EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS – 29 AUGUST 2014**

SUBJECT: **SEASONAL PRESSURES PLAN 2014/15**

REPORT FROM: **CHIEF NURSE AND DIRECTOR OF QUALITY & OPERATIONS**

PURPOSE: **DISCUSS AND SIGN-OFF PLAN WITH CAVEAT THAT ITS DEVELOPMENT WILL REMAIN AN ITERATIVE PROCESS AS FURTHER INFORMATION BECOMES AVAILABLE DURING SEPTEMBER**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Trust's Seasonal Pressures Plan 2014/15 is the cornerstone of the Trust's response to increases (surges) in activity and demand and summarises how the operational teams will organise their services. This Seasonal Pressures Plan underpins year round operational resilience and is aligned to the guidance from NHS England 'Operational Resilience and Capacity Planning for 2014-15'.

This Seasonal Pressures Plan will work in association with the whole systems Operational Resilience and Capacity Plan (East Kent Federation CCG Plan 2014 /15) and be implemented in line with other health and social care provider plans, such as Primary Care, Kent Community Health Trust, Social Services and SECAmb Trust.

The Seasonal Pressures Plan takes into account how the Trust will manage all non-elective and elective care during 'surges' in demand for our services. It builds on the key lessons learned during 2013/14 in terms of what worked well and areas requiring improvement.

The Seasonal Pressures Plan summarises Divisions' Seasonal Pressures Plans, and is reviewed annually in April and issued in September to go live 1st October. Changes to the Seasonal Pressures Plan may be requested at any time based on organisational changes, actual incidents or any other factors. A comprehensive Communications Plan will be in place to ensure that all staff members are aware of their roles and responsibilities to execute the Seasonal Pressures Plan. The Seasonal Pressures Plan will be fully exercised and tested both internally and externally at least once per calendar year.

The development of the Seasonal Pressures Plan will remain an **iterative process** as further information (external partners' plans) becomes available end August/September.

SUMMARY:

The aim of this paper is to provide an overview of the Trust's Seasonal Pressures Plan 2014/15 in terms of content, issues outstanding and next steps.

The primary aim of the Seasonal Pressures Plan is to be able to respond to increases (surges) in activity and demand effectively by maintaining service provision and ensuring the safety of patients and staff at all times throughout the year.

Timely patient flow is the responsibility of the whole health economy and this requires a proper understanding of how each organisation will respond to periods of increased activity and demand. It is absolutely essential therefore that the health economy has a clear understanding of the capacity required to ensure the whole health system achieves and

maintains safe and effective patient care. External benchmarking against capacity will be undertaken by KSS Academic Health Science Network.

The Trust's Seasonal Pressures Plan has defined the finite safe level of capacity which can be provided, but recognises that the Trust is unlikely to be able to meet the full demand required during times of extreme pressure such as winter. Therefore discussion will take place with CCGs as they will need to explore alternative ways of meeting the expected gap in capacity as well as reinforcing the need for responsive, consistent and effective admission avoidance. The internal capacity gap will continue to be worked through by Divisions as it forms the core part of the Trust's Seasonal Pressures Plan.

The Trust has bid for 'Surge Resilience Funding' and is awaiting final confirmation of funding for:-

- Surgical Assessment Unit
- Additional A&E consultant capacity
- Integrated Urgent Care Centre
    - Acute Medical Model of Care
    - Integrated Discharge Team

Building on the lessons from last year, comprehensive staffing plans are required for all professional groups to ensure safe and sustainable services are maintained throughout the winter months. Roles and responsibilities will be reinforced to ensure rapid response and resolution is achieved to emerging issues, maintaining patient safety.

The key risks to the safe and effective delivery of the Plan are:-

- Insufficient capacity to manage the demand within the whole health economy resulting in EKHUFT bearing the full pressure of managing the GAP and therefore providing an unsafe service
- Ongoing high levels of nursing vacancies at ward level and in A&E (post recruitment of newly qualified nurses August/September)

The Trust is required to submit its Seasonal Plan to feed into the whole systems Operational Resilience and Capacity Plan (East Kent Federation CCG Plan 2014 /15) by end August.

RECOMMENDATIONS:

To **discuss and Sign-off the Plan with the caveat** that the development of the Trust's Seasonal Pressures Plan 2014/15 will remain an iterative process as further information becomes available during September.

NEXT STEPS:

- Trust Board to **Sign-off the Plan with caveat** and submit to CCGs (end August)
- Obtain and test external stakeholder plans against ECIST '10 steps' to good winter planning (within 10 working days of receipt of plans)
- Engage in discussions with CCGs to ensure that health economy Directors of each organisation formally sign off their plans, recognise the capacity GAP within the health economy and develop solutions to bridge and manage the GAP (end August)
- Recommend that the Local Area Team formally scrutinises all providers' plans (mid-September)
- Update the Trust's Risk Register to reflect risks as they emerge
- Communicate approved Seasonal Pressures Plan to staff and external stakeholders (first week September)

- Carry out internal exercise of Trust's Seasonal Pressures Plan (September)
- Participate in external exercise testing of all plans within health economy (mid-September)

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

To provide operational resilience and capacity planning to deliver services to patients throughout the year.

LINKS TO BOARD ASSURANCE FRAMEWORK:
N/A

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

RISKS:

- Lack of capacity to manage the demand within the whole health economy resulting in EKHUFT bearing the full pressure of managing the GAP and therefore providing an unsafe service
- Ongoing high levels of nursing vacancies at ward level and in A&E (post recruitment of newly qualified nurses August/September)

RISK MANAGEMENT ACTIONS:

- Seek assurances from CCGs and partner organisations that their plans have sufficient capacity to manage 'surges' in demand.
- Develop 'contingency' plans to manage gaps in capacity in case CCGs and other partners fail to do so.
- Assess and challenge external stakeholder plans to ensure they are sufficient robust.
- Request that the Local Area Team and health economy Directors of external organisations meet to formally sign off plans, recognise the GAP in capacity and develop solutions

FINANCIAL AND RESOURCE IMPLICATIONS:

The Trust is awaiting formal confirmation from CCGs ('Surge Resilience Funding') of the outcome of its bid for monies required to support UC&LTC Division and Surgical Division in the implementation of additional capacity during winter.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
N/A

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
N/A

ACTION REQUIRED:

To discuss and Sign-off the Plan with the caveat that the development of the Trust's Seasonal Pressures Plan 2014/15 will remain an iterative process as further information becomes available during September.

CONSEQUENCES OF NOT TAKING ACTION:

The Trust will be unable to respond to surges in activity demand and as a result it is unlikely that key targets including A&E will be achieved and patient and care quality may be affected.

Trust's Seasonal Pressures Plan 2014 / 15

1 Overview:

1.1 The principle aim of the Seasonal Pressures Plan 2014/15 is to ensure that the Trust manages surges in demand for services throughout the year, delivering safe patient care through operational resilience.

1.2 The Trust's Seasonal Pressures Plan 2014/15 will work in association with the whole systems Operational Resilience and Capacity Plan (East Kent Federation CCG Plan 2014 / 15) and be implemented in line with other health and social care provider plans, such as Primary Care, Kent Community Health Trust, Social Services and SECAmb Trust.

1.3 This Seasonal Pressures Plan specifically brings together both elective and non-elective elements within one planning process to underline the importance of whole systems resilience to ensure areas are addressed simultaneously so that local health and care systems operate as effectively as possible in delivering year round services for patients.

1.4 To build upon the 2013/14 Seasonal Pressures Plan and experiences, all identified lessons have been incorporated into the 2014/15 Seasonal Pressures Plan. The working assumption is that the CCGs adhere to the expectations placed upon them such as ensuring sufficient capacity has been sourced throughout the health economy. ECIST's '10 steps' to good winter planning, states that *all parts of the local health community must be aligned to support each other, as well as 'consuming their own smoke'*.

1.5 The Trust's demand is constantly evolving, the demand for emergency and elective treatment is increasing and it is expected that there will be additional surges in activity at varying periods throughout the year.

1.6 Whilst winter is a period of increased pressure to the health community, establishing sustainable year round delivery requires capacity planning to be continuous and robust. This approach moves to year round operational resilience underpinning the development of this year's Seasonal Pressures Plan.

1.7 The capacity planning is likely to identify that the Trust will be unable to meet the full demand. Therefore, the CCGs will need to explore alternative ways of meeting any potential gaps in capacity. This requires a whole systems approach to ensure that the risk is not solely the responsibility of the Trust.

1.8 The CCGs have been asked to provide assurances that all health and social care providers have robust, sufficient and consistent capacity to ensure safe patient flow within the system.

2 Seasonal Pressures Analysis Calculator

2.1.1 The Seasonal Pressures Analysis Calculator has been developed to enable the Divisions to test various 'activity surge scenarios' to determine the overall impact on emergency admissions (A&E and non-elective work such as direct GP referrals), bed capacity requirements and readmissions.

2.1.2 This calculator is based on the assumption that the length of stay, clinical dependency and level of reportable Delayed Transfer of Care (DTOCs) are within normal limits. Any increase in these will mean that RAG status Red will

be reached at an earlier stage due to a greater proportion of the acute bed base effectively being 'unavailable' to manage emergency patient flow.

2.1.3 Using this model against the bed base, RAG Red will be reached once the bed requirements exceed baseline and any planned additional or continuity beds. Potentially this would mean that significant pressures would be experienced during certain months of the year.

2.1.4 The Seasonal Pressures Plan has been developed to ensure that comprehensive and robust plans will be ready to manage the predicted surges in activity this winter.

3 Monitoring of Seasonal Pressure Triggers & Plans & Organisation's Plans

3.1 This year, CCGs will be using SHREWD to monitor the performance of provider's plans across Kent & Medway. A set of key performance indicators (KPIs) will be agreed with each provider organisation during August/September 2014. These KPIs will be reported through a unified dashboard. Managers will be able to view current performance which will allow immediate identification of pressures and/or delays within the whole system allowing a more focused set of actions to be taken to manage capacity issues and maintain a safe patient flow throughout the system.

4 Risks and Mitigating Actions

4.1.1 The single biggest risk is that the Trust is heavily reliant on external providers having sufficient and robust capacity to support timely and consistent admission avoidance and facilitated discharge. To ensure the Trust does not take sole responsibility of the risks associated within the Seasonal Pressures Plan, a comprehensive risk register has been developed. This outlines the risks associated with the development, implementation and delivery of the Seasonal Pressures Plan and the impact of external providers with regards the sustainability of safe, efficient and effective patient care.

4.1.2 The key risks associated with the Seasonal Pressures Plan 2014/15 are identified below in Table 1.

Table 1: Key Risks Associated to the Seasonal Pressures Plan 2014/15

Risk	Mitigating actions
1. Lack of sufficient capacity within the community to support timely and consistent admission avoidance and facilitated discharge presents the greatest risk to the quality and timeliness of patient care. The Trust is heavily reliant on external providers having sufficient and robust capacity to support timely and consistent admission avoidance and facilitated discharge. It is also important to note that the success of the integrated admission and discharge teams will be dependent on capacity being available to transfer patients into.	a. Seek assurances from CCGs and partner organisations that sufficient capacity will be provided in direct response to protected activity and demand. (Lead – Deputy Chief Executive and Director of Operations to contact Lead Commissioner for Urgent Care – August 2014). b. Seek assurance from CCGs that alternative solutions will be explored to ensure safe, efficient and effective patient flow throughout the health economy. (Lead – Deputy Chief Executive and Director of Operations – 5 September 2014).

	c. Monitor performance against KPIs to ensure timely and appropriate actions are taken. (Lead – Forward Planning Group & Integrated Urgent Care Board supported by Lead Commissioner Urgent Care – September 2014 onwards).
2. Performance against access times will not be sustained due to insufficient internal emergency and elective capacity.	a. Complete the activity demand capacity scenario planning to highlight gaps in capacity. (Lead – Divisional Leads and Head of Information – 13 August 2014). b. Develop plans within the Trust to manage a defined level of capacity. (Lead – Divisional Leads/Divisional Directors – 15 August 2014). c. Formally advise CCGs of Trust's capacity and the identified gap in capacity. (Lead – Deputy Chief Executive and Director of Operations).
3. CCGs fail to hold all providers (Health and Social Care) to account for ensuring there is a robust and consistent response across East Kent to maintain safe, efficient and effective patient flow throughout the whole system.	a. Seek urgent assurance from Lead Commissioner Urgent Care of the monitoring process and of holding organisations to account for delivering sufficient response to surges in activity i.e. enough capacity. (Lead – Head of Emergency Planning and Business Continuity – End August 2014/Mid-September 2014).

4.2 The Trust has bid for 'Surge Resilience Funding' and is awaiting confirmation of funding the Trust's prioritised schemes to help to manage the winter pressures:-

- Surgical Assessment Unit
- Additional consultants in A&E
- Integrated Urgent Care Centre
  - Acute Medical Model of Care
  - Integrated Discharge Team

5 Next Steps:

- Trust Board to **Sign-off the Plan with caveat** and submit to CCGs (end August)
- Test resilience of external stakeholder plans against ECIST '10 steps' to good winter planning (within 10 working days of receipt of plans)
- Engage in discussions with CCGs to ensure that health economy Directors of each organisation formally sign off their plans, recognise the capacity GAP within the health economy and develop solutions to bridge and manage the GAP (end August)

- Recommend that the Local Area Team formally scrutinises all providers' plans (end August)
- Update the Trust's Risk Register to reflect risks as they emerge
- Communicate approved Seasonal Pressures Plan to staff and external stakeholders (first week September)
- Carry out internal exercise of Trust's Seasonal Pressures Plan (September)
- Participate in external exercise testing of all plans within health economy (mid-September)

6 Action required:

6.1 The Trust Board is asked to **discuss and Sign-off the Plan with the caveat** that the development of the Trust's Seasonal Pressures Plan 2014/15 will remain an iterative process as further information becomes available during September.

6.2 The Board is asked to note there will be challenging discussions with external partners and CCGs to achieve assurance that there is sufficient and safe capacity within the health economy to respond to surges in activity demand.

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

SEASONAL PRESSURES PLAN 2014/15

This Plan sets out East Kent Hospitals University NHS Foundation Trust's preparation for resilience during times of increases in activity and demand all year round. It outlines the predicted capacity gaps for the year. The Plan identifies the Trust's additional safely staffed capacity that will be used when there is an increase in demand. It notes the escalation triggers and processes to follow. Divisional Plans and Site Plans underpin this Seasonal Pressures Plan.

Version:	**7th Draft**
Ratified by:	Trust Board
Caveats of Ratification:	1) Iterative process – awaiting External Partners Plans 2) Recognition of Whole Systems capacity gap by External Partners and solutions are identified to address
Date ratified:	29th August 2014
Name of originator/author:	**Karen Miles:** Associate Director of Operations **Peter Johnson**: Emergency Planning and Business Continuity Manager
Director responsible for implementation:	**Julie Pearce** Chief Nurse/Director of Quality & Operations/Deputy Chief Executive
Date issued:	
Review date:	
Target audience:	All staff Trust Wide

Version Control Schedule

Version	Date	Author	Status	Comment
0.1	18th June 2014	**Peter Johnson** Emergency Planning and Business Continuity Manager	Draft	Format and Structure revised
0.2	15th July 2014	**Peter Johnson** Emergency Planning and Business Continuity Manager **Karen Miles** Associate Director of Operations	Draft	Incorporated information from Operational Resilience and Capacity Planning for 2014 / 15 Guidance Documentation
0.3	16th July 2014	**Peter Johnson** Emergency Planning and Business Continuity Manager **Karen Miles** Associate Director of Operations	Draft	Incorporated Divisional Key Headlines, Capacity and Demand, Discharges and PTS
0.4	21st July 2014	**Peter Johnson** Emergency Planning and Business Continuity Manager **Karen Miles** Associate Director of Operations	Draft	Refined Capacity Planning with Divisions. Completed governance arrangements and incorporated transport plans.
0.5	23rd July 2014	**Peter Johnson** Emergency Planning and Business Continuity Manager **Karen Miles** Associate Director of Operations **Sarah Maycock** Interim Head of Service Improvement	Draft	Incorporated updates to planning assumptions, inclusion of pandemic flu plan and mortuary arrangements, re-defined RAG status against bed base and clarified bed escalation process. Included further detail on Surgery's plans.
0.6	25th July 2014	**Karen Miles** Associate Director of Operations **Sarah Maycock** Interim Head of Service Improvement **Peter Johnson** Emergency Planning and Business Continuity Manager	Draft	Incorporated comments from risk assessment completed 23.7.14 against NHS England's Planning Guidance Checklist. Revised capacity and demand section to identify actions required. Incorporated mortuary capacity and escalation.
0.7	12th August 2014	**Peter Johnson** Emergency Planning and Business Continuity Manager **Karen Miles** Associate Director of Operations **Sarah Maycock** Interim Head of Service Improvement	Draft	Incorporated comments from Divisional Directors following meeting on 6th August, capacity planning, inclusion of provisional Surge Resilience schemes, Inclement weather and Patient Transport. Feedback from meeting with Julie Pearce and Jane Ely

CONTENTS

Introduction

The primary remit of this Plan is to maintain service provision and ensure the safety of patients and staff at all times throughout the year. Timely patient flow is the responsibility of the whole system across Kent and Medway, therefore requiring a consistent approach throughout Kent and Medway to ensure the impact on patients and staff are mitigated.

The Trust's Seasonal Pressures Plan will work in association with the whole systems Operational Resilience and Capacity Plan (East Kent Federation CCG Plan 2014/15) and be implemented in line with other Health and Social Care Provider Plans, such as Primary Care, Kent Community Health Trust, Social Services and SECAmb Trust.

Whilst winter is a period of increased pressure to the Health Community, establishing sustainable year-round delivery requires capacity planning to be ongoing and robust. The approach moves towards year-round operational resilience underpinning the development of this year's Plan. **It is absolutely essential that the health economy has a clear understanding of how much capacity will be required to ensure that the whole health system achieves and maintains effective patient care. This Plan will remain an iterative process until such reassurance is received.**

The Trust's Plan has a defined finite level of capacity to support provision of safe emergency and elective services. This capacity will not meet the expected level of demand unless all partners work collaboratively to optimise admission avoidance and timely facilitated discharge. Therefore, as the Trust will be unable to meet the full demand, CCGs will need to explore alternative ways of meeting the expected gap in capacity.

This Seasonal Pressures Plan has been developed and aligned with the "NHS England South Escalation Framework, 2013" and the guidance document "Operational Resilience and Capacity Planning For 2014/15" specifically bringing together both elective and non-elective elements within one planning process to underline the importance of whole-systems resilience to ensure areas are addressed simultaneously so that local health and care systems operate as effectively as possible in delivering year-round services for patients.

The Plan takes into account how the Trust will implement all non-elective and elective care during surges in demand for services. It builds on the key lessons learned during 2013/14 in terms of what worked well and areas requiring improvement.

The Integrated Urgent Care Board will monitor whole systems compliance and partnership working via a whole-systems dashboard and SHREWD.

The effectiveness of this Plan requires EKHUFT's partnership organisations to have robust and consistent plans in place that are responsive with sufficient capacity to support surges in demand and that deliver effective patient flow throughout the year.

Aim

The principal aim of this Plan is to ensure that the Trust manages surges in demand for services throughout the year delivering safe patient care through operational resilience during surges in demand for services.

This Seasonal Pressures Plan is to be used in the event of any Trust-wide seasonal pressures, activity surges or inclement weather which produce, or expect to produce, a significant surge in activity at any one of the Trust's sites.

Objectives

To ensure the Trust understands predicted emergency and elective activity during seasonal pressures and provides sufficient capacity to maintain safe, efficient and effective patient care. The Trust-wide approach must deliver the following:

- Sufficient and effective demand and capacity planning (Division/Site/Trust level)
- Efficient utilisation of internal and external bed capacity
- Clear communications (internal & external)
- Clear understanding of escalation triggers and response
- Accurate performance indicator reporting via SHREWD
- Understanding and compliance with 'Whole Systems' daily teleconferencing process (operational management)
- Staff knowledge and understanding of Plan through regular scheduled training
- Deliver resilience whilst maintaining financial balance.

Plan Excludes

- The Trust's Incident Response Plan
- Divisional Business Continuity Plans (Recovery Plans and/or Procedures). These are aligned to the Trust's Seasonal Plan
- External organisations (or suppliers (recovery plan and/or procedures). These plans would be available as part of Incident Response arrangements.

Ownership and Maintenance

- The development of the Seasonal pressures Plan will remain an **iterative** process as further information becomes available.
- The Emergency Planning and Business Continuity Committee own this Plan. The Plan will be reviewed annually by the Committee in April, updated and issued at least once per calendar year (in August, Plan to go live 1st October). Changes to the Plan may be requested at any time based on organisational changes, actual incidents or any other factors.
- All major changes need to be approved by a quorum of the Emergency Planning and Business Continuity Committee. Version control and governance of the Plan will remain the responsibility of the Emergency Planning and Business Continuity Department.
- This Plan will be distributed to individuals on the Executive on Call Rota and the General Manager on Call Rota, and to all service areas. The "ratified" Plan will be available on Trust's SharePoint.
- This Plan will also be distributed to all CCGs in East Kent.
- A comprehensive communications plan will be in place to ensure that all staff members are aware of their roles and responsibilities to execute the Plan.
- The Plan will be fully exercised and tested at least once per calendar year.

NB: Whilst this Seasonal Pressures Plan links directly to the individual Divisional Plans and Site-based Plans, Divisions have the responsibility for communicating and adhering to their specific plans.

NHS England South Escalation Framework 2013

The Seasonal Pressures Plan is aligned with the NHS England South Escalation Framework 2013 which states that all provider organisations have a responsibility to:

- Have a Surge Capacity Plan (SCP) that is consistent with the Level 1 SCP for each urgent care working group area, and with the Area Team Level 2 plan.
- Ensure that finally agreed plans are signed off by the appropriate body and internal policies and procedures are altered to ensure internal management and compliance.

The NHS England South Escalation Framework supports the above requirements and further states that all Service Providers have a responsibility to:

- Have an organisational Seasonal Pressures Plan consistent with the Integrated Urgent Care Board's Plan and Local Area Team Escalation Framework
- Provide their Seasonal Pressures Plan to CCGs for co-ordination
- Describe within the Plan how the organisation will determine its status (Green to Black)
- Describe how the organisation will respond to CCG declarations on the status of the health economy (as opposed to the status of an individual provider); and what cross organisational support the organisation can provide to other providers
- Ensure that their Seasonal Pressures Plan addresses the criteria set out in the NHS England South Escalation Framework
- Ensure that their staff are trained in their role in Seasonal Pressures Plans and that the Plan is tested through internal Trust exercises.

Principles of good practice

The Trusts' Plan supported by the Divisional Plans will embrace and work towards the "principles of good practice" and wider planning considerations set out in NHS England "Operational Resilience and Capacity Planning for 2014/15".

Principles of good practice for non-elective care pathways

Planning

- **Enabling better and more accurate capacity modelling and scenario planning across the system** to successfully accommodate normal variation in non-elective demand, as well as modelling to consider how to plan for capacity for the following day.
- **Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs.**

Primary Care

- **Additional capacity for primary care**, as part of local integrated strategies for supporting out-of-hospital care and wider community services. This should include seven day working across the whole system, adoption of ambulatory care, and ensuring that where possible, the system is not running at or near 100 per cent. This should also extend to schemes relating to proactive care and avoiding unplanned admissions. Plans should demonstrate comprehensive flu planning in line with guidance published by Public Health England in April 2014.

Seven Day Working

- **Improve services to provide more responsive and patient-centred delivery seven days a week**.
- **Seven day working arrangements** in place for social care workers to facilitate hospital discharge, brokerage of packages of care, and senior social care management sign off of delayed transfers of care.

Patient Experience

- **Expand, adapt and improve established pathways for highest intensity users within emergency departments.** To ensure these groups of patients get timely, consistent care in line with established best practice, pathways should be reviewed to maximise effectiveness.
- **Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand** to ensure swift, sound clinical decision-making and effective use of staffing and other resources.
- **All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge.**
- **Processes to minimise delayed discharge and good practice on discharge.**
- **Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes.**
- **Better understanding of the needs of the 2-5 per cent of highest risk patients.**

Measure-ment

- **The use of real time system-wide data.**

Principles of good practice for elective pathways

Planning

- Review and revise patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014.
- Develop and implement a referral to treatment (RTT) training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15.
- Carry out an annual analysis of capacity and demand for elective services at sub specialty level, keeping under regular review and updating when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16.

Building on Existing Work

- Build upon any capacity mapping that is currently underway, and use the outputs from mapping exercises as an annex to operational resilience and capacity plans.

Pathway Design

- Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each. This should be in place by September 2014 in order to ensure that activity is maintained at a level where waiting lists remain stable.
- Ensure that 'patient choice' and patient rights under the NHS Constitution are well communicated across elective care.
- 'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines.

Measure-ment

- With immediate effect, review local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses.
- Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary (or if not done in the last 12 months), and instigate a programme of regular data audits.
- Put in place clear and robust performance management arrangements, founded on use of an accurate RTT patient tracker list (PTL), and use this in discussion across the local system.
- Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored.

Governance

- Provide assurance during quarter two 2014/15 at Board level on implementation of the above.

Principles of good practice for wider planning considerations

Planning (1)

- **Discharge planning**
- **Avoid inappropriate delays**
- **Working with ambulance services**. About 31 per cent of attendances at emergency departments arrive by ambulance. System Resilience Groups (SRGs) should make sure ambulance services have access to live information from emergency departments to help distribute workloads between departments, develop area-wide capacity management systems that dynamically regulate flows between hospitals, and agree protocols for referrals between ambulance trusts and other providers.

Planning (2)

- **Unscheduled care** – Focus on avoiding unnecessary episodes.
- **Flu planning –** Meet all vaccination requirements.
- **Manage referrals effectively** and ensure that all referrals are appropriate and reflect best practice.

Patient Experience

- **Right care, right time, right place.** SRGs should facilitate open access with guidelines, and eliminate unnecessary gate-keeping, improve guidance and information for patients, and work to enable ambulances to take patients to urgent care centres (e.g. primary care centres, minor injury units or walk-in centres), and to access social care and mental health teams. SRGs may wish to explore opportunities to create for peak time, out of hours and bank holidays co-located urgent care centres with emergency departments where this is feasible, to provide effective alternatives to those patients who present at A&E and who could be seen by a GP.
- **Children's services.** Children and their parents or guardians should be able to access appropriate emergency care as close to home as possible.
- **Mental health services.**

Chronic conditions and home care

- **Caring for patients with chronic conditions**. In light of a high proportion of emergency admissions arising from an exacerbation of a chronic disease, SRGs should promote better self-care support for patients and case management techniques for those with more complex conditions, and consider auditing common re-admissions – patients who have more than three admissions per year.
- **Planning for care home residents.** Regular health surveillance decreases the risk of hospital admission, so should consider joint mapping requirements and calculating the appropriate occupancy to make sure beds are available at short notice, and work towards whole system escalation plans which are predictive, not reactive. There should be planned distribution of services across a locality to avoid duplication.

The Seasonal Pressures Plan

This Plan is an iterative process. It will be revised as further information and details become available from Divisions in the development of their plans and from external organisations' plans. It will be risk assessed and modified to ensure the Plan has the maximum possible resilience.

Demand and Capacity - Overview

On an annual basis, EKHUFT can expect to manage a pre-determined level of activity demand through the A&E Department, Elective admissions, Non-Elective admissions and Readmissions. However, it is also expected that there will be surges in activity at varying periods throughout the year; the winter months have proved challenging as winter brings an increased level of pressure to the Health Community. Seasonal variations in illness have been shown to result in increased emergency admissions and length of stay in hospital during the winter months, with pressures peaking between November and April, with evidence of pressures continuing during the summer months.

Although arguably the peak in demand in the winter is generally no worse than in summer, the increased demand often occurs alongside peaks in seasonal flu and norovirus. During last year's seasonal pressures, the Trust experienced an increase in patient acuity which also contributed to enhanced pressure on clinical staff, acute services and a greater length of stay throughout the year. The Trust therefore needs to plan for similar pressures all year round in order to be prepared to meet the expected demand on its services.

The Trust has submitted a number of schemes for external funding which improve the operational resilience of non-elective care during the winter months. The impact of these schemes on demand has been considered in the demand and capacity modelling undertaken by Divisions.

All schemes across East Kent are summarised at Annex B of this Seasonal Pressures Plan. However, the Trust schemes are:

- Surgical Assessment Units
- Additional A&E Consultant capacity
- Integrated Urgent Care Centre
    - Acute Medical model of Care
    - Integrated Discharge Team

It is essential that the health economy understands the drivers of system pressures in order to develop effective solutions through partnership working across the whole system, that actively supports achievement of reduced avoidable A&E attendances through provision of robust and responsive Admission Avoidance Schemes within community – based resources, such as direct access to 'step up beds' or domiciliary care via Social Care.

RISK: There are a number of concerns regarding this year's planning arrangements and assumptions, in particular the Trusts' reliance on the whole system understanding and appreciating the level of demand being placed upon the acute Trust. As a service provider in isolation the Trust cannot safely provide sufficient capacity to meet this demand, whilst ensuring both patient safety and staff wellbeing, without the reassurance that robust, sufficient and consistent capacity is provided by Health and Social Care providers. This is an essential

requirement if the Trust is to maintain timely patient flow associated with reduced A&E attendance, admission avoidance and early facilitated discharge.

RISK: Whilst internal capacity planning demonstrates flexibility and identifies constraints associated with safe staffing levels, the Trust requires information regarding external providers' capacity or degree of flexibility to support activity surges, in order to facilitate effective patient flow and help to avoid situations where the Trust's beds become 'blocked'.

Activity demand modelling – Impact of 'activity surges' on patient flow

Whilst it is important to understand the Trust's expected activity, it is essential to plan for unexpected surges such as those experienced during 2013/14.

A Seasonal Pressures Analysis 'Calculator' (at Annex A) has been developed to enable the Trust to test various 'activity surge scenarios' to determine overall impact on emergency admissions (A&E and non-elective such as direct GP referrals), bed capacity required and readmissions.

The Seasonal Pressures Analysis 'Calculator' is based on the assumption that the length of stay, clinical dependency and level of reportable Delayed Transfers of Care (DTOCs) are within normal limits. Any increase in these will mean that RAG status Red is reached at an earlier stage, due to a greater proportion of the acute bed base effectively being 'unavailable' to manage emergency patient flow.

Using this model against the bed baseline, RAG status red will be reached once the bed requirement exceeds baseline and any additional safely staffed beds. This would indicate that the Trust would experience significant pressures for certain months of the year, therefore sufficient planning must be undertaken to manage these predicted surges.

Demand and capacity assumptions

Demand assumptions:

- Demand is based on previous 18 months activity trend which is a more realistic projection of predicted demand levels than the Trust's Activity Plan 2014/15.
- A&E attendances are based on actual performance trend over 16 month period (January 2013 and end May 2014)
- Surgical Division has experienced activity growth year-on-year over past 5 years, so have planned for this growth to continue over the next 12 months.
- Surgical Division has a far greater requirement for beds Monday to Friday, as opposed to weekends, due to Elective activity. To support weekday variation, activity and demand is therefore based on 90% bed occupancy rates.
- UC&LTC Division has also planned for 90% bed occupancy to support weekday variation, based on historical trends. However, current activity **exceeds 5%** growth; if this trend continues, capacity will be insufficient.
- UC&LTC Division has allowed for a 5% reduction in A&E Attendances to reflect predicted impact of the forthcoming Integrated Discharge Team.
- Specialist Division have planned for a 10% specialty outlier rate within their bed base, in line with current practice.
- Readmissions activity is based on the year to date rate of 8.91% (June 2014 Trust Board report).

Activity Exclusions:

Specialties Midwifery, Day Surgery, Paediatrics, Renal
Wards, ITU (all sites) Hospital at Home (all sites) and Oxford ward.
Patients (aged under 18 years old at admission)
Sites – any site other than K&C, QEH, WHH.

NB: The exclusion of Renal beds and Oxford ward equates to a reduction in bed baseline by 43 beds. These beds will be fully utilised by patients with renal conditions or Infectious illness.

Capacity assumptions:

- Set out a range of bed occupancy rates with 85% being the optimum; however we recognise this is unachievable.
- Funded bed base is based on Divisions' confirmed position as at 15th August 2014 - exclusions outlined above.

Capacity Plans

The demand and capacity modelling work has identified the total bed capacity required per acute site, from September 2014 to August 2015, factoring in planning assumptions:-

- Expected activity through A&E – non elective
- Expected Emergency Admissions (per site)
- Expected Elective Admissions (elective per site)
- Average Length of Stay
- Acuity of patients (based on Charlestone score)
- Expected Discharges (per site)
- Total number of Reportable Delayed Transfers of care per site
- Bed occupancy rates

Bed Capacity Modelling Headlines (extracts from Model shown at Annex A)

- Bed requirements vary per site, per month, per Division.
- Based on 90% bed occupancy within the funded bed baseline, the Trust has insufficient bed capacity all year round,
- When compared to the Trust's bed baseline only the monthly capacity gap ranges from 0 (Aug 15) to 109 (Oct 14).
- If the Additional safely staffed bed base is utilised and the bed occupancy rate runs at 90%, the Trust has insufficient capacity for 7 months of the year. This gap ranges from 6 beds (Nov 14) to 68 beds (Oct 14). Monthly average capacity gap is 39 beds.

NB: Need to engage Commissioners and community service providers to agree a way forward where they provide this shortfall in capacity during the 7 months of the year.

- Assuming the Trust runs at **100%** occupancy including **all** Additional safely staffed beds, each Division will experience extreme pinch-points (above baseline and Additional safely staffed) in:
  - UCLTC – Oct 14 (10 beds) & June 15 (5 beds)
  - Surgery – March 15 (22 beds)
  - Specialist – April 15 (4 beds), July 15 (9 beds) & August 15 (5 beds)
- Because the Divisions experience these pinch-points at different times, other Divisions will be required to accommodate specialty outliers, to support safe patient flow (see Trust and Divisional Monthly bed requirements in Picture 1).

Picture 1: Trust and Divisional Monthly bed requirements at 90% and 100% occupancy. Also shows Baseline Beds and Additional safely staffed beds

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
TRUST												
Total Beds Required (100% Occupancy)	750	825	768	756	782	746	821	754	810	809	770	726
Funded bed base	48	-27	30	42	16	52	-23	44	-12	-11	28	72
Additional Safely Staffed	89	14	71	83	57	93	18	85	29	30	69	113
Total Beds Required (90% Occupancy)	825	907	845	832	861	821	904	829	891	890	847	798
Funded bed base	-27	-109	-47	-34	-63	-23	-106	-31	-93	-92	-49	0
Additional Safely Staffed	14	-68	-6	7	-22	18	-65	10	-52	-51	-8	41
UCLTC												
Total Beds Required (100% Occupancy)	437	493	449	436	453	431	452	441	459	488	419	395
Funded bed base	13	-43	1	14	-3	19	-2	9	-9	-38	31	55
Additional Safely Staffed	46	-10	34	47	30	52	31	42	24	-5	64	88
Total Beds Required (90% Occupancy)	481	542	494	479	498	474	497	485	505	536	460	435
Funded bed base	-31	-92	-44	-29	-48	-24	-47	-35	-55	-86	-10	15
Additional Safely Staffed	2	-59	-11	4	-15	9	-14	-2	-22	-53	23	48
SURGERY												
Total Beds Required (100% Occupancy)	283	304	284	297	300	280	340	271	315	289	305	287
Funded bed base	31	10	30	17	14	34	-26	43	-1	25	9	27
Additional Safely Staffed	35	14	34	21	18	38	-22	47	3	29	13	31
Total Beds Required (90% Occupancy)	311	335	312	327	330	308	374	298	346	318	336	316
Funded bed base	3	-21	2	-13	-16	6	-60	16	-32	-4	-22	-2
Additional Safely Staffed	7	-17	6	-9	-12	10	-56	20	-28	0	-18	2
SPECIALIST												
Total Beds Required (100% Occupancy)	30	28	35	24	29	36	29	42	37	33	47	43
Funded bed base	4	6	-1	10	5	-2	5	-8	-3	1	-13	-9
Additional Safely Staffed	8	10	3	14	9	2	9	-4	1	5	-9	-5
Total Beds Required (90% Occupancy)	33	31	39	26	32	39	32	46	41	36	51	47
Funded bed base	1	3	-5	8	2	-5	2	-12	-7	-2	-17	-13
Additional Safely Staffed	5	7	-1	12	6	-1	6	-8	-3	2	-13	-9

NB: It is neither achievable nor safe for the Trust to sustain 100% bed occupancy, Including all Baseline and Additional safely staffed beds, all year round.

Additional Safely Staffed Beds - Internal Capacity

In response to the predicted increased in activity demand, the Trust has identified a further 41 additional safely staffed beds. These are in addition to the funded adult bed baseline of 798 beds.

RISK: All additional safely staffed beds have been in use since winter 2013.

RISK: All staffing resources will be deployed flexibly during peak times of pressure. However the Trust has a shortfall of 40wte Nursing staff at ward level and 20wte nursing in A&E.
NB: this is after the current recruitment campaign.

Table 1: Adult Baseline and Additional Safely Staffed Beds

Site	Division	Adult BASELINE Beds	Adult ADDITONAL SAFELY STAFFED Beds
WHH	UCLTC	164	11 (175)
	Surgery	153	0
	Specialist	11	0
QEQM	UCLTC	132	10 (142)
	Surgery	105	4 (109)
	Specialist	15	4 (19)
K&C	UCLTC	154	12 (166)
	Surgery	56	0
	Specialist	8	0
INTERNAL SUBTOTAL		**798**	**41 (839 total)**

Whilst the Trust is managing patient flow within the funded baseline beds only it will declare itself as Green. The Trust will escalate into Amber once the additional safely staffed beds begin to be used. Once the Trust has used all additional safely staffed beds, status Red will be declared. Status Pre-Black will be declared once all non-urgent surgery is reviewed and Black when non-urgent surgery is cancelled.

NB: The Trust will not provide any unsafe, unstaffed beds at status Black and will therefore be reliant on External Providers' responses.

Table 2: RAG status against bed base

RAG Status	Bed Base - Adult
Green	Funded Baseline 798 beds.
Amber	Start to use additional safely staffed beds
Red	Have used all additional safely staffed beds (839 total).
PRE-BLACK	Review all non-urgent Surgery and plan to cancel where clinically safe to do so.
Black	No beds available and non-urgent Surgery has been cancelled. **The Trust will not provide any unsafe, unstaffed beds at status Black and will therefore be reliant on External Providers' response.**

NB: Whilst capacity is planned on a Divisional basis, the Divisions are responsible for communicating between themselves to facilitate a site-wide response and ensure that the status level declared represents the site, rather than a Division in isolation.

Reablement Capacity Planning – EKHUFT External Beds

Whilst it is important to create sufficient capacity within the Trust, it is recognised by the Trust that once patients are medically stable, it is far more beneficial for them to be cared for in a less acute environment. EKHUFT purchased 60 dedicated non-weight bearing and step down beds last year within the Ashford and South Kent Coast locality which proved extremely beneficial. Provision of these beds enabled a reduction in Reportable DTOCs, reduced numbers of Extra beds used and a reduction in speciality outliers, against the same period in 2012/13.

Through partnership working with CCGs, EKHUFT has block purchased a further 20 beds (80 beds in total) externally throughout East Kent, continuing the success of the 60 beds during 2013/14. This will support acute patient flow as well as ensuring that patient care, safety and experience are maintained. The remaining 20 step down beds will become operational in the Canterbury area in November/December 2014. This reablement capacity, in addition to the planned improvements to other Community provided beds, should ensure there are sufficient beds in the community to meet the expected demand.

The 80 step down beds will facilitate ongoing dedicated provision of 20-25 non-weight bearing beds (NWB) (orthopaedic pathway) and the remainder will be utilised for reablement /short term rehabilitation and assessment. Each 20 bedded locality bed base will be fully supported by a multi-disciplinary team, therefore patients requiring a comprehensive assessment (INP) can be transferred to these beds prior to assessment.

NB: Patients requiring Continuing Health Care will not be suitable for these beds due to the length of stay required by this patient group.

Access to these beds will be via the Discharge Manager and/or Integrated Discharge Team.

All patients identified for transfer to these beds must be medically stable, safe for transfer, and be accompanied with a completed EDN, TTOs and transfer letter rehabilitation plan. It is the responsibility of the acute Trust to ensure both patients and relatives are involved in the decision to transfer and are aware of the anticipated length of stay within the step down beds.

- Patients on a non-weight bearing pathway will have a LOS of up to 56 days
- Patients for assessment/reablement will have a LOS of 21 days (maximum of 28 days if patient is transferred prior to INP completion)

Whilst there are three acute sites, additional step down capacity will be provided for all four CCGs to ensure that, wherever possible, patients are transferred to a bed within their own CCG locality. For this reason, it is expected that each of the acute sites will be able to access at least two reablement step down bed bases, therefore co-ordination between the Discharge Managers will be essential.

Kent Community Health Trust plans to centralise NWB patients from their community hospitals onto a single site, replicating the EKHUFT Model of Care - QVM Herne Bay – thereby giving the other three community hospitals the opportunity to reduce their LOS to 21-25 days and essentially creating capacity for 20 extra beds in the system. The Community Trust is reviewing the eligibility criteria in line with these proposed changes.

In the event that Community based resources fail to be responsive or efficiencies within bed bases (regardless of provider), prove to be insufficient or unsustainable, it is highly likely that the Trust will experience similar pressures and associated risks to patient safety as experienced during the Trusts' 'Internal Incident' during April 2013.

Whole Systems Working – Key Organisational Interventions

RISK: Seasonal Pressures Plans are yet to be received from External Providers.

The Trust has identified the maximum number of beds it is able to staff safely. Beyond this point, the Trust is reliant on all External Partner Organisations to provide robust services to support both admission avoidance and facilitated discharge to ensure there are no 'bottlenecks' within the system. As such, this remains the greatest risk to delivering safe care during surges in demand.

Further work is required to describe the:-

- links between the Acute Trust, primary care services, Ambulance Trust and A&E Departments
- trauma network arrangements for managing surges in demand
- escalation processes – Acute Trust has internal arrangements but 'whole system' processes are pending further information
- support available from Mental Health Services to ensure access to services and primary care during Christmas/New Year to help maintain vulnerable people in the community
- 'out of hours' contingency arrangements to support people in their own homes
- 24/7 intermediate care working arrangements
- flexible discharge arrangements with transport services to ensure discharges can be maintained at times of peak pressure
- mechanism between health and social care for quick resolution of any issues arising from agreeing care packages (escalation process and additional capacity is unclear)
- how each stakeholder is going to work in isolation and also with colleagues to ensure that winter plans are clear and adhered to, the impact is understood and monitored with timely escalation when interventions are inadequate

NB: This work cannot be completed until the Trust has received Draft copies of External partners' plans and undertaken a gap analysis.

A **verbal** Summary of key interventions for each Organisation is provided below:

SOCIAL SERVICES have:

- Confirmed that arrangements will be in place to support 7 day working (8am – 8pm) for their staff, commencing 1st October 2014
- Enabled EKHUFT staff to automatically re-start existing care packages, without the need to refer to the Integrated Discharge Team (implemented across the Trust October 2013).
- Committed to provide Age UK available 10am – 8pm "low level contact" patients (shopping, meet and greet, discharge medicine checks) to enable suitable patients to be discharged from hospital rather than be delayed because circumstances prevent them from getting home.
- Arranged to "pull" patients from hospital earlier and take them home to support discharges from A&E late at night.
- Developed a bid for Canterbury Locality Surge Resilience to support provider organisations to deliver discharge and re-integration to home for patients across the three hospitals within the East Kent area over the busy Christmas and New Year Period. It is anticipated that this service will run from 15th December 2014 – 5th January 2015.
- If people are unable to be discharged from hospital on time and packages of care are not appropriately moved through the system and care and support delivered then it can result in delayed discharges, pressure on beds for those who are acutely unwell and potential re-

admissions to hospital. This service would ensure reduced pressure on EKHUFT and the East Kent CCGs. The Acute Trust will **clarify** whether Social Services will be providing additional capacity for care packages or an escalation process when delays occur to ensure that delayed discharges remain within safe levels.

- The support would be provided through a block purchase of on-call staff from domiciliary care agencies that will be paid on retainers to ensure delivery and at K&C unsocial Rates for the transport home, settling and support delivery over a 72 hour period.
- Requested and committed to attending monthly, escalating to weekly meetings with EKHUFT, to discuss any operational issues or concerns, to support joint working throughout the winter months. The Acute Trust will agree with partner organisations key trigger points which will generate the need for meetings and expectations/outcomes.
- Should demand exceed capacity, EKHUFT will work with its health and social care partners under direction from the CCG's to identify any further potential for additional capacity. The expectation is that Social Services and Kent Community Health Trust will maintain an average length of stay of 4 weeks/maximum length of stay of 6 weeks and will regularly review patients within their bed base to ensure discharge planning is robust and timely. The Acute Trust will **clarify** with Social Services the expected Length of Stay within their bed base and identify which processes and escalation will be established this year.

KENT COMMUNITY HEALTH TRUST

KCHT – (Canterbury locality) - has:

Developed a bid for funding a new "Inter-professional clinical model" capable of supporting the early discharge of patients who attend acute hospital and who, following assessment/ treatment, can return to their own home, rather than being admitted to hospital. The Local Referral Unit (1 per CCG) can facilitate a clinical handover between professionals and clinical decisions can be made in relation to future planning and whether or not a hospital admission is appropriate or whether other alternatives should be sought, including the service described responding and managing the patient at home.

The model is a key enabler for the future Local Referral Unit and Integrated Assessment and Discharge Teams who will both be able to access the services in a timely manner to ensure responses are efficient and effective. Discussions with Acute Partners, SECAMB and IC24 have indicated the ability of the Local Referral Unit to receive and communicate key information to other providers is crucial in improving decision making and response times for patients. Hence, this bid includes the need for a senior clinician to be associated to the Local Referral Unit to escalate clinical concerns brought to the Local Referral Unit to the correct service for care delivery. The Acute Trust will **clarify** the KPIs required to monitor the impact of this scheme.

The bid encompasses a number of bids that when brought together provide an opportunity to further enhance the model of the Neighbourhood Network Team to provide collaborative services which will enhance patient experience. The Acute Trust will **clarify** the KPIs required to monitor the impact/success of this scheme. The model will also ensure significant steps are taken towards the delivery of a 24 Hour 7 day a week service aimed at addressing strategic intentions of:

1. Supporting those with long term conditions to be cared for at home, (aligned with OOH providers and acute trust)
2. Reducing hospital admissions and attendances, (in line with SECAMB and OOH providers)
3. Facilitating the discharge process by enhancing the community services, (enabling acute hospitals to discharge into a more robust clinical service).

NB: The impact and success of robust Admission Avoidance or Facilitated Discharge processes will only succeed if there is sufficient Community capacity (Beds & Intermediate Care / Rapid Response). The Acute Trust will clarify the KPIs required to monitor the impact/success of this scheme.

4. Avoiding hospital admissions for those patients who are on an end of life pathway. (Supporting hospice planning)
5. Providing a rapid response to SECAMB where individuals do not need to be admitted to hospital,
6. Development of integrated services into the Neighbourhood Network Team.
7. Supporting the management of frailty associated admissions to hospital.

The model will also reduce therapy waiting times in the community through the added physiotherapy and occupational therapy input. Duplication of assessments and visits will be avoided through integrated working and there will be less calls coming from 111 as patients on the caseload will have access to the Local Referral Unit. There will be a faster response to patients requiring support and this should encourage confidence by the acute trust in relation to capacity and demand ability to manage patients in the community.

These posts are about delivering care out of hours and weekends in order to respond to the acute Trusts need of discharging patients in evenings and weekends (which will reduce the need for the patient's being admitted in the first case).

PILGRIMS HOSPICE

Reassurance will be sought from Pilgrims Hospice that their plans will ensure any patients 'known' to Hospice team will be 'pulled' from the Acute Trust as these schemes were ineffective last year.

KENT & MEDWAY PARTNERSHIP TRUST

KMPT Mental Health Trust has:

- Acknowledged concern expressed by Acute Trusts about the need to ensure timely assessment of people with mental health problems admitted to A&E at times when they have to implement their escalation plans due to system pressure.
- Made arrangements to ensure robust Mental Health Liaison Services and Crisis Resolution Home Treatment (CRHT) team response, to minimise A&E 4 hour breaches and timely assessment of in-patients.
- Confirmed that KMPT are not anticipating capacity issues due to winter pressures, in relation to beds and services. The Acute Trust will **clarify** confirmation of this.
- Confirmed that CRHT teams will provide a 24 hour service over the Christmas and New Year period, to provide care to acutely mentally unwell service users within their own homes as an alternative to in-patient treatment. The Acute Trust will **clarify** confirmation of this year's arrangements and ensure a reduction in inappropriate A&E attendance
- CRHT teams will also work with service users with alcohol and substance misuse problems but who also have a primary diagnosis of mental health disorder.

NB: As the schemes agreed for last year had minimal impact, the Acute Trust will request reassurance that the arrangements in place to ensure Admission Avoidance (Drugs & Alcohol) or more timely assessment &/or transfer will be effective.

SECAMB / NHS 111

RISK: SECAmb have not provided any Seasonal Plans, therefore it is unclear what further action will be taken to support patient flow and/or admission avoidance during the winter.

Out Of Hours Service

The Acute Trust will **clarify** for each organisation which services and response times are being provided 'out of hours' to ensure that plans are integrated between the key organisations.

PRIMARY CARE

Through working with CCGs, Primary Care has:

- Agreed to provide GP cover within the A&E department on all three sites. This will give WHH and QEQM support 7 days per week. Key metrics will be recorded around activity and admission avoidance.
- Are developing proposals to extend access for urgent primary care (8am – 8pm 7/7 week) from RVH Folkestone. The Acute Trust will **clarify** whether there any KPIs to monitor reduced attendance at A&E from the Surgeries involved.
- Open 5 GP practices each Saturday and Sunday mornings for 3 hours (would involve acute Trusts actively redirecting primary care re-attendances at A&E).

RISK: EKHUFT has not seen any Seasonal Pressures Plans at this stage therefore it is unclear what further action will be taken to support patient flow and/or admission avoidance during the surges in demand.

Discharges

The volume of daily discharges required per Division per site, will need to increase according to the overall pressures generated by increased activity through A&E, increased admissions, extended length of stay, increased patient acuity and pressures external to the Trust.

To facilitate timely patient flow, clear roles and responsibilities have been developed to ensure a proactive focus is maintained on both internal and external process delays. The UCLTC Capacity & Flow Managers are responsible for monitoring and supporting staff with internal waits whilst the Discharge Manager lead on DTOCs and the active Integrated Discharge Team caseload.

EDN's / TTOs

Wherever possible, a patient's EDN should be completed the day before discharge, to enable Pharmacy to prepare TTOs ready for discharge. Where this is not achievable, clinical teams should ensure that EDNs are completed within 2 hours of the decision to discharge being confirmed. Any delay with this process will constitute an internal wait and should therefore be reported to the UCLTC Capacity and Flow Manager to resolve/escalate.

DISCHARGE LOUNGES

Discharge Lounges are established on all sites:

QEQM	Off main corridor by Fordwich ward
K&C	St Lawrence ward
WHH	Old Arundel Unit on the ground floor

To ensure beds are available earlier in the day to maintain patient flow in A&E, every planned discharge must be assessed with the view of utilising the Discharge Lounge, therefore discharges directly from inpatient wards should be by exception (as per patient safety). UCLTC Division to lead on Discharge Lounge provision and ensure that all lounges are utilised to maximum capacity.

REPORTABLE DELAYED TRANSFERS OF CARE

During November 2012 – March 2013 the average number of reportable DTOCs was approximately 45 per week which occupied 6% of the adult funded bed base across the Trust. Since then, performance indicates the number of reportable DTOCs has reduced slowly.

November 2013 – March 2014 saw an average of 40 reportable DTOCs per week occupying 4.7% of the acute bed base across the Trust.

NB: This data excludes paediatrics, ITU, NICU, and SCBU because DTOC patients do not occupy these beds.

The key factor driving this reduction is the increase in the number of reablement beds in the community (Health & Social Care Village) increasing from 15 beds last year to 60 beds this year.

One of the indicators of patient flow is the number of reportable DTOCs – the Acute Trust should have no more than 20 reportable DTOCs per week to support effective patient flow.

PATIENTS WITH LEARNING DISABILITIES

Over the last 12 months there appears to have been a general reduction in admissions for people with learning disabilities. This is in part due to the ability to identify and track patients with learning disabilities and the joint protocols established with Kent Community Healthcare Trust to support patients with learning disabilities who experience high readmission rates.

EKHUFT and Kent Community Healthcare Trust have developed a pathway for patients with learning disabilities including the link nurse framework. This is to ensure that patients with learning disabilities are appropriately and timely discharged with an accurate plan.

Elective Admissions

The Trust's Seasonal Pressures Plan integrates non-elective and elective demand and capacity. Wherever possible, elective activity should be maintained across the Trust to ensure patient treatment and safety is maintained. The Surgical Division according to the Seasonal Plan will be required to provide an 8 bedded 'single sex' area to support the flow of 23 hour cases for surgical activity to enable conversion from 1-2 day LOS to 23hr LOS, thereby releasing inpatient beds without the need to cancel surgery.

In terms of managing surges in elective activity, the additional capacity for high risk areas will be secured by using the independent sector during July – November 2014. This is contingent upon the number of referrals not exceeding the expected level of demand built into the elective activity plan 2014/15.

Provision of dedicated external resource to focus on the elective 'backlog' will ensure that internal elective capacity is fully utilised for patients within a current 18 week pathway. This will therefore reduce the requirements for additional elective internal provision to support backlog activity.

A summary of the Trust's Operational Resilience Plan for elective care 2014/15 is shown at Annex C.

NB: Surgical Division are not planning to review the option of reducing Elective activity tom support increased Emergency admissions, until late September; Trust performance against 18 weeks will inform this decision. However, any gain from reducing Elective length of stay will be utilised for Emergency admissions.

Divisional Plans

Implementation of the Trust's Plan is supported by the Divisional Plans – their key headlines outline the actions the Divisions will take to ensure operational resilience during surges in activity demand. The Divisional Plans will comprise staffing rotas and contact details for festive holiday periods.

UC&LTC

Key Headlines

- UCLTC Plan covers the period from 1st November 2014 – to 30th April 2015 and ensures that the Division has a co-ordinated and appropriate response to seasonal variations across specialties with regards to all clinical activity.
- UCLTC plan to implement an Acute Medical Model of Care incorporating an Integrated Discharge Team, to support admission avoidance and timely facilitated discharge.
- The Integrated Discharge Team will maintain close links to the IUCC Navigation Centre / Local Referral Units.
- UCLTC has a detailed escalation plan and RAG status for the emergency floor (this covers staffing and activity) as well as a RAG status for UCLTC ward staffing.
- Division will consider establishing a process which ensures the Consultant(s) on call or Acute Physicians will field all GP referrals to reduce inappropriate use of A&E.
- Division to ensure optimum use of Ambulatory Care for all procedures to reduce avoidable admissions.
- Plan includes Site-based breakdown of UCLTC's bed base and where additional safely staffed beds are located by ward.
- Beds should be opened in a phased way to ensure that service quality, patient care and experience are upheld at all times. A priority order for opening and closing additional safely staffed beds is included.
- There is a clearly defined process for outlying patients into other clinical specialties beds and/or for transferring patients between wards and sites.
- Relevant operational policies are embedded within the UCLTC Division Plan to support staff.

- Divisional staff and Integrated Discharge Team to work with Therapies to increase the option of 'Discharge Home Visits'.
- UC&LTC Plan models the impact of surge resilience bids and links the impacts to the A&E Recovery Plans Risk Register.
- UCLTC will provide Managers at both WHH and QEQM each Sunday over 17 weeks from 30th December 2014. Their roles and responsibilities will be to ensure that the Urgent Care Divisional areas are functioning appropriately, but will not interfere with GM on Call who will have overall responsibility and accountability.

DIVISIONAL INTERDEPENDANCIES

UCLTC Plan is reliant on:

- Consultant and Clinical engagement with regards to provision of EDD
- Timely completion of EDNs
- Pharmacy support to wards and Discharge Lounges regarding provision of TTOs
- Provision of 7 day working by Therapies to support Admission Avoidance (A&E)
- Rapid and consistent access to Diagnostics
- Timely and consistent provision of NSL Patient Transport Services
- Timely and consistent response and provision of Community based resources.

Divisional Plans - Surgery

Key Headlines

- WHH are designated as an 'Interim' Trauma Unit (can support 'night flying' following provision of a lit Helipad).
- WHH has introduced 'all day' Trauma lists (5 out of 7 days a week) to ensure patients do not wait longer than 24hrs for Trauma surgery.
- Recruitment is in process to ensure the emergency model of care is in place by January 2015
- Surgical Division is finalising plans to provide a Surgical Assessment Unit (SAU) to enable rapid signposting to acute surgical assessment and treatment. This will be in place by winter 2014. Staffing requirements have been identified and the posts will be recruited to on Fixed term Contracts. A Standard Operating Procedure has been completed for the SAU.
- Facilities to support the provision of an 8 bedded 'single sex' 23hr surgical unit are currently being identified in association with Infection Control and Estates departments. On the WHH site, the Channel Day Surgery unit will be utilised for provision of beds overnight and patients will be transferred to the Discharge Lounge the following morning, to minimise impact on general Day Surgery.
- A process is in place to purchase beds within the Spencer Wing at QEQM and WHH to provide 23hr surgery &/or overnight stays to provide additional capacity for electives.
- Surgery has introduced 'extended recovery' in WHH Theatres for Colorectal Cancer patients, to support ITU contingency plans.
- Surgical Seasonal Plan provides a clear process for staff absence reporting, including the provision of Action Cards & staffing contingencies, to be led by departmental managers. All relevant information regarding staffing skills / access to 4x4 transport etc is available on the Divisional shared drive, to support staff co-ordination
- Clear and detailed process for the cancellation of operations and the actions to take to ensure patient access targets are maintained

- There is a detailed critical care preparedness plan which will be invoked in the event of increased respiratory admissions or a flu pandemic. An increase within the ITU bed base of 2 beds will be achieved through the planned use of 2 beds within the Coronary care unit.
- To support patient flow, the Division will mirror the Nursing Staff Plan of 'adopting a ward', by identifying 'ward buddies'. Administrative staff will provide additional ward clerk cover. Managerial staff will drive patient flow through managing any internal resolution/process delays.
- The Division will be ensuring that all Day Case patients have their EDN completed prior to leaving Theatres to ensure discharge is timely.
- 'One Stop' ward rounds will be introduced throughout the Division to ensure timely completion of EDNs thereby supporting the intention to discharge 50% of patients before midday.

DIVISIONAL INTERDEPENDANCIES

Surgical Seasonal Plan is reliant on:

- Consultant and Clinical engagement with regards provision of EDD
- Timely completion of EDNs
- Pharmacy support to wards and Discharge Lounges regarding provision of TTOs
- Timely and consistent access to Diagnostics (Surgical Assessment Unit)
- Timely and consistent provision of NSL Patient Transport Services
- No UCLTC specialty outliers. However, in the event this does happen, medical patients will be co-located into 1 dedicated ward area to reduce 'safari ward rounds' and facilitate robust decision making and discharge planning.

Divisional Plans - Specialist Services

Key Headlines

Child Health

- Provides a clear escalation plan and RAG status to be invoked during times of high activity, bed shortages and staff shortages. There is a clear documented process for the closure of acute paediatric beds and wards including a communication cascade both at time of closure and re-opening. This will be escalated as part of the teleconference with GM on Call.
- At status Black ONLY the Division will implement closure of the Children's Ambulatory Unit at K&C and Dover, and all medical and nursing staff will be diverted to the acute units.
- Community Doctors who could support the clinical management of patients and / or ward rounds will be called in.
- All non urgent meetings will be cancelled.

Women's Health

- Gynaecology wards should be used for women only but do accommodate female patients from other services i.e. surgical and in times of increased demand for beds during the winter months preventing discharges.

- During an epidemic / pandemic gynaecology will accept any women and when there is extreme capacity issues men could be accommodated (BLACK STATUS ONLY and all WOMEN on the ward MUST BE NOTIFIED in advance).

Renal:

- Renal have detailed plans which will be utilised during bed pressures, staff issues, inclement weather, and service failure. In event of snowfall renal patients are an essential service and therefore every attempt should be made to ensure the continuation of dialysis regime. The Thomas Becket Unit will extend opening hours to accommodate and to ensure sufficient treatment is provided for any patient arriving for dialysis.

Chemotherapy services:

- Staff with relevant skills to administer chemotherapy will be fully utilised to maintain service provisions during the winter, however at RED and BLACK status consideration will be given to cancel all non urgent or routine pre chemotherapy assessment clinics.

AML and Transplant clinics

- These are priority clinics and must be maintained throughout winter, however during inclement weather it will be considered that Patients will be treated at their nearest hospital if they are unable to access K&C.

Anticoagulant clinics

- These Clinics are considered to be an essential service, and must be maintained throughout winter.

DIVISIONAL INTERDEPENDANCIES

- Consultant and clinical engagement with regards to provision of EDD
- Timely completion of EDN's
- Pharmacy support to wards and discharge lounges regarding provisions of TTO's
- No specialty outliers by either UCLTC and / or Surgery Divisions
- Timely and consistent provision of Patient Transport Services.

Divisional Plans - Support Services

Key Headlines

Laboratory Medicine

- Laboratory Medicine will ensure sufficient blood transfusion stocks are maintained and will source stocks from other Trusts or National stocks as required
- A&E 1 hour turn around to be maintained
- 4 hour turn around for ward patients to be maintained
- Priority given to patients requiring a blood test who are waiting discharge
- Staff would flex internally to ensure staff working in areas of greatest pressure
- Staff to be moved across sites if required – all non-essential work to be stopped and all non- ward phlebotomy to be stopped.

Therapies

- Therapies to set up a robust escalation process. Site Leads to gather daily information from the teams in their hospital and relay this to the Therapy General Manager/Operation managers who will collate information and set plans, as well as escalating to Trust senior management staff as required
- Ensure admission avoidance/discharges within emergency floor are prioritised, as well as maintaining acute respiratory services
- Maintain discharge planning and facilitation across the medical and surgical wards
- Set targets for reducing out-patient services and moving released staff to the in-patient areas as required. Start with the rotational staff who will have relevant in-patient expertise/skills
- Consider the need to move staff across the sites as relevant and set targets for when this may happen
- Therapy staff to increase the number of Discharge Home Visits achieved each week.
- Develop plans for covering extended daily hours and weekends. Review what able to provide within current establishment and what extra staffing/funding is required
- Look at demands on the staff and how able to mitigate these

Outpatient Services

- Appointment Booking Office-Priority given to 2 week waits registration and booking. All inbound calls, pre-registration of 18 week outpatients, clinic maintenance to be actioned >6 weeks to be parked.
- Health Records - Retrieval of Heath Records for admissions, Clinic preparation for 2 week waits and other outpatient clinics that are running, transport of health records between sites.
- Nursing - Support for clinics that are running (during inclement weather)
- Reception - Support for clinics that are running (during inclement weather)
- Consider the need to move staff across the sites as relevant and set targets for when this may happen
- Develop plans for covering extended hours and weekends. Look at what we can offer within current establishment and what extra staffing/funding is required
- Look at demands on the staff and how we can mitigate this.

Pharmacy

- Weekend working well established – staff will remain until all work for that day is processed
- KPI for prescriptions to be maintained
- Medical gas suppliers to ensure sufficient levels are maintained
- Where possible support ward staff to ensure timely discharge and completion of EDNs
- Staff to be moved to those sites of greatest pressure.

Radiology

- Modality Superintendents will advise Radiology Site Leads of demand and activity balance
- Site leads to actively monitor situation and advise General Manager of developing situation

- Local Participation in daily Bed Meetings and active liaison with Bed Managers / Site Manager and A&E / Urgent Care Teams
- Divisional Director to be made aware and raise awareness of staff
- Reschedule any planned maintenance in times of extreme pressure
- Radiology Senior Management will monitor RAG status and on-going situation
- Initiate regular telephone conferences with Radiology Senior Managers across sites
- Actively liaise with key teams external to radiology
- Give regular updates to General Manager.
- Divisional Director will be regularly briefed by General Manager and all staff will be communicated with.
- A&E and Inpatients will be given priority – especially patients awaiting diagnostics prior to discharge
- Develop additional activity in key areas by re-developing resources
- Radiology Site Manager to monitor on-going bed situation by regular liaison with Bed/ Site Managers and A&E / Urgent Care Teams and attend daily bed meetings
- Radiology Senior Managers have identified areas of potential shortages in staffing and have requested permission to over recruit. If necessary, permission to use outside agencies will be requested
- Staffing rotas – review leave situation, offer overtime, if possible re-deploy staff across sites and if necessary request permission to use external agencies
- Give priority to inpatients and A&E patients by reduction of non-critical services and re-scheduling outpatients except 2 week waits and interventions
- Business Plan for 2nd CT Scanner at WHH is being worked on. If necessary mobile scanner will be retained at that site
- Recruitment and training of sonographers is on-going
- Regular breach meetings are held to monitor capacity and demand shortfall.

Mortuary Capacity

During the winter months it is highly likely that the mortuaries within the Trust will be under increased pressure especially over the Christmas and New Year Period.

The below table identifies the Trust's mortuary normal capacity, and additional temporary capacity,

Table 3: Trust Mortuary Capacity

Hospital	Normal Capacity	Temporary Capacity
EKHUFT	168	48

During the winter Pathology provides additional refrigeration units to increase the capacity from 168 to 216 spaces.

The Trust Mortuary Managers will liaise closely with local undertakers, local registrars of Birth, Marriage and deaths, crematoriums and cemeteries to minimise delays with funeral arrangements especially during the Christmas and New Year period.

Support Services have a clearly defined escalation process to use when there is insufficient capacity to maintain a safe service. The escalation process can be found within the Support Services Divisional Seasonal Pressures Plan. Where there is insufficient capacity to maintain a safe service the head of Mortuary will escalate through internal channels to Executive on Call, and GM on Call.

DIVISIONAL INTERDEPENDANCIES

Clinical Support Services Plan is reliant on:

- Consultant provisions of EDD to support MDT working
- Timely completion of EDNs and submission to Pharmacy
- Divisional 'Board Rounds' where appropriate to reinforce timely Discharge Planning
- Timely communication and transfer of patients to the Discharge Lounge.

Annual Leave Planning

Divisions should ensure that throughout the winter months, annual leave provision across the Division and within wards / departments is closely monitored to ensure sufficient cover is maintained to support service continuity. This is particularly important during planned school holidays, where historically, patient flow pressures increase.

Lessons learnt during April 2013 included concerns around the reduced availability of Medical and Nursing staff which further exacerbated situations that were already under pressure. Divisions' Plans should ensure that poor annual leave planning does not affect the level of services they provide to patients.

Service Plans - Patient Transport Services

Wherever possible, Patient Transport (against the criteria) to support discharge or transfer to a community resource, should be booked the day **before** discharge, to support the planning of journeys and resources. Where this cannot be achieved, Patient Transport for discharges may be booked on the day, but clear instructions must be provided regarding the patients 'Ready to Collect' time; NSL's standard waiting time is a maximum of 15 minutes.

RISK: NSL's performance and level of responsiveness with regards the provision Patient Transport to support transfers and/or discharges is an area of significant concern. The Trust provides Transport to cover shortfalls in NSL's service delivery.

The key headlines for the Trust's Transport provisions are identified below.

Escalation

- The Trust will continue to follow the Non Urgent Patient Transport 'Crisis Management Plan (appendix five) and will continue to follow the RAG Rating as defined within the Crisis Management Plan.

Provision for winter period: December 2014 to end January 2015.

- The Trust will provide additional resources and / or support to bridge any capacity gaps by supporting NSL with a fixed provision; this is only going to be related to inpatient discharges and transfer journeys.
- This will be provided directly via the Trust's Facilities Department utilising agency labour and hire vehicles to cover requirement.

- The Trust will regularly review the requirement and will potentially provide additional staff and vehicles if demand requires. Demand will be managed in a daily basis with weekly reports going directly to the Facilities Assistant Director.
- Based on 2013 figures the following will be provided at Status RED:

Table 4: Trust PTS Vehicles at Red

Site	Number of Vehicles	Times
K&C	1	12:00 – 20:30 & 14:00 – 22:30 Inclusively
WHH	2	
QEQM	1	

- A Status Black the following will be provided:

Table 5: Trust PTS Vehicles at Black

Site	Number of Vehicles	Times
K&C	2	12:00 – 20:30 & 14:00 – 22:30 Inclusively
WHH	2	
QEQM	2	

- Arrangements have been in place to cover the above RAG Status and have worked well in the past.
- It is recognised that should winter pressures extend beyond Jan 2015, the costs would be escalated pro rata and in line with demand at the time.
- A planning assumption has been made that NSL's performance will not deteriorate and that unexpected fluctuations in demand can be covered by utilising ad-hoc private resources as and when required.
- A clear and defined process for the use of Trust Transport and this has been communicated and will be managed within the Transport team, comprising crews, and floorwalker and Project Manager.

Emergency Capacity/outliers

- Any additional capacity required to cover an emergency will be considered on a case by case basis and will be used as a last resort.
- All patient Transport should be booked through NSL accordingly following the already defined processes.
- Further provisions such as a stretcher vehicle will only be made if demand is sufficient but can be increased with 7 days notice.

DIVISIONAL INTERDEPENDENCIES

- Vehicle availability from the lease organisation (and speed of resolving any VOR issues).
- Driver availability from driver-hire.
- Divisional support through service users booking appropriately to ensure best practice when planning discharges.

SERCO Specific Plans

Key Headlines:

SERCO have clear procedures in place to ensure that all Trust sites are sufficiently supported during inclement weather by:

- Ensuring adequate snow clearance
- Ensuring sufficient gritting has been conducted against sites 'Zonal Plans'
- Ensuring adequate quantities of grit is made available within the salt / grit bins.
- Clear staffing plans to ensure appropriate cover over weekends and Bank Holidays

SERCO will work continuously with the Trust to ensure that reactive tasks are carried out and completed. Last year's reactive task volume statistics will be used to prepare adequately and high standards of service is maintained.

Site Specific Plans

All EKHUFT main sites have site specific plans to ensure that they remain accessible and safe during times of inclement weather.

The Emergency Planning and Business Continuity Team will actively monitor weather reports/warnings issued by the Met Office and Kent County Council (KCC) during regular intervals throughout the day. Monitoring will commence from 1st October 2014. Recommendations will be provided based upon the information received.

During the winter, the Emergency Planning and Business Continuity Team will ensure that Public Health England's Cold Weather Plan is adhered to throughout the winter period. This plan sets out the actions to be taken by all NHS Providers, Social Care and other agencies throughout the year, in response to forecasted and/or actual severe weather. The plan encourages local communities to support the most vulnerable in the local community.

Inclement Weather:

The Emergency Planning and Business Continuity Team will actively monitor the weather and weather warnings issued by the Met Office and KCC at regular intervals throughout the day three times daily (08:00, 12:00 and 14:00). Out of hours and during the weekend, the Emergency Planning and Business Continuity Team will continue to monitor the weather and will continue to provide updates as and when required.

Flu Vaccination Plan

Seasonal flu is a highly infectious respiratory illness caused by a variety of different flu viruses. It spreads rapidly through droplet infection, the coughs and sneezes of infected people. The flu vaccination is offered to people in at-risk groups. There are people, such as pregnant women and the elderly, who are at greater risk of developing serious complications if they catch flu. All health care workers are also offered flu vaccination, to protect staff and their families and to prevent the transmission of flu to patients and visitors who may be very vulnerable to flu.

Frontline staffs, by the very nature of their roles come into contact with patients and visitors who are unwell on a daily basis. Simply by having the flu vaccination, staff can play an important role in helping manage the flu virus and avoid passing it on to other patients, who are already unwell and vulnerable to infection.

The Trust is aiming to vaccinate 75% of frontline staff to protect patients, staff and their families against flu.

Julie Barton is the Trust Lead for co-ordinating the Flu Programme and has produced a full Vaccination programme, available on the Trust Intranet.

Influenza Pandemic Plan

Whilst influenza pandemics have been relatively infrequent over the past century, a new pandemic could emerge at any time. Plans for responding to any influenza pandemic are built on and enhance this Seasonal Pressures Plan, Trusts Incident Response Plan and Divisional Business Continuity Plans.

When an influenza pandemic occurs, large numbers of the local population may become infected by the new virus over a relatively short period of time. It may be associated with mild to moderate illness (which may or may not be widespread), or significant severe illness and mortality in certain age or patient groups, and may significantly disrupt the normal functioning of society.

It is likely that a short but severe pandemic will have a greater strain on the health and social care services than the same number of people becoming ill over a more prolonged period.

The following actions will take place by the Department of Health:

- Local support to primary care if the pressures during a pandemic mean that it is no longer practical for all those with symptoms to be individually assessed by a doctor or other prescribers.
- A self-assessment telephony service where individuals will be determined whether the person who is ill is eligible for antiviral medicine or not.
- Friends or relatives of the patient or 'flu friends' can collect the antiviral medications.
- For people without the support network to have 'flu friends' to collect antiviral, a proxy service will be set up and co-ordinated by Public Health for volunteers to collect and deliver antiviral on behalf of patients.

N.B: If the demand for antivirus is too high to be met by the existing pharmacy network, then Antiviral Collection Points will be established.

Monitoring and assessing the progress and impact including the assessment of the efficacy of the interventions will be maintained throughout the influenza pandemic.

Risks and Mitigating Actions

The Trust has developed a comprehensive Risk Register which outlines the risks associated to the development, implementation and delivery of the Trust's Seasonal Pressures Plan 2014/15.

RISK:

- Lack of sufficient capacity in the community to support timely and consistent admission avoidance and facilitated discharge presents the greatest risk to the quality and timeliness of patient care. The Trust is heavily reliant on external providers having sufficient and

robust capacity to support timely and consistent admission avoidance and facilitated discharge. Please note the success of the integrated admission and discharge teams will be dependent on capacity being available to transfer patients into.

ACTION:

- The Trust will seek assurances from CCG's and all partner organisations via the Forward Planning Group that sufficient capacity will be provided in direct response to predicted activity and demand. All Plans and agreed actions will be closely monitored and where performance against KPI's is insufficient, timely and appropriate actions will be taken.

RISK:

- Performance against Access times and patient experience will not be sustainable due to insufficient internal emergency and elective capacity

ACTION:

- Trust will finalise its activity demand and capacity scenario planning which will highlight where potential capacity gaps exist, thereby underpinning the Trusts' and Divisional Seasonal Plans.

RISK:

- CCGs fail to hold all providers (Health and Social Care) to account for ensuring there is a robust and consistent response across East Kent to maintain safe, efficient and effective patient flow throughout the whole system.

ACTION:

- The Trust will seek assurances from CCG's that partner organisations plans and agreed actions will be closely monitored and where performance against KPI's is insufficient, timely and appropriate actions will be taken.

Command and Control

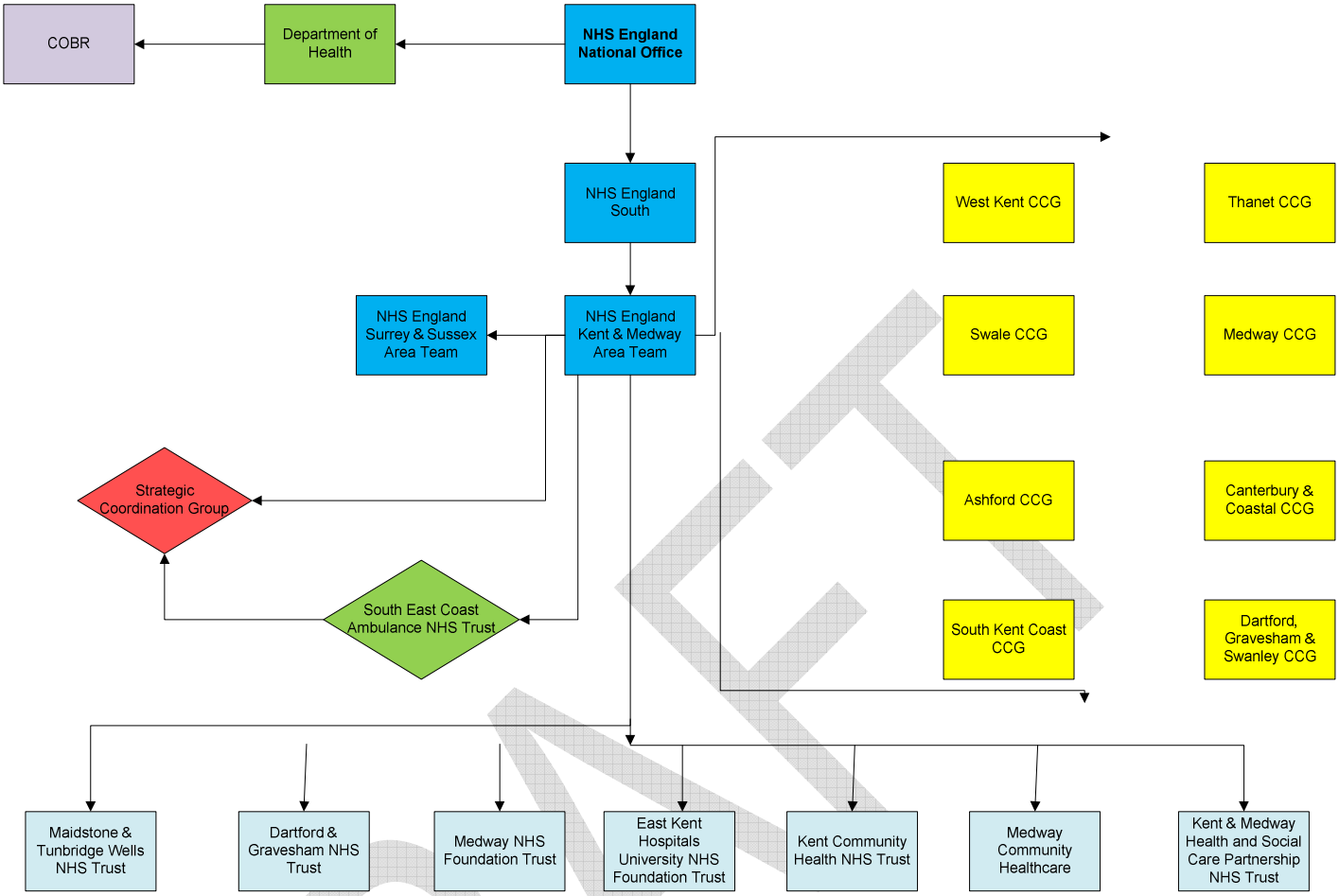
Command and control of remedial actions is maintained with the chair of the twice daily patient flow meeting at times where the site is deemed to meet the escalation status of Green and Amber. The process of declaring the escalation status, remedial actions and internal distribution of Green and Amber statuses is set out in Table 2 page 14.

At Red, pre-black and Black escalation statuses, the Executive-on-Call will take the overall responsibility of controlling the organisations response to the any seasonal pressures and / or inclement weather situation. This requires stepping up the crisis management teams (identified in Pictures 2 & 3).

To ensure effective management of this year's Seasonal Pressures, the Trust has a tried and tested effective and robust command and control arrangements. The flowchart below illustrates the communication links that would be employed between the various teams should this plan be implemented.

On implementation of this Plan the Trust is to report directly to the East Kent CCGs Federation, as set out on the right hand side of the diagram below:

Picture 2: NHS Kent and Medway Health System EPRR Response Model (NHS England Kent and Medway Area Team Incident Response Plan 2013)



Picture 3: East Kent Hospitals Command and Control Structure

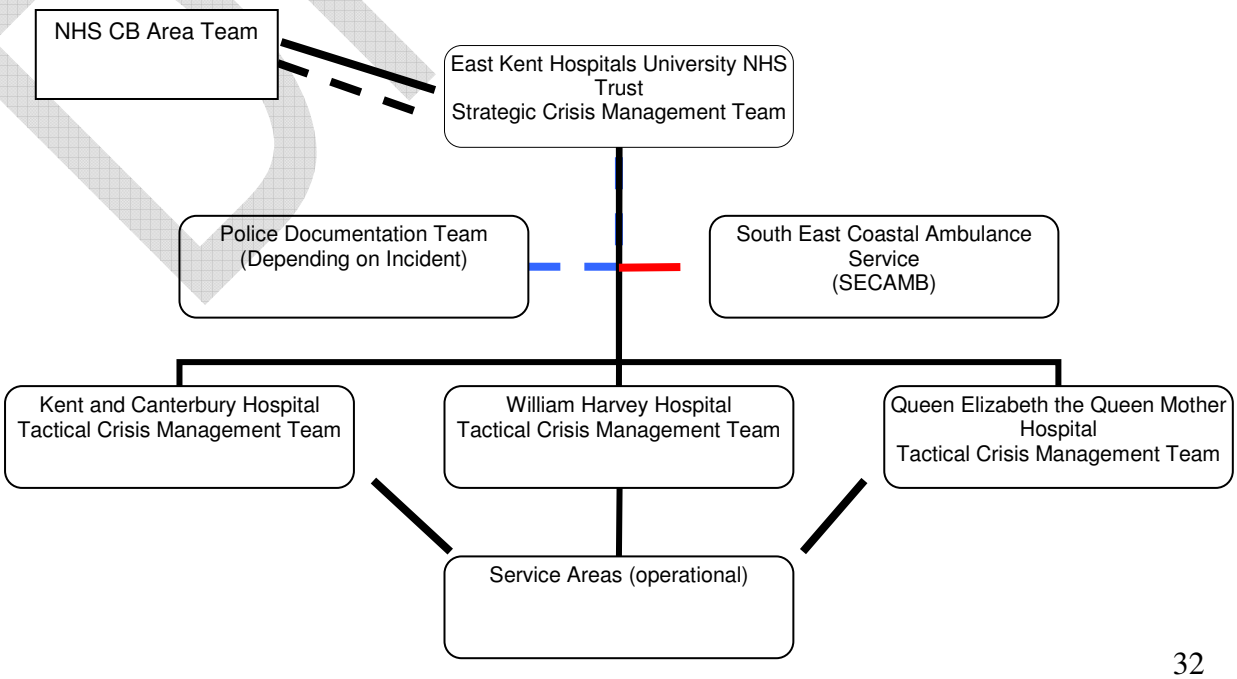
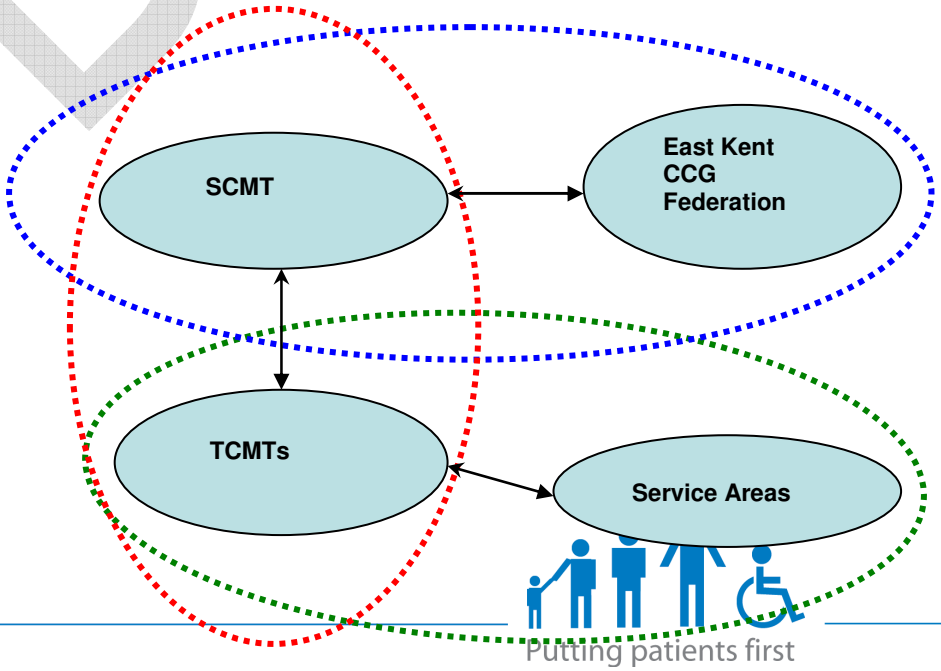


Table 6: EKHUFT Crisis Management Team Membership

Team	Description	Membership	Location Of Command Centre's
East Kent Hospitals Strategic Crisis Management Team (SCMT)	Members of the Trust's Executive management team who are responsible for the strategic management of any crisis across the Trust. Especially if the incident is too large to be managed at a local level.	**Executive on Call (chair)** Senior Estates and Facilities Manager, Medical Director on Call, Lead for communication, Lead for Emergency Planning and Business Continuity, Loggist (designated at the time of incident), Any other specialities which is deemed necessary based on the incident	K&C Boardroom Location of Key: Porters lodge Key for storage cupboard: is located in Chief Executive's Office
East Kent Hospitals Tactical Crisis Management Teams (TCMT) – One TCMT per site.	Senior clinical and non-clinical staff based across all sites who are responsible for the management of an incident affecting their specific site.	**The following individuals are responsible for managing the sites response:** **Chair (General Manager)** Hospital Manager, Estates Manager, Site senior Matron for each division, Medical Co-Ordinator, Loggist (designated at the time of incident), any other specialties which is deemed necessary based on the incident	WHH – Boardroom QEQM – Anaesthetic Seminar Room K&C – Operational Control Centre.
Service Areas (operational)	All Service Areas are responsible for ensuring that their critical functions (identified through Business Continuity) remain operational throughout the incident.	As designated by the Service Area impacted, identified through Business Continuity Plans.	As defined by Service Area / Division.

The flowchart (picture 4) below illustrates the communication links that would be employed between the various team (both internal and external) should this Seasonal Pressures Plan be activated.

Picture 4: Communication Links



SCMT / Emergency Services

The Strategic Crisis Management Team will communicate / receive information from the East Kent CCG Federation. This is bar the exception of any operational / normal communications between one of our sites and South East Coast Ambulance. This communication will be via a telephone on a designated number, as defined and communicated at the time of invocation.

SCMT / TCMTs

The Strategic Crisis Management Team will communicate to the Tactical Crisis Management Teams every 2 hours to obtain a status update on the issues, requirements, staffing levels the sites may be receiving. The communication between the 4 locations will be achieved through Video Conferencing telephone and Situation Reports, via the numbers detailed in.

TCMT / Service Areas

The Tactical Crisis Management Teams will communicate with the service areas located at their site every hour and a half, this will need to be managed correctly to ensure that the TCMT have the most up-to-date information for their hourly meeting with the SCMT. The communication will be achieved through face to face meetings and telephone calls, via the numbers identified in.

Monitoring and Reporting

Through monitoring the key indicators on SHREWD, the Urgent Care Dashboard (which is a real time dashboard based on current KPIs) and/or via a notification from a provider, the Urgent Care Programme Manager (Alistair Martin) on behalf of the 4 CCGs in East Kent shall trigger and chair a weekly Operational Meeting. Dependent on immediate and proposed impact on the local health economy, the Chair of the Weekly Operational Meetings shall decide whether to monitor the situation or trigger either more frequent Operational Meetings or Daily Teleconference calls (if not already initiated for the winter period).

The Chair shall ascertain whether or not the triggers identified in the NHS England Escalation Framework have been met, if so, Amber escalation shall be declared and appropriate actions taken. The Chair shall brief the On-call Director who shall then decide whether to either be kept informed of the situation or participate in the Weekly Operational Meeting (tbc by Lead Commissioner, Urgent Care).

Escalation to Red will occur if all actions outlined in Amber have been taken and the system is still continuing to experience an increasing or unacceptable level of pressure. The Chair of the Teleconference shall manage all activities at Trigger level Amber; the On-call-Director shall take the lead at Trigger level Red.

The same process shall be followed to move from Red Escalation to Pre-Black. If all escalation levels have been triggered and all actions taken and the local health economy is still experiencing increasing or unacceptable system pressure, **a provider should implement their Business Continuity Plans to alleviate some of the pressure.** This should be reported through the daily teleconference call and a decision should be made by all CCGs within East Kent as to whether a system wide major incident should be declared which would result in all providers to invoked and implement their respective Major Incident Plans.

Table 7 below sets out the whole systems governance and accountability for Level 1 and 2 incidents between the NHS England South Escalation Framework, different Surge Capacity Plans and how these relate to Urgent Care Boards, CCGs and providers.

Table 7: NHS England South governance and accountability for levels 1 & 2 incidents

Responsible Organisation	Framework or Plan	NHS England EPRR Framework Incident Level
NHS England	NHS England South Escalation Framework ↕	Level 2: An incident across local boundary requiring Area Team co-ordination
CCG	Urgent Care Working Group Surge Capacity Plan ↕	Level 1: An incident that can be managed by local organisations co-ordinated by local CCG
Providers	Provider Surge Capacity Plans	

NHS England South - Escalation Framework (May 2013)

To ensure consistency in reporting of RAG Status, NHS England South has provided Escalation Trigger levels for all Organisations and recommended actions for acute Trusts (see Matrix below).

These actions have been endorsed by the Local Area Team and the East Kent Seasonal Pressures Group, however EKHUFT have reiterated that Surgery will only be cancelled if it will release acute inpatients beds or enable required levels of Consultant presence on site (up to 24/7). Wherever possible, elective surgery will be maintained through day surgery and 23 hour surgical units. Cancer and clinically urgent surgery will not be cancelled, in order to maintain patient safety. The Trust will also maintain vigilance with regarding achievement of 18 weeks, wherever possible, without compromising patient care

Table 8: Whole Systems Escalation

	ACUTE TRUST	EKHUFT ACTIONS	Ambulance Service	Community Care	Primary Care	Social Services	Other
GREEN (Level 1) Baseline **(up to a maximum of 798 Adult beds)**	• Capacity available to meet expected demand • Good patient flow through A&E and other access points • A&E 4 hour target consistently being met	• Business as usual	• Offloading ambulances within 15 minutes. • Ambulance call volumes within expected levels • Resourcing Escalatory Action Plan (REAP) level 1	• Community capacity available across systems, patterns of service and acceptable levels of capacity are for local determination.	• Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand.	• Social Services able to facilitate placemen, care packages and discharges from acute care and other hospitals and community based settings	• 111 call volume within expected levels
AMBER (Level 2) **Start to use Additional safely staffed beds**	• Beds available, but additional safely staffed beds are in use • Anticipated pressure on maintaining A&E 4 hour target • Anticipated pressure in facilitating ambulance handovers • Discharges below expected norm • Slow patient flow through A&E, Assessment Units • Some unexpected reduced staffing numbers (due to e.g. sickness, weather	• Contact all On Call Consultants (including A&E) to offer support to staff & ensure that specialty patients in A&E are assessed rapidly • Implement a 'RAT' model if not routinely established • Undertake additional ward rounds to maximise rapid discharge of patients • Pharmacy services to prioritise TTO's for appropriate areas & ensure that medications are delivered to wards without delay • Clinicians to prioritise discharges & accept outliers from any ward as appropriate	• Delays breaching 30 minute turnaround time • Ambulance demand breaching predicted peaks • REAP level 2 and 3 • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	• Patterns in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues • Some unexpected reduced staffing numbers (due to sickness, weather conditions	• GP attendances higher than expected levels • OOH Services demand is above expected levels • Some unexpected reduced staffing numbers (due to sickness, weather conditions)	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing (due to sickness, weather conditions)	• 111 Call volume above normal levels • Surveillance information suggests an increase in demand • Weather warnings suggest a significant increase in demand

	conditions) in areas where this causes increased pressure on patient flow • Infection control issues	• Facilities, porters or transfer teams to prioritise cleaning & transfers • Implement measures in line with Trust Ambulance Service handover plan • Inform Minors / patients in A&E of pressures and potential delays and of alternative pathways where appropriate • Identify & encourage utilisation of alternative care pathways for Minor patients eg 'Out of Hours'. • Arrange alternative forms of Transport (private Ambulance, taxi) to discharge patients • Contact PTS providers & appropriate Ambulance service personnel to confirm that they are in liaison with their acute counterparts to prioritise discharges / transfers & minimise turnaround times for crews. • Notify CCG on call Director to ensure that appropriate operational actions are taken to relieve the pressure. • Utilise staff from other areas of service & deploy to relieve key pressure points.					

		• Maximise nurse-led discharges processes. • Consider Implementing all or part of the Seasonal Pressures Plan 2014 / 15 • Consider placing NHS patients in private patient wards if there are empty nurse beds as appropriate. • Ensure reverse triage has been implemented to support rapid discharge (**see Appendix 2 & refer to Action Cards 2 attached)** • Review and reschedule plans for scheduled maintenance work where it is likely to impact on capacity or patient flow • Liaise with Ambulance Service to ensure risk assessment and agreed clinical plan for any patients awaiting handover • Senior clinicians to actively scrutinise all GP requests for admission • Alert Social Services On-call Managers to expedite care packages • Implementation of Divisional Continuity Plans.					

	ACUTE TRUST	EKHUFT ACTIONS	Ambulance Service	Community Care	Primary Care	Social Services	Other
RED (Level 3) **Trust has used all Additional safely staffed Beds (Maximum of 839 beds)**	• Actions at Amber failed to deliver capacity • No further safely staffed beds vacant across the Trust – using all available safely staffed beds • Predicted discharges are far lower than expected admissions (Qlikview) • Significant failure of A&E 4 hour target (< 92% on Qlikview) • Patients awaiting handover from ambulance service within 15 minutes significantly compromised • Patient flow within acute site is significantly compromised • A&E patients have a Decision to Admit, but no plan / bed allocated • Significant unexpected	• A&E Consultant to be present in A&E Department 24/7 • Contact ALL on Call Consultants (including A&E) to offer support to staff & ensure emergency patients are assessed rapidly. • Senior Physician to be present in A&E 24/7 to monitor medical admissions. • Reschedule or put on hold **relevant routine** elective admissions. (Action must be taken to ensure there is no slippage against planned care targets) • Enact process of **cancelling** day cases & staffing day beds overnight **if appropriate** • Open extra beds on specific wards following discussion with Executive on Call and dependent on staffing availability • A&E to open an overflow area for emergency referrals again as staffing allows • Consider extra staffing in A&E (GP Emergency Care Practitioner, Advanced Nurse	• Significant delay in handing over patients to acute trusts • Hospital ambulance liaison Officer (HALO) implemented • Ambulance response to emergency calls compromised • REAP level 4 • PTS at RED alert • Significant unexpected reduced staffing numbers (due to sickness, weather conditions) in areas where this causes increased pressure on patient flow.	• Community capacity full • Significant unexpected reduced staffing numbers (due to sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Pressure on OOH / GP services resulting in pressure on acute sector • Significant unexpected reduced staffing numbers (due to sickness, weather conditions) in where this causes increased pressure on patient flow	• Social Services unable to facilitate care packages, discharges etc • Significant unexpected reduced staffing (due to sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests a significant increase in demand • 111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services • Infection control issues resulting in significant pressure

	reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	Practitioner and other hospital staff such as ITU, CCU, Paediatrics) • Bring in extra staff to radiology, pathology, pharmacy, OT, etc, If appropriate deploy staff from other areas of service to relieve key pressure points • Assign clinical staff to care for any ambulance patients waiting for space (in A&E assessment areas or other admission areas). • Notify CCG On-Call Director so that appropriate operational actions can be taken to relieve the pressure • Notify Executive On-Call of 'Red Status'					
	ACUTE TRUST	**EKHUFT ACTIONS**	**Ambulance Service**	**Community Care**	**Primary Care**	**Social Services**	**Other**
PRE-BLACK	**BEFORE ESCALATING TO BLACK:**	• Routine elective admissions have been cancelled • Urgent elective admissions have been reviewed and where possible rescheduled or cancelled					
	ACUTE TRUST	**EKHUFT ACTIONS**	**Ambulance Service**	**Community Care**	**Primary Care**	**Social Services**	**Other**
	• Actions at Red failed to deliver capacity	• Implement Trust's Business Continuity Plans and use all	• Cat A response target <70%	• No capacity in Community	• Acute trust unable to admit GP	• Unexpected reduced	

BLACK (Level 4) **Non-urgent Surgery has been cancelled. The Trust will not provide any unstaffed / unsafe bed capacity and is therefore reliant on External providers response**	• No capacity across the Trust – into unstaffed beds • Emergency care pathway significantly compromised • Unable to offload ambulances • A&E patients with DTAs >8 hrs. • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	Action Cards • A&E Consultant to be present in A&E Department 24/7 • Consultant Physicians to be present on wards and in A&E Department 24/7 • Surgical Consultants to be present on wards, in theatre and in A&E 24/7 • Align appropriate qualified clinician to manage care of patients awaiting handover from ambulance service to allow ambulance crews to be released • GP to be present in A&E 24/7 • Executive Director to be on site 24/7 • 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 Trust	• Ambulance delays affecting response to 999 calls • Ambulance handover of patients to acute trusts affecting response to 999 calls. • REAP level 5 and 6 (note that CAD system is barometer for SCAS	Services • Unexpected reduced staffing (due to sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety compromises service provision / patient safety	referrals • Inability to see all OHH / GP urgent patients • Unexpected reduced staffing numbers (due to sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	staffing numbers (due to sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	

Statutory Reporting via SHREWD / SITREPS

During the winter months, consistent information will be used to monitor and predict pressures to ensure that the whole health economy can act to minimise the impact on patients within East Kent. This will be conducted using two systems.

SHREWD

SHREWD is an on-line health system management tool. The primary function of SHREWD is to support decision making to manage system pressures, such as seasonal pressures by sharing information with all Providers, such as bed capacity and staff availability, across the local health system. It is an integral element of East Kent Seasonal Pressures Plan and provides a clear template for managing multi-agency seasonal conference calls. It is a key tool in the co-ordination of resources during winter and will be **going live on 1st October 2014**.

The system is accessed and updated by partners within a local health system on a daily basis and will be used to inform Teleconference calls. A unified dashboard can be viewed by managers (security access provided) at any time to allow immediate identification of pressures and delays in the system, enabling Teleconference calls to be more focused and for corrective actions to be proactive rather than reactive. It facilitates a collaborative whole health economy approach to working to reduce system pressures.

Each local economy is able to view their own position and the position across Kent and Medway which enables agreement on additional corrective actions based on the wider health economy.

The management and updating of SHREWD within EKHUFT will be managed within the Patient Flow team, hosted by UCLTC. Clear roles and responsibilities have been identified and implemented to ensure that reporting is consistent and provides an accurate reflection of the Trust.

SHREWD Indicators (see Table below) will be populated on a daily basis in preparation for the Operational Teleconference which will take place at 10:30 – 11:00 am Monday and Thursday.

NB: These indicators will change based upon further discussions with Alistair Martin and SHREWD Developers.

Table 9: SHREWD Indicators

Group	Indicator	Upload method
Critical Care	No of available ITU Beds	Automated
Critical Care	No of available CCU beds	Automated
Beds	No of beds closed (includes Baseline beds, and potential impact on the use of Additional safely staffed beds – if within a closed ward).	Manual – Operational Site Managers

Beds	No of Reportable Delayed Transfers of Care	Manual – Discharge Managers
Beds	No of open Additional safely staffed beds (per Site)	Manual – Operational Site Managers
Beds	Admissions in last 24 hours (by Division)	Automated
Beds	Admissions since Midnight (by Division)	Automated
Beds	No of GP referrals (admission method 28)	Automated
Beds	No of expected discharges today	Automated
Beds	No of expected discharges tomorrow	Automated
A&E	No of A&E attendances against the Trusts' daily activity plan	Automated
A&E	No of A&E attendances against the Trusts' activity plan by Minors / Majors / Primary Care stream with GP	Automated
A&E	Average wait time to be seen	Automated
A&E	No of patients seen within 1 hour	Automated
A&E	Performance against 4 hour CQI since midnight (un-validated)	Automated
A&E	Performance against 6 hour CQI since midnight (un-validated)	Automated
A&E	Performance against 4 hour CQI in previous 24 hours (validated)	Automated
A&E	Performance against 6 hour CQI in previous 24 hours (validated)	Automated

SITREPS

All Acute Trusts will be required to submit a daily Situation Report (Sitrep) to the Department of Health and NHS South England via UNIFY 2. Please Note that all other providers including the CCGs will not be required to submit these reports. Details of ambulance queuing will be provided by the appropriate Acute Trust in association and agreement from SECAmb.

The following information will be required which will commence from:

- A&E closures and Diverts
- Trolley waits of over 12 hours

- Urgent operations cancelled for the second or subsequent time in the previous 24 hours
- Urgent operations cancelled in the previous 24 hours
- Number of cancelled operations in the previous 24 hours
- Non clinical critical care transfers out of an approved group
- Number of non-critical care transfers within approved critical care transfer group
- Ambulance queuing for longer than 30 minutes
- General and Acute Beds
- Adult Critical Care, Paediatric Intensive Care and Neonatal Critical Care Cot / Beds
- Has the Trust experienced serious operational problems during the last 24 hours?

Operational Meetings

The information on SHREWD will be collected and will be used to facilitate and co-ordinate a weekly Whole Systems operational meeting which will be held …….. These meetings have replaced last year's operational teleconferences.

The Operational Meetings for winter will commence from Week Commencing Monday 6th October, and will continue throughout the winter period.

This meeting will:

- Ensure the efficient transfer through the health system
- Use trend analysis and the information contained within SHREWD to predict potential issues / pressure points within the local health economy
- Develop and action appropriate mitigation plans to prevent issues developing into escalation, particularly capacity issues
- Identify current issues and assign appropriate operational actions to all providers
- Monitor the operational effectiveness of Provider Plans and KPIs ensuring that any emerging risks have been identified and appropriate solutions point in place to mitigate those risks
- Request any additional analysis following periods of high pressure and ensuring lessons are identified and action implemented throughout the year.
- A whole systems weekly operation meeting will use SHREWD to collect information and co-ordinate

It is expected that the following individuals attend this meeting:

- General Manager for UCLTC
- General Manager for Surgery
- Representative form the Informatics Team?
- Emergency Planning and Business Continuity Representative?

Should there be periods of intensity where these meetings cannot be facilitated then the Chair of these meetings (Urgent Care Programme Manager (Alistair Martin)) will initiate an operational teleconference using the following details:

Telephone Number: 08444 737373
Pin: 993287

A Kent and Medway-wide command and control structure is in place to respond to any emergency including pandemic influenza. Full details are contained within the NHS Kent & Medway Strategic Major Incident Response Plan.

<<<TO BE CONFIRMED BY ALISTAIR MARTIN>>>

Communications Plan

Internal Communications

The Trust will communicate and raise awareness of the Seasonal Plan and incident exercises with its staff through:

- Trust Staff Zone (Intranet)
- Staff desktop backgrounds, presenting the campaigns image and slogan
- Trust News
- Team Brief
- Internal "news flash" emails
- Social Media: Twitter accounts @EKHUFTStaff and @EKHUFTEP; Yammer

Escalation Processes

The Trust will communicate clear escalation processes for staff to ensure timely communication is maintained at all levels and between departments. Examples will include:

- Opening up Additional safely staffed capacity
- Escalating patients within A&E at 3hrs (maximum) if no definitive plan
- Transport issues (refer to Crisis Management Plan)
- Staffing issues
- Infection Control

External Communications

Partners: e.g. local Trusts, CCGs, NHS England, Serco, NSL. The Communications Team will support other members of the Trust to ensure we communicate and raise awareness of the role partner agencies have in the Seasonal Plan and ask that their staff are made aware of any agreed expectations.

The Trust will work with the NHS England and local CCGs to promote a coordinated message to members of the community on how they can choose the most appropriate healthcare solution for their need. The Trust will be able to support this using the following communication methods:

- Trust website – redesigned to link with message from NHS England/CCGs
- Press releases to local newspapers, TV and radio stations on:
  - Launch of seasonal plan
  - TV invited to follow incident exercise
- Social media

Social Media templates:

High demand:

- We are currently experiencing high demand for our A&E services – please choose the best way to get safe care [LINK]

Adverse weather:

- We have cancelled all outpatient clinics at [insert hospital name] due to today's severe weather.
- All outpatient clinics are still open as planned; please take care as you make your way to your appointment.
- Our Emergency Planning team are currently out picking up staff to ensure our service to you can continue [insert photo of 4x4 in snow?]?

Message sign-off
Any communications on seasonal pressure will need to be signed-off by the Strategic Crisis Management Team, of which the Director of Communications is a member.

Annex A: Seasonal Pressures Analysis 'Calculator' – EXAMPLE ONLY

Seasonal Pressure Analysis

East Kent Hospitals University NHS
NHS Foundation Trust

Site	Trust
Division	All
Methodology	Adjusted

← Change selection here

Click here just adjust growth assumptions

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
	A&E Attends	15,889	15,818	14,947	15,551	15,254	13,992	16,699	15,750	16,916	16,536	16,918	16,495
	Elective	7,548	8,602	8,143	7,479	8,370	7,796	8,145	7,739	7,613	8,037	8,549	7,927
	A&E Admissions	3,643	3,625	3,430	3,560	3,475	3,188	3,811	3,621	3,919	3,799	3,900	3,787
	Other Non-Elective	860	927	870	806	987	981	1,040	836	859	890	1,112	1,166
	Elective Readmissions	397	453	429	394	441	410	429	407	401	423	450	417
	Non Elective Readmissions	795	803	759	770	787	736	856	786	843	827	884	874
	Total Elective Admissions	7,945	9,055	8,572	7,872	8,811	8,206	8,573	8,146	8,014	8,460	8,999	8,344
	Total Non Elective Admissions	5,298	5,356	5,059	5,136	5,249	4,905	5,707	5,243	5,621	5,517	5,896	5,827
Beds	Elective	80	112	126	90	94	113	106	97	98	107	109	101
	A&E Admissions	484	506	461	481	485	426	500	483	505	502	472	434
	Other Non-Elective	76	89	72	76	89	103	97	63	94	85	77	85
	Elective Readmissions	4	6	7	5	5	6	6	5	5	6	6	5
	Non Elective Readmissions	106	112	102	104	110	98	112	105	109	109	107	100
Bed Requirement	Total Beds (100% Occupancy)	750	825	768	756	782	746	821	754	810	809	770	726
	Total Beds (90% Occupancy)	825	907	845	832	861	821	904	829	891	890	847	798
	Total Beds (85% Occupancy)	863	949	883	870	900	858	945	867	932	931	886	834
	Funded Bed Base as at 01/07/2014	798	798	798	798	798	798	798	798	798	798	798	798
	Additional Safely Staffed	839	839	839	839	839	839	839	839	839	839	839	839
Options	Total Beds (100% Occupancy)	750	825	768	756	782	746	821	754	810	809	770	726
	Funded bed base	48	-27	30	42	16	52	-23	44	-12	-11	28	72
	Additional Safely Staffed	89	14	71	83	57	93	18	85	29	30	69	113
	Total Beds (90% Occupancy)	825	907	845	832	861	821	904	829	891	890	847	798
	Funded bed base	-27	-109	-47	-34	-63	-23	-106	-31	-93	-92	-49	0
	Additional Safely Staffed	14	-68	-6	7	-22	18	-65	10	-52	-51	-8	41

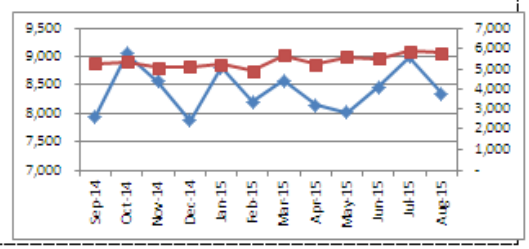
Exclusions:

Specialties: 501, 361, 420, 42*
Wards: ITU (all sites), H@H (all sites), Oxford, AMI
Patients: Aged under 18yrs old at admission
Sites: Any site other than K&C, QEH, WHH

Calculation's are based on Inpatient Spells
Criteria: Forecast based on trend in previous associated month period. Bed numbers take activity divided by days in month and multiplied by Length of Stay.

Oxford, plus: Maternity, NICU SCBU, Paediatric, Renal wards)

Division/Site	WHH	QEH	KCH	All
UCLTCBase	164	132	154	450
UCLTCAddsafe	175	142	166	483
SurgeryBase	153	105	56	314
SurgeryAddsafe	153	109	56	318
SpecialistBase	11	15	8	34
SpecialistAddsa	11	19	8	38
TrustBase	328	252	218	798
TrustAddsafe	339	270	230	839



Seasonal Pressure Analysis

East Kent Hospitals University NHS
NHS Foundation Trust

Site	WHH
Division	All
Methodology	Adjusted

← Change selection here

Click here just adjust growth assumptions

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
	A&E Attends	6,126	6,044	5,775	6,001	5,863	5,376	6,433	6,127	6,506	6,394	6,466	6,389
	Elective	2,201	2,455	2,425	2,134	2,356	2,148	2,293	2,145	2,213	2,284	2,405	2,191
	A&E Admissions	1,388	1,376	1,309	1,365	1,323	1,214	1,461	1,389	1,471	1,448	1,522	1,511
	Other Non-Elective	277	232	258	236	302	269	271	272	319	298	327	276
	Elective Readmissions	116	129	128	112	124	113	121	113	116	120	127	115
	Non Elective Readmissions	294	284	277	283	287	262	306	293	316	308	326	315
	Total Elective Admissions	2,317	2,585	2,553	2,246	2,480	2,261	2,414	2,258	2,329	2,404	2,531	2,307
	Total Non Elective Admissions	1,959	1,891	1,844	1,884	1,912	1,745	2,037	1,954	2,105	2,054	2,176	2,103
Beds	Elective	27	36	41	30	32	37	43	31	31	32	40	34
	A&E Admissions	201	233	216	227	207	188	220	220	228	223	207	201
	Other Non-Elective	24	24	23	25	23	22	26	21	41	31	29	25
	Elective Readmissions	1	2	2	2	2	2	2	2	2	2	2	2
	Non Elective Readmissions	43	48	46	47	45	41	46	46	49	47	44	42
Bed Requirement	Total Beds (100% Occupancy)	296	343	328	330	309	290	338	320	351	335	322	304
	Total Beds (90% Occupancy)	326	377	361	363	340	319	372	352	386	368	355	335
	Total Beds (85% Occupancy)	341	395	377	379	355	334	389	368	403	385	371	350
	Funded Bed Base as at 01/07/2014	328	328	328	328	328	328	328	328	328	328	328	328
	Additional Safely Staffed	339	339	339	339	339	339	339	339	339	339	339	339
Options	Total Beds (100% Occupancy)	296	343	328	330	309	290	338	320	351	335	322	304
	Funded bed base	32	-15	0	-2	19	38	-10	8	-23	-7	6	24
	Additional Safely Staffed	43	-4	11	9	30	49	1	19	-12	4	17	35
	Total Beds (90% Occupancy)	326	377	361	363	340	319	372	352	386	368	355	335
	Funded bed base	2	-49	-33	-35	-12	9	-44	-24	-58	-40	-27	-7
	Additional Safely Staffed	13	-38	-22	-24	-1	20	-33	-13	-47	-29	-16	4

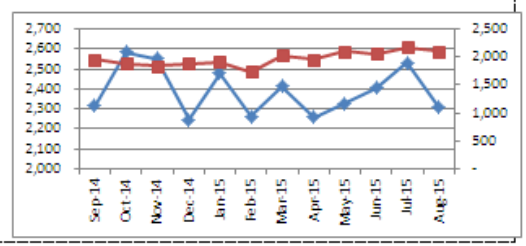
Exclusions:

Specialties: 501, 361, 420, 42"
Wards: ITU (all sites), H@H (all sites), Oxford, AMI
Patients: Aged under 18yrs old at admission
Sites: Any site other than K&C, QEH, WHH

Calculation's are based on Inpatient Spells
Criteria: Forecast based on trend in previous associated month period. Bed numbers take activity divided by days in month and multiplied by Length of Stay.

Oxford, plus: Maternity, NICU SCBU, Paediatric, Renal wards)

Division/Site	WHH	QEH	KCH	All
UCLTCBase	164	132	154	450
UCLTCAddsafe	175	142	166	483
SurgeryBase	153	105	56	314
SurgeryAddsafe	153	109	56	318
SpecialistBase	11	15	8	34
SpecialistAddsa	11	19	8	38
TrustBase	328	252	218	798
TrustAddsafe	339	270	230	839



Seasonal Pressure Analysis

East Kent Hospitals University NHS
NHS Foundation Trust

Site	QEH
Division	All
Methodology	Adjusted

← Change selection here

Click here just adjust growth assumptions

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
	A&E Attends	5,866	5,818	5,435	5,810	5,633	5,092	6,153	5,735	6,056	6,050	6,290	6,103
	Elective	1,993	2,304	2,082	1,969	2,215	2,070	2,102	2,149	2,052	2,087	2,274	2,065
	A&E Admissions	995	984	917	994	953	864	1,038	970	1,031	1,032	1,040	1,013
	Other Non-Elective	282	299	297	223	290	247	335	293	266	255	414	378
	Elective Readmissions	105	121	110	104	117	109	111	113	108	110	120	109
	Non Elective Readmissions	225	226	214	215	219	196	242	223	229	227	257	245
	Total Elective Admissions	2,098	2,426	2,192	2,072	2,332	2,179	2,213	2,262	2,160	2,196	2,393	2,173
	Total Non Elective Admissions	1,503	1,510	1,428	1,431	1,461	1,306	1,616	1,486	1,526	1,514	1,711	1,636
Beds	Elective	28	32	33	29	26	34	31	24	28	26	30	29
	A&E Admissions	167	156	145	153	169	147	163	158	160	169	156	140
	Other Non-Elective	29	29	31	25	31	28	36	27	23	27	34	38
	Elective Readmissions	1	2	2	2	1	2	2	1	1	1	2	2
	Non Elective Readmissions	38	36	34	33	39	33	38	36	36	37	39	34
Bed Requirement	**Total Beds (100% Occupancy)**	**263**	**254**	**244**	**242**	**266**	**245**	**270**	**246**	**248**	**260**	**261**	**242**
	Total Beds (90% Occupancy)	**289**	**280**	**269**	**266**	**292**	**269**	**297**	**270**	**273**	**286**	**287**	**266**
	Total Beds (85% Occupancy)	**302**	**292**	**281**	**278**	**305**	**281**	**310**	**283**	**285**	**299**	**300**	**278**
	Funded Bed Base as at 01/07/2014	**252**	**252**	**252**	**252**	**252**	**252**	**252**	**252**	**252**	**252**	**252**	**252**
	Additional Safely Staffed	**270**	**270**	**270**	**270**	**270**	**270**	**270**	**270**	**270**	**270**	**270**	**270**
Options	**Total Beds (100% Occupancy)**	**263**	**254**	**244**	**242**	**266**	**245**	**270**	**246**	**248**	**260**	**261**	**242**
	Funded bed base	**-11**	**-2**	**8**	**10**	**-14**	**7**	**-18**	**6**	**4**	**-8**	**-9**	**10**
	Additional Safely Staffed	**7**	**16**	**26**	**28**	**4**	**25**	**0**	**24**	**22**	**10**	**9**	**28**
	Total Beds (90% Occupancy)	**289**	**280**	**269**	**266**	**292**	**269**	**297**	**270**	**273**	**286**	**287**	**266**
	Funded bed base	**-37**	**-28**	**-17**	**-14**	**-40**	**-17**	**-45**	**-18**	**-21**	**-34**	**-35**	**-14**
	Additional Safely Staffed	**-19**	**-10**	**1**	**4**	**-22**	**1**	**-27**	**0**	**-3**	**-16**	**-17**	**4**

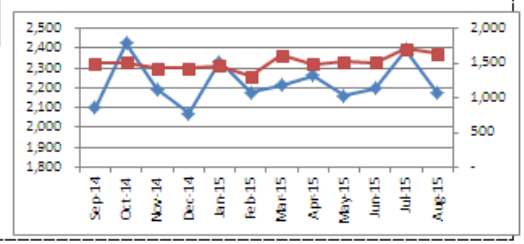
Exclusions:

Specialties: 501, 361, 420, 42*
Wards: ITU (all sites), H@H (all sites), Oxford, AMI
Patients: Aged under 18yrs old at admission
Sites: Any site other than K&C, QEH, WHH

Calculation's are based on Inpatient Spells
Criteria: Forecast based on trend in previous associated month period. Bed numbers take activity divided by days in month and multiplied by Length of Stay.

Oxford, plus: Maternity, NICU SCBU, Paediatric, Renal wards)

Division/Site	WHH	QEH	KCH	All
UCLTCBase	164	132	154	450
UCLTCAddsafe	175	142	166	483
SurgeryBase	153	105	56	314
SurgeryAddsafe	153	109	56	318
SpecialistBase	11	15	8	34
SpecialistAddsa	11	19	8	38
TrustBase	328	252	218	798
TrustAddsafe	339	270	230	839



Seasonal Pressure Analysis

East Kent Hospitals University NHS
NHS Foundation Trust

Site	KCH
Division	All
Methodology	Adjusted

← Change selection here

Click here just adjust growth assumptions

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
	A&E Attends	3,897	3,957	3,737	3,740	3,758	3,524	4,113	3,888	4,355	4,092	4,161	4,003
	Elective	3,353	3,842	3,636	3,376	3,799	3,578	3,749	3,445	3,348	3,667	3,871	3,671
	A&E Admissions	1,260	1,266	1,204	1,200	1,199	1,110	1,312	1,261	1,417	1,320	1,338	1,264
	Other Non-Elective	301	396	315	348	396	465	434	271	274	337	370	511
	Elective Readmissions	176	202	191	178	200	188	197	181	176	193	204	193
	Non Elective Readmissions	275	293	268	273	281	278	308	270	299	292	301	313
	Total Elective Admissions	3,530	4,044	3,827	3,554	3,999	3,766	3,947	3,626	3,525	3,860	4,075	3,864
	Total Non Elective Admissions	1,836	1,955	1,787	1,821	1,876	1,854	2,054	1,803	1,990	1,949	2,010	2,088
Beds	Elective	25	44	52	32	36	41	31	41	39	50	39	37
	A&E Admissions	117	118	100	102	109	92	117	105	117	111	109	94
	Other Non-Elective	23	36	19	26	35	52	35	16	29	27	13	22
	Elective Readmissions	1	2	3	2	2	2	2	2	2	3	2	2
	Non Elective Readmissions	26	27	22	23	26	23	28	23	25	25	24	23
Bed Requirement	Total Beds (100% Occupancy)	191	228	196	185	208	211	213	188	211	214	187	179
	Total Beds (90% Occupancy)	210	250	215	203	229	233	235	207	232	235	206	197
	Total Beds (85% Occupancy)	220	262	225	212	239	243	245	216	243	246	215	206
	Funded Bed Base as at 01/07/2014	218	218	218	218	218	218	218	218	218	218	218	218
	Additional Safely Staffed	230	230	230	230	230	230	230	230	230	230	230	230
Options	Total Beds (100% Occupancy)	191	228	196	185	208	211	213	188	211	214	187	179
	Funded bed base	27	-10	22	33	10	7	5	30	7	4	31	39
	Additional Safely Staffed	39	2	34	45	22	19	17	42	19	16	43	51
	Total Beds (90% Occupancy)	210	250	215	203	229	233	235	207	232	235	206	197
	Funded bed base	8	-32	3	15	-11	-15	-17	11	-14	-17	12	21
	Additional Safely Staffed	20	-20	15	27	1	-3	-5	23	-2	-5	24	33

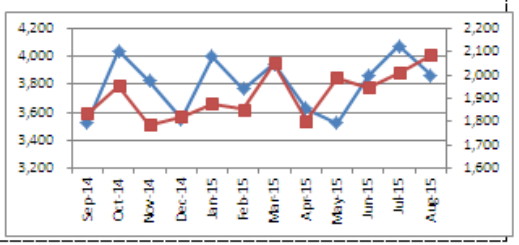
Exclusions:

Specialties: 501, 361, 420, 42*
Wards: ITU (all sites), H@H (all sites), Oxford, AMI
Patients: Aged under 18yrs old at admission
Sites: Any site other than K&C, QEH, WHH

Calculation's are based on Inpatient Spells
Criteria: Forecast based on trend in previous associated month period. Bed numbers take activity divided by days in month and multiplied by Length of Stay.

Oxford, plus: Maternity, NICU SCBU, Paediatric, Renal wards)

Division/Site	WHH	QEH	KCH	All
UCLTCBase	164	132	154	450
UCLTCAddsafe	175	142	166	483
SurgeryBase	153	105	56	314
SurgeryAddsafe	153	109	56	318
SpecialistBase	11	15	8	34
SpecialistAddsa	11	19	8	38
TrustBase	328	252	218	798
TrustAddsafe	339	270	230	839



Annex B: Operational Resilience Capacity Plan Non Elective Care 2014/15

Winter bids

The Trust has submitted a number of schemes (highlighted in bold) which improve the operational resilience of non-elective care during the winter months. Confirmation of the decision on funding is awaited.

Collectively these schemes work across the whole pathway/systems and aim to avoid or minimise attendance and/or admission to hospital and/or to improve delays in discharge. The schemes have been prioritised to ensure those with the greatest impact on ensuring efficient patient flow and patient safety were presented for consideration. Where appropriate, the schemes have been developed collaboratively with external partners.

The following schedule summarises approved schemes across all Providers':

Surgical Assessment Unit	• **WHH SAU to be based within Celia Blakely Unit** • **QEQM SAU TBC** • **Model to include 'Hot Ambulatory Care and Rapid Access Clinics'**
Consultants in A&E	• **Additional Sessions (TBC)**
Integrated Urgent Care Centre (I.U.C.C)	• **Acute Medical Model of Care** • **Integrated Discharge Team**
I.U.C.C Care Navigation Centre (24 / 7)	• Redirection in Ambulance Conveyance to A&E at WHH & KCH by 200 patients a month • Trail starts in September • QEQM Option TBC • Lisa Barclay leading the working group
Enhanced Intermediate Care Teams	• Improved capacity & response times • Links to rapid response (Care Navigation) • Provision of OT & Physio within A&E (IDT)
7 day primary care solution	• SKC, Ashford & Canterbury • Thanet wish to focus on GP in A&E (QEQM activity hub)
Increased beds for KCC (? How many)	• Dedicated bed base for NWB patients at Westbrook & Westview • Allow Community Hospitals to reduce LOS & take Step Up patients (IUCC Care Navigation) • Original plan for centralising NWB patients at QVHB appears to have been revised
SECAMB HALO for QEQM & WHH	• To underpin the HALO role, SECAMB will be providing an Intensive Training Programme across East Kent to improve & enhance knowledge, skills and experience of paramedics • Aim is to reduce Ambulance Conveyance to A&E
Paramedic Practitioner Service	• Alternative to ECP Model • Focus on Admission Avoidance & reduced Ambulance Conveyance • Competent to administer medicines via PGD's (34)

Patient Transport Augmentation	• Shared with NSL
Monitoring Performance	• Each scheme has clearly defined KPI's, to enable performance monitoring • All supported schemes will have their KPI's added to SHREWD • SHREWD will be accessible by IUCC / Care Navigation Centre • Will reflect activity / performance of NHS 111, SECAMB, KCHT, S/S

Annex C Operational Resilience Capacity Plan Elective Care 2014/15

	Admitted Activity			Non-admitted Activity			Total Cost	Cost Per Additional Pathway	
	Additional Completed Pathways		Cost	Additional Completed Pathways		Cost			
	Up to 18 weeks	Over 18 weeks		Up to 18 weeks	Over 18 weeks			Admitted	Non-admitted
Cardiology	0	0	£0	0	0	£0	£0	£0	£0
Cardiothoracic Surgery	0	0	£0	0	0	£0	£0	£0	£0
Dermatology	0	0	£0	0	0	£0	£0	£0	£0
ENT	15	18	£55896	54	60	£13,323	£69,219	£1,694	£117
Gastroenterology	0	9	£0	0	0	£0	£0	£0	£0
General Medicine	0	9	£0	0	0	£0	£0	£0	£0
General Surgery	24	24	£189,471	87	90	£20,568	£210,039	£3,947	£116
Geriatric Medicine	0	0	£0	0	0	£0	£0	£0	£0
Gynaecology	6	12	£45,042	96	105	£23,373	£68,415	£2,502	£116
Neurology	0	0	0	0	0	£0	£0	£0	£0
Neurosurgery	0	0	0	0	0	£0	£0	£0	£0
Opththalmology	0	0		0	0	£0	£0	£0	£0
Oral Surgery	0	0	£0	0	0	£0	£0	£0	£0
Other	0	0	£0	0	0	£0	£0	£0	£0
Plastic Surgery	0	0	£0	0	0	£0	£0	£0	£0
Rheumatology	0	0	£0	0	0	£0	£0	£0	£0
Thoracic Medicine	0	0	£0	0	0	£0	£0	£0	£0
Trauma & Orthopaedics	108	111	£1,322,50	312	318	£73,740	£1,396,302	£6,039	£117
Urology	0	0	£0	0	0	£0	£0	£0	£0
TOTAL	153	165	£1,612,971	549	573	£131,004	£1,743,975	£5072	£117

Appendix One: Definitions

Seasonal Pressures:
Seasonal Pressures for the Trust are defined as:

"the anticipated seasonal activity during the winter months (commencing 1st November 2013) which leads to increased bed pressures across the Divisions which can impact on the Trust's ability to meet its contractual obligations and maintain patient safety".

Daily SITREP:
A daily situation report to the CCGs which highlights each provider organisations pressures in capacity

Single Health Resilience Early Warning Database (SHREWD)
SHREWD is an on-line health system management tool with primary function to support decision making that assists in the management of the Trust's capacity and service provision during system pressures i.e. winter.

Delayed Transfer of Care (DTOC)
A weekly report which details the number of patients who are medically stable, MDT stable and have a safe discharge process &/or destination agreed, but remain within an acute hospital bed. A weekly report is produced by acute providers and validated by Social Services, prior to submission to Health Economy providers and CCGs.

Business Continuity / Significant Incident
Any event that cannot be managed within routine service arrangements which requires the implementation of special procedures and may involve one or more of the emergency services the wider NHS or a local authority. A significant or emergency may include;

A. Times of severe pressure, such as winter periods, a sustained increase in demand for services such as surge or an infectious disease outbreak that would necessitate the declaration of a significant (Business Continuity) incident however not a Major Incident.
B. Any occurrence where the NHS organisation is required to implement special arrangements to ensure the effectiveness of the organisation's internal response. This is to ensure that incidents above routine work, but not meeting the definition of a major incident, are managed effectively.

In addition to the NHS Commissioning Board's definition in section A and B a Business Continuity Event is when there is significant disruption to the Trust's critical services due to an internal issue including but not limited to:

- Loss of utilities
- Unavailability of staff
- Loss of access to service area
- Loss of telecommunications
- Loss of IT services

- Fire

A Business Continuity Event can only be declared should it be felt that a Trust-wide response is needed.

Complete Closure
An A&E department is unable to receive patients safely.

Escalation Triggers
All organisations have adopted the common triggers to ensure equity of pressure; capacity and access.

Local Health Economy
A health and social care whole system grouping (usually geographically defined).

Major Incident
Any event which presents a serious threat to the health of the community, disruption to the service, or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by NHS Commissioning Board, local area teams, NHS Trusts, ambulance services or CCGs.

It is **not** normally expected that escalation would be a cause of a major incident as escalation is a result of general capacity and demand pressure rather than pressure caused by a specific event. However, there may well be actions that are common to escalation levels 3 and 4 and major incident plans and this should be considered.

Partial Closure
An A&E department is only able to accept specific patient groups safely

Peripheral Divert
Border patients are taken by the ambulance service to neighbouring organisations to alleviate capacity issues.

Responsible Person

A senior employee authorised by the Chief Executive of an individual provider to implement agreed diversions and to notify relevant parties in accordance with this framework. The responsible person must have decision making ability and authority, and an organisation wide view.

The responsible person may be specified as a post (e.g. Duty Accident and Emergency Consultant, Duty Director, Operations Director) if desired.

24/7 arrangements must be in place for this person's role to be covered in person or by a deputy with clarity regarding communication. There must be a clear communication link between the responsible person and the Chief Executive.

Appendix Two: ACTION CARDS

In the event of the Trust experiencing significant Seasonal Pressures or a Business Continuity event, the following Action Cards have been developed to enhance patient flow:

- Site Manager and/or Senior Matron
- Patient Flow Team
  - Nurse in Charge of wards
  - Capacity & Flow Manager / Bed Manager
  - Discharge Manager
- Consultants
- Facilities Manager

ACTION CARD 1

Site Manager &/or Senior Site Matron – TCMT

Immediate Actions

1. On being informed of a Business Continuity event, report to the Tactical Crisis Management Team (TCMT) Command Centre on your respective site.

   WHH – Boardroom
   QEQM – Anaesthetic Seminar Room
   K&C – Operational Control Centre

2. Allocate a deputy to take over your ordinary day to day duties. Ask this Deputy to start contacting the inpatient wards & request they commence their Actions in response to a Business Continuity event.

3. Contact the Patient Flow & Capacity Manager, Bed Manager and Discharge Manager and inform them of the Business Continuity event. Ensure every member of the patient flow team have access to the relevant Action Card and adhere to it.

4. Ask the Capacity & Flow Manager, Bed Manager and Discharge Manager to attend each of the inpatient wards & collect their respective 'discharge / transfer lists' from each area. Confirm that they must report back to you / the TCMT (if established), with an updated list of actual and potential discharges.

5. Allocate nurses to reinforce your critical areas (as necessary) for additional support.

6. Ensure the ward areas are identifying additional staff who could be called in as necessary, but confirm they are **not** to call them in until instructed to do so by the Division or TCMT (if established).

7. Advice all areas within your Division that the Hospital is experiencing a Business Continuity event or significant Seasonal Pressures.

8. Contact the site-based Facilities Manager, inform them of the situation, ensure they have access to the relevant Action Card and request they adhere to it.

9. Ensure that Discharge Lounges expect additional patients and are preparing sufficient capacity to manage.

Subsequent Actions

1. As directed by the Divisional General Manager or the TCMT if established.

2. Refer directly to Divisional Seasonal pressures plan to ensure all relevant actions are followed and Implement Divisional Business Continuity Plans, as required

3. Maintain communication with the Patient Flow & Capacity Manager, Bed Manager and Discharge Manager, provide Bed Status updates as requested and assist with any 'difficulties' regarding patient flow & discharge.

ACTION CARD 2

Consultant(s)

Immediate Actions
1. On being informed of a Business Continuity event or significant Seasonal Pressures, you **may** be asked to reduce or cancel scheduled activity to support adhere to this Action Card 2. Senior Clinicians on Call to actively scrutinise all GP referrals / requests for admission. 3. Senior Clinicians to be present in A&E 24/7 to ensure rapid assessment of all patients. Admission Avoidance should be considered wherever clinically safe to do so 4. Ensure all inpatient wards areas are attended – the Nurse in Charge will have prepared potential 'Discharge Lists' to support focused review of patients 5. Ensure each patient is considered against suitability for; * Hospital at Home * Transfer to a Health & Social Care Step Down bed * Ambulatory Care Pathway * 23hr Surgical Pathway 6. All Clinicians to follow NHS England's 'Reverse Triage Algorithm' to support decision making regarding Discharge (see below) 6. Call in additional staff as required as agreed with the Divisional Clinical Director / Medical Director On-Call

Risk of Medical Event	Basis	Triage Category	Notes
1 - Minimum	No anticipated medical event during next 72 hours	Green	Deemed medically fit /stable
2 - Low	Calculated risk of non-fatal medical event. Consider early discharge	Green	Consider discharge home with assistance
3 - Moderate	Consequential medical event quite likely without critical intervention	Yellow	Discharge home not advisable
4 - High	Patient care cannot be interrupted without virtually assured morbidity or mortality	Red	Highly skilled care required
5 - Very High	Patient cannot be mover or readily transferred	Red	ITU care required

NB: In Extreme BUSINESS CONTINUITY

A Elective Surgery will be scrutinised to ensure patients are cancelled appropriately and safely
B 24/7 Consultant presence on site will be required to ensure timely patients flow and robust Assessment / Admission Avoidance is maintained 24/7

ACTION CARD 3

Patient Flow Team - Nurse in Charge of WARDS - TCMT

Immediate Actions

1. On being informed of a Business Continuity event OR during Status RED within the Seasonal Pressures Plan, ensure all staff are notified and the ward is adequately prepared to respond as required.

2. Review every inpatient on the ward and prepare a list of patients that are medically stable for discharge / transfer to a non-acute setting. Please note any Patient Transport requirements and patients' mobility accurately.

3. Ensure each patient is considered against suitability for:
   - Hospital at Home
   - Transfer to a Health & Social Care Step Down bed
   - Ambulatory Care Pathway
   - 23hr Surgical Pathway

4. Ensure that any patient safe for discharge / transfer, but requiring actions to support this (i.e: Dr.s Review, EDN, Care Package, ICT bed etc), are clearly noted on the list you are preparing.

5. Please take a photocopy of the list you have prepared. The Capacity & Flow manager / Bed Manager will collect the original discharge list & agree with you which actions you will take to resolve any INTERNAL issues (Dr.s review, EDN, Investigations etc).

6. The Photocopy should be given to the Discharge Manager, who will focus on those patients that require EXTERNAL services to support discharge (Care Packages, ICT Bed etc)

7. Identify staff who live close to the hospital and could be called in **if required**. Keep a list at ward level, until a senior nurse requests it (if required).

8. Advise patients and relatives, as necessary, that the Hospital is experiencing a Business Continuity event or significant Seasonal Pressures. This is particularly relevant for those patients that appear on the 'discharge / transfer' list previously provided.

Subsequent Actions

1. Ensure Patient Transport is booked for those patients that are ready for discharge / transfer, including the earliest time patient can be collected. **NB:** patients must be transferred to the Discharge Lounge (unless it would be unsafe) to ensure beds are vacated urgently.

2. Ensure any actions you are responsible for chasing / completing are prioritised and the Capacity & Flow / Bed Manager is informed of any outcomes. Any 'difficulties' should be escalated to the relevant Site Manager immediately.

3. Continue to liaise with the Capacity & Flow Manager / Bed Manager &/or Discharge Manager as relevant, to ensure they are aware of any updates regarding the patients for discharge / transfer.

4. Ensure that all discharge / transfers are timely and the bed manager is informed as soon as a bed is available to ensure an accurate bed status is maintained and patients requiring admission can be accommodated.

5. Continue to identify patients that can be considered for discharge / transfer throughout the day or until the Business Continuity event or significant Seasonal Pressures have been resolved.

Patient Flow Team - Capacity & Flow Manager / Bed Manager

Immediate Actions

1. On being informed of a Business Continuity event or significant Seasonal Pressures, provide an immediate and accurate bed status to the Site Manager or Tactical Crisis Management Team (TCMT) if established.

2. Attend every inpatient ward and collect the original copies of the 'discharge / transfer' lists from them. Agree with each ward's N-I-C, which actions requiring INTERNAL resolution, each of you will complete to support discharge.

3. Wherever possible, the Capacity & Flow Manager should lead on resolving INTERNAL issues, to enable ward staff to prepare patients for discharge and maintain safe care for inpatients.

4. Provide an updated list of actual and potential discharges to the Site Manager / TCMT at the earliest opportunity.

5. Liaise with the Discharge Manager to ensure they have collected the photocopies of the 'discharge / transfer' list and confirm which patients they are actively trying to discharge.

Subsequent Actions

1. Continue to liaise with all wards / clinical areas to ensure patient's are discharged / transferred to the Discharge Lounge in a timely way.

2. Maintain regular input with A&E / ECC / CDU to ensure patients requiring admission are allocated beds appropriately and quickly.

3. Any 'difficulties' with discharging patients or completing actions (i.e. investigations, EDN completion, Pharmacy, PTS) should be reported immediately to the Site Manager or Senior Nurse &/or Doctor within the TCMT (if established).

4. Continue to provide accurate bed status to the Site Manager / TCMT as requested by them, including the number of patients in A&E and those requiring admission (who do **not** have beds allocated)

5. Continue to obtain regular updates from each ward regarding discharge and feedback any actions taken by yourself to the relevant ward / N-I-C.

6. Maintain a 'log' of any significant issues or process 'blocks' which you encounter and submit this to the Site Manager / TCMT prior to leaving the site, to ensure issues can be resolved accordingly

Patient Flow Team - Discharge Manager

Immediate Actions

1. On being informed of a Business Continuity event or significant Seasonal Pressures, ensure that the site-based Social Services, Intermediate Care and Community Nursing staff are notified and request that they obtain an accurate Community bed state & Care Home vacancy list, to support urgent discharge / transfer of patients.

2. Ensure there is an accurate bed state obtained from the relevant Health & Social Care Step Down beds and inform the relevant Care Home of the situation. They should be advised of the need to respond within 4hrs of any suitable referrals they receive against the Eligibility Criteria.

3. Attend every inpatient ward and collect the photocopy of the 'discharge / transfer' list from them. Agree with each ward's N-I-C, which actions requiring EXTERNAL resolution, each of you will complete to support discharge.

4. Liaise with the Bed Manager and confirm which patients you are actively trying to discharge with your D.R.S colleagues.

Subsequent Actions

1. Meet with relevant members of the D.R.S to obtain the community bed state and identify those patients that can be safely discharged (quick wins: Restart existing Care Package (if safe) / seek interim placement in care home whilst awaiting new Care Package / ICT or Step down bed / permanent placement or assessment).

2. Complete actions involving EXTERNAL partners in a timely manner and ensure the Bed Manager and relevant ward areas are kept informed of progress.

3. Liaise accordingly with other members of the Multidisciplinary Team (Therapies, SALT etc) and relevant discharge teams (Hospital at Home) to ensure patient safety is maintained on discharge.

4. Maintain a 'log' of any significant issues or process 'blocks' which you encounter and submit this to the Site Manager / TCMT prior to leaving the site, to ensure issues can be resolved accordingly

ACTION CARD 4

Estates & Facilities – Facilities Manager - TCMT

Immediate Actions
1. On being informed of a Business Continuity event or significant Seasonal Pressures, liaise with the Site Manager (or TCMT if established) to obtain an update briefing 2. Contact Bed Bureau to ensure that all GP referrals are directed to the relevant Consultant on Call, so that advice may be given over the phone and avoid unnecessary attendance at A&E. Bed Bureau are also to issue Site-wide / Trust-wide SMS text messages as directed. **NB: ANY messages issued by the Trust Control Centre (SCMT) must be sent out as priority.** 3. Contact all key Facilities leads within SERCO, Laundry / Linen, Estates and inform them of the situation. 4. SERCO to ensure Portering staff prioritise 'ward moves', A&E transfers and transfers to the Discharge Lounge to support timely patient flow. 5. SERCO to ensure 'Ward vacation cleaning requests' are prioritised (alongside Infection Control) to ensure safe environments are maintained and patient flow is timely 6. Estates Department / EME to ensure any beds or equipment awaiting repair are prioritised / liaison with relevant Company (such as Huntleigh) is escalated. 7. SERCO / Estates to be informed regarding the opening of additional ward areas, to ensure they are safe to use and all relevant support is provided (ward domestic, food, beverages etc). 8. Laundry to ensure that sufficient linen is available on relevant / all acute sites to support increased number of beds and patient activity. 9. Ensure that services to key areas are fully operational 10. Receive regular updates from the SERCO contacts regarding actions taken by their staff in the portering/cleaning/catering teams 11. Follow any necessary Facilities procedures to ensure site remains fully functional

Subsequent Actions
1. Set up a 24 hour shift system (if required) to ensure continuity of services. 2. As advised by TCMT (if established)

Appendix Three: Communication Links

Location	Open Conference Bridge Line	Phone	Fax
SCMT – Boardroom K&C	0844 473 7373	01227 864177 (73553)	01227 866414 (73554)
WHH TCMT - Boardroom	0844 473 7373	01233 616149 (86149) 01233 616159 (86159)	01233 616079 (86079)
K&C TCMT - Operational Control Centre	0844 473 7373	01227 783050 (74199) 01227 783069 (74599) 01227 783053 (74499) 01227 783051 (74299)	01227 866390 (73878)
QEQM TCMT - Anaesthetic Seminar Room	0844 473 7373	01843 234276 (63455) 01843 234275 (62606)	01843 234446

Organisation	Contact Number
Community Health – Ashford Rapid Response	0300 123 0915

Appendix Four: Training and Exercising

The Seasonal Pressures Plan will be validated through a table-top exercise. Scenarios will be based on real life events which occurred during previous winter periods, such as inclement weather, infection control and demand / capacity issues.

The exercise will give the Trust's Executives and General Managers' On-Call the opportunity to familiarise themselves with the Plan, gain confidence with regards the setting up of the Control Rooms and test communication channels internally. Attendance will be mandatory for all staff on the GM On-Call rota and is advised for Executives and Medical Directors On-Call.

To facilitate attendance, the exercise will be repeated across all acute sites, over six dates (1 @ QEQM, 2 @ WHH and 3 @ K&C). This will further ensure that suitability of the Incident Command Rooms can be tested, and that site-based TCMT's are fit for purpose.

The exercise will be created and facilitated by the document author, Emergency Planning and Business Continuity Department and staff with detailed operational knowledge of seasonal pressures, to maximise the benefits for staff attending.
NB: It is the responsibility of Trust staff to ensure they are familiar with the Plan and maintain knowledge and competency levels.

Appendix Five: PTS Crisis Management Plan

1.0 Introduction

1.1 The Non Emergency Patient Transport Service (PTS) has been commissioned to provide 164,000 journeys per year for East Kent Hospitals, this would equate to 3,154 journeys per week. Based on our understanding of current performance the service provided is approximately 59% of the service commissioned – ie. 1,800 journeys per week average (approximately 90,000 journeys per year) according to NSL latest reports.

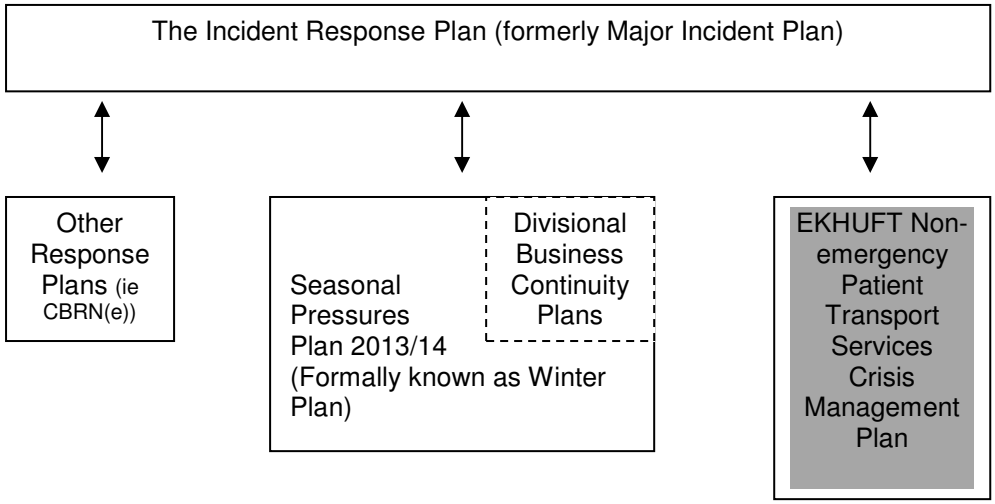
<<<Checking to ensure that this is still accurate>>>

1.2 This document provides Guidance to our Operational and Executive Teams in the event of further loss to Non Emergency Patient Transport Services. This Plan builds on the current day-to-day operational activities.

1.3 In the likely event that the transport provider will be unable to support the Trust activity throughout the year with particular emphasis on the winter months (October – May), this Crisis Management Plan outlines the actions to be taken to minimise the risks to patient flow and patient safety.

1.4 The Command and Control Structure set out within this Plan includes the process for escalation to the Clinical Commissioning Group (CCGs) and to the NHS England Local Area Team.

1.5 The diagram below provides a visual oversight of the relationship between all of East Kent Hospital's Response Plans including this Crisis Management Plan to deal with failure of non emergency patient transport services.



2. Aim

The aim of this document is to ensure that all key clinical services and patient safety are maintained throughout the year.

2.1 Strategic Objectives

To reduce the impact of a non emergency PTS failure to ensure:

- Continuity of patient care
- Safety of patient and staff wellbeing
- Continuation of Business Critical Activities
- Continuation of effective Patient Flow throughout the Trust
- Protect the Trust's reputation

2.2 Operational Objectives

- Establish a clear escalation process for current Transport issues and for more than 5 failed discharges in a 24 hour period Trust wide/ or full loss of service.
- Provide clear instructions to staff on the activation of EKHUFT's non-emergency Patient Transport Service Crisis Management Plan.
- Confirm the required actions the Trust must take to mitigate the risk of full loss of service (complete failure).
- Ensure alignment with the Trust's Major Incident Response Plan.
- Provide assurance to the Trust that robust arrangements are in place.

2.3 Plan Excludes

- Documenting specific recovery plans or procedures for any service area or their operations.
- Documenting specific recovery plans or procedures for external organisation or suppliers upon whom all service areas rely.

2.4 Ownership and Maintenance

EKHUFT Transport Operational Group (TOG) owns this Plan.

2.5 Document Amendments

This Plan will be updated and redistributed to all recipients twice a year (or more frequently in the event of changes during the year) by the Emergency Planning and Business Continuity Manager. Any updates required should be sent directly to the Emergency Planning and Business Continuity Team at: ekh-tr.EmergencyPlanning@nhs.net for inclusion in the next version.

2.6 Plan Limitations

All private resources such as St Johns Ambulance Service would potentially have been utilised by other providers therefore vehicles will be unavailable to our Trust.

3. Operational Procedure for escalating issues with non emergency patient transport.

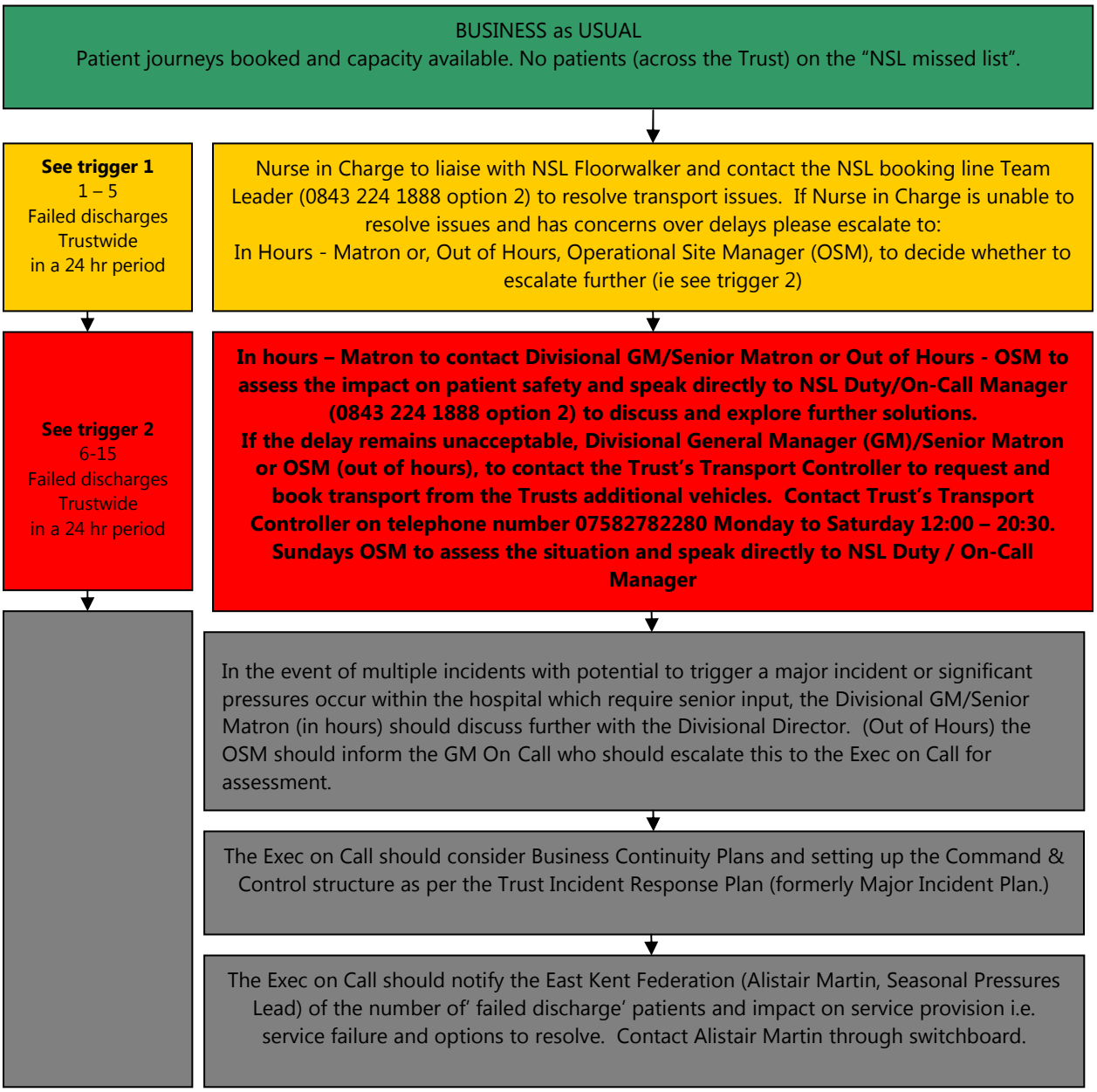
The following escalation process must be followed in the event that NSL Patient Transport fails where:

- Patient Transport has not arrived, at appointment time
- Patient(s) have not been picked up within the agreed time/KPIs ie renal 30 mins, outpatients 60 mins or discharge and transfers 3 hours

(On day journey planning can be viewed by staff on ebookings by searching for 'patient journey' and clicking 'on day' which will show planned collection slot).

or

- there is a significant impact on patient safety eg care package, diabetic patients etc



Note 1 – For cardiac transport only, contact: **Thames Ambulance 01268 5120**

Note 2 – The GM on-call should only be involved in escalated transport issues if there is either an external incident that triggers a major incident, or if significant pressures occur within the hospital which require senior input to test that all actions have been taken and whether anything else can be done.

Note 3 - It is not the role of the GM On Call to book transport out of hours – it is the responsibility of the Operational Site Manager to do this.

East Kent Hospitals University NHS
NHS Foundation Trust

4.0 Business Continuity

In the event that all Triggers on page 4 have been activated, and transport issues are persistent then the General Manager and Executive manager on Call should consider placing the Trust on Standby / declaring a Business Continuity Incident and follow the procedures as Identified on pages 7, 8, and 9 of the Incident Response Plan.

The Executive-on-Call will also be required to inform the CCG cluster on: **07623 503 823** (pager) and Kent and Medway Area Team on-Call Manager on: **07623 501 084** (pager) to inform them of standby / declaration state and any additional information required.

It is essential that the Critical Functions identified in Section 5 are maintained and remain operational at all times.

The Executive-on-Call is responsible for issuing the **Major / Business Continuity Incident Standby** instructions. **No other person has the authority to do this.**

5.0 Trust Critical Functions

The loss of non-emergency Patient Transport Services would have the greatest impact on the following critical functions. These critical functions must remain operational at all times.

Critical Function	Brief Description	Recovery Time Objective (RTO)
In-Patient Discharges	To maintain an effective transport service for in-patient discharges and ensure that hospital activity is not compromised.	0 hrs
Renal	Patients requiring life preservation dialysis treatment determined on "patient by patient" basis.	0 hrs
Internal Transfers	To ensure patient care is continued in the specialist centre appropriate to the patient's needs within one organisation. This includes patients transferred to reablement step down beds. (Halden Heights, Ami Lodge and Saltwood Care Centre).	2 hrs
External Transfers	To ensure patient care is continued in the specialist centre appropriate to the patient's needs outside the organisational boundaries.	2 hrs
Oncology	To maintain clinical treatment pathways for patients who require an out outpatient appointment.	2 hrs
Oncology Transfers	To ensure that patients within Hospices and non-specific oncology centres are transferred to the most appropriate site to maintain their treatment pathway.	2 hrs
Day Cases	To ensure that patients requiring Patient Transport for day case treatments are collected and dropped off in the identified timeframes, and that the return journey is swiftly available when the patient is fit and ready to be taken home.	2 hrs

Outpatients	To ensure that patients requiring Patient Transport for out patient appointments are collected and dropped off in the identified timeframes, and that the return journey is swiftly available when the patient is ready to be taken home.	2hrs

5.1 Data Capture of Service Failures

Service failures should be registered on Datix so that the Trust can escalate issues to NSL for them to review and rectify service improvements. For further information please refer to:
http://www.ekhuft.nhs.uk/staff/patient-transport-services/