Notice:

Plymouth Community Healthcare Community Interest Company adopted all Provider policies from NHS Plymouth when it became a new organisation on 1 October 2011.

Please note that policies will be reviewed to reflect the new organisation in line with the reader information sheet, or sooner where this is possible.

WINTER RESILIENCE PLAN

Plymouth Health Community

October 2010
Final version

John Richards
Chief Executive
On behalf of NHS Plymouth, Plymouth Hospitals NHS Trust, Plymouth Adult Social Care, SWAST, Devon Doctors and linking with Cornwall& IOS PCT and Devon PCT

1. Introduction

Plymouth community worked hard to improve the urgent care pathway for the population and, whilst the winter period was challenging the review of the processes and outcomes for 2009/10 were summarised as – the hardest winter, but the best results.

The challenges of combining pandemic flu planning with the local resilience planning were evident, but the lessons learnt are being fed into the winter planning for this year.

As usual there have been redesign and developments within the community which have been incorporated into standard working practices, and a few more initiatives which will be in place before the winter proper.

There were some key successes in last years plan, which will repeated because of their benefit to the services, patients and senior managers.

- The use of the resilience dashboard for the community, updated daily, was the focus for the community to review the system and plan ahead. This is being refined in the light of the CMS implementation but will be used again, it kept the community informed of the issues and provided assurance to senior managers that the problems were clearly identified and addressed.
- The health and social care pathway work, bringing more transparency to understanding what were the critical points creating delay.
- Standards set for response times between organisations through which we could hold each other to account.
- The use of the daily call arrangement if needed. In reality was used quite infrequently but was invaluable.
- Planning for an escalation workforce to be in place by a certain date, including the allocation of medical teams.
- Planning for maintenance and audit to take place in early January to reduce elective surgery and create capacity for more emergency cases.

Parts of this plan will look familiar, and is acknowledgement that last year's resilience plan worked well, and in light of this we plan to repeat where possible, and improve with the added experience.

The Plymouth community recognises the financial and operational challenges that face all of the providers and commissioners but is committed to working together to face the forthcoming challenges.

We also recognise some very particular issues for Plymouth which have already been escalated within the community as priorities for this busy period, the two particular areas of challenge are delayed transfers of care between organisations ,and the need to create much simpler processes and schemes of delegation to overcome the impact on patients and their families. The second is the need to meet the challenges of a very frail elderly population with cognitive impairment needing safe placement, with a very fragile local independent market.

John Richards
Chief Executive
NHS Plymouth

Separate appendices

- Equality impact assessment
- Community wide infection assessment

Lead responsibilities within the health and social care community.
All telephone numbers prefix 01752 unless indicated

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Senior operations managers PHT NHS Plymouth Plymouth adult social care Devon Doctors SWAST	 Richard Best Steve Waite Pam Marsden Chris Wright Steve Boucher	 Richard.Best@phnt.swest.nhs.uk Steve.waite@plymouth.nhs.uk Pamela.marsden@plymouth.gov.uk Chris.wright@devondoctors.nhs.uk Steve.boucher@swast.nhs.uk	 437250 434764 307398 01392823636 TBC
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Teleconference information held midday daily – an open invitation to join us if desired to listen in.

2. Lessons Learned from winter 2009/10

National & local

- The PCT has reviewed the national evaluation of the flu pandemic planning and will agree with the majority of the findings. For the Plymouth community the benefit of the evaluation requires us to work hard to consider certain key aspects of the plan.

- Our local evaluation also indicated that we had really improved on our communication and openness in relation to the system. The resilience dashboard was a jointly owned representation of the system at any time and was invaluable as the basis for conversations to move problems on, rather than argue about the real state of play. It also gave Directors across the community assurance, and did lead to greater flexibility for the operational managers to resolve problems rather than constantly report upwards.

- The notice that the H1N1 virus will be the vaccine basis for this year is helpful considering messages for patients as there was confusion as people were still unclear about the need for two separate vaccines.

- We do expect and are planning that there may be a downturn in flu vaccine uptake this year in the wake of the pandemic, as people assume that the risk of flu is not as great as anticipated.

- We also highlighted the need to increase the take up of the flu vaccine for staff, which was 30%. The arrangements in place worked more effectively where the vaccine was taken to staff for opportunistic vaccination and this will be incorporated into this years planning. We also did not optimise the numbers of clinicians trained to vaccinate staff, who could have helped in their own workforce.

- There was a subtle impact on staff across the organisations being aware of the financial issues in the system, and whilst there were no explicit refusals to discharge patients or refuse funding packages, there was a sense of a slowing down in the system at times of greatest pressure. This is being addressed this year in advance with discussions at board level regarding the issues and analysis of the problems to agree top down messages for staff, to enable them to ensure patients receive the right care at the right time.

- Whilst may other communities were struggling with infection control the hard work of the inpatient units with infection control team have to be commended. Whilst there were occasional outbreaks they were controlled and contained and did not lead to the widespread closure of capacity seen in other communities.

- As ever there were some services which were being implemented which took us ‘close to the wire’ and heavily dependent upon recruitment etc. this year we hope that some of the new schemes have been given sufficient time to ‘bed in ‘ and have an impact.

- There will need to be a restatement of the local ‘gentleman’s agreement regarding repatriation of patients to other communities when using Plymouth based tertiary services. This should be invoked after 48hrs. There is a locally agreed policy and its use needs to be strengthened this forthcoming winter.

3. Local Action Plan

Plymouth developed an urgent care work plan in 2009/10 which considered five key areas of work for the community. This has continued to be updated targeting some areas of process and system redesign, but a number of new developments this year have focussed on avoidance of hospital admission, ambulatory care options and really understanding the demand and capacity in the system.

4. Flu Pandemic Planning

- *Multi-agency approach*
- *Mass vaccination programme*

The lessons learnt from last year are embedded in our planning from last year which worked well, we are working on the principle that we are in the post Pandemic period but the plan is still in place and refreshed if it should be needed.

As we enter the post-pandemic period, this does not mean that the H1N1 virus has gone away. Based on experience with past pandemics, we expect the H1N1 virus to take on the behaviour of a seasonal influenza virus and continue to circulate for some years to come.

Therefore we can expect localized outbreaks of a different magnitude which may show significant levels of H1N1 transmission.

5. Flu Vaccination

Approach

- *Address and plan for capacity challenges in primary care*
- *Multi-agency approach*
- *Mass vaccination programme*

H1N1 is expected to be the predominant seasonal flu strain in the 2010/11 season. It is still important that NHS staff continue to protect their patients, themselves and their families from the risk presented by H1N1 and work continues to increase the take up of the seasonal flu vaccine for staff, which was 30%.

The arrangements in place worked more effectively where the vaccine was taken to staff for opportunistic vaccination and this will be incorporated into this years planning. We also did not optimise the numbers of clinicians trained to vaccinate staff, who could have helped in their own workforce/place.

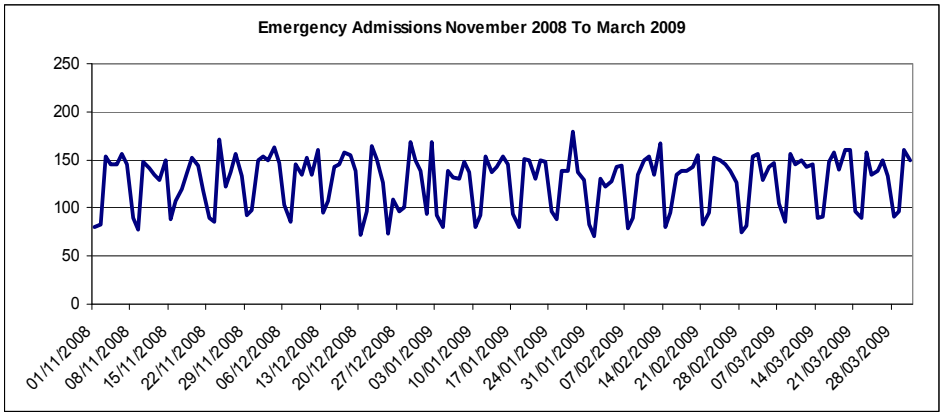
As with last year the Senior Management team will need to demonstrate visible and active leadership, including the setting out of expectations with regard to seasonal flu vaccine take up of their individual staff groups.

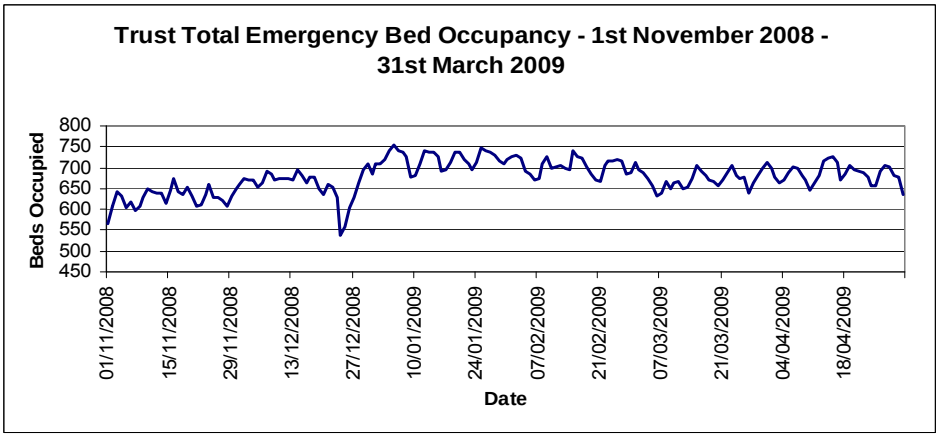
6. Expected Demand on the System - avoiding admission

- *Activity levels are predictable from previous years information flows*
- *Acuity of the illness increases not numbers which leads to an increased length of stay.*
- *There are new service options available to the city*

The issue is not the predictability of activity but the increased in acuity of patients which present to both GP's and the emergency departments. Consistent patterns of demand are available to 'call centres' with the period remaining very consistent but the peak demand varying. We know from years of data review of community based avoidance schemes that

the proportion of patients who can be safely cared for at home reduces, although the actual numbers of patients cared for increases.





The two tables of data above show the predictable admissions to Derriford Hospital and also show the impact on beds. The ability to swing from 600 to 750 beds outside of a pandemic is not sustainable, nor is it desirable with its potential to increase clinical risk and affect patient safety. The community approach to maintaining 'flow' and achieving the community 4 hour target is vital.

Length of Stay (los) will have a tendency to rise due to severity of presenting conditions - typically more complex respiratory elderly patients.

For the community this means that we have to continue our pressure on a number of points across the four hour pathway with particular reference to:

- Avoidance / community support
- Controlled LOS at PHNT/ LCC's
- Good handover to onward care
- Low delayed discharges
- Pulling of patients into a range of community resources – interim beds / joint domiciliary care brokerage and supportive discharge.

The use of the community wide resilience dashboard should enable us to be able to see if work if starting to increase in the community and start to predict where resources need to be deployed. The daily conference call building on the current three daily review meetings should enable us to make decisions when resources become short at any point in the system. The

Because length of stay is such a critical issue for the community the onward care and supported discharge services for each PCT will be in the spotlight in terms of their ability to step up capacity and work in partnership with their local authorities to minimise the impact of potential delays. None of the PCT's is in the position to invest any more additional resources in onward care and community capacity so are reliant on provider services using the resource available to them in their own community wisely.

There have been a number of new initiatives in the community which we anticipate will reduce pressure on acute hospital beds, but their impact is likely to be marginal this year as they are not fully operational, some of these are described below.

Capacity Management System (CMS) and NHS Pathways
On behalf of the seven PCT's SWAST our ambulance services are rolling out the implementation of CMS this year which will assist with the redirection of people who call asking for an ambulance but should be using other patient facing urgent care services. This also provides an overall community activity web based system (OHA) which will run in parallel this winter, with our own local systems. This will enable time to test the process and the efficacy of the information in supporting the operational management of the local system. Some of the functions of the resilience dashboard people will recall we used over the last winter with good effect. This has been updated, and contains more locally determined useful data for operational teams in managing the flow of patients.

The call handling changes will be linked with NHS pathways which is an NHS funded and developed algorithm process to direct people to the right options of care. It has been tested in the UK with over 2.5million sets of data with no adverse responses. Clinically it is overseen by a group of the Royal Colleges. This is seen as a critical piece of underpinning work to get people to match with the right service delivery. In the North East where it has been running some time, in over 10% of calls an ambulance is not sent and in a face to face pilot being run in Blackpool some 25% people are being offered different options to that which they had chosen. There is the potential for our entire patient facing urgent services to implement this as well as referral hubs, so that for the same set of symptoms the person always gets the same response. Locally the directory of services will be completed for the top 25 local services, by the end of October.

We plan the OHA and CMS component to go live in October 2010 with the link to NHS pathways in February 2011.

Long term condition management
Much of the more pressing work for the urgent care work plan focused around our own processes across the community with good effect, but in the last six months has turned more 'upstream'. Rather than just dealing with the urgent cases as they present, projects and pieces of work which are being initiated to reduce the risk of the person's condition deteriorating. Whilst recognising that people with a long term condition are nearly always likely to have a exacerbation and possible crisis, our system for planning and managing these needs to become far more robust. The role of long term condition management is critical to 'turning off the tap' of unplanned urgent and emergency care and is more possible and predictable than may be imagined. We are therefore very closely watching the impact of the LTC work plan, particularly in relation to

- Combined predictive modelling (go live November 2010)
- RAPA – repeat admissions reporting (august 2010)
- Care planning (TBC)
- End of life advanced care planning (October 2010)
- Long term condition care co-ordination (recruitment dependent but hopeful of November 2010)

The community has also received a refresh of data related to excess winter mortality in the Plymouth community and this is being used to target the work load of district nursing teams and prioritise the roll out of the new long term condition managers in the city.

End of life care
Last December in a small scale way a co-ordination centre developed to align care needs with capacity. This has been highly successful, reducing the numbers of emergency admission for broken packages significantly (one on nine months). The number of hours contracted to the district nursing service and Marie Curie Nursing services has expanded in August 2010 , leading to a guaranteed 300hrs of care time available a week for package. In addition the Adastra End of Life register is to go live in September starting to connect clinical teams more effectively. The community will also roll out advance care planning with the start of a clinical facilitator in September.

Clinical referral hub development and ambulatory care
In March 2010 the community started to track all calls for urgent care (hospital admission) through a single telephone number, this allowed us to track capacity and demand, by speciality, by source, by time of day. It also enabled the capture of addition clinical information providing local evidence of the gaps in the system which were leading to a default of admission. We estimate approximately 20% of all referrals could have been cared for differently and are now incorporating these plans into a programme of development of ambulatory care. We have already implemented new pathways for, TIA's, first fits, DVT, Pleural effusion, pulmonary embolism and are now working on priorities of:

- Cardiology fast track opinion
- Respiratory fast track opinion
- 24hr response to endoscopy
- Intravenous therapy service based in the community

7. Approach to stepping down elective capacity across the community – hospital and primary care

- *Planned maintenance linking with times of greatest medical bed and service need.*
- *Knowing your caseloads*
- *Consistent trigger points.*

The community acknowledges that the acute services will be put under extreme pressure to deliver as much elective activity as it can throughout the year. The impact of the reduction in waiting times achieved, means there is less flexibility in the patient pathway for treatment if continued compliance with the RTT standards is to be achieved. However in understanding this backdrop the acute trust has sufficient data to know that the impact of trying to delver a high level of acute activity in January at the same time the acuity of patient's increases is very challenging for front line staff.

There is therefore a planned maintenance and governance plan which was agreed earlier in the year by the Trust which will see a rolling plan during January of the closure of theatres on a weekly basis. Whilst some core activity has been agreed the acute trust reserves the right to review the activity levels and waiting times and urgency of patient groups and flex the remaining theatre capacity as needed at the time. Day case activity will continue.

With regards to the community, intermediate care and onward care capacity is described further on, but generally community services need to step up activity at times of increased demand to meet the impact of deteriorations in health of people particularly with long term conditions and the frail elderly. Work had been undertaken to bring forward as much screening and planning of patients needs as possible to try to optimise their health status.

There has been a concerted effort in increasing the numbers of patients with long crisis care plans, but tempered with the knowledge that acuity is often greater and intermediate care services will be under pressure. Services such as district nursing and long term condition managers have been reviewing case loads and working to identify which components of their work can be stepped down as crisis levels are reached. The decrease in elective activity will have appositive impact on the community services as less people will need work

up for elective care, thus creating some capacity, but this is likely to be filled with more admission avoidance and discharge planning work.

In addition it should be noted that the PCT has commissioned additional community based activity across the PCT particularly in relation to the new 8-8 GP clinic based at the local care centre which can be used by Plymouth and more distant residents. The Minor injury unit is also expanding its opening hours in November 2009 and has seen a continued increase in utilisation. The 8-8 service has a significant increase over contract of walk in patients and this capacity is currently under review as well.

8. Link with region wide escalation plan

- *Information sharing*
- *Consistent escalation*

The regional escalation plan will be supported by the information collated for the local resilience dashboard.

As the main acute trust is distant from other facilities it has never been in the position of closing its doors to ED and GP admissions, although sometimes needs to work in collaboration with other critical care and high dependency facilities. This process is expected to continue over the winter and will be stretched at times with response to flu pandemic, but will use its usual escalation processes ion line with the regional escalation plan.

We will however be contributing to OHA through the SWAST development which will allow visibility for the HA of our capacity and will also allow us visibility of neighbouring trusts and communities

9. Communication Plans

The purpose of this plan is to ensure that Health Communications Plans are properly co-ordinated and planned for Winter 2010/11. This plan supports and builds on the existing communications strategies that health organisations have.

It is essential that we have clear sign posting to ensure patients access the right health care for their particular needs. During the Christmas period last year there was an increased number of to Devon Docs out of hour's services which appeared to be because people thought their GP was surgery was closed, despite building on the feedback from the previous year when the same issue occurred.

An increased number of the public access emergency services over the Christmas and New Year period. Some of the increased access is inappropriate where people are attending the Emergency Department or calling 999 when they could either have waited until surgeries reopen or could have called NHS Direct or visited a pharmacy that was open over Christmas and New Year. Some of the increased access is appropriate and is just a product of the winter or seasonal activity. We also want to ensure that where appropriate patients go to the Minor Injury Unit which is open everyday of the year and now has extended opening hours as wall.

We are concerned about the level of potential take up of the flu vaccination this year. We have a raised target, but feedback is that people feel generally they were encouraged into vaccination last year because of the pandemic, but don't feel the need to be so encouraged this year.

The PCT will be taking stock of the Winter Health Messages and will issue 30,000 to the most vulnerable, but this is being linked with Public Health data related to excess winter mortality black spots for the city as well.

Aims

- To encourage people to look after themselves during winter
- To promote good news stories to encourage confidence in NHS Plymouth and other health services
- To ensure people know how and which service to contact
- To ensure robust crisis management
- To promote healthy living
- Sign post people to the appropriate care
- To ensure staff are communicated with appropriately
- To ensure that all messages link in with specific swine flu communication

Working in Partnership
The Communications Plan has been written to co-ordinate communications with the main health partners in Plymouth. Many of the messages will require close working with other colleagues and partner organisations. This will include Plymouth City Council and the Voluntary Sector. It will also include co-ordinating messages with health care partners - Neighbouring PCTs, Mental Health, Acute Trusts and the Strategic Health Authority.

Personnel
Jacqui Gratton, Communications Manager will lead the Plymouth Winter Communication Plan for NHS Plymouth working with leads in each of the partner agencies.

- Plymouth Hospitals Trust Brydie Willis
- Devon Doctors Lee Grant
- Plymouth City Council Angie Scoot

Key spokespeople for winter communications have also been identified. They have been chosen to ensure appropriate knowledge base and expertise as well as to ensure sufficient numbers of clinicians.

- Steve Waite Chief Operating Officer and Joint Swine Flu Director
- Dr Alex Mayor Medical Director PHNT
- Richard Best Director of operations PHNT
- Deb Lapthorne Deputy Chief Executive, Director of Public Health and Joint Swine Flu Director
- Denise Rudgely Community Practitioner in Public Health
- Nicola Jones Deputy Director for primary Care
- James Glanville Primary Care Manager
- Dr Peter Rudge GP and PEC Chair
- Sharon Palser Director of Development, lead executive

All have received media training.

Messages

Promoting Good News Stories to Increase Confidence and Reputation
Throughout the winter period we will be publicising positive work going in health. The process of communicating these via the media, as well as via our internal communication systems. A full plan of positive stories and news events will be produced.

Choose Well
This is a national campaign to ensure patients have the right information to make good choices about how to access treatment. It aims to signpost them to appropriate care and will be recognisable no matter where a patient lives. The importance of getting the right treatment is re-iterated throughout our communications as often as possible. As part of the 'Your Guide to Services' - patient guide a detailed section advising readers about how to access the right treatment is included. Copies of the guide are available at GP surgeries, opticians, dentists and pharmacies as well as libraries. A series of media releases will be issued in the run up to Christmas explaining how and where people can access health

services including NHS Direct, GP, pharmacy, MIU and dentists. This will set out what to do in different circumstances, signposting people to the appropriate service including pharmacies, GP surgeries, MIU, Emergency Department and 999 services. It will also include advice on staying healthy and how to avoid having an emergency.

Promote Caring Side
We have identified certain groups to target such as the elderly but also the young. The messages cover prevention of accidents, healthy living, sexual health and illness prevention such as flu jabs and infections.

Examples

- Get a seasonal flu jab – elderly and those with chronic conditions and a targeted campaign is already underway to encourage staff
- Get a swine flu jab – messages around when offered it take up the offer. Will also include messages around safety. Specific messages about importance for staff.
- Staff illness – internal message on prevention of spread
- Healthy living at Christmas
- Stopping smoking – case study and advice
- Prevention of spread of Chlamydia
- Keep warm, keep well – case study
- Falls Prevention and Support
- Increasing access to hard to reach groups

Proactive handling of Local Issues

Mechanisms for Keeping Aware
As at all times of year we keep it is important that all health agencies keep in touch about key issues. We ensure that information is shared quickly so that there is full opportunity to be proactive. The Communications Team within NHS Plymouth has a policy of sharing media requests from regional media with Comms Leads from across the Peninsula and SHA and briefing up to the SHA with information about any serious, untoward or high profile issue with the SHA at the earliest opportunity. Throughout the winter and including Christmas and New Year the local media will continue to be closely monitored.

Robust Defence
Wherever possible stories are identified before they become public so that robust defence can be prepared and journalists and their editors can be briefed to ensure the story/news is correct or pulled before it goes to print/air. This helps to ensure that when a story breaks journalists are properly briefed as to the facts in a positive light. Media coverage will also be monitored to ensure that where appropriate corrections can be issued.

Staff Communication
Staff at NHS Plymouth is being kept informed of all the messages that are being issued via the weekly newsletter, Trust Talk, and the intranet. In addition some messages are being targeted specifically to staff such as what to do if they are unwell with D&V or flu-like symptoms. There are very specific campaigns around the need for staff to take up the offer of vaccinations and their responsibility for patients.

Daily monitoring of media coverage/ reporting will continue, and briefings will be shared with the Board members, Executive Team and Senior Managers. The Communications Plan and its messages will be monitored throughout with key monitoring points at the end of each month. This will include reviewing messages such as going for flu jabs in light of take up rates and developments in seasonal and particularly swine flu. It will also include looking at weather forecasts and forecasts of illnesses to identify opportunities for communication.

10. Infection Control (including Norovirus outbreak control)

- ***Maintenance of usual good practice***

The Infection Prevention and Control Team (IPCT) have an established Outbreak management strategy which works well throughout the year and is well supported by all clinical teams. An Infection Control Nurse is available between 08.00hrs and 21.00hrs throughout the year. This service is supported by the Consultant Microbiology service providing 24hour cover with Infection Control Doctor advice. The wards alert the IPCT who visit the wards daily, co-ordinate the Outbreak meetings, review the recommended control measures are in place and escalate any concerns to the necessary department or manager.

Review of last year indicated that the community suffered no less than others in terms of outbreaks and infectious illnesses but was less affected than neighbouring hospitals,due to prompt action. The protocol for closing wards (and bays) worked effectively and the deep cleansing process for bringing wards back into operation worked well.

All ward closures or restrictions are communicated Trust–wide through the Notes of meetings, and directly communicated to the Operational team.

The Trust has a Clostridium difficile action plan which is formally monitored on a quarterly basis and the monthly progress is reported to the Quality and Safety Infection Prevention Board... All C.difficile patients are reviewed daily by the IPCT and their care discussed at a daily meeting chaired by the Directors of Nursing.

• IPCT has a far more proactive approach with a greater emphasis on clinical work and direct management of patients with hospital associated infections

• Enhanced presence of IPCT in clinical environment has greatly increased their accessibility for guidance and advice and has driven improvement in the reduction and management of hospital associated infection

11. Capacity Assurance - Staffing & Escalation: Ambulance Trust

- *Maintaining existing good standards*
- *Maintaining current non conveyance rates*
- *Supporting the ambulance service with access to clinical advice and locations for taking patients*
- *Critical importance of PTS on patient flow*

The performance of the ambulance service in Plymouth is excellent with local targets in all cases exceeding the whole organisation achievement, and with one of the highest non conveyance rates in the country. In addition the acute trust has made one of the most significant improvements in ambulance turnaround times in the region, with delays down a very low level. This has occurred through close working relationships with the ambulance service and regular communication at all times. However here is an increase in ambulance conveyance rates for the city which do not appear to have one or two significant reasons but are more random, but falls and category C calls are areas of joint working in an attempt to reduce the burden.

However there is still much that can be done to support SWAST personnel by creating routes to provide clinical support and advice and also information about all the services which can be used to offer choice to the person on scene. The ambulance service are one of the critical players in the daily teleconference because of their on the ground knowledge.

As an integral part of its winter planning arrangements, the South Western Ambulance Service NHS Trust will:

- Agree with NHS and Social Care partners robust local protocols to ensure patients are referred to the most appropriate care with a minimum of delay. Escalation processes will include arrangements to spread demand between hospitals, particularly at times of peak pressure;

- Provide efficient handling of 999 calls to include and address: fast activation, effective resourcing, demand matching, dynamic as opposed to station-based cover, adequate relief levels and flexible 999 responses;

- Agree with critical care services transfer protocols and appropriate transport to ensure the safe and timely transfer of patients between facilities, where necessary, building on 'Emergency Care, New Service Standards, Reflecting the True Patient Experience';

- Contain any transfers of critically ill patients for non-clinical reasons within agreed critical care transfer groups:

- If exceptionally, a transfer of a critically ill patient takes place outside an agreed transfer group, this must have been agreed by the responsible consultants for both NHS Trusts and the respective NHS Trust Chief Executives or Duty Directors must be informed. The NHS Trust from which the transfer took place must ensure that the Chief Executive of the relevant local commissioning body (Primary Care Trust) is informed within two working days;

- Work with primary care colleagues to ensure that general practitioner generated Card 35 HCP calls (formerly urgent) are managed in such a way to optimise patient flows at times of exceptional demand

- Ensure that the scheduling and planning of ambulance staff will be carried out up to four weeks in advance and known absences covered by relief or overtime staff;

- Ensure that the Patient Transport Services Planning department continues to plan adequate resources in advance to meet predicted demand according to contractual requirements. This was a critical issue for the community last year as decisions to reduce PTS in times of inclement weather without discussion with local operational managers led to significant problems with flow of discharges out of the hospital. The community has received additional assurance from SWAST and contact arrangements in the event of exceptional problems occurring.

- In addition to SWAST's provision of non-emergency patient transport services, PHT will continue to utilise local private ambulance services and volunteer car service to manage demand beyond SWAST's capacity to transport same day discharges.

12. Capacity Assurance - Staffing & Escalation: GP Services (including out of hours Primary Care)

- *Earlier warning of increasing demand on primary care to inform the rest of the system*
- *Agreeing plans upfront and enabling services to respond without having to come back to the PCT for permission*
- *Use of national guidance to get primary care to work collaboratively*

Primary care services have always responded well to winter excesses, by bringing forward any planned work, engaging their patient group in flu and pneumovax vaccinations and with support from the PCT plan to be fully operational for all days except the bank holidays.

In addition the PCT has a fully functioning 8-8 primary care service which will works across the bank holidays (365 days per year). The service has a high walk in rate and we would expect it to manage demand working with other local primary care providers.

With the increased pressures on primary care the PCT developed a comprehensive Primary Care Capacity Challenges Escalation Strategy based on the best practice guidance 'Pandemic flu – Planning and Responding to Primary Care Capacity Challenges'. Whilst fortunately it was not needed , it helped significantly in planning work and relationships between neighbouring practised and the lessons have been embedded in general practice.

Four GP practices and two community pharmacists again will be asked to be spotter practices for the PCT feeding in weekly (and more frequently if needed) information around trends and activity increases in the community. This is the first trigger on the resilience dashboard and will help secondary care and other community services to be prepared for the increased workload which will occur.

This year we face a four day bank holiday which creates particular challenges for primary care. Despite co-ordinated communication plans we, with our out of hours services are making some assumptions in our planning (which will not preclude robust planning but we are creating contingencies)

- Patients seem to assume that the practice will not be open in the afternoon of the Christmas Eve
- We will expect to be very busy with peaks of activity on the Sunday and particularly the Monday.

OOH's services are run by Devon Doc and as part of the contractual negotiations the PCT has agreed a spike clause which enables the service to respond to excessive activity demands without needing prior permission from the PCT, this will enable them to continue to delver a service and support the community by keeping people at home. This is important as any gaps in primary care services will encourage people to default to the next point in the; pathway which will be ED attendance or calling of 999 for emergency ambulance care. Devon Doctors have a good reputation of delivering good standards of care and have very robust reliance planning processes which re effective. The only area of outstanding work is to firm up a local informal agreement regarding transfer of primary care work from ED departments.

Community pharmacies were key to the PCTs swine flu planning; of the 50 community pharmacies in Plymouth 47 acted as live antiviral collection points. The flexibility and co-operation of the pharmaceutical services was a critical success factor for the flu planning and we hope to be able to build on this.

To ensure there is good access to community pharmacies for patients over the Christmas New Year period the PCT has double the amount of time community pharmacies will be open on Christmas day. Access to pharmaceutical services remains excellent throughout the rest of the festive period.

13. Capacity Assurance - Staffing & Escalation: Emergency/Assessment Department

Each directorate as been required to develop internal escalation plans, the one for the ED is attached as an appendix to this plan. This is supported by a daily dashboard which has been in use form over a year which identified numbers and trigger points within the system. It is reviewed daily to match capacity problems with patient flow by managers and clinicians and has been found to be a highly effective tool to plan and to reflect on past performance.

14. Capacity Assurance - Staffing & Escalation: Medical Beds & Nurse Staffing

This section is described in some detail to provide evidence of the level of assurance provided by PHT of the staffing capability which is one of the areas of concern expressed during last winter.

Notionally, an average ward will at any one time have 4% of the establishment vacant and, dependent on level of other absence, can normally manage with this level. In addition to this wards will have to accommodate annual leave, study leave etc, and work on a total absence factor of 21.5% Given this absence factor of 21.5%, and the notional vacancy factor of 4%, a

level of absence above a total of 25.5% is likely to result in the reduced ability of a given ward to (a) maintain normal patient flow and/or (b) provide the requisite standard of care.

Routinely on a monthly basis support tools are used to assess the operational capability of each ward area. This review

- Takes place two weeks ahead of the next rota period
- Use Roster Central first for overview and then Roster Analyser for ward by ward detail.
- Be undertaken by the directorate manager and matron
- Escalated to Director of Nursing/nominated deputy and Director of Operations/nominated deputy.

The collation of this information is undertaken and reviewed by the Trust Director of Nursing.

Contingency

Absence level	Measures to be deployed/considered	Escalation to
21.5-25.5%	o NHSP ad-hoc requests o Internal redeployment on a daily basis	Deputy Director of Nursing.
≥25.5%	o NHSP Line of Work or FTC o Short term internal redeployment	Director of Nursing Director of Operations
≥30%	o Medium term internal redeployment o Restriction of Study Leave o Small scale bed closure o Agency FTC o Each CNS covering the area to work one clinical shift at ward level per week	Chief Operating Officer
≥35%	o Ward Sister – 5 days clinical o Matron & CNS's to work 2 days clinical o Partial Ward Closure **or** closure of other functions to support.	Chief Executive

Escalation beds

General escalation beds are a small number of beds scattered across a range of wards and will be managed by absorption of workload by the current teams (for one or two escalation beds per ward) or largely by using NHSP nursing staff when a greater number of escalation beds are open.

The escalation beds on Monkswell are likely to be utilised in the management of 'winter pressures'. The staff for this will in the main is short term redeployments from other wards, supported by NHSP.

A dedicated ward sister and dedicated matron will be identified for the Monkswell escalation beds, and the Directors and Deputy Directors of Nursing will work regular clinical shifts on these wards to ensure standards are maintained.

General Escalation Beds

- These beds are available to manage the peaks in normal activity.

Order	Ward	No. Beds	Staff required	Decision to open
1	Bracken	1	Nil	Ops team
2	Lyhner	1	Nil	Ops team
3	ASU	5	Nil	Ops team
4	Hartor	3	Assess need based on no. of beds open and dependency.	Ops team
5	Hembury	4	1 RN or HCA depending on dependency	Ops team
6	Sharp	4	1 RN or HCA depending on dependency	Ops team

Winter Escalation Beds

- These beds are available to manage increased activity during winter **or** other planned/anticipated peaks in emergency activity.
- Staff to man these beds will be identified during September of each year, coordinated by the Deputy Director of Nursing (Operations).

	Ward	No. beds	Staff required	Decision to open
	Monskwell	24	Please see PHT internal plan for establishment and proposed redeployment list.	Deputy COO Director Ops Director Nursing

15. Capacity Assurance - Staffing & Escalation: Critical Care

- *Increased , stepped capacity*
- *Clinically led planning*

The critical care services planned for a major flu pandemic last year and have plans which are described below which can be operationalised, *but only if* a major pandemic is announced. The expectation is that this year critical care will work on usual winter planning levels which has a well rehearsed escalation plan

- Emergency admissions have priority over elective/booked admissions.

- The Critical Care consultant is responsible for and has the necessary authority to decide where individual patients should be managed. The following steps should be followed when there are inadequate critical care beds to meet demands.

  a) Ensure discharge from critical care of any patient not requiring level 2 care.

  B) Postpone booked elective post –operative admissions.

  c) At weekends and public holidays, closed bed(s) may be opened to accommodate additional patients. If the patient dependency within the whole of Critical Care does not allow this to be managed safely with the duty nursing establishment (as assessed by the nursing co-ordinator) then the duty outreach nurse will suspend ward duties and care for patient(s) within critical care (as allocated by nursing co-ordinator). This should be seen as the

exception rather then the rule and each occasion should be reported to the critical care management group for review.

- If there are empty beds on Cardiac ICU (CICU), the Critical Care Consultant may arrange admission of an appropriate patient requiring level 2 or level 3 cares to CICU by direct consultation with the duty Cardio-thoracic Anaesthetist. Non cardiac patients admitted to CICU will be managed by the Cardiac Anaesthetic Registrar supervised by the Critical Care Consultant.

- If no beds can be created, patients will need to be transferred to another hospital for Critical Care.

- Usually the most recent referral will be transferred out unless such a patient requires management from Tertiary Specialties specific to Derriford Hospital (e.g. Neurosciences, Cardio-thoracic Surgery). In such circumstances the most appropriate stable patient will be transferred.

- Referral of a patient who needs to be transferred for critical care is the responsibility of the duty Critical Care Consultant and will be on a direct consultant to consultant basis with the receiving Unit. The referring non-ICU consultant and their equivalent at the receiving hospital must be informed of the planned transfer.

- Transfers should be within the local Transfer Network whenever possible (Exeter, Torbay and Truro). The emergency bed service can provide up to date information on ICU bed availability. The duty hospital manager must be informed of all out of network transfers.

Pandemic flu plan for critical care – only if pandemic called.

In order to accommodate an anticipated surge in demand for Critical Care beds that an influenza pandemic would generate, plans have been developed to significantly expand critical care facilities at Derriford Hospital – increasing bed numbers from 18 general and paediatric critical care beds up to a maximum of 91 Level 2 and 3 beds. This will initially involve utilising the cardiac and neuro beds resulting in 50 critical care beds at Derriford Hospital and the end of Phase 1 and impacting on tertiary services across Devon and Cornwall. Capacity beyond that level will involve opening additional beds on Postbridge (19) and Freedom Theatres (5) totalling 74 by the end of Phase 2. Further additional capacity is available in Freedom Theatres to increase critical care capacity to 80 beds at the end of Phas3 and maximum of 91 beds at Phase 4.

To achieve these bed numbers, cardiac and neurosurgical activity requiring critical care support post operatively, will be curtailed from the outset. As demand increases, crucial care beds will be flexed to ensure care is provided to flu and non-flu patients. This will be achieved through utilising triage scoring system to determine appropriate access and levels of care and the reduction in elective activity. These plans have been developed utilising existing ventilation equipment and regular staff supporting others with qualifications or experience in critical care. An enhanced training programme is also in progress to facilitate the redeployment of staff into critical care areas. It is recognised however, that staffing ratios will decrease from 1:1 or 1:2 down to 1:4 with critical care staff supporting suitably trained non-critical care staff.

16. Capacity Assurance - Staffing & Escalation: PHNT Site Management

- *Enhancing existing structures rather than adding in layers*
- *Learning lessons from demand and capacity planning*
- *Levels of escalated support within the hospital*

The acute trust had introduced 24hour bed management with good effect over the last winter period. It provides leadership throughout for the decision making in relation to the use of the bed and staffing resource. This has proved to work well and evidence suggests that the escalation process to include other managers and clinical leaders to unblock issues has worked on a number of occasions.

PHT has also introduced site management daily from 0730- 1800hrs weekdays this year which has added in support to the bed managers. From the 1st December this will be enhanced with site management also being available from 1400 – 2000hrs on Saturdays and Sundays which are periods of time identified as being vulnerable. All site managers have received additional training to support them in operational decision making and have been selected carefully to match times of anticipated need with the greatest t levels of capability.

Directors on call are available at all times and will be in the hospital during the Christmas period, with directors with highest levels of operational experience being on call for the two weeks from the 21st December until the 3rd January 10 .

17. Capacity assurance – staffing and escalation: Adult social care

- *Business as usual*
- *Redirecting resource to points of need*
- *Full establishment*

Through the Winter Period we will expect times of surge demand that will create higher volumes of need for assessments and discharges to help support the whole system respond and safely manage these peak periods. We also have the potential of a flu pandemic which is likely to exacerbate this situation and potentially also create higher levels than normal of staff sickness.

Where work volume exceeds available resources through a surge in demand, or resources within the team reduce to a point where unacceptable levels of Adult Social Care staff are available then through its management of this situation we will call upon assessment staff from other areas to provide support. We already have in place a working escalation process to achieve this. The levels of staff drawn into support would always be proportional.

This year further work has gone into improving the discharge process and the health and social care pathway, by all involved organisations, which would also help to ensure together we work to shared priorities helping to eliminate duplication and maximise the number of discharges we can achieve. This work has already shown benefit and further activity in ongoing with regards to integrating these services.

A number of mechanisms are now also in place to closely monitor the status of Derriford through the resilience dashboard and a schedule of regular conference calls that include representation from all organisations including social care.

We also work closely with health services that are focussed on preventing admissions (RITA) and will continue to ensure this remains a key focus during the winter period.

18. Capacity Assurance - Staffing & Escalation: Interim Placements

- *Need to create capacity outside hospital to continue assessment process*

- *Reduce the numbers of people making decisions regarding long term crew whilst at their most vulnerable*
- *Reducing delays in transfer of care.*

Collectively the community is committed to reducing delayed transfers of care to an absolute minimum, but is not achieving this target. The reasons for delays are mixed and the definitions coded by STEISS hide a complexity which is only evident when drilling down into individual cases. However the community is not achieving this nationally set target of no more than 7/10,000 population. The current reported achievement to date is 9.6/100,000 population for the community. The community work programme on the health and social care pathway released almost 7,000 bed days in the last year by improving working practices and we are expecting to improve again over the next year, but are now approaching the work programme where there are more complex reasons for delay.

Because of the concerns highlighted related to non achievement of the delayed transfers of care and the impact this has on patient flow, the health community has already escalated the issue to board and chief executive level. At the PCT board meeting held in September a set of actions were agreed and supported to resolve some of the operational blocks for the teams.

A hospital admission is often a 'tipping point' in health and wellbeing status in older people. It also can lead to a loss of confidence for a person and on occasions can also be the point at which a tired and overburdened family decides they can no longer to continue to care. Therefore we find that on many occasions the admission to hospital also becomes the point as which an older person's independence is compromised and there is pressure to move to institutional care and support.

Clearly this not only has a significant personal impact but directly impacts on the ability of the community to deliver a number of critical targets – four hours target, emergency bed days and delayed transfers of care.

Adult social care and the PCT have agreed with PHT and its own provider unit that it is inappropriate for people to remain in hospital settings once safe to transfer whilst assessments and ongoing recovery take place. It has undertaken an option appraisal regarding processes to move these people to locations where their assessments can be completed in a sensible timeframe, and this has contributed to the improvements for adults with physical problems. The service is now working on developing and expanding the scheme to incorporate people with cognitive impairment, which becomes more complex as we need to ensure there is sufficient community capacity to keep people safe and well cared for whilst the assessments are ongoing. This extended model format has been agreed and over September the capacity needs and capability within existing service will be defined.

There is an expectation of implementing more long term condition care co-ordination before winter proper but this is dependent upon recruitment.

19. Capacity Assurance - Staffing & Escalation: Domiciliary Care

- *Increased capacity*
- *Greater transparency in utilisation of available resources*
- *Escalation process to reduce domiciliary care input to people deemed of lower need as a surge develops.*

The NHS has recognised as part of its work across the urgent care network, that, unlike its adult social are colleagues its approach to commissioning as not been as robust as it should be, leading to providers of domiciliary care being unable to respond to our needs. Adult social care have completed an extensive tendering exercise this year which assures itself of greater capacity and working relationships with their four main providers.

The community has agreed a brokerage arrangement with adult social care. This proved contractually far more complex than originally anticipated but has commenced for LD and long term CHC packages; with some minor adaptations it should be able to go live November 2010. This enables the NHS to plan and purchase care in a more co-ordinated way, reducing staff time in booking but also being able to have a much better understanding of capacity and need across the community. It will enable it to plan when capacity becomes tight to direct the available resource to the neediest and instances where there will be the most positive impact on the community.

20. Capacity assurance – staffing and escalation community services (onward and intermediate care)

- *Recognition of capacity gaps*
- *Health and social care pathway work rollout*
- *Integration of health and social care teams*

During the year the PCT has invested additional funding to increase the capacity of the onward care team and RITA services to reflect the expectation of needing to expedite patient discharge from hospital safely and increase the numbers of people who can be cared for safely at home as an alternative to hospital admission.

The PCT has taken the approach of considering how the RITA and onward care team can cross cover each other and have taken active steps in recruitment. In times of need RITA service staff will enhance the onward care team which is helpful, but usually when the hospital is busy and discharges need to be expedited so are the community teams as well.

The team will be working throughout the winter period, and will be up to full capacity. We know that the period immediately prior to Christmas is particularly busy and will be looking to support the team at this time as more people, are keen to be home for the Christmas period. Discussions are underway in relation to the appropriate use of the extra capacity and consider slightly longer working says or possibly weekend working provided there is the hospital infrastructure to support then.

The RITA service provides our hospital avoidance scheme and is a key piece of the community jigsaw. The service has new senior leadership which is deemed essential to support the ongoing negotiation needed with adult social care to continue to review and move people back to usual patterns of care and support as soon as possible. At any one time the RITA service with onward care.

At any time the RITA service combined with the onward care service can be managing approximately a 100 patients in community settings, and during the winter this number has increased to circa 140. this does place pressure on community resources such as domically care and care home placements and can create competition for capacity, but it is hoped that the use of the resilience dashboard and the daily teleconferencing facility will enable a overview of the community position to take place and thus agree where any scarce resources be best utilised to maximise flow through the services. Currently the ratio of care home base placements to home based care is 60:40 but the service is striving to reverse this ratio and accommodate more people in home settings.

In the past the ability of the RITA team to mobilise more resource to support it in times of greatest need has not been as good as it should be, but with more senior leadership support this will create the capacity to negotiate more effectively across the community to gain the right interventions to maintain patient safety.

They particularly need support in combining patient settings to reduce travel time for clinical teams, and robustly discharge patients at the right point in time. The CHC contracts team have offered support to do this, and we will be looking to renegotiate the use of the enabling home care teams in home and care home settings to ensure we have created good therapeutic environments. The single most problematic issue is obtaining timely review

assessments which will be apriority so that people can be moved back to usual packages of care more quickly and thus create capacity to take more clients.

Health and social care have collectively looked at their processes for placements in long term care, domiciliary care and continuing health care funding to acknowledge that speed and safety will be priorities but administrative processes cannot be allowed to slow down discharges from hospital work within the integrated team approach in several parts of the city has provided a greater degree of confidence that health and social care can trust each other in decision making and securing of resources and it is hoped that this will enable the smoothing of the processes.

The PCT has negotiated with adult social care an increased its investment in community equipment services and has a new service provider this year. Responsiveness targets are improving and contingency planning for winter stock need still to be agreed... This capital injection has enabled the service to purchase a significant number of beds and pressure relieving mattresses which is one of the key pinch points in the system in terms of discharge. This will negate the need for the delivery of equipment and the resultant delays with this process.

Again there have been some changes in service delivery over the year, including the expansion of intermediate care service, to continue assessments in the community settings. This has led to a reduced number of people being funded for CHC, but also reduced care packages as they have been given the time to recuperate. This up front cost is demonstrating long term financial benefits and improved outcomes for propel especially older people. The service was easier to set up for the person etui physical problems but the community is now working hard to offer a similar service for people with cognitive impairment.

The community has agreed a model of care to support early discharge for the stroke pathway and is in negotiation with partners to implement additional social work time for this pathway with the intention of reducing overall bed occupancy. A start date is not confirmed yet as will depend upon recruitment.

21. Specific Planning for Christmas & New Year

- *Business as usual*

The approach to Christmas is that the teams involved in discharge planning will be working throughout the period except for the bank holidays. There will be no reduction in the level of services available as it is critical that length of stay does not increase. This in conjunction with staffing levels on the wards should facilitate continued discharge rates.

Detailed below is a summary of operational capacity for all of the key areas:

Service	December 20th-26th	December 27th-2nd January	January 3- 9th
Onward care team	Usual working practices Monday – Friday No weekend cover but Bank holidays opening as usual weekdays	Usual working practices Monday – Friday No weekend cover but Bank holidays opening as usual weekdays	Usual working practices Monday – Friday No weekend cover but Bank holidays opening as usual weekdays
Adult social care	Seven staff on duty over the three weeks (increase on last year) no weekend of bank holiday working based on past experience but increasing cover on Fridays (no early finish) and providers have	Seven staff on duty over the three weeks (increase on last year) no weekend of bank holiday working based on past experience but increasing cover on Fridays (no early finish) and providers have	Seven staff on duty over the three weeks (increase on last year) no weekend of bank holiday working based on past experience but increasing cover on Fridays (no early finish) and providers have

	been informed will be expected to take referrals right up to closing time, out of hours covered by duty arrangements.	been informed will be expected to take referrals right up to closing time, out of hours covered by duty arrangements.	been informed will be expected to take referrals right up to closing time, out of hours covered by duty arrangements.
RITA	Fully operational 9.30-6.30 normal working days and 9.30 - 3.30 for bank holidays and weekends	Fully operational 9.30-6.30 normal working days and 9.30 - 3.30 for bank holidays and weekends	Fully operational 9.30-6.30 normal working days and 9.30 - 3.30 for bank holidays and weekends
End of life co-ordination centre	Normal working hours Monday to Friday with contact details being held by community teams out of normal working hours	Normal working hours Monday to Friday with contact details being held by community teams out of normal working hours	Normal working hours Monday to Friday with contact details being held by community teams out of normal working hours
Discharge case managers	Fully operational weekdays and staff in place additionally for bank holidays. (not in place for weekends)	Fully operational weekdays and staff in place additionally for bank holidays. (not in place for weekends)	Fully operational weekdays and staff in place additionally for bank holidays. (not in place for weekends)
Access to mental health services (covers adult and older people)	Normal working practices apply. Monday to Friday 9-5. Emergency arrangement in place using out of hours gateway with adult social care which includes nursing. Specialist teams such as AOS and Home treatment, usual hours.	Normal working practices apply. Monday to Friday 9-5. Emergency arrangement in place using out of hours gateway with adult social care which includes nursing. Specialist teams such as AOS and Home treatment, usual hours.	Normal working practices apply. Monday to Friday 9-5. Emergency arrangement in place using out of hours gateway with adult social care which includes nursing. Specialist teams such as AOS and Home treatment, usual hours.
Equipment services	Normal operational hours and emergency arrangements for out of hour's services apply. increased stock at centres arranged	Normal operational hours and emergency arrangements for out of hour's services apply. increased stock at centres arranged	Normal operational hours and emergency arrangements for out of hour's services apply. increased stock at centres arranged

22. Capacity assurance – mental health

- *Business as usual*
- *Crisis care planning for high risk client group*
- *Information sharing*

The mental health services response over the winter period is vital to the community. Delays in assessment, treatment and discharge can have a huge impact on the community flow and the patients and carers.

The psychiatric liaison service for adults and older people will be working normally over the Christmas and winter period with a constant presence on site at the main hospital sites. These services are the main port of call for support and assessment in the care of people with acute mental health needs in a general hospital setting. They are also hugely supportive in prioritising mental health resources and responses from other parts of the service.

Priority areas for cover over the period are

- Psychiatric liaison
- Section 136 facilities
- Home treatment team
- Access to mental health services (gateway team)

The Section 136 facility in the Glenbourne is and will be fully operational and is deemed as a high priority area taking staff from other places as needed to support its use. In addition there are de-escalation facilities available on the two inpatient units to provide support if there are a number of requests for use, or patients need longer for assessment. These have only just been completed but are already proving an asset for clients, staff and the police.

Home treatment teams identify people who are most at risk over the winter period and develop crisis care plans and extra measures with options for treatment and support and a lower threshold agreement for admission if needed. They will be working normally which includes back holiday cover.

The access to mental health services (gateway team) will be working normally again this is a seven day service and will be fully operational over the bank holidays.

Rotas are being made available now for the acute trust to ensure they know who is available for support for detention and assessment.

On a daily basis the psychiatric services are participating in the daily combined meeting between onward care, adult social care and complex discharge team. This meeting reviews all the patients needing discharge support and prioritises the workload, the inclusion of the mental health workers provides much needed support for the general trained staff and provides advice and direction to facilitate the assessment and discharge process well. This will continue over the winter period as usual.

23. Capacity assurance – mortuary and bereavement services

- *Increased capacity*
- *Bereavement service approach as opposed to just mortuary capacity*

The community has a robust mortuary capacity plan which is led and monitored by the lead pathologist. The community has planned for an increase in capacity at the main hospital site with additional capacity having been purchased, with subsidiary sites across the city at other health locations including Mount Gould Hospital. In addition the NHS has negotiated with the council and local funeral directors. The NHS plan has now become stage one of a three part escalation plan for the community, which has been overseen by a multiagency groups considering exceptional winter deaths and excess mortality. The plan describes

- Phase 1 use of NHS plans and capacity
- Phase 2 increase of funeral director capacity by another 300 places, using existing funeral director premises.
- Phase 3 – an isolated council owned property which can be put into service as excess storage capacity.

The community has also negotiated with the council so that coroner's offices and bereavement services and crematoria will only be closed for the actual bank holidays and will not close for the main Christmas week. This should facilitate smoother flow of deceased throughout the city.

24. Resilience Dashboard and Status

- *Use of existing information flows*
- *Single spreadsheet of shared information*
- *Transparency*
- *Trigger points and consequences*

Included in Annex 1, is the Plymouth Health Community resilience dashboard. This will be used as a daily/weekly vehicle to share information across the Community. The aim of the

dashboard is to have a clear set of Community data to improve a joint Community response to circumstances. Past challenges for the community is being sure that all partners have a clear understanding of the impact of the increased demand across the community. Each component of the plan has a trigger point, some which still need to be agreed and as the trigger point is reached the escalation processes should kick in. the agreement about trigger

10.2 Key Metrics

- "Call Activity" - including locally arranged "spotter clinics and pharmacies" to give an early indication of activity

- "Acute Bed Occupancy" – is specifically about Plymouth Hospitals NHS Trust beds

- "4 Hour Target Performance" – daily graph on achievement

- "Ambulance Waits" – daily graph showing >30 minute waits and >15 minute waits

- "Staff Information" – weekly absence position to highlight risk at Plymouth Hospitals NHS Trust, Local Care Centres and Onward Care Teams

- "Domiciliary Care Availability" – forward view of Plymouth availability

- "Community Resource Availability" – table showing availability of a range of services/beds across the Community

- "Delayed Transfers of Care" – statement of delays from Plymouth Hospitals NHS Trust and also from NHS Plymouth provider units

- "Attach Rate" – record of A&E admits and inpatient stays to plot a trajectory

- "Mortuary Availability" – to show available capacity

- "Vaccinations" – still to be developed but to show % of over 65's vaccinated and % of Healthcare of the Elderly vaccinated

10.3 Data will be supplied daily to the Plymouth Hospitals NHS Trust Co-ordinator for entry into a spreadsheet, this input is required by 9.30am daily.

It is proposed to e-mail out the spreadsheet to all parties by 10.30am daily.

10.4 Any of the Community organisations can escalate performance through a joint Community telephone briefing

Persons to be involved:-
- Elaine Fitzsimmons – NHS Plymouth
- Richard Best – PHNT (chair)
- Lindsay Collinge – SWAST
- Michelle Thomas – NHS Plymouth Provider
- Gary Walbridge – Plymouth Adult Social Services

Also, leads from Devon & Cornwall Onward Care Teams as required

25. Community Operational Meeting and escalation process arrangements

- *Use of existing meeting structure*
- *Planned teleconferencing which can be stepped down if not needed*
- *Linked winter plan and silver command process*

Part of the success of the work programme for the community is greater transparency and communication between all of the respective service providers and this will be enhanced for the winter rather than intersecting new systems and processes.

On a daily basis the community holds an operational meeting three times a day 1100hrs, 1300hrs, 1600 hrs. This enables the community to understand how the system is working, particular blockages or issues , and as well as dealing with current problem enables the services to consider next day planning as well. All onward care teams as well as ambulance and hospital staff attend, which ensures there is knowledge across the Devon, Cornwall and Plymouth community. The escalation processes within the community arise from these meetings and is well used already, with each person having responsibility to bring information to the meeting, but also feed back to the relevant people within their own organisation to put escalation processes into place. This escalation of information plans include to directors, directors on call, key operational managers and chief executives as well. This also ensures that operational staff (who knows the system and solutions the best) is freed up to implement the responses, but also keep key directors within the organisations abreast of the developing situation.

This will continue, but the four main service providers have agreed a daily time for a teleconference to take place which will be triggered by any issue identified as part of the community wide dashboard. This will take place at midday daily with the chair rotating. In the last year the benefit of having this opportunity was welcomed. Although it was operational from the beginning of October, the numbers of times it was called were very few:

The four main providers represented are

- Plymouth Hospitals NHS Trust (lead Richard Best)
- Plymouth Adult social care (lead Gary Walbridge)
- NHS Plymouth (lead Michelle Thomas)
- South West Ambulance Services (lead Lindsay Collinge)
- Commissioner (lead Elaine Fitzsimmons)

Daily breach meeting 0930hr (reviewing all breeches from the previous day)
Daily morning bed meeting 1000hrs (consider current day look ahead)
Optional daily teleconference 1200hrs (as above membership)
Lunchtime bed meeting 1400 hrs (consider actions agreed at 1100 and their impact)
Early evening bed meeting 1700hrs (look ahead for next day)

Teleconference information
Membership as described above with offer to listen in and participate when needed to the wider community

Reserved PIN: 017291
Dial-In Number: 0844 473 7458

Throughout the winter period the usual process of urgent care network, operational standards and chief executive escalation meetings will continue.

26. SITREP/STEISS Process

It is expected that the STEISS reporting will be initiated from the OHA reports from the SWAST system, available to the SHA via web, further guidance is awaited.

27. Recovery

This development of winter plans have usually ignored the issue of recovery and return to normal business, but the possible impact of the flu requires us to consider this more carefully this year. Whilst at this point in time we cannot actually plan our response we are aware of a number of areas where we need to consider carefully the process:

- Staff - It has been calculated that following a period of sustained pressure it may well take us up to two months to fully recover, not only in terms of staff being back to work, but also compensating for extra hours worked, annual leave not taken etc.
- Patients- it is likely that a number of patients planned for elective procedures may well not be well enough o contemplate admission for some time and we wall need to consider how we manage waiting list and bring forward cases if needed to fill capacity. Likewise the use of outpatient clinics and diagnostic capacity may be mixed and possibly underutilised.
- Planned maintenance and repairs may not have taken place and need to be factored in again.
- Stocks may be low for certain items and products which may have an impact on operational working
- Commissioning and contracting may need to recover preciously achieved positions and performance levels and may be agreeing a way forward over the months of poor performance if created by the flue and winter excesses.
- Operational recovery and communication routes. Certain services may be reinstated earlier than other and this needs

Recovery from the winter period will be determined by the level of disruption and the operational teams will be working with colleagues planning for flu to develop a coherent plan.

Winter plan co-coordinator
Elaine Fitzsimmons
Asst Director of Commissioning
NHS Plymouth

Appendices

- Resilience dashboard example
- Example of escalation plan for ED

Plymouth NHS
Teaching Primary Care Trust

Plymouth Hospitals NHS Trust
Escalation Procedure for Insufficient Capacity in Emergency Dept

Standard: Lack of patient flow throughout Plymouth Hospital NHS Trust compromising provision of safe, effective clinical care, which will effect achievement of core government standards.

Measurement: Named leads review demand/capacity (planned and unplanned admissions) against confirmed discharges. Site Manager to review escalation beds open or to be opened.

Instigated: When only 1 trolley available and no patient flow identified for patients requiring admission from Emergency Dept

Nurse Co-ordinator for Majors:
- Liaises with Consultant/Registrar in charge of ED
- Considers utilising 1 minors cubicle – dependent upon workload
- Ensures CDU and CDU Lounge are fully utilised
- Considers staffing requirements
- Escalates situation to Directorate Team, Operational Support Team

ED Consultant:
- Ensures that specialities with patients awaiting admission are aware of the deteriorating situation
- Informs On-Call Consultant of appropriate speciality.

Operational Support Team
- Informs wards of serious situation in Emergency Dept
- Confirms to Nurse in Charge of Majors what beds have been identified and predicted times of when they will be available for use

If Duty Senior Doctor: *(identified by JP/on rota)*
- Informs Speciality Consultants that they are required to attend wards to actively review patients and flex discharge criteria, to alleviate flow problems

IF SITUATION DETERIORATES:
Emergency Department full, ambulances queuing to handover patients and no patient flow identified for 30 minutes

Nurse Co-ordinator for Majors:

- Accommodates 2 patients in each for cubicles 1 and 9 if clinically appropriate
- Identifies predicted patients coming in via ambulance
- Assesses patients in majors to determine whether alternatives to admission are available
- Deteriorating situation escalated to Operational Support Team
- Informs On-call Manager of requirement for Hospital Co-ordination Team to be assembled to co-ordinate response

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On-call Manager:

- Escalates situation to Executive Director, Duty Senior Nurse and Hospital at Night
- Duty Senior Doctor to be informed of further deterioration of situation
- All to report to Control Centre immediately – as situation in ED is clinically dangerous

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HOSPITAL CO-ORDINATION TEAM FORMED – in Control Centre to lead response

- *Internal Serious Incident Declared*
- Executive Director up-dates Duty Executive Director for NHS Plymouth of situation
- On-call Manager informs Duty Manager at SWAST of latest position
- Message conveyed to all wards of situation and requirement to potentially accommodate additional patients on wards until beds become available
- On-call Speciality Consultants to report actions undertaken taken to Control Centre
- HCT to oversee response until situation improves and patient flow has improved

Ref: Linda Field / MCS Vs 2 – 4/12/2008