the epidemiology of flu viruses throughout the world. Each year it makes recommendations about the strains to be included in vaccines for the forthcoming winter.

The World Health Organization (WHO) recommendations for the composition of the trivalent and quadrivalent vaccines for use in the 2017/18 influenza season in the northern hemisphere

WHO recommended changing two of the three strains in trivalent influenza vaccines for the next influenza season in the northern hemisphere: H3N2 and influenza B. The chosen strains are the same as those recommended for this year's influenza season in the southern hemisphere.

WHO recommended that trivalent vaccines for use in the 2017/18 influenza season in the northern hemisphere contain the following:

- *A/Michigan/45/2015 (H1N1)pdm09-like virus;*
- *A/Hong Kong/4801/2014 (H3N2)-like virus; and*
- *B/Brisbane/60/2008-like virus.*

Quadrivalent vaccines should contain the above three viruses and a B/Phuket/3073/2013-like virus

As in previous years, national or regional authorities approve the composition and formulation of vaccines used in each country and are responsible for making recommendations regarding the use of the vaccine

Data collections for 2017/18

Monthly data collections will take place over six months during the 2017/18 flu immunisation programme. The first data collection will be for vaccines administered by the end of October 2017 (data collected in November), with the subsequent collections monthly thereafter, with the final data collection for all vaccines administered by the end of February 2018 (data collected in February). These collections will enable performance to be reviewed at board level during the programme, with time to take action if needed, and for the uptake from the completed programme to be measured.

England have increased the window in which we have to vaccinate staff by 2 months. For the purpose of the CQUIN the last reporting date for the CQUIN will be the end of February NHS

The Occupational Health Service will provide monthly reports on uptake across all wards and departments to the trust boards. The OH service will monitor weekly any areas which have low

uptake will be visited by OH to discuss any problems and strategies to increase the uptake in vaccine.

All Trusts will report uptake of flu vaccine of their front line staff those delivering direct clinical care as described in the DOH guidance. Occupational Health Service will input the data via ImmForm website (www.immform.dh.gov.uk at the end on each month.

Review and monitoring

The OH service will review the progress at the end of each month and produce a short report for the trust boards. The OH service will monitor progress continually, be able to respond to the changing needs of the trusts the DOH and the trends in the flu virus locally and nationally.

Incentives

The NHS has a “Flu Fighter” campaign to encourage uptake and offer incentives for staff to bare their biceps for vaccination. A number hospitals have offered their staff entry into cash prize draws, as well as chocolates, lollipops, cakes, biscuits, stickers that read “I’m a Flu Fighter,”. Some have offered an extra day’s annual leave but will those days off work be offset by the average 0.04 days saved through vaccination.

While Incentives do show limited value in persuading staff to have the flu vaccine, ULHT have tried a number of different approaches to this date. The most successful has been to supply lollipops in return for the vaccine as it is instant, although it goes against health and wellbeing. Raffles and prize drawers have had less of an effect in persuading staff to have the vaccine.

Other suggestions have been:

Win one day’s annual leave
Get a free hot drink voucher when you’re vaccinated
Peer vaccinators – reward peer vaccinators e.g. first to vaccinate or highest number.

This year 2017/18 we will give away pens with the Flu Fighter Logo and he very clear message this is about staff protecting themselves their families and their patients.

We have considered £4.00 lunch vouchers as this has worked in other Trusts, as we are confident we can achieve the 70&% this year we will retain this idea to use it next year when we need to achieve 75%

While the financial reward is important we must not lose sight of the fact the Flu campaign is about Protecting Patients, Staff and their Families

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418038/Flu_Plan_Winter_2015_to_2016.pdf

www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

WHO recommendations about strains to be included in flu vaccines can be found at: www.who.int/influenza/vaccines/virus/recommendations/consultation201502/en/

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Appendix 1

Examples of this year's publicity materiel we will be using

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