NHS
Dorset
Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

OPERATIONAL RESILIENCE AND CAPACITY PLAN 2014/15



Supporting people in Dorset to lead healthier lives

NHS DORSET CLINICAL COMMISSIONING GROUP

DOCUMENT CONTROL SHEET

TITLE OF DOCUMENT: OPERATIONAL RESILIENCE PLAN 2014/15

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V1.0	15/07/14	Tracy Hill	Draft	Update Plan
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V.1.2	28/07/14	Tracy Hill	Draft	Further amendments
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DORSET CLINICAL COMMISSIONING GROUP

OPERATIONAL RESILIENCE PLAN 2014/15

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EXECUTIVE SUMMARY

The Dorset Operational Resilience and Capacity Plan describes the arrangements put in place to co-ordinate capacity planning and operational delivery across the health and social care system.

Dorset's Operational Resilience and Capacity Plan:

- Demonstrates how organisations will deliver non-elective and elective care pathways on a day to day basis and during periods of increased demand;
- Outlines the process by which Dorset's Urgent Care Board will be developed into a System Resilience Group;
- Aligns with and build upon capacity planning being done throughout the system, including flu planning and the wider transformation programmes, including Clinical Services Review, Better Together Programme and Urgent Care;
- Outlines the learning from previous years and the key findings, which have informed planning for 2014/15;
- Outlines the agreed system wide escalation plan;
- Outlines the specifics of the operational resilience communication plan.

Urgent Care is a priority area for NHS Dorset as currently there are extreme and ongoing pressures across the system. This plan highlights the work undertaken to date and work which is underway in order that a safe, responsive service which meets the needs of our local population can be delivered at all times. This includes:

- Development of a medium term strategy for urgent care which identifies five key priroty areas;
- initiated discussions with the Emergency Care Intensive Support Team (ECIST) to urgently undertake an assessment of the current pressures and to ascertain what some of the key causes may be;
- Commissioned a review of NHS 111 alongside NHS Somerset CCG, NHS Devon CCG and NHS Cornwall CCG;
- Development of a real-time urgent care dashboard building on the abilities of the Capacity Management System.

The Operational Resilience and Capacity Plan has been developed in partnership with all providers and will be further developed to deliver a system wide response to manage the current demands being experienced within the system. This will take account of the change in demand profile with greater peaks being seen in the out of hours period. The plan will be signed-off by the System Resilience Group on meet on 14 August 2014.

DORSET CLINICAL COMMISSIONING GROUP

OPERATIONAL RESILIENCE AND CAPACITY PLAN 2014/15

1. INTRODUCTION

1.1 The Operational Resilience and Capacity Plan describes the arrangements put in place by NHS Dorset Clinical Commissioning Group (CCG) to co-ordinate capacity planning and operational delivery across the health and social care system.

1.2 In contrast to previous years, this plan covers both elective and non-elective services, with the acknowledgement that bringing together both elements within one planning process underlines the importance of whole-system resilience. It also recognises the need for both parts to be addressed simultaneously for local health and social care systems to operate as effectively as possible in delivering year round services for patients.

1.3 Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires capacity planning to be ongoing and robust. This will put the NHS, working with its partners in Local Authorities, in a position to move away from a reactive approach to managing operational problems and towards a proactive system of year round operational resilience.

1.4 The Operational Resilience and Capacity Plan has been developed by all members of Dorset's Urgent Care Board, which from August 2014 will be developed into a System Resilience Group.

1.5 The plan will be presented to the System Resilience Group on 14 August 2014 for final sign-off by all providers.

1.6 Dorset's Operational Resilience and Capacity Plan:

- Demonstrates how organisations will deliver non-elective and elective care pathways on a day to day basis and during periods of increased demand;
- Outlines the process by which Dorset's Urgent Care Board will be developed into a System Resilience Group;
- Aligns with and build upon capacity planning being done throughout the system, including flu planning and the wider transformation programmes, including Clinical Services Review, Better Together Programme and Urgent Care;
- Outlines the learning from previous years and the key findings, which have informed planning for 2014/15;
- Outlines the agreed system wide escalation plan;

- Outlines the specifics of the operational resilience communication plan.

1.7 A schedule setting out a breakdown of how the Organisation Resilience and Capacity funding will be allocated, together with wider additional investments that contribute to meeting capacity issues throughout the whole system is in Appendix 1. Included on the template is the ambulance funding which will be awarded to SWAST via the lead commissioner – South Devon and Torbay CCG. Planning and costing templates have been completed by each of the three Dorset Acute Trusts and, once agreed through the System Resilience Group, will be appended to this plan.

2. CONTEXT

2.1 Currently there are extreme and ongoing pressures across Dorset's urgent and emergency care system, the CCG has initiated a number of actions to understand and respond to this, including:

- Review of NHS 111 services provided by SWAST, in partnership with other commissioners of this service;
- discussions with the Emergency Care Intensive Support Team (ECIST) to undertake an assessment of the current pressures;
- pro-actively engaging with local authorities to reduce admissions due to largely social reasons.

2.2 Jane Pike is the full time Director level lead with responsibility for surge and escalation planning and assurance for NHS Dorset Clinical Commissioning Group.

2.3 Frances Stevens, Deputy Director and Tracy Hill, Principal Programme Lead, support Jane Pike on this agenda.

2.4 Monthly contract performance management includes early identification of potential RTT issues and agreeing trajectories in these areas, where necessary.

2.5 Table 1 shows the details of the accountable Chief Officers / Directors in each organisation within the local health economy.

Table 1: Accountable Chief Officers

Organisation	Title	Contact details
Dorset Clinical Commissioning Group	Director of Review, Design and Delivery	jane.pike@dorsetccg.nhs.uk 01305 2135333
Royal Bournemouth and Christchurch Hospital NHS Foundation Trust	Chief Operating Officer	helen.lingham@rbch.nhs.uk 01202 704998
Dorset County Hospital NHS Foundation Trust	Interim Director of Operations	Robert.McEwan@dchft.nhs.uk 01305 251150 ext. 4272
Dorset Healthcare NHS Foundation Trust	Chief Operating Officer	Sally.O'Donnell@dhuft.nhs.uk 01202 541470
Poole Hospital NHS Foundation Trust	Chief Operating Officer	Mark.Mould@poole.nhs.uk 01202 442547
South Western Ambulance Service NHS Trust	Director of Nursing	Jennifer.Winslade@swast.nhs.uk 01392 261637
Urgent Care Out-of-Hours service	Director of Nursing	Jennifer.Winslade@swast.nhs.uk 01392 261637
Bournemouth Borough Council Social Services	Chief Executive	Tony.williams@bournemouth.gov.uk 01202 458719
Borough of Poole Social Services	Chief Executive	A.Flockhart@poole.gov.uk 01202 633633
Dorset County Council Social Services	Chief Executive	d.ward@dorsetcc.gov.uk 01305 251414

Establishment of System Resilience Group

2.6 Work is now underway to develop the existing Urgent Care Board into a System Resilience Group in line with Operational Resilience and Capacity Planning Guidance for 2014/15. Draft terms of reference are set out in Appendix 2 will be submitted to the current Urgent Care Board in August 2014 for discussion and sign-off.

2.7 Development of the Operational Resilience and Capacity Plan and accompanying templates has been co-ordinated through the Urgent Care Board and Surge and Escalation Planning group.

Surge and Escalation Planning Group

2.8 The Surge and Escalation Planning group, which is a sub-group of the Urgent Care Board, takes on a strategic planning role for part of the year and a monitoring and operational roll during the winter and during periods of high demand. The terms of reference of this group are attached in Appendix 3.

2.9 Members of the Surge and Escalation Planning Group schedule in weekly teleconferences which take place each week throughout the year. The calls are chaired by Dorset CCG and are stood down if not required. There is a requirement for all partners to participate.

2.10 The Operational Resilience and Capacity Plan should be used in conjunction with a number of other key documents. These documents include:

- NHS Dorset CCG Annual Operating Plan 2014/15;
- NHS England Winter Flu Plan 2014/15;
- NHS South of England Escalation Framework April 2013;
- Major Incident Plan;
- Mass casualty plan.

3. TRANSFORMATIONAL PROGRAMMES

Clinical services review

3.1 The Clinical Services Review (CSR) will review clinical services across Dorset, with the aim of developing a modern model of clinically sustainable, high quality health services (including workforce) across Dorset. This is an extensive programme, which will recommend a blueprint for the future, by April 2016. Significant transformation work will continue during the review period.

Urgent care Medium Term Strategy

3.2 The Dorset Urgent Care Board commissioned the Kings Fund to review the current urgent and emergency care system during 2013/14, which included the following elements:

- Examining the routine data for the health economy and comparing this with other similar systems in the South of England and elsewhere;

- Commissioning the Oak Group to undertake a large point prevalence study of admissions across acute medicine, older people's medicine and the community hospitals;

- Reviewing existing urgent and emergency projects and initiatives;

- Facilitating the development of a frail and elderly pathway.

3.3 As a result of the work undertaken by the Kings Fund and the Oak Group it is apparent that there is nothing in the data to suggest any particular issues relating to the urgent and emergency care service within Dorset that are unique:

- Emergency admissions are rising not out of line with national trends;

- The current system is not designed to cater for the current activity levels and is unsustainable in the longer term;

- There is no single identifiable cause for the continuing increasing levels in demand and activity so there will be no single solution;

- The system is complex and confusing with multiple access points, making it confusing for patients to navigate;

- Different services are available depending on geographical location or provider rather than patient need;

- A wide spectrum of initiatives will need to be not only implemented but also evaluated to determine effectiveness**,** quality and outcomes.

3.4 The Dorset Urgent Care Board Strategy Development Group built on this work to identify and take forward the priority areas that would make the most difference in the short term. During 2013/14 the Urgent Care Board commissioned the Kings Fund to conduct an examination into what is driving the continued rise in non-elective activity, how well services are currently dealing with the demand and what steps might be taken to arrest the trend, contain the demand and manage its impact.

3.5 During 2013/14, the Dorset Clinical Commissioning Group invested in the region of £4 million in service enhancements or developments that were anticipated to deliver in-year improvements and help alleviate seasonal pressures. Each of these projects was subject to an evaluation to determine their effectiveness against key performance indicators.

3.6 Proposals were invited from all stakeholder organisations and encouraged partnership working. Projects were then agreed and established around four hubs - Poole, Bournemouth, Dorchester and South Western Ambulance Services.

3.7 As a result of the evaluation of these projects, some funding has been continued during 2014/15 and the outcomes of these projects will help support the further development of this strategies work programmes. The projects that received continuing funding for 2014/15 include:

- **Acute Hospital at home**, which provides expert staff to care for patients in their own home environment where they remain throughout (West Dorset);

- **Alternative Offer,** an assessment of a patient's long term care needs is carried out in their own home rather than hospital, giving a more accurate picture of the support required (West Dorset);

- **Interim Care Pilot**, this focuses on supporting and implementing the utilisation of residential and nursing home "interim beds" within Bournemouth and South-East locality of Dorset for patients requiring social care on discharge (Bournemouth);

- **Virtual Ward**; which builds a community multidisciplinary team and integrates health and social care delivery across all sectors for 'patients' (Bournemouth and Christchurch);

- **Assisted discharge,** the British Red Cross offers an assisted discharge service which support older patients to return home safely (Poole)**;**

- **Alcohol Nurse,** helps manage patients with alcohol related conditions through alternative pathways (Poole);

- **Rapid Response,** an additional two Emergency Care Practitioners in Rapid Response Vehicles are made available in areas of high demand (East Dorset) between 08:00-18:00 hours daily**,** this service is accessed via the Single point of Access service (East Dorset);

- **Advanced Nurse Practitioner**, advanced nurse practitioner or emergency care practitioner is available within each of the three acute providers to see and treat patients as an alternative to other clinical input (Pan Dorset).

3.8 Work is currently underway to develop a two year interim urgent care strategy for Dorset, which will inform the Clinical Services Review. The strategy is due to be signed-off at the August 2014 Urgent Care Board. The board will be asked to agree the following five key high priority areas for delivery within the next six months. These areas are:

- Progress locality MDT working with GP clusters, to maximise incentives to undertake risk stratification systematically across all care sectors. This will enable effective targeted case management through anticipatory care plans. for high risk patients over 75, that are shared across sectors;

- ED attendance avoidance programmes to promote self care and use of more appropriate alternative services;
- Evaluate and rollout effective models that support discharge to assess and hospital at home to improve patient flows through all sectors;

- Evaluate Mental Health Street triage pilot to determine effectiveness in reducing ED attendances or admissions for Section 136;

- Work in a more collaborative way to secure sufficient domiciliary care resources in a market that currently encourages competition and perverse incentives for providers.

Better Together Programme

3.9 The Better Together Programme, aims to transform health and social care across Dorset to enable and deliver a sustainable improvement in health and care outcomes. This will be delivered through person centred outcomes that are focussed on preventative and co-ordinated care.

3.10 One of the workstreams of Better Together is to agree a service specification and model for Integrated Locality Teams The model will initially be piloted in the Purbeck locality and will offer a co-ordinated delivery of care in line with the aims of the programme.

3.11 The Better Care Fund has been established across the three local authorities and NHS Dorset CCG, made up from existing budgets to form a significant pooled budget that will drive the integration of Health and Social Care across Dorset

Primary Care Development

3.12 NHS Dorset CCG is committed to supporting the key role that primary care plays in the pro-active management of patients who are frail and complex. Funding has been identified to enable practices to better support the over 75 population to reduce avoidable admissions.

The Care Act 2014

3.13 This plan recognises that the Care Act 2014 will impact on capacity on the wider system. The key elements include:

- The introduction of a new national minimum eligibility threshold to access adult care and support;

- Introduction of preventative regulations;

- The introduction of a cap on care costs and an extension to means tested support;

- New criteria to assess carers;

- Awareness of new statutory responsibilities for safeguarding.

4. ESCALATION

4.1 Development of an effective escalation management process across the Dorset Health and Social Care system has been a key priority. A thorough review of local escalation processes took place as part of the development of the 2013/14 plan.

4.2 Dorset's escalation plan has been aligned to NHS South England Escalation Framework. The framework sets out the procedures to manage day to day variations in demand across the health and social care system as well as the procedures for managing surges in demand.

4.3 There are four levels of escalation as shown in Table 2.

Table 2: Levels of escalation

Green	Amber	Red	Black
Business as usual	Pressure above expected levels or capacity below expected levels. Some contingencies deployed.	Pressure significantly raised or capacity significantly reduced. Most contingencies deployed.	Major incident – all contingencies deployed – system requires external support

4.4 Local action cards are in place, which outline the triggers for escalation at each level and the actions required for all service areas to support if need be. The full set of action cards are provided in Appendix 4.

4.5 The trigger for external assistance from NHS England will be a declaration by the Local Health Economy of whole system 'black' status.

4.6 The Urgent Care Board has identified a need to further improve the whole systems management of capacity and the need for a detailed analysis of the status of each organisation on a daily basis with access to real time system-wide data building on the capabilities of the Capacity Management System. In response to this, Poole Hospital have arranged for two companies who have developed system management tools to present to the Urgent Care Board in August 2014.

4.7 Following the presentations the Urgent Care Board will agree a way forward, with the understanding that this has been recognised as a priority for capacity modelling and overall management of the system.

De-escalation

4.8 The learning from previous years shows that de-escalation needs to be well planned and managed.

4.9 De-escalation should comprise of the following elements:

- Reduction to appropriate escalation level as laid out in the escalation cards in Appendix 4;
- Audit the backlog of assessments;
- Agree time-frame to meet any performance targets not currently being met;
- Complete a risk-assessment against recovery time-frame;
- Plan for additional resourcing and agree if necessary through appropriate internal Governance arrangements;
- Communicate de-escalation status to partners.

Resilience Email System

4.10 The way in which the health and social care community alert one another that triggers are evident in their system is via a single email account resilience.alerts@dorsetccg.nhs.uk. The purpose of this email is to accept information / alerts which are then cascaded to the health and social care community as appropriate. The email account is managed 24/7 by SWAST.

4.11 This method of communication has been successfully in operation for three years.

4.12 The Surge and Escalation Planning Group review the resilience alerts on a six monthly basis in order to identify any learning or changes required in how the system operates.

Directory of Services (DoS)

4.13 The Directory of Services (DoS) is a web based application which can be viewed on almost any internet connection and over NHS net. It has password protection, but does not contain any patient identifiable information. It is a resource mapping facility arranged as a structured database of the services that are available in a locality.

4.14 The capacity grids held on the DoS are the:

- Overall Hospital Activity (OHA) grid, which presents the pressure status and bed states for acute hospitals, including A&E and ITU beds.
- Community hospital grid which shows the bed status and admissions and discharges for Community Hospital direct access wards.
- Provider Escalation Screen grid which shows other services and capacity including; palliative care services, community nursing, rehabilitation teams,

intermediate care services MIUs and mental health beds. Social Services can update this grid if there are capacity issues.

4.15 All of the information held in the DoS capacity grids can be viewed by other services as well as the Single Point of Access team who use the knowledge, for example when helping with discharges into community hospitals.

4.16 Providers are ultimately responsible for ensuring the information regarding their services are kept up to date and work closely with commissioners to ensure this happens. This is included in provider contracts with NHS Dorset CCG.

5. LESSONS LEARNT

5.1 National, regional and local learning is embedded in this plan.

5.2 The Surge and Escalation Planning Group meets bi-monthly and regularly reviews the current pressures and areas for learning and development.

5.3 In October 2013 a table-top exercise was held to test the NHS Dorset CCG Surge and Escalation Plan, including the escalation processes. A further table-top exercise was held in June 2014, to test the revised action cards and identify areas for further improvement.

6. COMMUNICATION

6.1 Good communication is essential for smooth and effective management of all services particularly at times when services are stretched due to increasing demands or where services are reduced over the holiday period.

6.2 Providers are required to develop their own communication plans that follow the National Heatwave Guidance which is released annually.

6.3 As the real and more immediate risk to the health system is winter with excess deaths and unnecessary admissions to hospital, more emphasis is given to communication over the winter period. NHS Dorset CCG develops an annual winter communications plan with partner agencies to ensure well planned communication messages are shared with staff, patients, carers, the public and healthcare professionals in a timely manner.

6.4 NHS Dorset CCG is committed to ensuring that people have the information they need to make sensible choices about their health and wellbeing and that they are enabled to provide feedback if they wish.

Communication escalation processes

6.5 NHS Dorset CCG's communication lead manages routine issues and keeps NHS England Wessex Area Team informed of issues that may be of major significance, reporting incidents that could potentially attract national media attention and taking appropriate advice where help is required regarding media handling.

6.6 The 2014/15Annual Winter Communication Plan will be finalised shortly and will support the delivery of this plan. This year messages will be targeted at specific 'at risk' groups using a range of channels as opposed to generic communications to the whole local population.

6.7 Specific communication action cards have been developed and circulated to communication colleagues (see appendix 4). All partner organisations have an Emergency Care Network Directory with relevant contact details. An emergency directory of all relevant personnel sits alongside the Major Incident Plan. Out of hours media issues will be dealt with by the relevant on-call Senior Manager/Director.

6.8 The Dorset Local Resilience Forum warning and informing group are well placed to prepare information in anticipation of bad weather or pressures on the system. NHS Dorset CCG Communications are part of this group that meets quarterly along with other partners including Dorset Fire and Rescue Services, Dorset Police and Local Authorities.

6.9 Primary care providers are informed of any pressures in the system through an existing internal communication network. All providers are informed of any upsurges in emergency pressures and advised when the pressure has abated. GP practices are encouraged to feedback information about any emerging trend or upsurge in emergencies that will potentially impact on other organisations.

6.10 In the event of a major incident being declared the Dorset Police will, under most circumstances, take control of the incident and will assume responsibility for all communications involving leads from other organisations as necessary.

Communication channels

6.11 Trusted and recognised communication channels will be used to target groups directly. This will be in addition to information on the NHS Dorset CCG web site. The channels that may be used are as follows:

- Health websites;
- Local media;
- Articles in council magazines;
- Church and faith newsletters and magazines;
- Partner newsletters;
- Email bulletins and information;
- Newsletters;
- Posters in GP surgeries, pharmacies and other public places;
- Source Directory web site (http://www.sourcedirectory.org.uk);
- Social media - Dorset CCG Twitter account @DorsetCCG and Facebook www.facebook.com/NHSDorsetCCG
- Face to face communication through events.

6.12 NHS Dorset CCG has good links with the local media and are confident that information can be issued to the public as required. Where appropriate information is given via the twitter account (@DorsetCCG), website (www.dorsetccg.nhs.uk), networks and partner organisations.

6.13 When required NHS Dorset CCG can distribute relevant information to staff via established internal communications systems (intranet, bulletin, CCG update) and externally (twitter, website). The Business continuity plan includes contact details for staff and information cascade requirements.

6.14 Seasonal vaccination promotional activity will begin in early October 2014. Cascading messages to the public and staff regarding vaccination will be co-ordinated to ensure a wide spread group of people are reached. Further information on vaccination plans is provided in Section 6. The following steps will be taken:

- Working with Public Health to promote the benefits of accepting the offer of the influenza vaccination;
- Early circulation of information regarding the seasonal influenza vaccination programme;
- Development / circulation of posters and leaflets;
- Targeted information to groups who would benefit from the vaccination;
- Communication to staff to advise them that the vaccination programmes will begin;
- Information on availability of flu clinics for staff.

7. FLU PREPARDENESS

7.1 The objective of the flu programme is to minimise the health impact of flu through effective monitoring, prevention and treatment, including:

- Actively offering the flu vaccination to 100% of all those in the eligible clinical risk groups, and vaccinating at least 75% of those aged 65 years and over, and healthcare workers with direct patient contact;
- Providing direct protection to children by extending the annual flu immunisation programme over a number of years so that eventually all children aged two to less than 17 years will be offered flu vaccination, and also interrupting the transmission of flu by these children to those unvaccinated children and adults, including those in clinical risk groups for whom flu can be extremely serious;
- Monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS;

- Enabling the prescribing of antiviral medicines to patients in at-risk groups and other eligible patients as set out in Schedule 2 to the National Health Service (General Medical Services Contracts) (Prescription of drugs etc) Regulations 2004), commonly known as the Grey List or Selected List Scheme (SLS). These may only be prescribed once the CMO/CPhO letter has been sent to prescribers informing them that they are now able to prescribe antiviral medicines at NHS expense;

- Providing public health information to prevent and protect against flu;

- Managing and implementing the public health response to incidents and outbreaks of flu;

- Ensuring the NHS is well prepared and has appropriate surge and resilience arrangements in place during the flu season.

7.2 The priority groups eligible for seasonal flu vaccine for 2014/15 are as follows:

- People aged 65 or over;

- Those aged six months to under 65 in clinical risk groups;

- All pregnant women;

- All two, three and four year olds;

- School-aged children in pilot areas;

- Those in long-stay residential care homes;

- Carers;

7.3 There is an expectation that health and social care workers who in direct contact with patients or service users we expect to be offered flu vaccination by their employer, including GP practice staff.

7.4 Flu vaccination should commence in September and run until November.

Flu Reporting

7.5 Public Health England produces a weekly report over the winter period which will include a range of indicators on flu, including:

- The amount of flu-like illness in the community;

- The prevalent strain(s) of flu circulating;

- The proportions of clinical samples that are positive for flu or other specified viruses;
- The number of flu-related hospital admissions;
- The relative impact of flu on different groups of people, by age and by clinical condition;
- Excess mortality monitoring;
- The international situation.

7.6 Monthly data collections start in early November for all GP Practices and from all local areas and continue to early February. Weekly data provide representative estimates of national uptake by GP Patient groups and monthly collections provide national and local level estimates of vaccine uptake by GPs' patients and healthcare workers and with direct patient contact.

Vaccine Supply

7.7 Flu vaccine is procured directly by the provider from the manufacturer. Immunisers must ensure they have ordered from more than one supplier and have adequate supplies for the 2014/15 season, allowing for greater uptake than in previous years.

7.8 Section 5.12 of this plan provides an overview of the communication plan for staff and patient immunisation. 2013 data awaited

Vaccination Rates September to December 2012 (Immform Data)

Table 4: Vaccination rates for frontline Healthcare Workers

YEAR	DORSET PCT	BOURNEMOUTH POOLE PCT	RBCHFT	DCHFT	PHFT
2012	65%	43.1%	46.6%	39.1%	36.5%

Table 5: Vaccination rates for GP Practices

YEAR	PCT	>65	<65 at risk	Pregnant women
2011	Dorset	73.7%	50.4%	51.0%
	Bournemouth & Poole	72.9%	48.9%	44.6%
2012	Dorset	72.4%	48.5%	41.7%
	Bournemouth & Poole	69.8%	46.5%	35.2%

8. SERVICE AREAS

8.1 This section of the Operational Resilience and Capacity Plan focuses on specific service areas, which includes:

- Overview of the key service areas, non-elective and elective care;

- Service specific escalation plans to managed anticipated periods of increased demands, for example critical care.

8.2 Within Dorset there are three acute NHS Trusts;

- Poole Hospital NHS Foundation Trust (PHFT);

- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBHFT);

- Dorset County Hospital NHS Foundation Trust (DCHFT).

PHFT

8.3 The PHFT winter plan will continue to focus on a strong operational management approach that is well established across the organisation. This will ensure that key areas such ED and assessment units and patient pathways remain operational and effective thus minimising length of stay and avoiding unnecessary admissions.

8.4 Continuation of the British Red Cross assisted discharge scheme to support ED and RACE Unit.

8.5 Adapted Trust Command and Control structures internally to better manage capacity within the Trust and to maximise discharge opportunities to partner agencies. The Trust intends to the principals of the “Perfect 3 Day” events as part of our Service Resilience plan, triggered by health system pressures.

8.6 Calibration of beds following capacity review of bed compliment across the organisation:

- Evaluating the “virtual ward” concept and sub-acute pathways as part of the Trust’s Service Resilience Plan (dependant on funding).

- Reviewing Trust plan for a dedicated Winter Ward to open in early autumn 2014 (dependant on funding).

8.7 A number of other actions will be taken:

- Deployment of the following schemes to maintain patient flow have been supported by the Urgent Care Board;

- Expansion of ‘front door’ acuity model – 2 acute physicians, evening DMFE consultant ward rounds, additional nurse practitioners and additional therapy support (dependant on funding)

- Expansion of discharge model – additional discharge staff to support discharge planning;

- 7 day working in Radiology and Pathology;
- Extended working for Social Services into the evening;
- Expansion of the Alcohol and Drug liaison service.

8.8 Over the critical Christmas and New Year period inpatient elective admissions will reduce and will increase incrementally during January.

8.9 In addition over the Christmas/New Year and post New Year few days outpatient clinics will be reduced enabling clinical sessions to be transferred to ward rounds/decision making to support inpatient flow.

8.10 Resilience plans provide for inpatient beds that can be opened flexibly across specialties

8.11 Continued focus on reducing length of stay including the following measures, all of which will also support the winter plan resilience:

- Use of Medical Investigation Unit capacity to reduce length of stay and reduce admissions;
- A LOS transformational project underway to reduce LOS by implementing good practice around bed management, discharge processes, capacity and demand studies and strengthening with external partner;.
- Monthly readmission audits undertaken by specialty teams;
- Continuation of the Stroke Early Support Discharge service;
- 7 day working in Pharmacy, therapies and consultant assessment;
- Additional older peoples nurse practitioners to review patients in ED and Trauma specialties to aid discharge where possible, 7 days a week;
- Improved discharge facility to support reduction in length of stay across all specialties;
- Access to social workers at weekends on medical assessment units and ED, covering all 3 local authorities;
- Continuation of addictions pathway, led by addictions nurse.

RBHFT

8.12 The Trust's Winter Plan sets out a range of actions and initiatives being put in place to ensure that essential services are maintained including safe management of emergency admissions, the delivery of elective workload and achievement of all performance targets over the winter period.

8.13 The Trust has been building on the lessons learnt each year to ensure that the Winter Plan is progressive and current. Experience demonstrates that emergency activity increases, patients are sicker with more complex needs and the health economy as a whole is not always able to respond to the demands made upon it during this period.

8.14 There is significant evidence to date this year that shows emergency admissions are growing and creating capacity concerns prior to the official winter period starting.

8.15 Proposed initiatives include:

- To deliver a robust minors pathway within 90 – 120 minutes;
- To provide alternatives to admission where possible by effective integration with wider health system;
- To increase see and treat in minors and establishing nurse led rapid access and treatment in majors;
- To deliver EDQI, internal time and the four hour standards;
- To undertake board round on at least a 4 hourly basis to increase the focus on individual patient timelines;
- To ensure all resuscitation cases are led by a senior ED clinician;
- To frontload clinical expertise at the front door and proide more comprehensive ambulatory emergency care;
- To identify frail elderly patients and put in place pro-active comprehensive geriatric assessment and assertive case management at the earliest opportunity;
- To ensure all frail older people are reviewed by a geriatrician within 12-24 hours of referral;
- To ensure a relentless focus on discharge from day one - discharge to assess with wider effective engagement with the wider health care system to secure a timely response for the on-going needs of the patient.

DCHFT

8.16 The Trust formally reviews its surge and escalation procedures twice each year and now has a Patient Flow and Bed Management Policy which clearly sets out steps to be taken at times of higher than planned demand, regardless of the time of year. A number of specific actions have been taken to prepare for winter, namely:

- The Trust currently has inpatient 307 beds, excluding Maternity. Modelling has been undertaken to identify periods of high demand and capacity required to inform the winter plan. The winter resilience planning includes the reconfiguration of medical wards to allow wards to flex in the winter to provide additional inpatient beds depending on demand. Additional staff have been employed by the Trust to allow this flexibility within the permanent wards.

- The Trust's Patient Flow and Bed Management Policy has been amended. The overriding principle of the policy is that all patients presenting as emergencies should be assumed to ambulatory until proven otherwise. The emergency medical unit (EMU) also hosts the acute Hospital at Home team/service which promotes early discharge and support and keeps patients in their own homes within the Dorchester and Weymouth areas.

- Physician and Surgeon of the day models are in place. Consultants in these roles are free of the majority of elective commitments to enable them to focus on the safe management of emergency pathways. A seven day service of on-site consultant care for acute medical patients is now in place.

- Ambulatory Care pathways have been increased to support admission avoidance.

- Surgical emergency assessment facility has been incorporated into the Short Stay surgical Ward. This will enable rapid assessment and diagnosis of patients presenting as surgical emergencies and reduce the time to theatre and overall length of stay.

- Decrease in inpatient elective activity over Christmas and New Year periods with an increase in day surgery during this time.

Elective Care

8.17 Maintenance of required standards: the CCG has an excellent record of delivery of RTT standards and is planning to maintain this throughout 2014-15. All providers have been maintaining the aggregate admitted and non-admitted RTT position and meeting the required standards for non-admitted RTT. The CCG has weekly PTL information available allowing for early warning of increasing backlogs or speciality level pressures. The pressure areas at speciality level can be grouped into those with referral pressures, those with capacity issues in trusts and those with small numbers of clock stops per month. Each of these issues varies between providers and specialities however common themes so far in 14-15 are around

Dermatology, ophthalmology and orthopaedics referral increases combined with capacity issues in Dorset County. The CCG will use established working relationships and contractual mechanisms if required to, maintain RTT standards over 2014-15.

8.18 Improving RTT backlog position before winter: each local provider has submitted bids to clear backlog RTT patients before winter. This will greatly ease the pressures in the healthcare system prior to any impact of urgent care over the latter half of 2014-15 on the system capacity. Each provider is already starting to treat additional patients who have breached the RTT standards and these plans should be complete by October 2014. More detailed work on capacity and referral analysis is ongoing along with GP incentive schemes to control referral growth.

8.19 Assurance on keeping elective on track under winter pressures: the operational resilience planning process is working on the assumption that elective capacity will be maintained in providers throughout the latter half of 2014-15. All local providers are aware of the requirement to maintain the RTT standards and avoid breaches of waiting times commitments. Contract review meetings have a standing item for performance against these targets and the operational processes are discussed at weekly telephone calls with the providers. There is an escalation plan in place should providers start to indicate that they may breach a waiting time standard so that there can be escalation of action to address issues at an early stage. The CCG has access to private sector providers that can provide additional capacity and can raise awareness with GP's should there be referral or capacity issues in local providers.

Same Sex Accommodation

8.20 Compliance with same sex accommodation is a key priority for NHS Dorset CCG, particularly in light of the bed pressures which may be faced during times of escalation.

8.21 NHS Dorset CCG undertake regular visits to provider organisations to monitor compliance, and utilise the contract meetings as a mechanism by which to address any non-compliance issues and seek assurance as to how compliance will be achieved during times of over the winter months.

Paediatrics

8.22 There is a Policy for Paediatric Management in a Pandemic, which includes three levels of escalation. The policy outlines the actions which would be taken for each identified level of escalation.

8.23 The key principles across the three acute trusts include:

- PHFT would facilitate the expansion of the Paediatric ward/HDU and ICU facilities of demand increases;
- DCH would open 7 additional paediatric beds;

- Trusts would contact one another if further support is required after all additional beds have been opened;

- PHFT provides critical care in partnership with Southampton University Hospital based on a hub and spoke model; there are clear plans regarding the transfer of paediatrics between the two hospitals;

- RBHFT would take adult emergency admissions in order to enable PHFT to accommodate more paediatric patients in adult beds;

- There is agreement between PHFT and RBHFT that all paediatric patients, including those requiring critical care should be accommodated within PHFT rather than across two hospital sites where possible; this will be reliant on the ability to transfer patients to RBHFT.

Critical Care

8.24 All three Acute Trusts provide critical care capacity for the health economy.

8.25 The Acute Trusts currently have critical care capacity of:

Table 6: Critical Care Capacity

NHS Trust	Critical Care Beds
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	12 ITU Beds 10 Coronary Care Beds
Poole Hospital NHS Foundation Trust	11 Critical Care Beds (x5 L3 and x6 L2) 8 CCU beds; 4 HDU paediatric beds 4 neonatal ITU beds 4 neonatal HDU beds (will increase to 10 beds in June 2014 following refurbishment). The ITU and HDU beds are interchangeable during the refurbishment.
Dorset County Hospitals NHS Foundation Trust	4 ITU Beds 4 HDU Beds 6 Coronary Care Beds

8.26 In extreme circumstances, such as a pandemic, acute trusts can escalate as follows:

- PHFT - can escalate from 12 to 30 (Level 2 and level 3), a 136% increase, although some services would have to be suspended in order to facilitate this;

- RBHFT – adult critical care can be trebled;

- DCHFT – 6 level 3 beds and 4 level 2 beds which are used flexibly;

- Paediatric care capacity can be increased by 100% with escalation measures in place between the acute trusts;

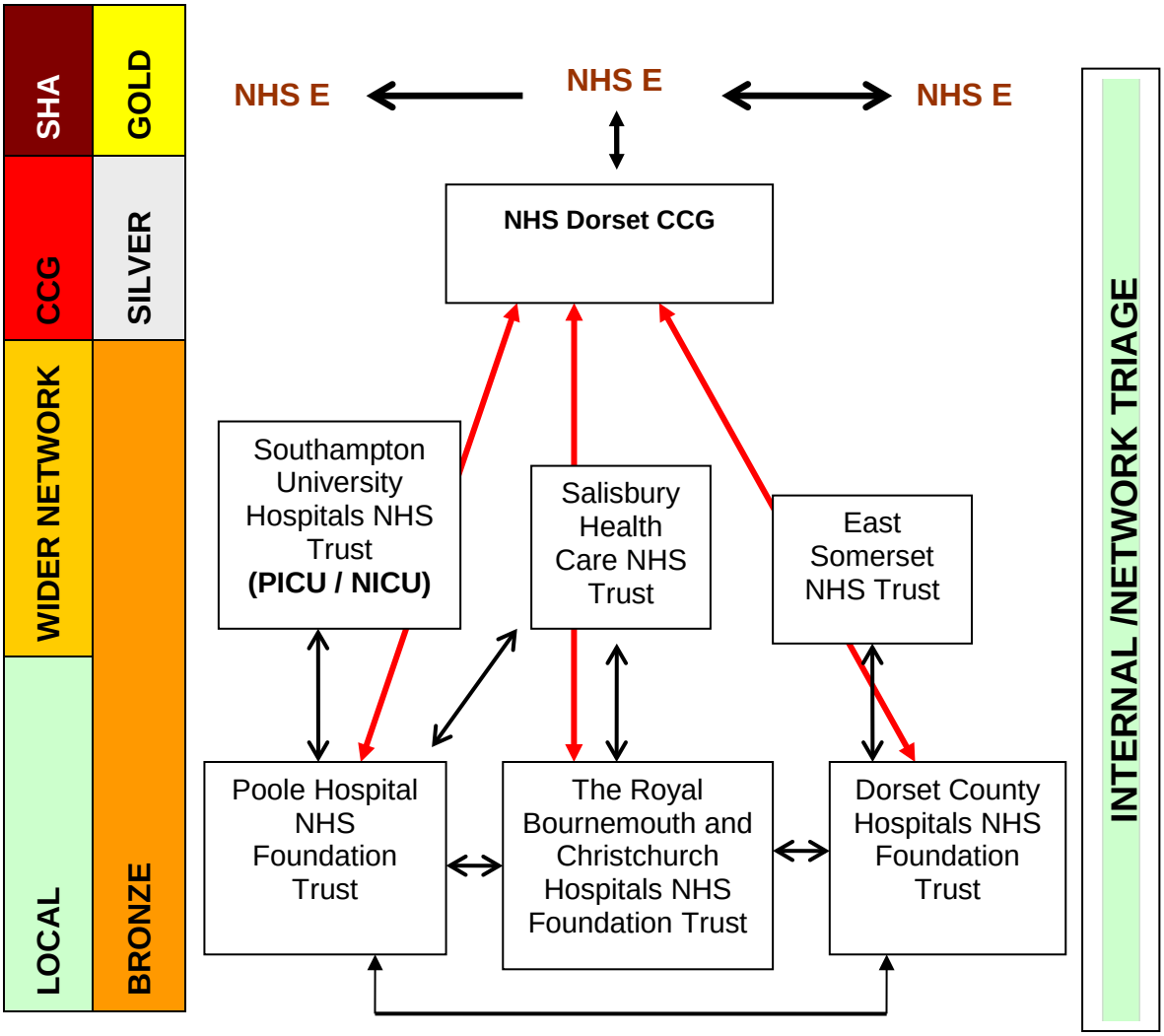
- There is no capacity to increase current neonatal critical care beds.

8.27 The established local critical care transfer network is shown in table 7. Should patients need to be transferred outside of the critical care network then the decision to consider mutual aid will be made; figure 1defines the escalation process.

Table 7: Critical Care Transfer Network

NHS Trust	**NHS Trust in agreed Critical Care Transfer Network**
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Poole Hospital NHS Foundation Trust Dorset County Hospitals NHS Foundation Trusts Salisbury Health Care NHS Trust
Poole Hospital NHS Foundation Trust	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Dorset County Hospitals NHS Foundation Trusts Salisbury Health Care NHS Trust Southampton University Hospital – PICU/NICU
Dorset County Hospitals NHS Foundation Trusts	Poole Hospital NHS Foundation Trust The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust East Somerset NHS Trust

Figure 1: Critical Care Escalation



8.28 Any transfers between critical care units will be actioned in line with SWAST's Standard Operating procedures for Transfers.

8.29 As highlighted earlier in the plan Poole Hospital provides paediatric critical care in partnership with Southampton University Hospital based on a hub and spoke model and there are clear plans in place regarding the transfer of paediatric patients between the two hospitals.

8.30 It is noted by all trusts involved that if the pandemic influenza takes hold it is unlikely within the critical care networks that any organisation will be able to provide much in the way of additional capacity for their partners.

Primary Care, 111 and Urgent Care Services

Confirmation that primary care details are correct awaited; need to add additional hours

8.31 The Wessex area team, part of NHS England is currently responsible for the commissioning of primary care services in Dorset.

8.32 Primary Care Services play a large part in keeping patients out of hospital and away from the Emergency Departments allowing these services to be used more appropriately and potentially creating more available capacity in times of greater need.

General Practice

8.33 General Practice plays a key role in keeping people out of hospital and for many is the first point of contact when they become ill. Therefore activity is often escalated during the winter period.

8.34 Currently within Dorset are 100 General Practices all providing core, additional and enhanced medical services to the local population. In addition to their contracted hours, all practices except one in Dorset are also offering extended opening hours as part of enhanced services agreements.

8.35 As part of the services outlined above, all practices offer their registered patients routine and urgent care. Unregistered patients are also able to register as a 'temporary resident' should they need medical care, and anyone in the practice area can seek immediate necessary treatment from any GP practice.

8.36 Late September, early October also sees a significant number of students arriving in the Bournemouth and Poole area to begin University and college courses and these people also tend to register with a local GP at this time.

8.37 The development of the Primary Care Pandemic Flu Escalation Strategy has provided the Primary Care Trust with the tools to support frontline general practice services during the peak period of an influenza pandemic.

The strategy is based on five levels of escalation as follows:

- Level 1 normal activity;
- Level 2 increased activity due to vaccination programme;
- Level 3 suspension of non-core activities;
- Level 4 managed suspension of clinical services;
- Level 5 full suspension of services; and
- De-escalation appropriately between levels as needed.

Pharmacy

8.38 Community Pharmacies have a key role in providing the public with a range of services, including:

- Essential service delivery (dispensing and medicines supply);
- Self-care advice and treatments for a variety of conditions;
- Maintaining care of people with long term conditions/vulnerable elderly;
- Co-ordinating logistics in medicines supplies;
- Services where pharmacists may be utilised such as patient screening and education of the public with approved messages and materials.

8.39 They have the ability to provide a range of locally commissioned and enhanced services (in some cases directing pressure away from general practice and increasing access and choice).

8.40 Geographically accessible to local communities with long opening hours, community pharmacies provide an accessible, trusted and high quality service in the community.

8.41 Community pharmacies were successfully used as antiviral collection points (ACPs) during the 2009 flu pandemic. It is not clear that this model of supply would be used in the future as it is dependent on national systems. However the process and systems could be repeated if appropriate.

8.42 There are 15 100 hours pharmacies across Dorset.

Medicines Management Team

8.43 The Medicines Management Team in NHS Dorset CCG has a key role in providing specialist advice to GP Practice staff who are in face to face prescribing roles with the public. This would include keeping abreast of changing national guidance and emergency legislation including potential distribution systems for antivirals and advice for GP Practices on switching medications if stocks are running low.

NHS 111

8.44 NHS 111 in Dorset is provided by South Western Ambulance Service NHS Foundation Trust (SWASFT) and the full public launch took place on the 19 March 2013.

8.45 SWASFT also provide all urgent care services providing an integrated service hub in Dorset.

8.46 Performance so far this year has been challenging in meeting the call answering KPI of all calls answered in 60 seconds, continued work around resourcing and profiling the service based on the demand profile for the last 15 months is on-going with a performance trajectory in place to ensure the target will be met.

8.47 NHS Dorset CCG alongside the three other counties, Devon, Somerset and Cornwall who also commission 111 services from SWAST have commissioned a review into the current 111 service. The objectives of the review are as follows:

- To review the operational delivery of the 111 service for Dorset, Devon, Cornwall and Somerset, whilst ensuring patient safety and a high quality experience for patients seeking access to the 111 service is maintained;

- To consider the impact of the differential positions in each ccg contract arrangements and whether this has any impact on the operational delivery of targets;

- Look for opportunities to more closely align to deliver better performance for all commissioners;

- To provide an update on the current status of the implementation of the process evolution report recommendations;

- Identify any gaps and areas for development within the service and produce an improvement plan in order to implement across both hubs.

- To confirm what diagnostic analysis has been undertaken, the outcome indicated and the impact on an improvement plan.

8.48 NHS 111 routinely prepares for peak-pressure periods as part of an ongoing, rolling programme of forecasting and capacity planning. This may include seasonal or event specific elements where appropriate. However, prior to key public holidays such as Christmas Day and Boxing Day, there is always an intensified period of preparation which is integral to their usual forecasting and capacity planning.

8.49 A planning assumption has been made that there will be a 10% increase in call volume for winter escalating to 35% over the Christmas and New Year period based on last year's call profile and call volumes. In order to effectively manage this surge in demand the service will be increasing staff rostering and minimising leave over this period.

8.50 Christmas 2014 has been identified as a four day holiday, this will be profiled in a similar way to Easter 2014 for all services including 111 with the required uplift in resourcing and in particular to the demand assumptions detailed above.

8.51 NHS 111 have tried and tested arrangements for prioritising demand for their service, optimising call centre capacity and ensuring clinical pathways dovetail with those of both regional and local NHS partners.

8.52 NHS 111will continue to work alongside the 999 dispatchers to ensure agreed transfer of appropriate Category C calls.

8.53 NHS 111 is alerted via the Directory of Services (Dos) of any capacity issues.

Out-of-Hours (OOH)

8.54 The South Western Ambulance Service NHS Foundation Trust SWASFT is commissioned to deliver the Out of Hours Urgent Care Service for Dorset (UCS).

8.55 UCS provide three different service disciplines across four different counties and these are set out as follows;

8.56 Urgent Care Service (Out of Hours GP service OOH) – Covers Dorset, Somerset & Gloucestershire patients;

8.57 NHS 111 service – Covers Dorset, Devon, Cornwall & Somerset patients;

8.58 Single Point Of Access (SPoA) – Covers Dorset Patients and Dorset & Somerset Paramedic alerts.

8.59 UCS has three core service disciplines, one that only operates in the Out Of Hours (OOH) period, the OOH period is defined as 18:00 to 08:00 Monday to Thursday and 18:00 Friday through to 08:00 Monday and is inclusive of Bank Holiday periods, the NHS 111 services and SPoA services operate on a 24/7 basis 365 days of the year.

8.60 The plan for out of hours specifically focuses on the winter period, although the steps outlined in the plan could be adopted at any time if the appropriate resource was available.

Table 8: Requirements detailed for each service discipline:

Service Discipline	Location of Change	Winter Plan actions
NHS 111 – Services	East & West Clinical Hubs	• Increased Call Advisor capacity to meet predicted winter pressure demands particularly during weekend and bank holiday periods • Increased Clinicians capacity to meet predicted winter pressure demands particularly during

		weekend and bank holiday periods
Out of Hours – Dorset, Somerset & Gloucestershire	**Out of Hours - Dorset** • St Leonards • Bournemouth Treatment Centre • Poole Treatment Centre • Swanage Treatment Centre (Seasonal) • Weymouth Treatment Centre • Dorchester Treatment Centre • Shaftesbury Treatment Centre • Blandford Treatment Centre **Out of Hours (OOH) – Somerset** • Bridgwater Treatment Centre • Burnham on Sea Treatment Centre • Minehead Treatment Centre • Taunton Treatment Centre • SheptonMallet Treatment Centre • Yeovil Treatment Centre **Out of Hours (OOH) – Gloucestershire** • Quedgeley (GTEC)	**Out of Hours – Dorset** • Increase clinical capacity at treatment centers where site capacity allows. • Increased central triage capacity • Additional mobile units operating from St Leonards • Use of agency clinicians • Use of ECPs **Out of Hours - Somerset** • Increase clinical capacity at treatment centers where site capacity allows. • Increased central triage capacity • Additional mobile units operating from St Leonards • Use of agency clinicians • Use of ECPs **Out of Hours – Gloucestershire** • Increased triage capacity • Increased mobile capacity

SPoA – Dorset	East Clinical Hub	• Increased Call Advisor capacity to meet predicted winter pressure demands particularly during weekend and bank holiday periods • Increased Clinicians capacity to meet predicted winter pressure demands particularly during weekend and bank holiday periods • Ability for remote working by clinicians who are unable to attend site due to weather • Close links with providers to implement direct referrals should service capacity be an issue

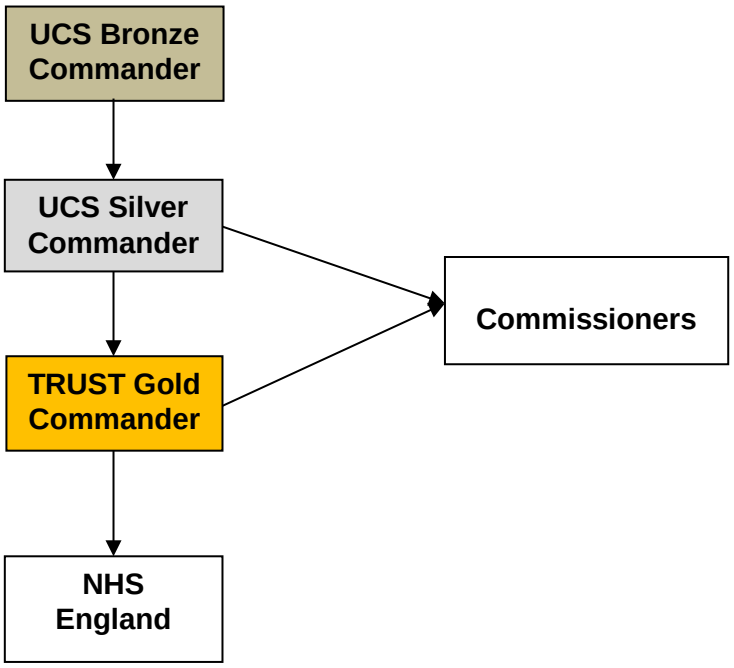
8.53 The above requirements are dependent on the financial structure for each service discipline, the UCS Business lead is responsible for ensuring that the above requirements are funded and agreed by the Trust Board (SWAST) to support the implementation of this plan

Escalation Requirements

8.54 During normal working hours defined as 08:00 – 18:00 it is the responsibility of service leads to escalate through their chain of command and direct with commissioners any issues that are affecting service delivery such as demand and resources through regular meetings and or teleconferences.

8.55 During the Out of Hours periods defined as 18:00-08:00 the UCS operates a two tier on call service in line with South Western Ambulance Trust command structure and as part of our requirements under the Civil Contingencies Act 2004 and the Department of Health Emergency Planning Guidance 2005.

8.56 The escalation process during the out of hours period is outlined below;



REAP – Resource Escalation Action Plan

8.57 Six levels of escalation have been developed and agreed by the National Director of Operations Group (NDOG). Trigger points have been agreed which identify, as demand levels increase, the actions needed to protect each trust's core services and supply the highest level of service within the resources available.

8.58 Director of Operations Group (NDOG). Trigger points have been agreed which identify, as demand levels increase, the actions needed to

protect each trust's core services and supply the highest level of service within the resources available.

8.59 REAP forms part of the forward planning process within each trust to forecast performance and service delivery for the forthcoming week by assessing the likely impact of specific key influencing factors. Each trusts then determines the appropriate REAP level for that coming week on the basis of this forecast.

8.60 South Western Ambulance Service Foundation Trust (SWAST) uses a comprehensive report detailing activity both forecast and actual against performance. A meeting takes place on a weekly basis with the reports being considered on a Monday morning. These reports are taken to the Duty Director who confirms the REAP level for the coming week. Where there is a change in the REAP level then a Gold meeting maybe called to set the new level. REAP is also a standing agenda item on the Corporate Performance Review meeting which is chaired by Deputy Chief Executive once a month

8.61 Notification of a change in REAP levels are communicated as soon as they occur. This includes:

- e mailing all managers via the Duty managers report contact group
- e mailing the Department of Health
- advising Trust communications department for inclusion in the weekly
- Bulletin
- advising the Trust information cell to inform the ambulance leadership
- forum website (ALF)
- change the REAP signs in Trust Headquarters

8.62 Having assessed the various factors that influence demand and the predicted likely performance, the appropriate REAP level is selected. The Trust then adopts measures which, if implemented effectively, will protect and maintain performance at national target levels.

8.63 The key components used by ambulance trusts to deliver the required performance are the ability to match service supply to demand and ensure maximum efficiency of the service through effective processes and procedures, particularly within the Clinical Hubs.

8.64 The six levels of REAP are set out in the table below:

Figure 2: SWASFT REAP LEVELS

REAP Level 6	Potential Service Failure
REAP Level 5	Critical
REAP Level 4	Severe Pressure
REAP Level 3	Moderate Pressure
REAP Level 2	Concern
REAP Level 1	Normal Service

8.65 The Urgent Care Service REAP escalation plan is detailed below:

Table 9: Urgent Care Service REAP Escalation Plan

Urgent Care Service		
REAP Level 6 - POTENTIAL SERVICE FAILURE	111	Seek assistance from partner organisations to take over Service and transfer calls to them (National Contingency arrangements)
	OOH	Seek assistance from CCGs in providing primary care support from in hours Doctors
	SPoA	Implement fallback to providers to undertake direct referrals
REAP Level 5 - CRITICAL	111	Collapse more administrative tasks and re-deploy staff to operational duties Seek further assistance from commissioners , other public services and local employers to provide additional non-clinical resources Re-deploy operational/clinical officers to 111 on out of hours shifts
	OOH	Seek further assistance from commissioners and LMCs to increase clinical resources available Collapse more administrative tasks and re-deploy staff to operational duties Seek further assistance from commissioners , other public services and local employers to provide additional non-clinical resources Re-deploy operational/clinical officers to UCS on out of hours shifts

		Seek agreement with commissioners to cease treating a wider range of non-urgent conditions See further agreement with other providers for assistance - e.g. refer cases direct to other OOH services
	SPoA	Seek further assistance from commissioners to increase clinical resources available Collapse more administrative tasks and re-deploy staff to operational duties Seek further assistance from commissioners , other public services and local employers to provide additional non-clinical resources Re-deploy operational/clinical officers to SPoA on out of hours shifts Seek agreement with commissioners to cease referring a wider range of non-urgent conditions See further agreement with other providers for assistance - e.g. direct case referrals
REAP Level 4 - SEVERE PRESSURE	111	Seek assistance from commissioners and to increase clinical resources available Collapse some low priority administrative tasks and re-deploy staff to operational duties Cease non-vital training and re-deploy staff on operational duties Ask staff on annual leave to defer leave and work as directed Remove ECPs from training and operational standby work and re-deploy full-time to 111 on out of hours shifts Cancel all meetings
	OOH	Seek assistance from commissioners and LMCs to increase clinical resources available Collapse some low priority administrative tasks and re-deploy staff to operational duties Cease non-vital training and re-deploy staff on operational duties Ask staff on annual leave to defer leave and work as directed Seek assistance from commissioners and other public services to provide additional non-clinical resources Remove ECPs from training and operational standby work and re-deploy full-time to UCS on out of hours shifts Seek agreement with commissioners to cease

		treating some non-urgent conditions Cancel all meetings
	SPoA	Seek assistance from commissioners to increase clinical resources available Collapse some low priority administrative tasks and re-deploy staff to operational duties Cease non-vital training and re-deploy staff on operational duties Ask staff on annual leave to defer leave and work as directed Seek assistance from commissioners and other public services to provide additional non-clinical resources Remove ECPs from training and operational standby work and re-deploy full-time to SPoA on out of hours shifts Cancel all meetings Communication with community team highlighting service issues and possibility of direct referrals
REAP Level 3 - MODERATE PRESSURE	111	Install further additional call taker shifts using bank/overtime as demand forecast requires Install further additional clinical shifts using nurses or ECP staff as demand forecast requires Cancel all non-essential meetings
	OOH	Install further additional clinical shifts using sessional GPs, nurses or agency staff as demand forecast requires Install further additional car(s) and drivers with agency mobile GPs as demand forecast requires Cancel all non-essential meetings
	SPoA	Install further additional call taker shifts using bank/overtime/agency as demand forecast requires Install further additional clinical shifts using nurses or ECP staff as demand forecast requires Cancel all non-essential meetings
REAP Level 2 - CONCERN	111	Install additional call taker shifts using bank/overtime as demand forecast requires Install additional clinical shifts using nurses as demand forecast requires
	OOH	Install additional clinical shifts using sessional GPs or nurses as demand forecast requires Install additional car(s) and drivers with mobile GPs as demand forecast requires

	SPoA	Install additional call taker shifts using bank/overtime/agency as demand forecast requires Install additional clinical shifts using nurses as demand forecast requires
REAP Level 1 – ROUTINE	111	Normal Service
	OOH	
	SPoA	
	OOH	
	SPoA	

Community Services

Dorset Healthcare University NHS Foundation Trust

8.66 Dorset Healthcare University NHS Foundation Trust is the provider of community health services and mental health services across the county of Dorset.

8.67 Admission avoidance is vital during the winter to ensure business continuity of Acute Trusts and also to ensure capacity for patients who urgently need secondary care input. Currently there are a number of rapid response teams including:

Dorset Locality Intermediate Care Teams

8.68 This service provides a locality integrated health and social care multi-professional Intermediate Care Service to home service for all adults over the age of 18 who are registered with a Bournemouth and Poole or Dorset GP, which will undertake acute assessment and diagnosis, crisis and rapid support, intensive rehabilitation / re-ablement and treatments for adults and older people. These services are available 7 days per week from 0800-2200 (0800-2000 for new referrals).

8.69 The provision of enhanced integrated services delivered in partnership with the Boroughs of Poole, Bournemouth and Dorset Councils means that unnecessary hospital admissions are prevented and effective rehabilitation services can be provided to enable early discharge from hospital and reduce the need for premature or unnecessary admission to long term residential care.

8.70 Intermediate Care can be provided in a person's own home, residential and residential with nursing home, and in a "step up/step down" inpatient community beds which are currently on Dorset Healthcare's 11 Community Hospitals

Long Term Conditions Teams

8.71 These services will identify people with long term conditions and provides them with access to a range of services which are personalised to meet their needs. They are supported by services which promote self-management, health and well-being, independence, reduce the exacerbation of their long term condition, and prevent unnecessary use of hospital or specialist services, and supporting timely effective transfer from hospitals to community services.

8.72 People who have complex long terms conditions, and are very high intensity users of hospital and specialist services, will be supported by this service through a process of systematic case finding using agreed case finding tools and a process of case management by Community Matrons and other professionals within the team.

8.73 Dorset has strengthened capacity in its intermediate care teams for physical and mental health services. Many teams are integrated and have health and social care teams providing services as part of the Connecting Health and Social care implementation programme. These services are available 7 days a week from 0800-2000.

8.74 Dorset has enhanced community nursing services to provide evening and night cover. The Night Nursing Service covers the whole Dorset area from 2000 to 0800.

8.75 Community Matrons are in post across provider services, providing care for patients with long term conditions and managing more care out of hospital for this group of patients.

8.76 Dorset has arrangements in place for community hospital staff to sleep over if they cannot travel home due to bad weather.

8.77 Where bad weather conditions are anticipated staff plan and deliver whatever support is possible for patients prior to the weather arriving, including telephone support and earlier and more frequent routine visits. In addition, where patients circumstances necessitate home visits then staff living in close proximity are allocated to those patients.

Community Hospitals

8.78 There are 11 community hospitals across the Dorset Healthcare geographical area.

Table 10: Community Hospital Beds

Community Hospital		Number of Beds
Alderney Hospital, Jersey and Guernsey wards		48
Blandford Community Hospital	Tarrant Ward	24
Bridport Community Hospital	Langdon Ward	22
	Ryeberry Ward	22
Portland Community Hospital – Castletown Ward		16
St Leonards Hospital	Fayrewood Ward	22
Swanage Hospital – Stanley Purser Ward		15
Victoria Community Hospital, Wimborne	Hanham	22
Wareham Hospital		16
Westhaven Community Hospital – Radipole Ward, Weymouth		34
Westminster Memorial Hospital, Shaftesbury		20
Yeatman Hospital, Sherborne		34

8.79 Occupancy of the community hospitals has increased and the length of stay decreased over recent years, enabling them to be a real asset in planning intermediate care.

8.80 There are weekly teleconferences to discuss delayed transfers of care across the health community including within Community Hospitals.

Older People's Mental Health Services (OPMHS) - Dementia

8.81 To work more effectively with the beds that the OPMHS have at Alderney hospital, the service is working towards identified Social Workers have being nominated in each local authority to facilitate discharge of patients. In both units east and west (Alderney and Chalbury), there is daily monitoring to oversee the bed occupancy in the service and work with the wards and social services on discharges. Currently the Bettywood Unit at Blandford Hospital is closed due to low numbers of qualified nursing staff. The date of reopening has not been set.

8.82 All Older Peoples Mental Health beds for the Bournemouth, Poole and east of Dorset areas have moved to the restructured Alderney site. The total number of beds has reduced to 48 - two ITU wards and two assessment and treatment. Increased community service provision, seven days a week for older people's mental health has occurred with the development of the

Intermediate Care Dementia Service for this geographical area. These developments are in line with the national dementia strategy.

8.83 In the event of the beds being full Dorset HealthCare NHS Foundation Trust, may have to work with neighbouring providers to access mental health beds.

8.84 The Intermediate Care Dementia Service (ICDS) is operational since April 2013, the role of this team is to provide intensive assessment and support for people in the community / in their place of residence with a primary diagnosis of dementia for patients in the Bournemouth, Poole and east of Dorset areas. The team will provide a similar function to the existing Crisis and Home Treatment Team covering the Bournemouth, Poole and east of Dorset (East) area; the difference being this team will specialise in assessing and supporting people with dementia; the service will run seven days a week 8am - 8pm. The pathway into the ICDS will be through the Community Mental Health Team, or the Crisis and Home Treatment Team (East) outside the operational hours of the CMHT. The ICDS will act as a bed management service; all admissions to dementia inpatient beds in this area will be arranged via this team. When waiting for package of care to be put in place / reviewed, ICDS staff will assess whether the patient requires intermediate care and if so contact relevant care providers to spot purchase social care.

8.85 The Crisis Home Treatment Team (East) will refer to the ICDS service when the CMHT are closed.

8.86 The In reach team into Care homes covering the Bournemouth, Poole and east of Dorset area work to keep residents in care homes who have dementia.

Mental Health Services Adult and Older People (Functional – not dementia)

8.87 Demand for care in mental health services does not tend to peak in the same way as other services over the winter months. Crisis resolution and home treatment teams are accessible to individuals aged 18 years and over all year round with the specific purpose of preventing avoidable mental health admissions.

8.88 A telephone helpline for known mental health patients is also operated by the Crisis resolution and home treatment team.

8.89 Mental Health liaison teams work within the acute general sector to support local acute hospitals in their management of mental health presentations and prevention of delayed discharges due to mental health need.

8.90 Early Intervention in Psychosis teams work pro-actively with individuals aged between 14 and 35 years who are experiencing their first episode of psychosis with the aim of preventing the need for hospital admission.

8.91 Normal emergency admission procedures will continue over holiday periods and Consultant Psychiatrists are on call and available to mental health staff.

Learning disabilities

8.92 A number of initiatives are in place to support patients who have a learning disability accessibility to healthcare services, including the following;

- Integrated health and social care Community Learning Disability Teams (CLDT's) work with individuals and monitor packages of care closely to ensure service users' needs are being met adequately. They work proactively with individuals to reduce the risk of crisis and subsequent unscheduled hospital admissions. Links between the CLDT's and local acute hospitals continue to develop to ensure servicer users' needs are communicated effectively and that support is available to develop and facilitate appropriate discharge plans.

- The CLDT's are supported by a pan Dorset Intensive Support Team (IST) who works with individuals once additional risks or support needs are identified. The IST has a specific remit of working intensively with individuals to prevent placement breakdown and avoidable admissions to hospital.

- Each of the local three acute hospital trusts have now developed initial flagging systems to ensure individuals with LD are identified at the point of admission and that appropriate management plans are implemented in conjunction with the relevant support service

- Across the Dorset, 'My Care Passport' is used by individuals with a learning disability as a means of conveying significant information to hospital staff in the event of an admission. Yellow Health Books are also used as a hand held patient record that outline specific health and social care needs and a management plan that health staff can use to support the individual.

Vulnerable Groups

8.93 Health and social care have identified within their caseloads vulnerable individuals who may require additional support at specific time's i.e. severe weather. Vulnerable groups include those with a suppressed immunity

system; long-term condition and those who live on their own and are unable to get out.

8.94 People who are homeless or in temporary accommodation have also been included within the planning process and arrangements to ensure they have access to the flu vaccine has been commissioned as appropriate within primary and community settings. Dorset Healthcare will provide the flu vaccine for vulnerable or house bound patients.

Home Oxygen Service

8.95 The home oxygen service is provided by Air Liquide; the service has a contingency plan in place, which outlines the Indicative order of priority for homecare operational activity in an emergency or critical situation where resources become overstretched due to unforeseen events or an abnormal demand epidemic or pandemic situation.

Social Care Services

8.96 Dorset is covered by three Local Authorities Social Care teams (Dorset, Bournemouth and Poole) and each has a vital role to play in seasonal planning and in the preparation for pandemic flu.

8.97 At times of pressure on beds within the acute hospitals, the Social Work teams, in acute settings, will do the following:

- Regularly consult with hospital discharge staff regarding bed state.
- Identify with the discharge liaison staff those patients who require social work input and are nearing discharge or those whose discharges could potentially be brought forward.
- The Hospital Social Work Team Manager and staff will prioritise the above cases with allocated workloads and, if necessary, put current less urgent work on hold whilst the priorities are dealt with.
- Hospital cases which are care managed by a social worker in a community team will similarly be prioritised when required.
- Managers with staff on more than one site will consider staff moving between sites to areas of greatest pressure.
- The Brokerage service will be alerted to bed state and request higher priority to identifying placements and packages of care for hospital discharge.
- Intermediate care services and reablement will be approached regarding any availability and any additional capacity.
- All staff will review those service users who are ready for discharge and awaiting placements or large packages of care, and decide if needs could

be met by interim/short term placements to be followed up by community teams or dedicated interim bed social workers . This will be in accordance with the operational protocol for the use of interim beds;

- All staff will focus on quickly achievable discharges;

- The Locality Manager / Team Leaders / Social Care Discharge Manager will notify appropriate service managers of bed state and any actions that they may propose to implement to assist safe and timely discharges.

- The Locality Manager / Team Leaders / Social Care Discharge Manager will notify Local Offices of implications for discharges and seek potential assistance from local teams.

- The Managers will document cases identified and maintain a log of cases prioritised so that information can be obtained quickly and efficiently.

- Administration staff will filter telephone calls and take messages. Team members will check for messages on hourly basis (minimum).

- At times of pressure within the Social Work team the locality Manager / Team Leader / Social Care Discharge Manager will ensure that the relevant hospital management and staff in acute hospital bases are aware of the pressure and cause - for example, unforeseen high level of sickness, planned essential training, risk caused by IT problems, high level of Safeguarding Adults referrals. The relevant team will also ensure CMS is updated to reflect their position.

- Relevant staff will include discharge team and leaving hospital support staff as appropriate.

- Brokerage will maintain information on available independent sector provision if required.

- Contingency plans are in place should a private sector home become unavailable at short notice to provide on-going care for residents.

- Poole, Dorset & Bournemouth LA's have designated teams of Social Care Staff Monday-Friday to support admission avoidance and support hospital discharge. There is also a Social Worker based on a Saturday and Sunday as follows:

    - 1x SW Saturday & Sunday 1000-1530 based within RACE at PHT
    - 1x SW Saturday & Sunday 1000-1530 based within OPAL at RBH

8.98 A key principle to be achieved is the recognition that communication should initially take place at an operational level and escalated to higher levels only if no response / actions are taken forward.

Ambulance Service

8.99 This section of the document has been produced to ensure robust planning and preparations are in place, which will ensure that South Western Ambulance Service NHS Foundation Trust (SWAST) is able to meet its performance targets and maintain an effective and safe service over the winter period.

8.100 Work is currently underway to agree with SWAST how the ambulance service funding will be allocated, Dorset CCG have agreed to fund two key schemes which are currently underway:

- Roll out of the nurse practitioner model currently operating in Poole Hospital in Royal Bournemouth and Dorset County – in Poole Hospital this service manages an average of 25% of minors activity when operating;

- An additional two Emergency Care Practitioners in Rapid Response Vehicles are made available in areas of high demand (East Dorset) between 08:00-18:00 hours daily**,** this service is accessed via the Single point of Access service (East Dorset).

8.101 An essential element of the planning arrangements is agreed through local arrangements with NHS and Social Care partners to ensure patients are referred to the most appropriate care with minimum delay. This will ensure SWASFT will maintain efficient management of 999 calls to which includes fast activation, effective resource, demand matching and dynamic deployment.

8.102 The Resource Operations Centre will ensure scheduling and planning of ambulance staff is carried out up to six weeks in advance and known absences covered by relief or overtime staff to maximise the resource requirement as identified later in this document. The process of managing resource requirement will engage with the independent /voluntary sector, who provides additional capacity for responding to non-life threatening Health Care Professional calls.

8.103 Rostering for Christmas and New Year will take place as in previous years. The Trust will be unable to accept leave applications from any operational employee group (other than substantive relief staff who are wholly employed externally to rotas) during the Christmas / New Year period on the following dates:-

- December 24th
- December 25th
- December 26th
- December 31st
- January 1st

Emergency Departments

8.104 Emergency Care, New Service Standards, Reflecting the True Patient Experience asserts that NHS Chief Executives should ensure that ambulance-borne patients wait for no more than 15 minutes on arrival at accident and emergency before their care is transferred to a clinically qualified member of staff. The standard of 15 minutes for handover of patients from ambulances is to address the issue of delays to ambulance borne patients waiting outside of accident and emergency when the department is busy.

8.105 Local health partners, including SWASFT have worked together to draw up contingency arrangements to ensure the NHS can cope efficiently with increased demand.

8.106 In the event of ambulance vehicles becoming delayed in excess of 30 minutes due to the inability to handover their patients, the Standard Operating Procedure may be enacted.

8.107 During periods of excess demand affecting capacity management at emergency departments, a SWASFT manager will be dispatched to assist with patient triage and facilitate ambulance handover arrangements as per agreed protocols.

8.108 The Trust has an agreed operating procedure which is used when any handover delay occurs over 30 minutes. This procedure clearly indicates how the escalation works if the delays are excessive i.e. more than two vehicles delayed in excess of 1 hour causing impact on local performance.

Weather

8.109 Long range Weather forecasts and warnings are cascaded to various SWASFT departments and managers thus providing advanced notice for forward planning. The Responding to Severe Weather Incidents document provides guidance on managing all weather variations.

8.110 All front line vehicles should have snow socks on board, these are available through The Equipment Champions, workshops or via the fleet help desk on 0845 8100 200 Option 4. A snow sock fitting guide is also available on the intranet. Winter tyres are being fitted to all vehicles on a normal tyre replacement basis. Staff taking vehicles in to ATS for a tyre change should ask for winter tyres to be fitted. Vehicles are also being provided with ice scrapers and de-icer.

8.111 Salt sticks are currently being made available on all front line vehicles; salt sticks are hand portable salt dispensers that can be used to rapidly clear small areas of snow to ease vehicle or patient access. All ambulance stations are supplied with salt and grit to ensure local access. Local authorities have agreed to ensure access to stations.

8.112 A limited supply of emergency salt is being held at central stores. This is in the case of an emergency shortage at an ambulance station and can only be requested with the authorisation of the Operations Managers or the Logistics

Team. Formal requests for this to be made available should be sent to Central Stores.

4x4 Arrangements

8.113 SWASFT has a number of options which are identified in the Responding to Severe Weather Incidents document. The ability to respond under blue light conditions using a 4x4 is limited to SWASFT and those acquired from St John and British Red Cross.

8.114 Hired-in vehicles from either, Wessex 4x4 or St John Ambulance can be used to take a SWASFT clinician to a 999 response but only under normal driving conditions. This response will need to be supported by clinical advice from the Clinical Support Desk's and escalated to the Silver if this involves a delayed response to any RED call. The rationale to this type of response must be logged using the appropriate Trust procedures.

8.115 Additionally, across East and West Divisions all-wheel drive Skoda Scouts are utilised as Rapid Response Vehicles to improve capability and safety when driving in limited traction.

Estates

8.116 All ambulance station grit bins throughout the Trust have been filled and contractors have stocks of salt/grit so that bins can be replenished as required. Staff at ambulance stations must be made aware of these arrangements and informed by line managers that it is their responsibility to keep access to the station clear of snow at all times.

Community First Responders

8.117 It is likely that during severe weather conditions and service disruption the contribution of these individuals will become even more important. It is therefore essential that we communicate effectively with them throughout.

8.118 The CFR managers should share the winter plan with this group on publication and direct them to any areas that are particularly pertinent to them.

8.119 During any periods of service disruption or severe weather conditions examples of how CFRs are supporting the Trust's winter plans should be showcased in the weekly brief and via the media – good examples and case studies must be shared with the communications team.

Non-Emergency Patient Transport Services (PTS)

8.120 Non-Emergency Patient Transport Services are provided by E-Zec Medical. The provider organisation has worked with SWAST on their Operational Resilience Plan, including support they can offer during a major incidents to inform the overall plan held by SWAST. E-Zec's escalation / resilience plan will also form part of the Acute and Community Organisation escalation plans.

9.0 CROSS CUTTING THEMES

Seven day working

9.1 Dorset County Hospital is one of 13 early adopter sites for seven day working across the United Kingdom. Any learning arising from this will be shared across the health and social care system.

9.2 There is an expectation that all areas of the health and social care system within Dorset begin to initiate seven day working plans and some of the pilot projects commissioned through the urgent care board during 2013/14 enabled the impact of seven day working for some services to be tested, particularly in regard to diagnostics.

End of life Care

9.3 The Community Generalist Palliative Care Service provides general palliative care for all patients in Dorset who are aged 18 or over suffering a life threatening illness, cancer or non-cancer and wish to die in their home environment.

9.4 The provision is available seven days a week between 0830 hours and 2100 hours with night cover when required. It offers a comprehensive service to patients by working in close partnership with Twilight services, Marie Curie, Social Care, Specialist Palliative Care consultants, Acute Hospitals, Continuing Health Care team and Out of Hours services.

Deaths in the Community

9.5 Death in the community is managed as part of general practice core business, and generally (and over the winter) there is capacity in the system to provide certification of death by GPs.

9.6 During an influenza pandemic there could be an increase in deaths in the community which could in light of other increases in activity in general practice mean we struggle to find people to certify death. This would be addressed through the training of nurses to provide verification of death.

Mortuary Capacity

9.7 The mortuary capacity within the Acute Trusts is:

- **The Royal Bournemouth Hospital** – 48 places available (+ 3 places for bariatric and 2 paediatric places). Capacity to firstly double up + 50. Second stage to use adjoining rooms with chillers + 40 – total 90;

- **Christchurch Hospital** – 12 places available with capacity to double up;

- **Poole Hospital** – 50 (+3) places available (including 3 deep freeze units and 5 places for bariatric individuals.

- **Dorset County Hospital** – 33 places (+3 deep freeze units)

9.8 The Acute Trusts have the ability to increase capacity if urgently required during a pandemic flu outbreak as part of the partnership working with the local authorities and third sector providers.

Workforce

9.9 As leaders of the local health community the NHS Dorset CCG has a key role to play in workforce assurance across the health system.

9.10 Provider organisations remain responsible for the employment, deployment and management of their staff; however NHS Dorset CCG as commissioners of services must be assured that the providers have the workforce capacity and capable to deliver high quality services in line with commissioning intentions and contract monitoring arrangements.

9.11 This is particularly critical during times of surges in demand and arrangements are in place through the contract monitoring framework to review and monitor workforce information and associated quality issues and seek the necessary assurance that adequate staffing levels are in place.

9.12 The Urgent Care Board have acknowledged workforce as a key priority within the medium term strategy in terms of the availability of specific areas of the workforce, including domiciliary workers, Nurse Practitioners and many other staff groups. Additional assurance is sought prior to anticipated period of increased demand, for example winter and bank holiday weekends.

9.13 All organisations are required to have business continuity plans in place which identify critical functions, and where necessary reciprocal arrangements have been identified in the event that staff are not able to either attend work or access specific information systems from their normal place of work.

9.14 Organisations are advised to have an ‘Adverse Weather Policy’ in place, which provides advice for staff in the event that they are not able to attend or access their normal place of work.

9.15 If there was a pandemic the Department of Health predicted that up to 50% of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic, affecting 35%- 50% of the population, this could be even higher as some with caring responsibilities will need additional time off.

9.16 Staff absence should follow the pandemic profile. In a widespread and severe pandemic, affecting 50% of the population, between 15% and 20% of staff may be absent on any given day. These levels would be expected to remain similar for one to three weeks and then decline.

9.17 Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, to look after children in the event of schools nurseries closing.

Infection Prevention and Control

9.18 Dorset CCG will ensure the monitoring and management of infection prevention and control (IPC) in collaboration with the Infection Prevention and Control Teams of the three local acute NHS Trusts, Dorset Healthcare University Foundation Trust, General Practitioners, Wessex and Local Public Health teams and South West Ambulance NHS Foundation Trust to create a seamless approach to the management of incidents and outbreaks of infection.

9.19 NHS Dorset CCG receives assurance from all NHS providers that high quality systems exist to prevent cross infection and reduce healthcare associated infection rates. This includes ensuring that staff are competent and trained to identify patients at risk and manage their care appropriately. Audits are reviewed to ensure compliance with cleaning standards and hand washing. The CCG also conducts unannounced visits on a quarterly basis to carry out spot-checks in relation to environmental cleanliness.

9.20 Systems include:

- A patient assessment algorithm for infectious and potentially infectious patients used by South Western Ambulance Service NHS Foundation Trust (SWASFT) to ensure appropriate management of potential infections in the Emergency Department or other admitting area;
- A patient assessment in the Emergency Departments is timely and follows an agreed algorithm;
- Side room assessment tools to enable immediate patient isolation and movement if required;
- Adherence to Outbreak Policies (reference to Norovirus toolkit);
- Outbreak reviews at daily capacity meetings with agreed plans of action;
- Cleaning plans agreed to enable increased cleaning during outbreaks and deep clean following end of outbreak to ensure prompt re-opening of a closed area;
- Reporting of outbreaks through Public Health England, PHE data reporting system, and local circulation of alerts;
- Escalation within the trusts as per escalation policy;
- Notification to CCG Infection Control of infection outbreak;

- Pressures identified through Capacity Management System (CMS) reporting.

9.21 An outbreak is defined as:

- An incident affecting two or more people thought to have a common exposure to a potential source, in which they experience similar illness or proven infection;

- A rate of infection or illness above the expected rate for that place and time, where spread is occurring through cross infection, or person-to-person;

- Norovirus or other infection leading to the closure of 2 or more wards in acute setting and 2 or more associated cases in other inpatient settings (e.g. ITU, HDU, CCU) or in community based hospitals and care homes.

9.22 Work has been undertaken to:

- Ensure consistency in approach via organisations' outbreak management policies relating to periods of isolation, cleaning regimes and responsibilities, incubation and stand down times and advice to the general public;

- Establish an alert system of email notification to all infection control staff of outbreaks in the county;

- Develop a trigger tool for appropriate level involvement during outbreak management.

9.23 The relevant IPC Team are contacted immediately in the event of a suspected outbreak and an outbreak control meeting will be convened as necessary, with CCG attendance as required in compliance with local policy

9.24 Actions will be agreed to limit the outbreak, provide information to the public, ensure safe staffing levels, and liaise with other local Trusts and independent sector care homes regarding movement of patients.

9.25 All transfers and discharges to community hospitals and care homes would be assessed to minimise the risk of further spread.

9.26 During out-of-hours and at weekends/bank holidays the nurse in charge of the respective ward/hospital will contact the on-call manager for their Trust if an outbreak is suspected. Action will include liaising with the Director on-call and specialist advice may be sought from the microbiologist on-call.

9.27 Policies include guidance on cohort/isolation nursing of infected patients, restricted movements between departments of symptomatic patients,

enhanced infection control and cleaning schedules and outbreak control procedures.

9.28 Policy implementation is supported by mandatory infection control training for all staff.

9.29 PHE notify IPC teams within Dorset of infectious outbreaks in care homes.

9.30 Primary care staff receive training and education to enable the management of their clients in their own homes. Staff give advice on symptom management and reduction of spread, for example avoiding unnecessary visiting by family members. Services to clients with active infections would be assessed and continue if required.

9.31 Root cause analysis is undertaken to review outbreaks and identify learning that can be disseminated across the health community. All outbreaks affecting more than 2 wards or relating to a unique area of the hospital such as ITU, HDU or CCU are declared as Serious Incidents. All root cause analysis reports are reviewed and quality assured by the multi-agency Infection Control HCAI review Group.

- Reviews of Norovirus outbreaks have shown that due to effective infection control measures, Norovirus was not as prevalent both within the acute trusts and community hospitals as in previous years.

- When it did occur, all three acute hospitals effectively managed outbreaks, which included quickly restricting visiting in order to prevent further spreading.

- Improved awareness and control measures in residential care homes has led to reduced hospital admission.

9.32 The CCG will monitor outbreaks through information available from the PHE surveillance system and weekly reports on outbreaks within Dorset including care homes

9.33 Awareness messages regarding Norovirus and Influenza will be sent to the public and partners in Dorset supported by PHE and NHS England.

9.34 Planned activities for this year include: a poster campaign, media release, and website information

10. INFORMATION AND REPORTING

10.1 Each year there is additional information/monitoring requirements at each level of the health economy. This information is submitted, primarily by Acute Providers. Information is submitted via UNIFY2 through to NHS England. NHS Dorset CCG Performance and Information Team will co-ordinate submissions as required.

10.2 Acute Providers are expected to report a daily SITREP to NHS England running from 1 November 2014 until at least 31 March 2015. National reporting requirements have not yet been clearly defined however it is expected similar reporting to that in 2013/14 will be required. Information expected to be included in this report is shown below:

- Emergency Department Closures or Diverts;
- Ambulance Handover delay in excess of 30 minutes;
- Cancelled Elective and Urgent Operations;
- Bed Availability including reporting against D&V/Norovirus like symptoms and Delayed Transfer of Care;
- Critical Care/Intensive Care Bed (cots) information relating to patients with flu or suspected flu.

10.3 In addition to normal winter reporting there are a number of additional reports which have been requested previously in the event of pandemic flu. Provider organisations

10.4 should be aware that in the event of a pandemic additional national reporting will be required.

10.5 The Clinical Commissioning Group will require Providers to report on the uptake of Flu Vaccinations undertaken with the organisation on a monthly basis.

10.6 The Clinical Commissioning Group will collect local information from Dorset Healthcare University NHS Foundation Trust as this is not required nationally but will provide useful insight to the local health pressures.

Local Resilience Forum

10.7 In the event of a flu pandemic the NHS command and control structure may be established. This would follow the format below which remains consist for all types of major incident requiring health involvement.

Table 11: Command and Control Structure

Command and Control Structure	
Role	**Membership**
GOLD level representation at the Strategic Co-ordinating Group	**NHS England (Wessex Area Team)** -Director on-call or equivalent

(SCG)	
Role	**Membership**
SILVER level representation at the Tactical co-ordinating Group (TCG)	**NHS Dorset CCG** -CCG Senior Manager on-call
Role	**Membership**
BRONZE Operational	-Dorset acute and community healthcare providers

10.8 The NHS England 2014 guidance on pandemic flu planning emphasises that a response should be proportionate and flexible, and should deliver care through a business as usual approach as far as possible.

10.9 The pandemic flu plan is currently being updated by Wessex Area Team in line with the latest guidance.

10.10 The plan will provide a range of command and control options including a Dorset Strategic Coordinating Group with representation from Wessex Area Team working with NHS Dorset CCG as the link to Dorset Health

11. WORKFORCE

11.0 12.2 As part of the Operational Resilience and Capacity Planning process NHS Dorset CCG will write to all provider organisations to seek assurance that they have adequate staffing levels in place, specifically over the Christmas and New Year period.

11.1 NHS Dorset CCG must also ensure that it remains 'fit for purpose' and able to deliver its statutory functions and priorities. All Directorates have business continuity plans in place which identify critical functions, and where necessary reciprocal arrangements have been identified in the event that staff are not able to either attend work or access specific information systems from their normal place of work. An 'Adverse Weather Policy' is in place and provides a framework for staff in the event that they are not able to attend or access their normal place of work.

11.2 As leaders of the local health community NHS Dorset CCG has a key role to play in workforce assurance across the health system. Provider organisations remain responsible for the employment, deployment and management of their staff; however the CCG must be assured that the providers have the workforce capacity and capable to deliver high quality services in line with commissioning intentions and contract monitoring

arrangements. This is particularly critical during times of surges in demand and arrangements are in place through the contract monitoring framework with Human Resources Directors to review and monitor workforce information and associated quality issues and seek the necessary assurance that adequate staffing levels are in place.

11.3 If there was a pandemic the Department of Health predict that up to 50% of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic, affecting 35%- 50% of the population, this could be even higher as some with caring responsibilities will need additional time off.

11.4 Staff absence should follow the pandemic profile. In a widespread and severe pandemic, affecting 50% of the population, between 15% and 20% of staff may be absent on any given day. These levels would be expected to remain similar for one to three weeks and then decline.

11.5 Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, to look after children in the event of schools nurseries closing.

APPENDIX ONE

FINANCE AND PLANNING TEMPLATES

Finance Template – attached as separate spreadsheet

(Planning templates to follow once agreed at System Resilience Group, August 2014)

APPENDIX TWO

SYSTEM RESILIENCE GROUP

DRAFT TERMS OF REFERENCE

NHS DORSET CLINICAL COMMISSIONING GROUP

DORSET SYSTEM RESILIENCE GROUP TERMS OF REFERENCE

July 2014

1. INTRODUCTION

The Dorset System Resilience Group is being created in line with the requirements of NHS England and Dorset CCG to monitor and assure the quality and continued effectiveness of urgent care and capacity planning in Dorset. The membership of this Group reflects the recognised importance of achieving 'whole-service' change that integrates services throughout the Dorset Health and Social Care community.

2. REMIT

The System Resilience Group will:

- Build on the work undertaken by the Dorset Urgent Care Board by extending its remit to include co-ordinating capacity planning across the health and social care system
- Agree, authorise and monitor Dorset's Operational and Resilience Capacity Plan.
- Complete a full system review, including the development and implementation of a future vision and sustainable service model(s) for urgent care in Dorset;
- Review and analysis of the drivers of system pressures;
- Develop solutions to meet system pressures for both elective and non-elective pathways;
- Advising and agreeing on the use of non-recurrent funds and marginal tariffs;
- Oversee the use of NHS Dorset Clinical Commissioning Group prioritised funding, ensuring that plans are agreed and adhered to and committed funds are used to support any aspect which will support the delivery of the Dorset Operational and Resilience Capacity Plan and providers' ability to deliver required operational standards;

2.1 Scope

- Appropriateness, consistency and effective use of a full range of capacity planning data;
- Effectiveness of primary, community and secondary care services,
- Effectiveness of ambulance services;
- Effectiveness of NHS 111;
- Key categories of patient who attend or are admitted frequently;
- Patients with multiple comorbidities, especially those with poorly controlled chronic disease:
    - Frail elderly, especially those with mental health problems;

    - Sick children linking with the Maternity, Reproductive and Family Health CCP;
    - High dependency individuals, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems);
- Services available to acute trusts for those patients who need services not provided by acute hospitals;
- Early discharge (working with local authorities).

2.2 Not in scope

- Operational management and day to day running of urgent and emergency service provision;
- Operational and day to day discussions on meeting RTT targets or other contract capacity issues.

3. MEMBERSHIP

The System Resilience Group brings together strategic decision-makers of the partner organisations and disciplines, with support of CCG Officers.

Consideration will be given to the best way to optimise clinical and patient/public input. This may be most effectively delivered through:

- A clinical reference group for pathway considerations
- A PPI group that supports the clinical reference group and the SRG.

Membership will include:

Dr Simon Watkins (Chair)	GP Partner, Evergreen Surgery. Chair of Co-ordinating CCP.
Jane Pike (Programme Executive)	Director of Service Delivery, NHS Dorset CCG
Frances Stevens	Deputy Director, Review Design and Delivery (West)
Tracy Hill	Principal Programme Lead, NHS Dorset CCG
Alice Land	Programme Officer – Urgent Care Review, NHS Dorset CCG
Phil Dove	Head of Performance Intelligence Contracting, NHS Dorset CCG
Nicola Rowland	Deputy Director of Finance, NHS Dorset CCG
Chris McCall	Lead GP for Poole Locality , Chair of the General Medical and Surgical CCP
Patricia Miller	Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust
Robert McEwan	Interim Director of Operations,

	Dorset County Hospital NHS Foundation Trust
Helen Lingham	Chief Operating Officer, Royal Bournemouth & Christchurch Hospitals NHS Foundation
Mark Mould	Chief Operating Officer, Poole Hospital NHS Foundation Trust
Sally O'Donnell	Interim Director of Community Health Services, Dorset Health Care University NHS Foundation Trust
David Partlow	Clinical Development Manager, South Western Ambulance Service NHS Foundation Trust
Steve Frost	Head of Urgent Care Services, South Western Ambulance Service NHS Foundation Trust
Phil Hornsby	Head of Commissioning and Improvement – People Services, Borough of Poole Council
Andy Sharp	Service Director, Adult Social Care, Borough of Bournemouth Council
Tim Branson	Service Manager - Adult Social Care Services Unit, Borough of Bournemouth Council
Ali Waller	Senior Commissioning Manager, Dorset County Council
Andrew Archibald	Head of Adult Services, Dorset County Council
To be advised	Wessex Local Area Team
To be advised	Public Health Dorset

4. ATTENDANCE AT MEETINGS

Members who are unable to attend should ensure whenever possible that a suitable deputy attends on their behalf. Any person attending on behalf of a System Resilience Group member must have full delegated decision-making authority.

Full System Resilience Group will be expected to attend a minimum of two out of three meetings.
Individual members of the System Resilience Group have the responsibility to ensure that the key priorities and agreed recommendations agreed by the Board are formally communicated within their organisation and reciprocally that the views of their organisation are communicated to the System Resilience Group.

Representatives of other organisations may be invited to attend meetings on an ad hoc basis to present or discuss matters relevant to issues being considered by the System Resilience Group. Such attendance will authorised by the Chair and members will be informed in advance of the meeting.

A minute taker will also be in attendance.

5. FREQUENCY OF MEETINGS

Meetings will be bi-monthly; this frequency may be changed by formal agreement of the System Resilience Group members.

6. SUB-GROUPS OF THE URGENT CARE BOARD

6.1 The System Resilience Team will act as the operational group of the board with the following key responsibilities:

- Manage the urgent care system and identify any issues to be reported to the Systems Resilience Group;
- Develop the agenda and relevant papers for the Group;
- Lead the development and implementation of Dorset's Operational and Resilience Plan;
- Advise the System Resilience Group on any issues or risks that require Group level attention.

6.2 The Resilience and Capacity Planning Group will act as the operational group managing day to day issues associated with resilience and capacity with the following key responsibilities:

- Co-ordinate the development of Dorset's Operational Resilience and Capacity plan;
- Monitor and address any issues regarding operational resilience and capacity;
- Undertake an assurance exercise with providers at predicted times of increased demand i.e. Winter and Easter;
- Lead the delayed transfers of care agenda;
- Provide operational oversight of Delayed Transfers of Care;
- Advise the Systems Resilience Group on any issues or risks that require Group level attention.

The System Resilience Group will agree the terms of reference for each of these sub-groups.

7. REPORTING PROCEDURES

- The agenda and relevant papers will be circulated 5 operational days prior to the meeting, with agenda items submitted to the Chair at least 10 operational days before the next meeting;

- Minute taking will be undertaken by Clinical Commissioning Group staff.

- NHS Dorset Clinical Commissioning Group is committed to environmental sustainability, therefore all papers will be circulated electronically and where possible, information technology will be used to facilitate meetings.

- Minutes of each meeting will be submitted by members to the appropriate Committees and Boards with their organisations. Minutes and Action Plans will also be shared with neighbouring Clinical Commissioning Groups.

- In extreme or urgent situations, decisions can be taken in consultation between the Chair and Programme Executive, who will endeavour to involve as many other System Resilience Group members as possible in discussions but will not be required to wait until the next meeting to take action.

8. ACTION TRACKER

Actions agreed by the group will be monitored via an action tracker. The tracker will be distributed immediately following the meeting and also circulated with the agenda and papers, members are responsible for fulfilling their actions in a timely manner.

NHS Dorset Clinical Commissioning Group will be responsible for progress chasing and updating the action tracker.

9. REVIEW

The Terms of Reference will be reviewed at six monthly intervals and may be reviewed at other times by agreement of the System Resilience Group Members.

APPENDIX THREE

SURGE AND ESCALATION PLANNING GROUP

TERMS OF REFERENCE

DORSET CLINICAL COMMISSIONING GROUP

SURGE AND ESCALATION PLANNING GROUP
TERMS OF REFERENCE
MAY 2014

1.0 PURPOSE

1.1 This Terms of Reference document outlines the roles and responsibilities of the Surge and Escalation Planning Group incorporating Delayed Transfers of Care and its members.

1.2 The overall purpose of the this group is to ensure that there is a multi-agency agreed procedure for managing the safe transfer of care of individuals from hospitals and other health and social care settings

1.3 The aims of the Group are:

- To lead surge and escalation planning across the Dorset health and social care system;
- To review relevant periods of escalation to capture learning and inform future planning;
- To inform and implement strategy developed by the Local Resilience Forum with a clearly defined transition pathway into escalation level 4 (black);
- To ensure service quality and patient safety is maintained at all times.
- To lead on the monitoring and resolution of Delayed Transfers of Care

1.4 This document will outline the following:

- Groups objectives;
- Teleconference agenda;
- Method of information sharing;
- The role of members.

MAIN DUTIES

2.1 The objectives are as follows:

- To lead the development, implementation and review of a collaborative Pan-Dorset surge and escalation plan across the

health and social care community in order to reduce avoidable hospital attendances, admissions and deaths; prevent delays and ensure an effective health and social care system is in place;

- To plan for surges in demand for services i.e. winter, heatwave and ensure the triggers and required actions have been identified;

- To identify gaps and areas of risk within the current plans and identify solutions;

- To ensure an effective robust agreed escalation and de-escalation process is in place and is being used by all partners;

- To address any issues with agreed escalation methods and processes;

- To co-ordinate communication messages in line with surge planning.

- Monitor effectiveness of the surge and escalation plan;

- To enable group members to share service developments which may impact on other areas of the health and social care systems to ensure the system works effectively together.

2.2 Main duties of the Delayed Transfer of Care Group are:

2.2.1 To develop and agree a whole systems action plan to reduce the numbers of delayed transfers of care;

2.2.2 To improve the patient transfer of care pathway;

2.2.3 To monitor performance of the whole system, ensuring systems and processes are in place to minimise delayed transfers and maximise schemes facilitating discharge;

2.2.4 To evaluate the efficacy and cost effectiveness of schemes that facilitate discharge and/or avoid admission

2.2.5 To agree and achieve performance targets;

2.2.6 To identify areas for service redesign to inform commissioning strategies; and

2.2.7 Promote the sharing of best practice and a continuous improvement approach;

3.0 MEETING FORMAT

3.1 Reporting structure

The Group will report to the Urgent Care Board

3.2 Chair and deputy

The Senior Programme Lead within the General Medical and Surgical Team will chair the group with support from the Principle Programme Lead.

3.3 Frequency

The group will meet on a bi-monthly basis as a face-to-face group.

The meetings will rotate venues.

The meetings will be divided into two parts to allow the DTOC agenda items to be covered by the appropriate representative(s) and will continue to the Surge and Escalation agenda allowing members to leave.

3.4 Membership

Each organisation listed within this section is signed up to this policy.

Each organisation is required to ensure a representative attends meetings and dials into the weekly teleconferences when they are in operation:

- NHS Dorset Clinical Commissioning Group;
- Poole Hospital NHS Foundation Trust;
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust;
- Dorset County Hospital NHS Foundation Trust;
- Borough of Poole;
- Bournemouth Borough Council;
- Dorset County Council;
- South Western Ambulance Service NHS Foundation Trust – 999, Urgent Care and Single point of Access representative;
- Dorset Healthcare University NHS Foundation Trust;
- Voluntary sector representative.

4.0 ROLE OF MEMBERS

- To actively participate in the meetings and teleconferences for the whole duration of the call;
- To provide information from their organisation as required enabling a deep dive into specific areas / concerns;
- To take back key messages / actions and disseminate in a timely manner throughout their organisation;
- To alert the surge and escalation planning group of any potential demand and capacity issues;
- To ensure their organisation has a robust way of ensuring the DOS is updated as agreed.

5.0 INFORMATION SHARING

The Directory of Service should be utilised by all partners across the health and social care community as a method by which to share and ascertain the current levels of demand and capacity.

Members should be familiar with DOS and ensure their organisation has a robust plan in place to ensure the system is updated on a daily basis at regular intervals.

6.0 TELECONFERENCE

Organisations should plan for weekly resilience teleconferences to commence in the first week of October until the last week in March the following year (the calls may commence at an earlier date or continue for longer if required).

Weekly and daily calls can be called at other times throughout the year as required.

Group members are required to ensure that a representative dials into the calls and has up-to-date information on the demand and capacity within their own organisation and predicted position for the next 24 hours.
Prior to the call, Providers should ensure their current status is updated on the Directory of Service (detailed in section 5.0) so all members can view this and update themselves of the current situation prior to the call.

Exception reporting and agreement of any actions will be the focus of the calls.

The agenda for the calls is attached in Appendix 1

7.0 RESILIENCE ALERTS

- A single email account has been established resilience.alerts@dorsetccg.nhs.uk . The purpose of this email is to accept information / alerts which can then be cascaded to the health and social care community as appropriate.

- The email account is managed by South Western Ambulance Service Foundation Trust 24/7.

- If a provider needs to raise a resilience alert the template attached in appendix 3 needs to be completed and sent to the resilience email address. Resilience alerts should be sent from the Chief Operating Officer.

- Only one resilience alert should be sent for each period of escalation, further updates should be provided on the Directory of Skills (DOS) on an hourly basis.

- DOS must be updated once the situation has been resolved to ensure providers stand down any escalation actions they may have put in place.

Policy Review Date – August 2015

Julie Brown
Senior Programme Lead
General Medical and Surgical Clinical Commissioning Programme

Appendix 1

NHS DORSET CLINICAL COMMISSIONING GROUP

RESILIENCE TELECONFERENCE

EVERY TUESDAY 11.00 – 11.30

Dial in – 0844 546 4000
Pin - 3692110

AGENDA

1. Welcome, introductions and apologies

2. Current position ***(prior to the call please review the current position using DOS):***

   https://nww.pathwaysdos.nhs.uk
   (If you do not have a username and password contact Lou Crockett)

3. Current issues

4. Update on D&V rates across the community

5. Agreed actions including timeframes

6. Any other business

7. Future calls

Appendix 2

REQUEST FOR INFORMATION TO BE CASCADED VIA RESILIENCE

Name	
Organisation	
Contact Details	
Date	
Time	
Current Issue(s)	
Action already taken i.e. additional wards open, additional staff contacted, elective lists cancelled, fire brigade called	
Specify distribution list (if left blank will be sent to general information cascade group which includes all SEAPG Members)	
Any other information or specific action required from others	

Please complete this form and email to resilience.alerts@dorsetccg.nhs.uk

APPENDIX FOUR

ACTION CARDS

Actions taken at Amber (level 2)

This action card outlines the minimum expected levels of action at Amber (level 2) status.

Illustration of minimum actions at alert status AMBER which may be taken to mitigate pressure prior to (and with the intention of avoiding) further escalation:	
WHOLE SYSTEM	
1	Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation as appropriate.
COMMISSIONERS	
2	Expedite additional available capacity in primary care, out of hours, independent sector and community capacity.
3	Co-ordinate the redirection of patients towards alternative care pathways as appropriate.
4	Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers.
ACUTE TRUSTS	
5	Contact on-take and A&E on-call consultants to offer support to staff and to ensure that speciality patients in A&E are assessed rapidly.
6	Implement a “see and Treat” pathway if not already in place routinely.
7	Undertake additional ward rounds to maximise rapid discharge of patients.
8	Pharmacy services to prioritise TTOs for appropriate areas and ensure that medications are delivered to the wards without delay.
9	Clinicians to prioritise discharges and accept outliers from any ward as appropriate.
10	Facilities, porters or transfer teams to prioritise cleaning and transfers.
11	Implement measures in line with trust Ambulance Service handover Plan.
12	Inform minors patients in A&E of pressures and potential delays and of alternative care pathways where appropriate.
13	Identify and encourage utilisation of alternative care pathways for minors patients. (e.g. OOH).
14	Contact PTS provider(s) and appropriate ambulance service personnel to confirm that they are in liaison with their acute counterparts to prioritise discharged/transfers and minimise turn-round times for crews.
15	Utilise staff from other areas of service and deploy to relieve key pressure points.
16	Maximise use of nurse led wards and nurse led discharges.
COMMUNITY CARE PROVIDERS	
19	Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. Maximise use of re-ablement beds.
20	Task community hospitals to bring forward discharges to allow transfers in as appropriate.
21	Additional ward rounds within community providers to expedite discharge and create capacity.

22	Community providers to lower admission/treatment thresholds wherever possible through implementation of previously agreed flexible working arrangements to alleviate pressure.
23	Apply flexibility regarding beds and staffing to increase capacity where possible.
24	Expedite rapid assessment by multidisciplinary team (MDT) including Social Services assessment.
SOCIAL CARE	
25	Expedite care packages and nursing / EMI / care home placements. Ensure all patients waiting within another service are provided with appropriate service.
26	Where possible, increase support and/or communication to patients at home to prevent admission. Maximise use of interim care arrangements that support discharge.
PRIMARY CARE	
27	Community Matrons to support district nurses in supporting higher acuity patients in the community.
28	In reach activity to A&E departments to be maximised.
29	Alert GPs to escalation and request alternatives to A&E referral be made where feasible.
MENTAL HEALTH	
30	Expedite rapid assessment for patients waiting within another service.
31	Where possible, increase support and/or communication to patients at home to prevent admission.
AMBULANCE SERVICE	
32	Review and reallocate resources to meet current emergency work load.
PTS SERVICE	
33	Ensure current PTS capacity is fully utilised for patient discharge and transfer.

Actions taken at Red (level 3)

This action card outlines the minimum expected levels of action at Red (Level 3) status.

Illustration of minimum actions at alert status RED which may be taken to mitigate pressure prior to (and with the intention of avoiding) further escalation:	
WHOLE SYSTEM	
1	All actions listed in **Appendix 3A**
2	Utilise actions from organisational major incident/significant incident plans to create capacity.
3	Utilise actions from organisational business continuity plans to ensure continuity of service.
COMMISSIONERS	
4	CCG to co-ordinate communication and co-ordinate escalation response across the whole system.
5	Notify CCG to ensure appropriate operational actions are taken to relieve the pressure.
6	Escalation information to be cascaded to all primary care providers with the intention of avoiding admissions wherever possible.
7	Inform OOH providers of the current system-wide alert status and advise to recommend alternative care pathways.
8	Cascade current system-wide alert status to GPs and to 111 service and advise to recommend alternative care pathways.
9	Consider Continuing Healthcare funding to be agreed outside panel.
10	Ensure that liaison between and within PTS service is robust and functioning well, especially where provided other than by the Ambulance Service.
ACUTE TRUSTS	
11	A&E consultant to be present in A&E department as appropriate.
12	Contact on-take and A&E on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly.
13	Senior Physician to be present in A&E as appropriate to monitor medical admissions.
14	Reschedule or put on hold relevant routine elective admissions. For example, cancelling routine audiology day cases is unlikely to impact on system pressures. The Trust must remain mindful of the need to maintain planned care targets and take on-going action as necessary to ensure that there is no slippage against these.
15	Enact process of cancelling day cases and staffing day beds overnight if appropriate.

16	Place NHS patients on private patient ward(s) if there are empty nursed beds as appropriate (if applicable).
17	Ensure reverse triage has been implemented to support rapid discharge.
18	Open additional beds on specific wards, where staffing allows as per winter plan.
19	A&E to open an overflow area for emergency referrals, where staffing or space allows.
20	Review and reschedule plans for scheduled maintenance where work is likely to impact on capacity or patient flow.
21	Consider extra staffing in A&E (i.e. GP, Emergency Care Practitioner / Advanced Nurse Practitioner and other hospital staff, such as ITU or CCU staff, paediatrics staff.)
22	Liaise with ambulance service to ensure risk assessment and agreed clinical plan for any patients awaiting handover.
23	Bring in extra staff to radiology, pathology, pharmacy, occupational therapy etc. If appropriate, deploy staff to care for any ambulance patients waiting for space.
24	Assign clinical staff to care for any ambulance patients waiting for space (in A&E, assessment units and other admission areas etc.)
25	Senior clinicians to actively scrutinise all GP requests for admission if facility is in place.
26	Alert social Services on-call managers to expedite care packages.
COMMUNITY CARE PROVIDERS	
29	All community care teams to review all patients awaiting assessments in order to expedite discharge or transfer – this to include in reach terms, deliberate self-harm, community hospitals.
30	Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible.
31	Community service providers to expand capacity wherever possible through additional staffing and services.
32	Community providers to consider the use of wider group of agencies to increase staffing capacity.
33	Patients waiting at home for admission to be referred to Community Teams (by in reach nurses).
SOCIAL CARE	
34	Social Services on-call Managers to expedite care packages.
35	Social Services to review all assessments in pipeline to expedite discharge.
36	Increase domiciliary support to service users at home in order to prevent admission.

37	Increase staff resource at the front door.
38	Encourage providers to identify where existing packages could be reduced.
39	Flex staff to areas of greatest need – utilise mutual aid agreements between Poole, Bournemouth and Dorset Social Services Teams.
PRIMARY CARE	
40	OOH services to recommend alternative care pathways.
41	In hours GP services to recommend alternative care pathways.
42	Review staffing level of GP OOH service.
MENTAL HEALTH	
43	To review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible.
44	Increase support to service users at home in order to prevent admission.
AMBULANCE TRUST	
45	Review and reallocate resources to meet current emergency workload.
46	Ensure usage of managers/officers, staff and community responders is maximised.
47	Ensure (in conjunction with other PTS providers if commissioned) current PTS capacity is fully utilised for patient discharge and transfer.
48	Maintain communication with GP, 111 and OOH services to review potential delays to patient admissions.
49	Ensure all duty officers and directors are aware of current status levels.
50	Liaise with acute trust to risk assess and agree clinical plan for any patients delayed in being handed over to the acute trust.
51	Reinforce with ECPs and other A&E staff the need to use alternate care pathways whenever possible.
52	Utilise actions from REAP plan to create capacity where possible.
PTS SERVICE	
53	Ensure that capacity is fully utilised for patient discharge and transfer, and that liaison between different PTS providers and the Ambulance Service is functioning well.

Actions to be taken BEFORE escalating to 'Black' (level 4)

This action card outlines the minimum expected levels of action before escalating to 'Black' (level 4).

BEFORE REQUESTING ESCALATION FROM RED TO 'Black' the following actions should have been completed:	
WHOLE SYSTEM	
1	All escalation actions listed in appendices 3A and 3B have been implemented.
2	CEOs / Lead Directors have been involved in discussion and agree with escalation.
COMMISSIONERS	
3	CCG to continue to co-ordinate communication and co-ordinate escalation response across the whole system.
4	Expedite additional capacity and increased support wherever possible (including voluntary independent sector capacity).
5	Make a risk based assessment of the best use of capacity and resource across the whole system and shift resources to best meet demand and maintain patient safety.
ACUTE TRUST	
6	Routine Elective admissions have been cancelled.
7	Urgent elective admissions have been reviewed and, where possible, rescheduled or cancelled.
8	Increase staffing in A&E to manage queue.
9	Provide additional beds in A&E for patients.
10	Provide 24/7 senior management support in A&E to manage situation.
COMMUNITY CARE PROVIDERS	
11	All possible capacity has been freed and redeployed to ease system pressures.
SOCIAL CARE	
12	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
13	Flex staff to areas of greatest need – utilise mutual aid agreements between Poole, Bournemouth and Dorset Social Services Teams.
PRIMARY CARE	
14	All possible actions are being taken on-going to alleviate system pressures.
MENTAL HEALTH	

15	Continue to expedite discharges increase capacity and lower access thresholds to prevent admission where possible.
AMBULANCE TRUST	
16	Review current GP Admissions with GPs to ensure safe standards of care to patients.
17	Review on-going 111 advice strategy.
18	Call in additional Operational & Communications Centre Staff and additional resources i.e. St Johns, private ambulance services etc.
19	Review all long-distance inter-hospital transfers.
20	Ensure all Ambulance Trust PTS resources are directed to maintaining patient flow across the whole system. Ensure appropriate co-ordination with other PTS providers where other provision is commissioned.
21	Ensure direct communication between acute trust on call Director, lead CCG commissioner and wider health system executives is under way.
22	If emergency response is severely compromised, consider use of Major Incident /Significant Incident procedures.
23	Utilise actions from REAP plan to create capacity where possible.
PTS SERVICES	
24	Ensure all capacity is being utilised to alleviate system pressures.
SOCIAL SERVICES	
25	Ensure all actions at previous levels of escalation have been put into place.

Actions to be taken at 'Black' (level 4)

At Alert Status 'Black' the following actions must be completed:	
WHOLE SYSTEM	
1	Continue to explore actions in Appendices 3A, 3B and 3C and take decisive action to alleviate pressure.
2	Contribute to system-wide communications to update regularly on status of organisations (as per local communications plans).
3	Provide mutual aid of staff and services across the local health economy as appropriate.
4	Stand-down of '**Black**' alert once review suggests pressure is alleviating.
5	**Post escalation:** Contribute to the Root Cause Analysis and lessons learnt process through the SIRI investigation.
COMMISSIONERS	
6	Area Team notified of alert status and involved in decisions around support from beyond local boundaries.
7	**CCG report Serious Untoward Incident on the STEIS system.**
8	In conjunction with Ambulance Service and Whole System the CCGs act as the hub of communication for all parties.
9	**Post escalation:** Complete Root Cause Analysis and lessons learnt process in accordance with SUI process.
ACUTE TRUST	
10	A&E consultant to be present in A&E department 24/7 as appropriate.
11	Consultant Physicians to be present on wards and in A&E department.
12	Surgical Consultants to be present on wards, in theatre and in A&E department.
13	Assign appropriate qualified clinician to manage care of patients awaiting handover from ambulance service to enable ambulance crews to be released.
14	GP to be present in A&E department 24/7.
15	Executive Director to be on site 24/7.
16	Any request to divert patients from A&E must be initiated by the Acute Trust who, having exhausted all internal divert options, must contact the CCG to request a divert to neighbouring trusts whether these are in or out of region.
AMBULANCE TRUST	
17	Alert neighbouring trusts to seek appropriate support as dictated by circumstances of '**Black**' Alert.
18	Continue to make a risk based assessment of the best use of capacity and

	resource across the whole system and shift resources to best meet demand and maintain patient safety.
19	Review the escalation status every 2 hours and communicate this across the system.
AREA TEAM	
20	Sign-off the use of support from beyond locality and/or regional boundaries.
21	Assist in the management of communications and media handling.
22	**Post escalation:** Involvement in and sign-off of SIRI investigation process.