MEETING DATE:	9 October 2014	NHS North Lincolnshire Clinical Commissioning Group **REPORT TO THE** **CLINICAL COMMISSIONING GROUP** **GOVERNING BODY**
AGENDA ITEM NUMBER:	Item 6.1	
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Jane Ellerton Senior Manager; Commissioning NL CCG	

NORTH LINCOLNSHIRE RESILIENCE PLAN

PURPOSE/ACTION REQUIRED:	Decisions for Approval
CONSULTATION AND/OR INVOLVEMENT PROCESS:	*This should identify each key Committee/Group which has led prior involvement/consultation in developing the recommendations in the paper*
FREEDOM OF INFORMATION:	*Is this document releasable under FOI at this time? If not why not? (decision making guide being developed)* **Public**

1. PURPOSE OF THE REPORT:

The attached Resilience Plan sets out the North Lincolnshire approach to management of surges in demand across health and social care services, in response to the NHS England 'Operational and resilience planning for 2014/15 guidance; June 2014'. The plan, developed in conjunction with local stakeholders and in line with the guidance requirements is currently within the NHS England assurance process, and has undergone local table-top scenario testing involving all key stakeholders.

Whilst a surge in demand is expected during winter months, both health and social care services are now seeing surges throughout the year. The plan describes how stakeholder organisations will work together to monitor demand and escalate across the system in response to surge in demand.

An operational group will manage pressures on a day to day basis within organisations, calling on support and response from other organisations in line with the triggers set out in the plan. The Urgent Care Working Group, set up in 2013/14 will continue to oversee the whole urgent care system, with stakeholders working together to manage system issues. A System Resilience Group has been set up in 2014 in response to the Operational resilience and capacity planning guidance and will take an overview of both planned and unplanned care to ensure robust arrangements are in place to sustain delivery of urgent care alongside RRT and cancer wait requirements.

NL CCG will receive an allocation of £1.118m of non-recurrent funding to support resilience within the health and care economy to March 2015. The plan sets out how this funding will be allocated to increase capacity and service resilience, to support avoidable admissions and reduced length of stay.

NL CCG Governing Body is asked to accept and approve the Resilience plan, and agree this be published on the NL CCG Website.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:

Continue to improve the quality of services	
Reduce unwarranted variations in services	
Deliver the best outcomes for every patient	**X**
Improve patient experience	**X**
Reduce the inequalities gap in North Lincolnshire	

3. ASSURANCES TO THE CLINICAL COMMISSIONING GROUP

4. IMPACT ON RISK ASSURANCE FRAMEWORK:

Yes		**No**	**X**

5. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:

Yes		**No**	**X**

6. LEGAL IMPLICATIONS:

Yes		**No**	**X**

7. RESOURCE IMPLICATIONS:

Yes	**X**	**No**	

The plan sets out the use of allocated non-recurrent funding. Recurrent funding, where required will be built into 2015/16 financial plan and Better Care Fund plan

8. EQUALITY IMPACT ASSESSMENT:

Yes		**No**	**X**

9. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:

Yes	**X**	**No**	

Routine communications to patients take place to clarify service access around Bank Holidays. Proactive media releases will be instigated as appropriate during times of surge in demand and in line with national events such as self-care week.

10. RECOMMENDATIONS:

The CCG is asked to: -

- Accept and approve the Resilience plan
- Approve the publishing of the plan on the NL CCG website

NHS
North Lincolnshire
Clinical Commissioning Group

North Lincolnshire Resilience Plan; 2014/15
Draft v3.1

Group Approved	Date approved
System Resilience Group	
Urgent Care Working Group	
NL CCG	
NLAG	
RDaSH	
NLC	
EMAS	

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North Lincolnshire Resilience Plan

1.0 Introduction

The North Lincolnshire Resilience plan has been developed by the local stakeholders to provide Health and Social Care Organisations with a structured set of arrangements and guidance when 'normal' operating functions are challenged, either through loss of staff, resources or external operational pressures. This will assist services in coping with periods of high pressure and maintain the quality of patient care.

The plan builds upon the individual business continuity plans of each organisation to provide a system-wide co-ordinated and mutually supportive environment to monitor, assess and respond to system pressures.

This remains a live document and will be updated throughout the year. The plan will work in conjunction with individual organisational business continuity plans. These business continuity plans are reviewed and shared with the Chair on an annual basis to enable plan updates to be made. There have been a number of minor changes to the escalation triggers and actions, and these remain in alignment with business continuity plans. Further analysis of the NHS 111 business continuity plan and the resilience plan is required as NHS 111 is reporting demand exceeding contracted activity levels.

Organisations involved in the development of this plan, and with responsibilities for its implementation are;

- North Lincolnshire Clinical Commissioning Group
- East Riding Clinical Commissioning Group
- Northern Lincolnshire and Goole NHS Foundation Trust
- Rotherham, Doncaster and South Humber Mental Health Foundation Trust
- East Midlands Ambulance Trust
- North Lincolnshire Council
- NHS 111 (Yorkshire Ambulance Service)

The five levels of escalation identify trigger points as demand levels increase and determine what actions could be needed to protect each organisation's core services and supply the highest level of service within the resources available. These levels have been in use during previous years and have been further developed to reflect social care and community services.

The resilience plan arrangements are designed to support the principles of NHS system resilience against disruptive challenges and both internal and external operating pressures within both elective and non-elective systems.

The potential for significant service or business disruption in the modern world is ever present and North Lincolnshire Health and Social Care Organisations are required to ensure that suitable, robust arrangements are in place to cope with disruptive challenges that may affect service delivery and functionality.

During periods of challenge to performance, quality or safety, North Lincolnshire Health and Social Care organisations will consider a variety of strategic and tactical options that are most suitable to deal with the situation. The resilience plan will form part of the decision making processes when assessing the impact or potential impacts of internal or external pressures within the whole service system.

It is recognised that each organisation has a range of performance targets to achieve and that achievement of these targets need to be managed and balanced against each other. There is a particular requirement to ensure both elective and non-elective systems are balanced and that peaks in non-elective activity do not have a detrimental effect on elective performance.

This resilience plan works in conjunction with the existing organisational escalation plans, policies and procedures to enable assessment of current and predicted pressure levels. Equally, in escalating the resilience plan, consideration should be given to the pressure levels experienced across Northern Lincolnshire, such as bed status and ambulance turnaround times.

2.0 Development of the plan

The resilience plan replaces the previous North Lincolnshire Surge Plan; 2013/14 and will be operational year round, however it is noted that specific pressures can be expected during the winter period, specifically from the beginning of November until the end of February. In general, the health and social care system will operate at escalation level one, when the services across North Lincolnshire are operating within normal parameters. There are varying escalation levels reflecting increasing pressure on services, up to level five, where there is the potential for service disruption due to a major incident, or sustained adverse weather conditions.

During 2013/14 and into 2014/15, there has been considerable pressure within the acute hospital system, with peaks in activity through the urgent care centre (without obvious cause) and high bed occupancy due to the fact that conversion rate of attendees at the urgent care centre to admissions has remained unchanged. The Urgent Care Working Group has had a recovery action plan in place, with monitoring of the plan through the UCWG. This remit of the group will continue and the group will maintain responsibility for examining and analysing the drivers of system pressure to inform the action plan. The group has recently mapped all services contributing to the urgent care pathway to identify gaps and duplication, and has agreed a dashboard. The dashboard continues to be developed, but is starting to provide useful information on the system. The inclusion of social care and practice level primary care information remains a challenge.

The System Resilience Group performs a similar function in relation to elective care, examining drivers of activity in order to develop plans to manage demand and match capacity to managed demand levels, thus ensuring continued achievement of referral to treatment times. This group also has a remit to undertake analysis and modelling to ensure the delivery of both elective and non-elective work-streams together, without impact on quality or performance.

As part of the development of this plan, a review of the lessons learnt from 2013/14 have been considered and addressed. (See appendix 1). The learning from 2013/14 has also informed the development of the proposals for use of non-recurrent funding such as the short term increase in Patient Transport Services to support discharges from hospital as this has a significant impact on patient flow and achievement of the 4 hour target.

In addition, an assessment of the local system configuration against best practice has been undertaken. Whilst the new urgent care model is based on best practice, this assessment has identified a number of areas requiring further development, which are included within the proposed local innovations. Some of these had already been highlighted through NLAG's visit and assessment by the Emergency Care Intensive Support Team (ECIST) during 2013; following this review a detailed action plan was developed and in most parts implemented, however work continues around some key issues relating to discharges and the full implementation of Ambulatory Emergency Care pathways. Plans are in place to deliver these further changes and will be monitored through the contract KPIs and the resilience funding tracking process.

In developing this plan, consideration has been given to the North Lincolnshire Better Care Fund (BCF) plan and how that plan supports the delivery of both non-elective and elective care targets. The BCF plan focuses on caring for people within the community setting, facilitating early discharge and maximising independence to avoid the need for people to go into long term care. There is therefore significant overlap between the BCF plan and achieving local resilience. By supporting people within the community, we will require increased resource, particularly during poor weather when travel times are increased. This approach however, does free up hospital bed capacity to support achievement of the 4 hour target. In assessing other proposals for local innovations, consideration has also been given to the general practices actions to implement the Pro-active Care DES and the Elderly Care Fund (Accountable GP) to ensure plans align.

This Resilience and escalation plan is a working document which will be reviewed and updated by the operational leads working group. This plan sets out how the organisations will assess and escalate and provides a basis for joint working to deliver a safe health and social care system during periods of resilience, underpinned by system-wide understanding of the interdependencies of individual organisational plans. It sits alongside and works in conjunction with; organisational business continuity, pandemic flu and major incident plans.

This plan has been cross referenced with current version business continuity plans, however, individual organisations have processes in place to regularly review their internal business continuity plans and members of the operational group will highlight these as completed, with an assessment of the impact of changes in business continuity plans on the resilience plan.

The operational group will lead a scenario testing event during September to test the plan, and the plan will be further reviewed based on this learning and amended as required.

3.0 Roles and responsibilities

The role of NL CCG is to:

- Provide a leadership role to the local health community in planning for resilience in demand, including those during winter, supporting and working with organisations to ensure they have risk based plans in place to meet the challenges of winter and other periods of increased demand.

- Ensure that organisations providing NHS commissioned care fulfil their contractual duties in relation to both business continuity planning (capacity and capability, maintenance of critical services) and winter preparedness (SITREP reporting, escalation process).

- Ensure that each organisation's own escalation plans for dealing with pressures recognises the higher-level requirements of winter preparedness.

- Take the appropriate management action where pressures in the local health system impact on service delivery.

- Ensure that there are clear protocols for the co-ordination of the health and social care economy in order to maximise the use of community hospital bed capacity in liaison with local acute hospitals and any available local bed management system

- Monitor the impact/effects of winter on vulnerable groups, such as children, dialysis patients, elderly, medical or physical dependency and mentally health patients.

- Support co-ordinated and proactive public communications around access to services

3.1 Organisational leads

Name of Organisation	Executive Lead	Operational Lead
NL CCG	Caroline Briggs carolinebriggs@nhs.net	Jane Ellerton Jane.ellerton@nhs.net
ERY CCG	Alex Seale alex.seale@nhs.net Karen Ellis k.ellis1@nhs.net	Sue Ward Sue.ward19@nhs.net
RDASH	Sharon Schofield Sharon.schofield@rdash.nhs.uk	Belinda Clark-Vessey Belinda.Clark-vessey@rdash.nhs.uk
NLaG	Karen Griffiths	Graham Jaques

	karen.griffiths11@nhs.net	graham.jaques@nhs.net
EMAS	Richard Henderson richard.henderson@emas.nhs.uk	Andy Hill andy.hill@emas.nhs.uk (c.c. clare.smith@emas.nhs.uk)
NHS111	Steve Page Steve.page1@nhs.net	Mark Leese Mark.leese@yas.nhs.uk
Northern Lincolnshire Council Adult Social Care	Lorna Wakefield Lorna.wakefield@northlincs.gov.uk	Marian Davison Marian.davison@northlincs.gov.uk

3.2 Organisational responsibilities

The operational lead for each organisation is responsible for;

- implementation and monitoring of their own organisational escalation plans.

- meaningful action on behalf of the organisation (with the appropriate delegated authority) to support the system wide delivery of services through periods of surge in demand
- contribution to the conference calls- generally weekly but more frequent during periods of escalation
- contribution to the provision of data and analytical review of the systems and pressures
- contribution to the development and delivery of solutions to manage drivers of system pressure
- ensuring robust communication throughout their organisation of the system pressures and actions required

3.3 Operational group

The operational leads will work together as the operational group for resilience management. Terms of reference for this group are shown in appendix 2. The group will function mainly on a virtual basis, convening regular telephone conferences throughout the winter period and instigating these throughout the year where system pressures are sustained. The operational group will agree and implement specific and immediate actions to address system pressures and cascade information through their organisation to support management of pressures in line with the plan.

3.4 Governance

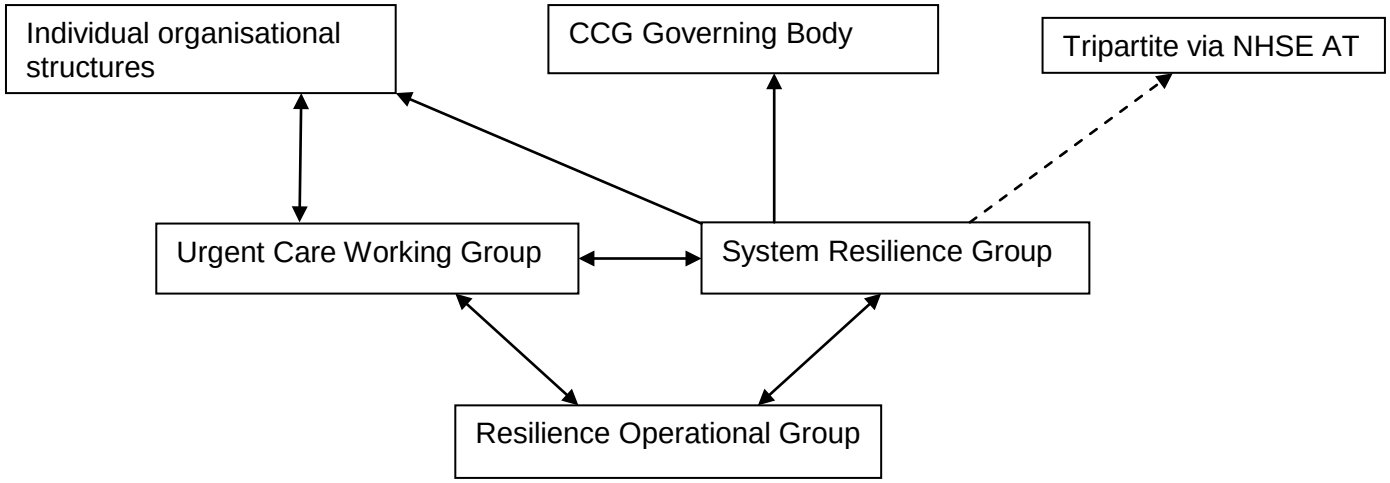
Individual operational leads will report to the director lead within their organisation regarding both organisational escalation level and actions and the system-wide escalation level

The Operational group will report to the Urgent Care Working Group (UCWG) and the System Resilience Group (SRG) on a monthly basis. The SRG will take an overview of the capacity issues across the system and the strategic actions required to address these. The operational group will work together to manage the system day to day, taking appropriate action in line with the plan during periods of escalation.

The UCWG will also report to the SRG –a Director level group with responsibility for overseeing planning within the whole system (elective and non-elective systems)

The Escalation plan details the requirements for escalation to Directors and NHS England Area Team

Governance model



3.5 Communications

The Resilience Operational Group is already established and convenes weekly conference calls throughout the winter period, increasing to daily if local system pressures require this. This process will continue, but the Acute Trust representative will also highlight the impact of pressures on the elective pathways as well as non-elective. This group will agree and ensure implementation of actions to immediately address system pressures. Escalation will be to both the established Urgent Care Working Group (for non-elective issues) and the newly established System Resilience Group (for elective care issues).

The Urgent Care Working Group is now well established with representation from key stakeholders across health and social care. This group provides the forum for the analysis of system-wide themes and issues, and planning and monitoring of actions to address these. This group will also consider proposals for investment and/or service redesign to improve services and patient flow.

The System Resilience Group is newly established and will provide Director level oversight of the whole health and care system and pay particular attention to the impact of system pressure on both elective and non-elective pathways. This group will monitor performance against all key elective and non-elective targets. The Urgent Care Working Group will escalate those non-elective issues it is unable to resolve to the SRG for action. The SRG will consider proposals for investment and service redesign for the whole system, making recommendation to the CCG and represented organisations on the use of non-recurrent funding.

Appendix 6 sets out the expected reporting flows between the groups.
Both UCWG and SRG will each report into individual organisational structures as well as the NHS England Area Team for the purpose of reporting progress against plans and investments.

4.0 Risks

There are a number of recognised risks in relation to surges in activity. The most significant identified risks to service provision are:

- Key or widespread staff absence (Due to Adverse weather, industrial action, flu etc.)
- Ambulance availability (PTS and emergency)
- Pandemic Influenza, norovirus or other infectious diseases
- Fuel shortages
- Loss of, or restrictions in access to key Trust Buildings
- Computer/Network failure
- Telephony failure – site or network specific
- Utility Failure (electricity or gas)

Whilst these are generic risks and covered by organisational business continuity plans, there are specific risks associated with current services during periods of increased demand;

- Demand for beds exceeds capacity
- Implementation of services as part of Better Care fund fails to avoid hospital admission
- Capacity within NHS 111 to respond to increase in demand
- Primary Care ability to respond to increased demand
- Provider ability to recruit to non-recurrently funded posts
- Bed closures associated with norovirus (hospital and community beds)
- Transition of Intermediate care service to new location during winter period
- Temporary centralisation of hyper-acute stroke patients on Scunthorpe site

The table below sets out the specific risks and mitigating actions.

Risk	Mitigating Actions	Update
Demand for beds exceeds capacity	Implementation of the full Urgent Care model, including use of Ambulatory Emergency Care pathways Identified contingency to spot purchase care home beds for those well enough to be discharged but requiring time limited on-going care Services focussing on facilitating discharge	NLAG progressing implementation-monitored through Urgent care monitoring group Lessons learnt from May pilot being taken forward to ensure robust process in place for rapid discharge Proposals being developed to improve current service and increase throughput
Implementation of services as part of Better Care Fund fails achieve reduction in hospital admissions	Robust, joint planning of services and agreement of trajectories for reducing admissions.	KPIs for each element of service being developed Joint Implementation board monitors implementation of plans
Capacity within NHS 111 to respond to increased demand	Work with the Lead Commissioner to understand risks and alternative models of working.	NHS 111 discussions led via lead commissioner. NL CCG responding to proposals for managing demand. Potential financial impact above plan.
Primary Care ability to respond to increased demand	Utilisation of GPs during OOHs period in the urgent care model, supported by Emergency Nurse Practitioners both in and out of hours. ENPs now trained in management of minor injury and minor ailments. Bid for use of resilience funding for GP in UCC 24/7 to support patients presenting with primary care needs Roll-out of Productive General Practice to NL practices to support them in redesigning working practices Development of Primary Care Development Group within CCG	NLAG to ensure adequate GP OOHs cover within the urgent care model, supported by ENPs. Development of system wide communications plan to encourage appropriate use of services. Roll-out continues, 18 practices engaged Initial meeting on 31/07/14
Provider ability to recruit to non recurrently funded posts identified in	Early notification of funding supports early dialogue and planning with providers.	Providers actively engaged in development of proposals and associated workforce plans

the resilience funding		
Reduced bed capacity (hospital and community) due to Norovirus	Established procedures for ward transfers and discharges. Approximately 20% care home bed capacity available at any one time	
Reduction in community capacity due to relocation of Intermediate care facility planned for February 2015	Development of detailed transition plan for transfer of Intermediate care unit to new facility.	Planning in progress- working group including providers and commissioners in place.
Additional demand for non-elective beds due to temporary centralisation of hyper-acute stroke beds	Additional beds opened in June 14. Pathways for direct admission to stroke unit in development to avoid impact on A/E. In the interim, these patients are cared for in A/E on arrival by staff from the Stroke Unit.	The permanent site for hyper-acute is currently subject to public consultation. The plan may need to be revised dependent on the outcome of this consultation
Short term reduction in A/E space during reconfiguration work	NLAG to put in place contingency plans to ensure patient safety and performance are not compromised	Planning of scheme commenced. On completion, the scheme will deliver additional majors cubicles and a dedicated Ambulatory Emergency Care facility
PTS capacity to support timely hospital discharges impacting on availability of beds	NLAG have a contract in place with Independent sector provider. PTS service specification is being revised but will not result in change in 14/15. Bid being developed against resilience funding to support	

The implementation of the Better Care Fund in 2014/15 and 2015/16 will create risks associated with delivery of trajectories for reducing hospital admission. Alongside this, there is a public consultation over the summer of 2014 regarding centralisation of hyper-acute stroke services and Ear, Nose and Throat services. Once the formal decision has been taken regarding future locations of service, the associated activity impact will be modelled into the relevant capacity plans.

5.0 Escalation

5.1 Acute Trust escalation

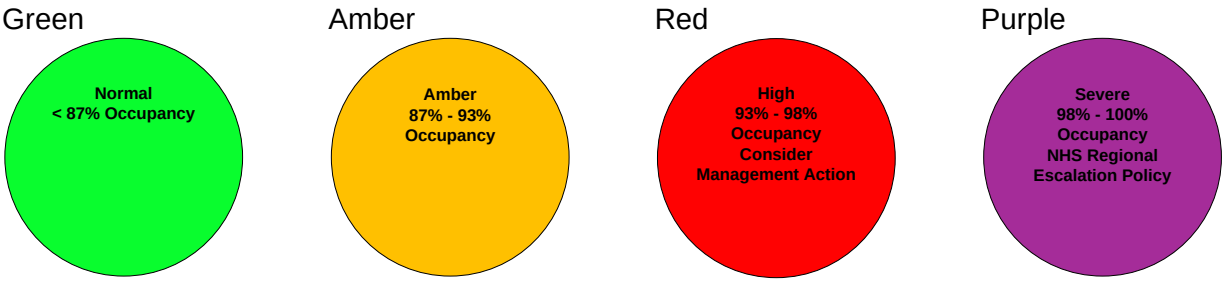
Each Acute Trust has their own operational Escalation Policy which includes their alert status triggers which are reported to the CCGs. The alert status is triggered by available bed capacity within the Trust concerned. Each Trust has its own trigger points regarding available bed capacity.

Within each Escalation Policy there are actions identified for each alert status level which are carried out on a daily basis within each Organisation. NLAG has revised its escalation policy, with the draft due to be formally ratified by the NLAG Executive team. Once ratified, final amendments will be made to reflect the approved version.

The existing levels of alert status are as follows:

Green – normal operations with no pressure on beds being experienced
Amber – increase in operational pressure with a reduction in available bed capacity
Red – severe pressure being experienced with limited bed capacity available
Purple – severe pressure being experienced where mutual support is required

Figure 1: Northern Lincolnshire and Goole DRAFT Escalation triggers;



NLaG updates its bed status across all sites via the website on a live basis. The CCG lead monitors bed status via the web on a daily basis. Trust Managers and CCG leads will be made aware of trust alert status via email on a daily basis whenever the bed status reaches purple or above. When a trust alert status trigger moves to Purple the CCG lead will cascade this information across primary care via email.

The Trust also has an internal automated escalation system to support patient flow through the urgent care centre. This aims to ensure all patients are seen, assessed and either discharged or admitted as required within 4 hours of arrival.

5.2 Diversion of patients across Trust sites and outside of Trust

The decision to divert patients between NLaG Trust sites or divert outside of the Trust should only be taken when the site does not have a single bed into which a patient can be placed including having opened escalation beds. Under no circumstances should it be used to protect elective beds, or to avoid excessive waits in Accident and Emergency Departments.

The decision to divert patients either within the organisation or to divert to alternative acute Trust must be authorised by the Trust's Chief Operating Officer or their Executive Director on Call.

Any request for patient diversions must be escalated to the Executive Director on call immediately the request is made and the Director has reviewed the request taking into consideration multiple site issues where applicable. This should include diversions that are put in place because of equipment failure/or planned maintenance.

Before approaching other acute hospital trusts all pre-diversion arrangements must be exhausted. Trust Executive Directors must contact the CCG Director On Call in hours and North Yorkshire and Humber Commissioning Collaborative Director on call out of hours to ensure that all support has been maximised and gain agreement to progress to a formal divert request.

Where pressures within Primary Care are not contained and impact across the system, the CCG should contact the on-call Director within the Area Team to seek support regarding primary care capacity.

All diverts should be actively managed to support removal of the divert within 4 hours. Any agreed divert will be communicated to health economy partners as a matter of urgency by the Trust, in conjunction with the CCG.

5.3 System-wide escalation

In addition to the Trust escalation procedure, which is well established year round, there is a system wide escalation.

Figure 2 – North Lincolnshire Escalation Levels

RESILIENCE PLAN Level 5 (Black)	**Major Incident with service disruption**	All services severely disrupted with the need to employ special measures to ensure essential services are provided.
RESILIENCE PLAN Level 4 (Purple)	**Critical Pressure on services**	All actions in Level 3 have failed to contain service pressures and the local health economy is unable to deliver comprehensive emergency care. There is potential for patient care to be compromised.
RESILIENCE PLAN Level 3 (Red)	**Severe Pressure on services**	Actions taken in Level 2 have failed to return the system to Level 1 and pressure is worsening. The local health economy is experiencing major pressures compromising patient flow. Further urgent actions are required across the system by all partners
RESILIENCE PLAN Level 2 (Amber)	**Moderate Pressure on services**	The local health economy is starting to show signs of pressure. Focused actions are required in organisations showing pressure to mitigate further escalation. Enhanced co-ordination will alert the whole system to take action to return to green status as quickly as possible
RESILIENCE PLAN Level 1 (Green)	**Normal service**	The local health economy capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources.

Each level is triggered by intelligence from North Lincolnshire Health and Social Care organisations, either individually or collectively, or from the external environment. The triggers are detailed in Figure 3 and the mitigating actions are outlined in Figure 3A (Green = Level 1, Amber = Level 2, Red = Level 3, Black = Level 4 and Purple = Level 5).

5.4 Resilience Plan Triggers

The table below sets out the triggers for escalation within each service. These triggers and actions (section 5.5) are shared across all participating organisations to ensure cross organisational understanding and to confirm alignment of plans. Not all services will be exposed to the same pressures; however winter peaks in illness and bad weather conditions are likely to be common across all organisations. This is based on the DRAFT NLAG escalation triggers and will be revised once the NLAG policy is approved

Figure 3 resilience plan triggers

Resilience plan Level		Ambulance Impact	Hospital Impact	Community Services Impact	Social Care Impact	RDaSH Impact	NHS 111
	5	Cat A < 60% Cat B < 65%	Major or Significant Incident declared – either receiving or supporting at any hospital in the region. Mass Casualty Incident declared. Or SGH and DPOW sites at 'purple' capacity status. All A&E activity matrix at 'purple'.	Major issues affecting ability to deliver essential services. Major or prolonged bad weather impacting on ability to deliver service Major staffing shortage not managed via internal bank or agency	Minimal care home vacancies Major issues affecting delivery of essential services putting people at risk. Major staffing shortage not managed via internal bank or agency	Major issues affecting ability to deliver essential services. Major or prolonged bad weather impacting on ability to deliver service Major staffing shortage not managed via internal bank or agency	Call abandonment >25% Call answering <35%% Clinical Queue over 10hrs
	4	Cat A 60%-65% Cat B < 70%	SGH declaring 'purple' capacity status (98-100% occupancy) and DPOW declaring 'red' status. More than 1 A&E department activity matrix at 'purple'.	Weather impacting on ability to travel. Requiring deployment of 4X4 vehicles if weather related Requirement for instigation of walking model due to weather Major staff sickness, not managed via internal bank staff, resulting in need to deliver essential services only Mutual aid in place between health and social care. Walking model instigated.	Weather impacting on ability to travel. Mutual aid in place between health and social care. Walking model instigated. Use of 4x4 vehicles by internal CST services. Major sickness resulting in prioritising calls & delivering essential services only.	Weather impacting on ability to travel. No local bed availability, requiring admissions out of area	Call abandonment >15% & ,25% Call answering >35% & <55% Av call answer c 10 minutes Clinical Queue 6hrs - 10hrs

	3	Cat A 65%-70% Cat B < 80%	SGH site occupancy at 93% - 98%. A&E activity matrix at 'red' in both hospitals.	Increased pressure resulting in need to prioritise workload Reduced staff requiring use of bank staff Poor weather conditions impacting on journey times and capacity	Increased pressure resulting in need to prioritise workload Reduced staff requiring use of bank staff Poor weather conditions impacting on journey times and capacity Limited vacancies within care homes impacting on hospital discharges	Increased pressure resulting in need to prioritise workload Reduced staff requiring use of bank staff Poor weather conditions impacting on journey times and capacity Bed occupancy limited but managed within organisation	Call abandonment >8% & <15% Call answering >55% & <70% Av call answer c5mins Clinical Queue 4-6hrs
	2	Cat A 70%-72% Cat B < 85%	Occupancy at 87% - 93% in SGH. A&E activity matrix at 'red' in both hospitals.	Pressured managed internally. Significant increase in demand but manageable Significant staff sickness, but managed within own resources Adverse weather forecasted	Pressured managed internally. Significant increase in demand but manageable Significant staff sickness, but managed within own resources Adverse weather forecasted .	Pressured managed internally. Significant increase in demand but manageable Significant staff sickness, but managed within own resources Bed occupancy limited locally but managed	Call abandonment rate >3% & <8%. >70% & <90% calls answered. Av call answer c3mins Clinical queue 2-4 hrs.
	1	All National performance indicators achieved	Occupancy <87% at SGH site. No pressures elsewhere in wider Humber system that would impact on North Lincolnshire	Normal levels of activity. No undue pressures	Normal levels of activity, No undue pressures	Normal levels of activity, No undue pressures	Call abandonment rate <3%. >90% calls answered. Clinical Queue 0-2 hrs.

5.5 Escalation actions

The following table identifies the actions that should be taken by each organisation as the North Lincolnshire moves from green to purple.

Figure 3A

	CCG	NLAG	NLAG Community Services	North Lincolnshire Council	RDaSH	EMAS	NHS 111	
G								
	Monitor hospital and community situation Weekly conference calls in place	Monitor hospital and community situation	Monitor hospital and community situation	Work as normal	Monitor hospital and community situation	Work as normal	Work as normal	
A								
	Notifications received from organisations and monitored. Offer support as required Weekly conference calls in place	Operations Centre monitors and manages patient flow. Maximise flow through UCC/AEC and CDU Maintain usual admission/discharge arrangements Operations Centre monitor and manage internally	Daily review of workload within teams Rapid response teams to provided support as appropriate to alleviate pressure Review patients on see and keep to avoid admissions	Expedite care packages for those patients waiting in another service Increase support and/or communications to patients at home to prevent admissions Review Intermediate Care patients to bring forward discharges to create capacity for transfers if required	Expedite rapid assessment for patients waiting for another service Increase support and / or communications to patients at home to prevent admissions	Work with acute trust to minimise delays in handover Ensure current PTS capacity is fully utilised for patient discharge and transfers	Reduce demand via level 2 telephone messaging Increase staff capacity Escalate to NHS 111 duty manager Inform OOHs providers via Broadcast email Consider sending all under 1s and over 75s to OOHs providers, depending on size of queue, if they are able to receive them Consider sending under 5s to OOHs if they are able to receive them Consider comfort calling	
R								
	Cascade status alert across the health and social care system Co-ordination of the escalation response across whole system to ensure alternative pathways to admission are utilised Notify NHS England's Local Area Team; CCG	As above. Implement range of actions to create Capacity and ensure continuity of services as per the Escalation and Surge Policy. Liaise with EMAS to prioritise discharges. Utilise alternative transport for discharges Assign staff to attend	All actions listed above Utilise actions from major incident and business continuity plans to create capacity and ensure continuity of services All community teams to review all patients awaiting assessment to expedite discharge or transfer Consider increasing capacity	All actions listed above Utilise actions from major incident and business continuity plans to create capacity and ensure continuity of services Review all assessments in pipeline to expedite discharges Increase domiciliary support	All actions listed above. Utilise actions from major incident and business continuity plans to create capacity and ensure continuity of service. Maximise inpatient discharges Assist within the whole system to accelerate	All actions listed above. Utilise actions from major incident and business continuity plans to create capacity and ensure continuity of service. Ensure usage of managers / officers, staff and community responders is	All actions listed above Activate level 3 telephone messaging Maximise available staffing using bank/overtime etc. Activate direct transfer of under 5s and over 75s to OOHs provider if on clinical queue, if OOHs can receive them	

	On-call Director and Chief Executive Utilise business continuity plans to create capacity and ensure continuity of service Instigate mutual aid where appropriate Make risk based assessment of best use of capacity and resource across the whole system to maintain patient safely and meet demand Instigate daily conference calls until de-escalation	patients being held in ambulances	Patients at home waiting admission to be referred to community teams	as available to service users at home to prevent admissions as appropriate	discharges from acute and non-acute facilities Cancel all non-urgent appointments Consider pharmacy escalation plans to support discharges etc. Snr. management teams to co-ordinate	maximised. Maintain communication with GP and UCC to review potential delays to patient admissions.	Advise NHS 111 Senior On Call Manager Advise ROC and request inform Gold Commander If pressure likely to be >3hrs, inform commissioners Inform all OOHs providers and establish conference calls	
P								
	All actions listed above Take decisive action to alleviate pressure Alert neighbouring Trusts and Ambulance Services and seek support Provided and receive mutual aid to staff and services across the system Review the escalation status every 2 hours Stand-down from black alert once review suggests the pressure is alleviating Post escalation review	Notification of status to staff. Implementation of purple action cards. Additional operations centre meetings implemented as per NLAG Escalation and Surge Policy. Contribute to system wide communications to update on status Provided and receive mutual aid to staff and services across the system Stand-down from black alert once review suggests the pressure is alleviating Post escalation review	All actions listed above Take decisive action to alleviate pressure Contribute to system wide communications to update on status Provided and receive mutual aid to staff and services across the system Stand-down from black alert once review suggests the pressure is alleviating Post escalation review	All actions listed above Take decisive action to alleviate pressure Contribute to system wide communications to update on status Provided and receive mutual aid to staff and services across the system Stand-down from black alert once review suggests the pressure is alleviating Post escalation review	All actions listed above Take decisive action to alleviate pressure Contribute to system wide communications to update on status Provided and receive mutual aid to staff and services across the system Stand-down from black alert once review suggests the pressure is alleviating Post escalation review Post incident debrief and support to staff	All actions listed above Contribute to system wide communications to update on status Stand-down from black alert once review suggests the pressure is alleviating Post escalation review	All actions listed above Activate level 4 messaging Consider mutual aid from other NHS 111 providers Increase capacity – request support via ROC Call in senior independent clinical floor walkers from pool Liaise with lead Commissioner to invoke wider BC clinical capacity through OOHs providers, sending all clinical advice calls to OOHs Consider reduced NHS pathways assessment to focus on priority cases Snr Manager to attend nearest call centre Advise YAS Gold Command via ROC. Request Gold Command	

							attend site Escalation to Area Team Consider YAS Gold Major Incident standby/declare Post escalation review	
B								
	All actions listed above Contribute to communications regularly Provide mutual aid Alert neighbouring services to seek support Notify NHS North of England Risk based assessment on best use of capacity, and support shift of resources Review 2 hourly Stand-down once pressure alleviated	Implement 'Purple plus' action card as per the Escalation and surge policy. Contribute to communications regularly Provide mutual aid as appropriate Stand-down once pressure alleviated Contribute to root cause analysis and lessons learnt process	All actions listed above Contribute to communications regularly Provide mutual aid as appropriate Stand-down once pressure alleviated Contribute to root cause analysis and lessons learnt process	All actions listed above Contribute to communications regularly Provide mutual aid as appropriate Stand-down once pressure alleviated Contribute to root cause analysis and lessons learnt process	All actions listed above Contribute to communications regularly Provide mutual aid as appropriate Stand-down once pressure alleviated Contribute to root cause analysis and lessons learnt process	All actions listed above Contribute to communications regularly Provide mutual aid as appropriate Stand-down once pressure alleviated Contribute to root cause analysis and lessons learnt process	All actions listed above Consider transferring a percentage of calls through mutual aid through national process Consider reduced NHS Pathways assessment through agreed protocol to focus on priority cases(fast tracking)	

The resilience plan and escalation levels apply to the whole of the North Lincolnshire. However, each individual organisation will have its own specific pressures, at any given time.

An over-arching North Lincolnshire escalation level will be established based on an assessment of the service pressure levels within the North Lincolnshire Health and Social Care organisations. The operational group will consider the pressures faced within Hull and East Riding and North East Lincolnshire, and the contribution that North Lincolnshire can make to supporting them.

All North Lincolnshire Health and Social Care organisations have a responsibility to know the current escalation level and communicate any increasing pressure within services between stakeholder organisations and to the CCG. The operational leads have a responsibility to assess the need for local escalation and to do so via the CCG lead. Operational leads are expected to respond to calls for teleconference due to pressure in the system, even when their own system is free of pressure.

Each North Lincolnshire Health and Social Care organisation has a responsibility to understand the resilience plan and to have a corresponding escalation plan for their service area. All organisations and their operational leads are required to take meaningful action, with the appropriate urgency, as the resilience plan escalates.

6.0 De-escalation

De-escalation within the acute Trust is managed via the bed management system viewable on line. Wider de-escalation will be agreed via the conference calls as described in section 7.0 and communicated to health and social care partners by the CCG/CSU operational lead. All providers are responsible for timely communication to other partner organisational leads when de-escalation takes place. This will be via email in the first instance, reinforced during the conference calls. Experience demonstrates weaknesses within the de-escalation system. De-escalation processes will therefore be re-iterated within conference calls to support good practice.

7.0 Use of non-recurrent funding and contingencies

Individual partners will identify internal staffing and financial contingencies to support peaks in activity. This includes the flexing of staff working hours, use of bank staff and short term investments to manage demand. In addition, investment of non-recurrent resilience funding will provide additional and specific support into the system on a non-recurrent basis to March 2015. Plans for use of this funding have been developed by stakeholders and agreed by NL CCG. Monitoring arrangements will form part of the funding agreements, with providers required to report KPIs in line with agreed proposals to the UCWG and SRG. UCWG and SRG both meet monthly and if decisions are required outside of these meetings, processes will be put in place to achieve virtual sign-off.

Stakeholders submitted a wide range of proposals for non-recurrent funding, over and above the allocation. The UCWG reviewed all proposals and undertook a process of confirm and challenge to ensure those proposals presented to CCG would impact positively on patient flow and providing resilience within the system. This process also provided opportunity to assess whether any proposals built on any currently commissioned services and how the voluntary sector could contribute.

Prioritisation of this funding has been undertaken by NL CCG to target funding at those services with greatest impact on patient flow; reduction in admission, achievement of elective care targets, early discharge and maintaining people in their own homes. There is a requirement during August, to review the detailed business cases for each of these proposals and undertake further confirm and challenge with the providers to ensure costs are robust and provide value for money, and the KPIs are realistic. This may result in some further revision to the allocation against each scheme.

There is a reserve list of proposals not supported at this time and these will be considered against any slippage and other funding mechanisms, including marginal rates and Better Care Fund.

8.0 Reporting

Weekly conference calls will be in place from 1st November 2014 to end March 2015 to support periods of expected winter pressures, and extended if required in response to continued pressures. During periods of system-wide escalation of red and above, conference calls will increase to daily during the period until de-escalation. In addition, conference calls can be instigated at any time of pressure by a member of the operational group.

Local Manager leads will be expected to join the calls which will be facilitated by NL CCG in conjunction with Y&H CSU. Operational leads will be expected to provide a named deputy if they are unable to participate, these calls will identify pressures within the system and mutual aid required to manage the demand within the system. Where system pressures require, these calls will move to daily for the duration of extreme pressure, returning to weekly following de-escalation. Should pressures require, conference calls will be re-instated beyond this period, based on provider feedback regarding system pressures or as a result of key metrics identifying system issues. In addition, the operational leads have a responsibility to assess the need for local escalation outside of this period and to do so via the CCG lead. Operational leads are expected to respond to calls for teleconference due to pressure in the system, even when their own system is free of pressure.

A template for the conference call is provided in appendix 3

Provider trusts will submit daily SITREP reports via UNIFY in line with NHS England requirements. It is expected that details will be released by NHS England later in the year. SITREP reports will be made available to NL CCG staff by 3pm on the day following NLAG submission via email and the Business Intelligence Zone. The social care dataset for winter pressures is not currently developed, therefore information will be shared as a routine part of the conference call and by escalation to the CCG Lead as required outside of the calls, in line with operational manager responsibilities to escalate (section 4.5 Escalation actions)

9.0 Key Metrics

Urgent Care metrics have been developed and there are a number of metrics which will monitor the system. These include A/E attendances and 4 hour target performance, hospital bed alert status and ambulance handover times. Both UCWG and SRG will review the performance against these metrics via the monthly meetings.

Programme Level Performance Metrics

Avoidable emergency admissions (Ambulatory Care Sensitive Conditions) and composite measure	Non elective admissions > 65
Performance against 4 hr target	Urgent Care activity/outcomes 0-16 yrs and >16yrs
Delayed discharges and transfers of care by responsibility	Ambulance turnaround times
Non elective admissions from care homes	Readmissions from Intermediate care
Utilisation of reablement packages	Primary care stream activity
RTT targets; admitted, non-admitted and incomplete	Cancer waiting times

10.0 External communications

North Lincolnshire CCG, in conjunction with its partners will develop a communications plan which will include communications to the general public, both planned and in response to significant pressures, and to health and social care professionals.

Examples of planned communications includes a range of information available through the internet and via the press on opening hours of various services over bank holiday periods, including advice to the public on self-management, pre-ordering of repeat prescriptions and where to access help when needed

Appendix 1

Winter Review Meeting Notes
19th May 2014

Feedback from key stakeholders

Graham Jaques,	NLAG
Greg Cox,	EMAS
Marian Davison,	NLC
Jane Ellerton,	NL CCG

NLaG

- Internal Review has taken place post winter with planning meeting to be arranged in September
- Action plan to be in place re lessons learnt from this winter
- Experiencing 'batching' of ambulance admissions
- Time of day of decision making impact on patients journey and length of stay
- NLaG contract with Amvale for intra hospital transfer but also used to discharge patients due to weakness in the PTS contract – creates a cost pressure for NLAG
- Hyper-acute stroke required 24/7 transfer between sites
- Recognised need to bring forward decision to discharge to support admissions from A/E
- Increase in DTOC 158 bed days last month. 40-80 normally. The group considered that this is a result in change to culture and working practices in NLC
- Action card approach to manage surge across all groups has been a positive move
- Action plan will focus discharge/transfer decision to mornings to support patient flow from A/E to wards
- Increase use of discharge lounge
- All patients considered for appropriateness for rehab at Goole
- It feels like the Lilacs is the only route out – blockage at exit for Lilacs – Pilot of use of care home beds is running for the duration of May and evaluation to be used to assess future level of need

EMAS

- RFID – project lead has been identified in EMAS to focus on NL to NEL
- Issues in logging data as this is activated by a tag and some staff leaving tag in the ambulance – need to work with EMAS staff to change behaviours
- Patient discharge via PTS – many providers do not offer same day discharge, whereas EMAS do, but don't accept same day bookings after 3:30pm creating blockages to discharge. Need to address response through revised specification and contracting process
- A need to involve NLaG in discussions re PTS contract to fully understand them and reflect in specification
- Intra hospital transfers – debate over what is emergency with both sites delivering similar services. Stroke/emergency, ENT/ophthalmology emergency
- Batching is based on GP calls for 4 hour admissions – impact in diagnostics etc

NLC

- A need to develop an escalation policy for internal use
- Weekly conference call in meetings essential as were very useful
- Significant sickness/absence across services
- Sharing of contingency plans across health and social care – some training has been done

- Reform services to address the issues relating to biggest demand in Scunthorpe North and South – staffing to reflect this
- Development of a new CST locality to sit over Scunthorpe North and South to absorb the pressures within this area is been developed
- Need a joint locality approach to surge planning, the joining up of contingency plans with health and social care partners within each locality
- NLC development of the PSG group which is designed to challenge referrals and assessments to focus practice on R&R interventions is now in place and working, which may be why R&R services are filling up to capacity
- Discussion re behaviours etc across all staff groups in relation to supporting an integrated approach is on-going
- Involve Commissioners as and when required
- Good D&V processes supported by good Care Homes intelligence and sharing of relevant information

Actions

- Internal Action Plan from NLaG to be shared with Urgent Care Working Group
- Escalate to GPs the impact of their working practice re batching of home visits and impacts
- Evaluation of the Bridgewater Pilot
- Ambulance divert policies – clarify divert and defect situation
- Assess options and draft business cases for winter funding
- Internal escalation policy (NLC)
- EMAS – Clarification across EMAS staff re Intra-hospital transfers/ emergency transfer and repatriation of patients, e.g. Hyper-Acute stroke
- MD/GJ provider issues discussions to take place to reduce blockages between NLAG and NLC
- Patient Transport Service specification to be reviewed
- RFID – completion of project to ensure information recording
- End of June refresh of the Winter Plan/ Surge Plan

Appendix 2

Operational Group for Resilience Management: Terms of Reference

Introduction

Surge in demand can happen at any time of year as a result of an individual factor or multiple factors. However variation in demand can also be predicted. Periods of poor weather and/or limited access to services associated with public holidays can typically lead to a surge in demand, however recent evidence points to an on-going increase in hospital activity not associated with either of the above. Identification of the real reasons for the current increase in demand are complex and poorly understood both locally and nationally.

Purpose

The operational group will convene regularly to;

- Develop and refresh the resilience plan on an annual basis including scenario testing
- Update and amend in year as a result of on-going learning and service changes
- Agree escalation status during periods of resilience and agree both organisational and system-wide actions to address the pressures within the health and social care systems
- Report via a highlight report to the SRG on a monthly basis with immediate escalation of urgent issues via the SRG chair
- Report to individual organisational director leads on escalation status
- Report to the Urgent Care Working Group on escalation status and requirements for Urgent Care Working Group interventions

Responsibilities

Individual members are the identified organisational operational leads and have delegated responsibility to act for their employer organisation.

Individual members are responsible for assessing the escalation level within the organisation on a daily basis and escalating to the CCG operational lead any escalation or de-escalation

The CCG lead is required to take an active role in the Area Team weekly conference calls, ensuring the NL locality position is shared with the Area Team

Membership

Membership comprises;

Name of Organisation	Operational Lead
NL CCG	Jane Ellerton jane.ellerton@nhs.net
ERY CCG	Sue Ward sue.ward19@nhs.net
RDASH	Belinda Clark-Vessey belinda.clark-vessey@rdash.nhs.uk
NLaG	Graham Jaques graham.jaques@nhs.net
EMAS	Andy Hill andy.hill@emas.nhs.uk
NHS111	Mark Leese mark.leese@yas.nhs.uk

Northern Lincolnshire Council Adult Social Care	Marian Davison marian.davison@northlincs.gov.uk

Frequency of meetings

Meetings will be held virtually where appropriate, however some face to face meetings will be required e.g. scenario testing.

Weekly telephone conferences will be held during the period 01/11/13 – 31/03/14. These will be extended beyond March if there remains significant resilience within the system.
Telephone conferences will be instigated outside of the winter period if required at the request of a member of the operational team**.**

Members will be expected to dial into each meeting, however if they are unavailable to join, they must ensure a nominated deputy with the authority to act joins the call. The Area Team will be made aware of the conference call dates and will join these as required.

Minutes of meetings

Meetings will utilise the conference call template (appendix 3). The completed version of this will be circulated as minutes of the meeting, within 1 day of the call.

Reporting

Members of the Operational Group will escalate to the relevant organisational Director those issues relevant to that organisation that the member is unable to satisfactorily address in a timely manner to support the day to day operations of the system.

The Operational Group will report to the Urgent Care Working Group and is expected to regularly share information regarding issues and actions taken to resolve, themes and areas across the health and care economy for consideration of redesign to improve patient flow.

The Operational Group will report to the System Resilience Group urgent issues relating to planned care where Director level support is required, and will provide update reports for information.

Appendix 3

North Lincolnshire Resilience Planning
Conference call template

Dial in number	Dial in on 0800 032 8069
Chair	Chairperson 25317330#
Participants	Participants 47121625#
Time	

Participants

Name	Organisation
	CCGs/CSU
	NLAG
	NLAG Community
	RDaSH
	EMAS
	NLC

Organisational updates
To include reflection of situation over the previous week and impact of actions agreed in previous conference calls

Organisation	Performance, Alert status & predicted activity levels	Update
CCG's NL/ERY		
NLAG	A/E R | A | G Bed occupancy P | R | A | G	
RDaSH	Bed occupancy R | A | G	
NLC	Intermediate care R | A | G Community Support R | A | G	
EMAS	Performance	999 PTS
NHS 111		

Action plan
To record decisions made, lead and timescales, agreed communications- organisational and public, and any escalation to Director leads.

Action	Lead	Timescale

Agreed Status
Next call: Weekly ☐ Daily ☐

Is de-escalation notification required? Yes ☐ No ☐

INSTIGATE DAILY CALLS WHEN SYSTEM WIDE STATUS IS RED

Appendix 4

Draft Terms of Reference

North Lincolnshire System Resilience Group

Introduction

The operational resilience and capacity planning guidance for 2014-15 sets out the requirement for the development of a System Resilience Group (SRG). This group, supported by the Urgent Care Working Group, forms a strategic partnership of Health and Social Care organisations from across North Lincolnshire. The SRG Terms of Reference have been developed to reflect the above guidance to ensure safe delivery of both elective and non-elective care within the health and social care system.

The resilience plans are based on the local unit of planning and A/E footprint. The SRG and UCWG do not replace the individual contract management boards where performance against annual contracts is reviewed. However the SRG is responsible for the on-going analysis and review of drivers of demand, both elective and non-elective and approving actions to address in order to meet national and local performance requirements.

Purpose

The SRG provides strategic and operational leadership across the healthcare system of North Lincolnshire, for both elective and non-elective care. With strategic responsibility to ensure a whole system response, the SRG has the responsibility to ensure the commissioning and provision of high quality, safe and integrated planned and unplanned care that is designed to meet the needs of the populations of North Lincolnshire and, where they use NLAG services, East Riding. The SRG is supported by the established Urgent Care Working Group and the Resilience Operational Group.

Functions

The SRG will have a number of functions;

- Provide Director level strategic overview and support to the local 'resilience plan' and ensure links to individual organisational escalation plans.
- To ensure that detailed capacity planning is undertaken and agreed across the whole system, based on analysis of the pressures and drivers in the local system
- Monitor impact of surges in demand on both elective and non-elective performance, ensuring a proactive whole system response to capacity management across the planned and unplanned care systems
- Direct and support the Resilience Operational Group in leading the implementation of action in response to unpredicted surge in demand

- To make recommendations on the use of non-recurrent funding and marginal tariff to support safe delivery in line with national and local performance requirements, based on business cases.

- To make recommendations on the use of contingency funding (where available) as required to ensure safe delivery in line with national and local performance requirements.

- To monitor delivery against plans, outcomes, KPIs and funding allocations, ensuring all new innovations/services are appropriately evaluated to support future funding decisions

- Reference best practice, innovation and patient experiences to ensure local services are of high quality, efficient and meet patient needs.

- To clearly identify interdependencies between services and plans across elective and non-elective care and ensure these are co-ordinated.

Key performance targets

- Delivery of all NHS Constitution rights and pledges including 18 week Referral to treatment targets, Cancer waiting times, diagnostic waiting times and A/E waiting time targets.
- Matching of capacity to demand, ensuring patients are admitted to the most appropriate bed and discharge efficiently and effectively to the most appropriate place to meet their needs
- Maintain financial balance and sustainability across the whole system
- Ensure consistent, good measure of patient experience of the system

Accountability

The SRG is not a statutory body and does not have delegated authority. Individual members are accountable to their individual organisational boards. The SRG is accountable for the delivery of the North Lincolnshire Resilience Plan.
The SRG is accountable to the tripartite Monitor, NHS England, NHSTDA and adass. SRG plans must be assured and approved by the Tripartite before funding is authorised for release to CCG.

Responsibilities

The SRG is responsible for;

- Holding each other to account for actions resulting from the system wide review of capacity and demand
- Implementation and review of a local resilience and capacity management plan
- The communication and translation of the plan into partner organisational plans and strategies.
- Involvement of appropriate clinical input into development of plans and capacity reviews, and secure their engagement into the delivery of the plan
- To receive highlight/ exception reports as appropriate against performance and capacity plans and take appropriate action in response.

- To direct the UCWG and the Resilience Operational Group in order to ensure delivery of overall plans.
- To approve recommendations submitted by the UCWG
- To ensure effective and full involvement of all partners in decisions which relate to the programme
- To identify and manage system-wide capacity risks and issues

Procedural Issues

a) Frequency of Meetings

Meetings will be held at least monthly.

b) Chairperson

The Director of Commissioning, NL CCG will chair the meetings

c) Secretary

The Snr Administrative Officer, NL CCG will provide the administrative support for the meetings

d) Attendance

Each member must ensure that in their absence a nominated deputy is briefed and authorised to act on their behalf

e) Quorum

Meetings will be considered quorate if at least 50% of the representatives or their deputies are present, with both NL CCG and NLAG represented at all meetings

f) Minutes of meetings

Minutes of meetings will be circulated with the agenda papers to all members in advance of each meeting but no less than five working days before each meeting

g) Review

To be reviewed December 2014 and thereafter annually.

Membership List

Title	**Organisation**
Director of Commissioning,	NL CCG
Chief Operating Officer,	NLAG
Director of Strategic Planning,	NLAG
Assistant Director, Adult Services,	NLC
Principal Contract Manager	Y&H CSU on behalf of NL CCG
Snr Manager; Commissioning,	NL CCG
Director of Commissioning	ERY CCG

Others will be co-opted as required, e.g. mental health Trust, Ambulance services.

Appendix 5

Terms of Reference

North Lincolnshire and East Yorkshire Urgent Care Working Group (UCWG)

Introduction

The North Lincolnshire and East Yorkshire Urgent Care Working Group is a strategic partnership of Health and Social care organisations from across North Lincolnshire & East Riding. The following terms of reference have been updated to reflect the recommendations of NHS England and the national directive to produce an A&E recovery and improvement plan.

The SGH A&E recovery and improvement plan has been incorporated into the existing unplanned care work programme. The programme is designed to retain and develop the work streams that are realising benefits and to identify and deliver new initiatives to deliver sustainable improvement. The programme is focused to impact on patient experience and outcomes. Key objectives are to improve quality and safety whilst ensuring equitable access and achieving the 4hr standard.

The UCWG does not replace the individual contract management boards where performance against annual contracts is reviewed. However the UCWG is accountable for the delivery of the improvement plan and associated programme of work.

Mandate

With strategic responsibility to ensure a whole system response, the UCWG has the mandate to deliver the unplanned care programme and A&E recovery plan. The UCWG has the responsibility to ensure the commissioning and provision of high quality safe integrated unplanned and emergency care that is designed to meet the needs of the populations of North Lincolnshire and East Riding.

The North Lincolnshire and East Yorkshire Unplanned Care Working Group will

- Develop, oversee and monitor the implementation of the A&E recovery plan and the associated programmes of work to ensure strategic alignment to national guidance and other local work programmes within agreed milestones.
- Act as enablers to support teams leading the implementation of action plans
- Agree and monitor delivery of internal and external communications
- Inform commissioning strategies in response to the current and future unplanned care needs of the populations of North Lincolnshire and East Yorkshire
- Align the programme with the strategic objectives of partner organisations
- Empower the public to be in control and understand their choices in relation to unplanned care.
- Optimise capacity and capability across the whole system of unplanned care and align resource with strategic priorities.
- Oversee the implementation of the work streams and review benefits realisation

- Monitor the performance of the programme by setting agreed standards and metrics which provide information on achievement against quality and efficiency and taking remedial action where plans are not delivering the required improvements
- Provide strategic overview and support to the local 'surge plan' and ensure links to individual organisational escalation plans.
- Make recommendations on the use of the marginal rates funding and any future Winter pressures funding.

Programme Benefits

- A reduction in the number of patients attending Accident and Emergency with associated reductions in ambulance journeys and non-elective admissions
- Improvement in patient experience by minimising delay and ensuring 24/7 access to integrated unplanned care across the whole patient journey
- Patients and the public informed about the choice of unplanned care and availability and function of each level of provision
- Patient and public engagement in the design of local systems and pathways
- An increase in people receiving the right care in the right place by those with the right skills, first time.
- Information critical to a person's care being available where they present
- An increase in older people who do not require an acute hospital response being assessed and treated in a community setting
- A decrease in delayed transfers of care
- A proactive whole system response to capacity management across the unplanned care system

Programme Objectives

- Organisational sign up from ALL partners to whole system transformation
- Strong clinical leadership
- Maintaining quality, patient outcomes and patient experience at the centre of all developments and redesign
- Determination of levels of care and access to information and signposting for unplanned care from a single point (111)
- Using existing resources and capacity more efficiently
- Providing alternatives to hospital admission in primary and community care
- Maximising efficiency and capacity within the Urgent Care Centre and Clinical Decision Unit, utilising appropriately AEC pathways. Timely transfer of care from hospital with access to integrated reablement services

Programme Level Performance Metrics

Avoidable emergency admissions (Ambulatory Care Sensitive Conditions) and composite measure	Type 1 attendance by LOS in department
Non elective LTC admissions	Type 1 attendance by LOS > 65 years
Non elective admissions > 65	Attendance at MIUs
Urgent Care Centre Activity/outcomes 0-	Ambulance turnaround times

16 yrs and >16yrs Performance against 4 hr target	Delayed discharges and transfers of care by responsibility
Non elective admissions from care homes	Utilisation of reablement packages
Primary care stream activity	Readmissions from Intermediate care

Responsibilities

- To provide and receive highlight/ exception reports as appropriate against the programme milestones.
- To review and realise the benefits delivered by the programme.
- To monitor and ensure sustainable performance improvement against programme milestones.
- To make recommendations to and requests of reporting work streams and projects
- To ensure effective and full involvement of all partners in decisions which relate to the programme
- To provide support in managing and identifying programme level risks and issues
- To identify and manage interdependencies at programme level

Reporting

The UCWG will report to the System Resilience Group. Urgent issues requiring escalation will be notified to the SRG via an issues log. In addition, the UCWG will report monthly to the SRG by providing a highlight report for information.

Procedural Issues

a) Frequency of Meetings

Meetings will be held monthly

b) Chairperson

The meeting will be chaired by the CCGs. The Senior Manager: Commissioning for NL CCG will act as chair.

c) Secretary

NL CCG will provide administrative support to the group

d) Attendance

Each member must ensure that in their absence a nominated deputy is briefed and authorised to act on their behalf

There should be attendance by each member or their deputy at a minimum of 80% of meetings.

e) Quorum

Meetings will be considered quorate if at least 50% of the representatives or their deputies are present, including at least one CCG representative

f) Minutes of meetings

Minutes of meetings will be circulated with the agenda papers to all members in advance of each meeting but no less than five working days before each meeting

g) Review

To be reviewed annually

Membership List

Name	Title / Organisation
Jane Ellerton	NL CCG lead- unplanned care, Chair
Graham Jaques	Operations Centre Manager, NLAG
Collette Cunningham	General Manager, Medicine Group; Unscheduled Care, NLAG
Maureen Georgiou	General Manager, Community & Therapies, NLAG
Andy Hill	General Manager, Lincolnshire Division, EMAS
Fergus MacMillan	CCG Clinical Lead
Wendy Lawtey	Service Manager, Case Management (Older People) , NLC
Marian Davison	Service Manager, Rehabilitation & Reablement Services, NLC
Jeremy Newton	ERY CCG Unplanned Care
Sue Ward	ERY CCG- Unplanned Care Lead

Others will be co-opted as required, e.g. mental health Trust, other Trust Directorate representatives

Appendix 6

Communication plan

The following table sets out the communication flows between the following;

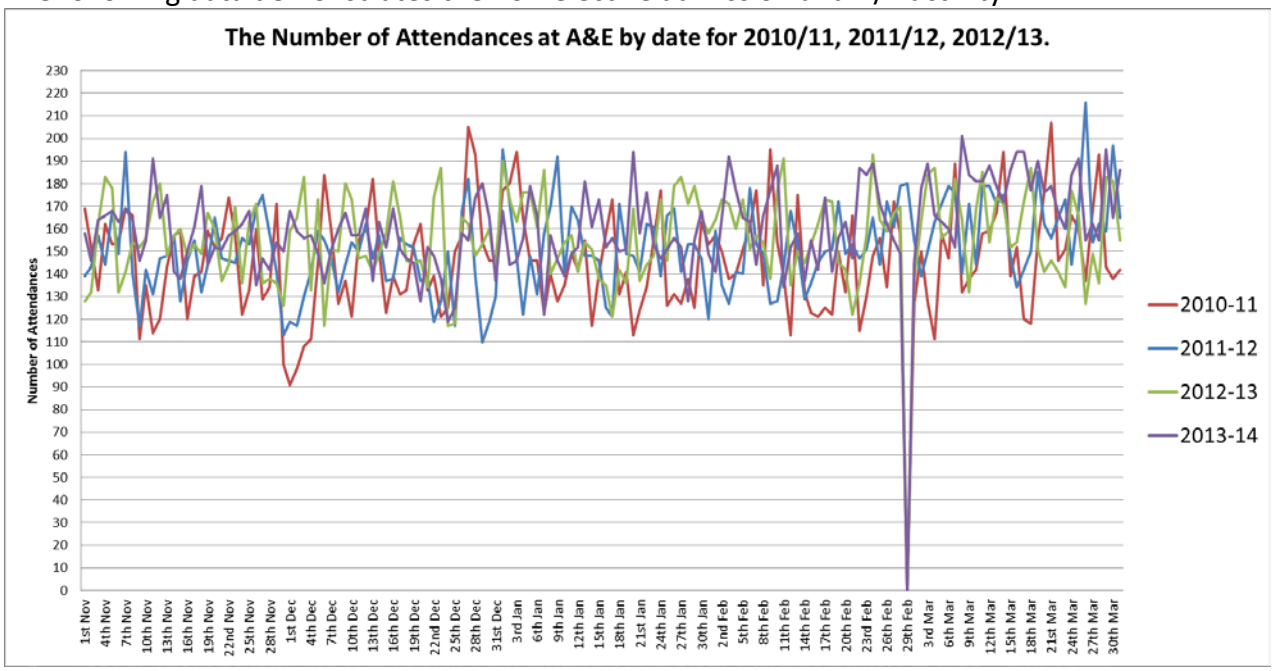
- Resilience Operational Group
- Urgent Care Working Group
- System Resilience Group
- Individual Organisation Director leads

Report from	Report to	Product	For
Resilience Operational Group Member	Organisation Director	Conference call notes	Escalation
Resilience Operational Group	SRG	Conference call notes	Escalation re elective care issues
Resilience Operational Group	UCWG	Conference call notes	Escalation
Resilience Operational Group	UCWG	Highlight report	Information and action as required
UCWG	SRG	Issue log	Escalation
UCWG	SRG	Highlight report	Information

Planning analysis

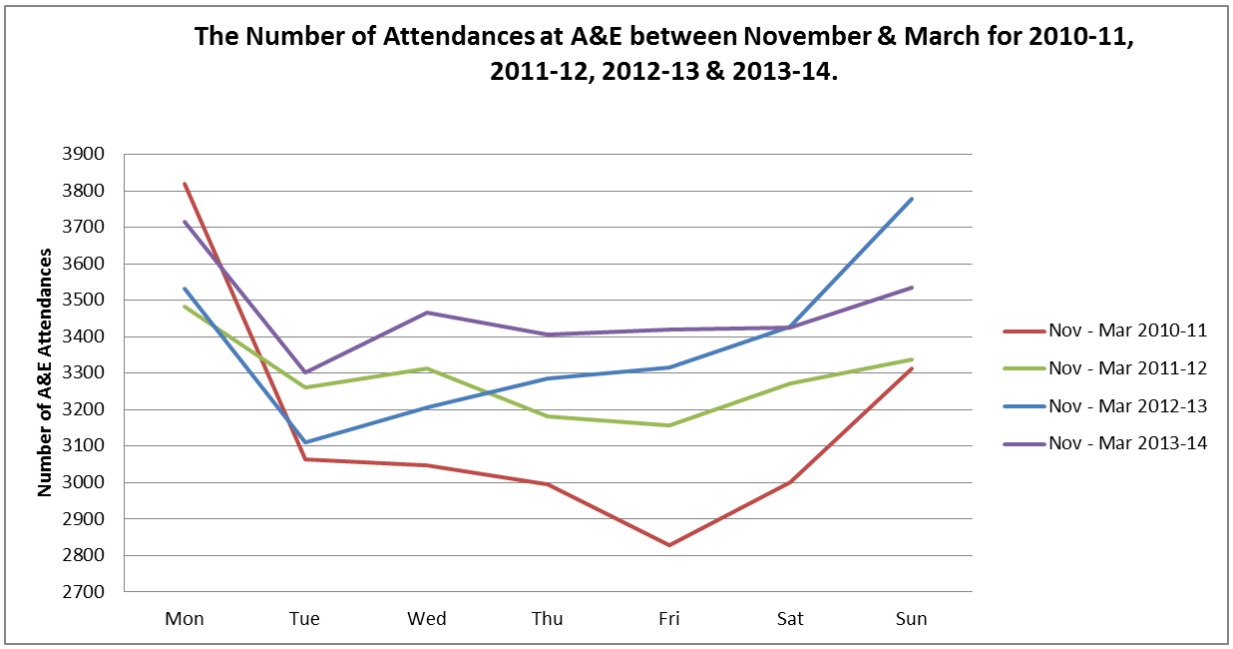
Joint elective and non-elective capacity planning has not yet been undertaken. The resilience plan requires completion on specialty level of elective and non-elective demand to support capacity planning. This analysis will provide detailed understanding of the overall bed demand for the SGH site, by specialty to support planning and delivery of elective and non-elective activity.

Whilst it is recognised that this large analysis is not yet complete, NL CCG has undertaken analysis of local admissions and A/E attendances compared to previous years to support non-elective planning.
The following data demonstrates the non-elective admission and A/E activity.



The above chart plots A/E attendances by day over the winter pressure periods from 2010/11 through to 2013/14 and shows similar levels of activity. Whilst analysis of overall activity through A/E has shown a small year on year increase, the impact of this on a daily basis is small. However whilst historically, we have seen a predictable increase in activity during winter periods, 2014/15 has seen this pressure maintain and increase over the spring and summer months. The reasons for this are poorly understood and are not confined to the Scunthorpe site.

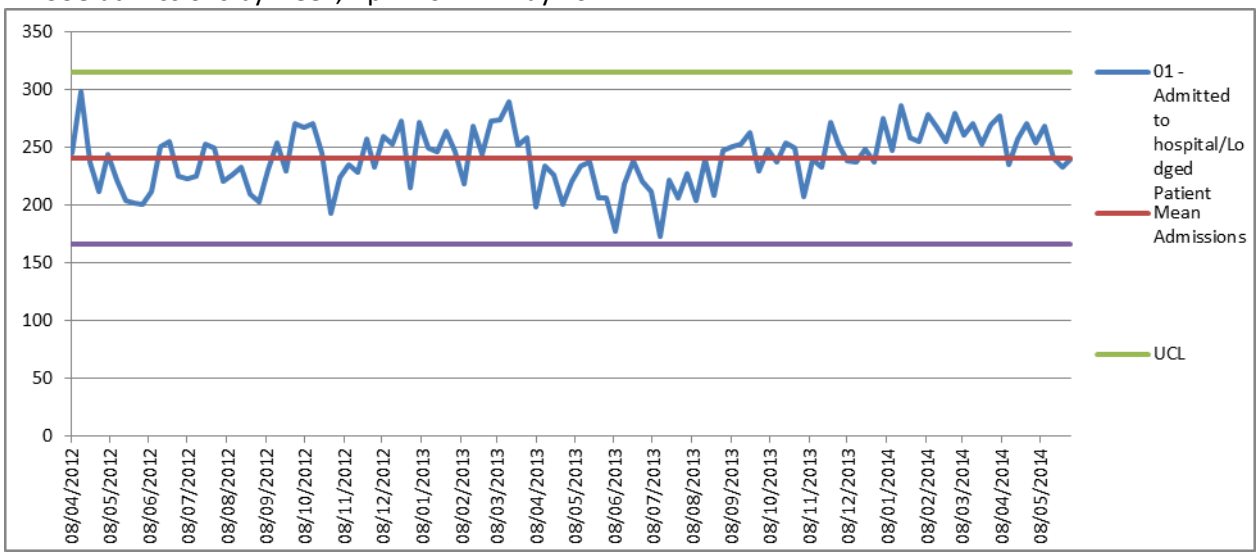
There is a level of predictability in terms of the days of highest attendances, with peaks on Mondays and weekends as shown in the chart below .



Non-elective admissions

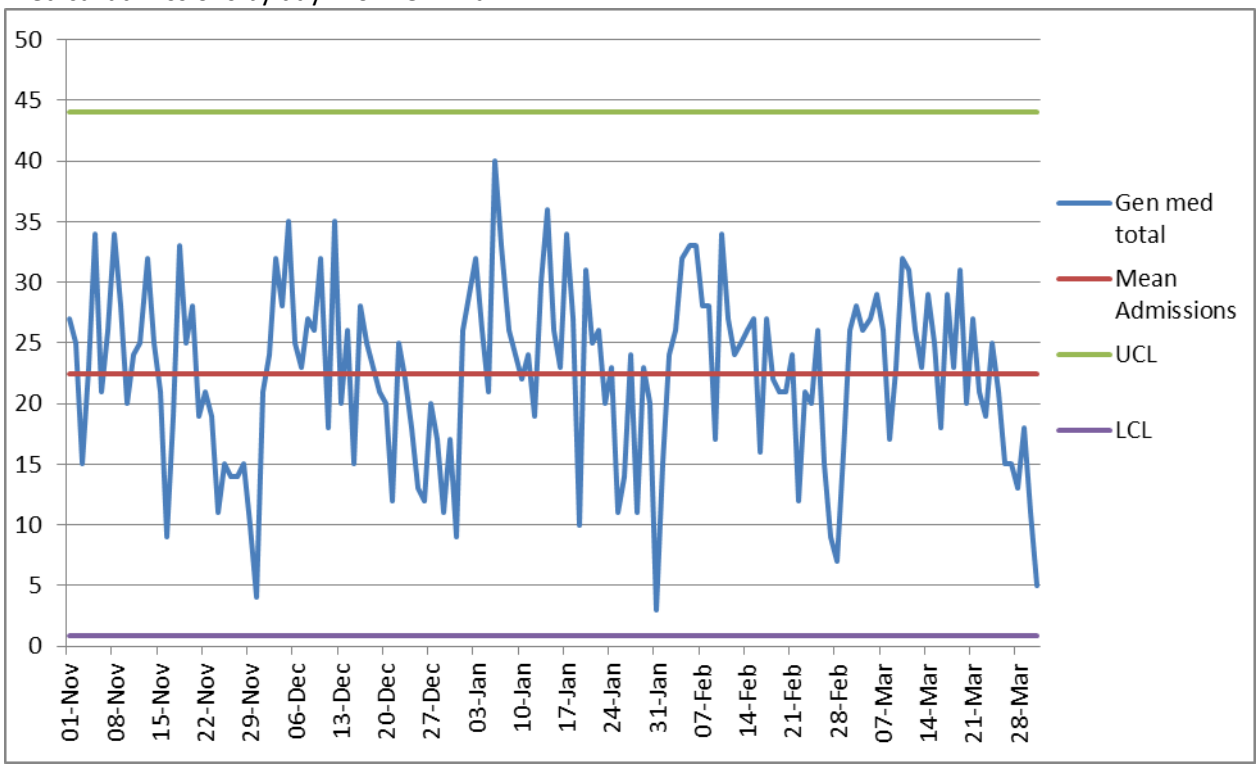
The chart below shows non-elective admissions by week, including upper and lower confidence levels. This shows a reduced level of variation in admission levels over the course of 2014, however these are all generally above the average.

NL CCG admissions by week; April 2012 – May 2014



However, analysis of general medical admissions, including smaller sub-specialties, as these are admitted to general medicine wards, shows a distinct pattern of lower admissions at the end of each month, rising over the course of the month, then falling away again at month end. There is no obvious cause for this and application of SPC shows the system to be 'in-control'. Further analysis and exploration is required to understand the reasons for this in month variation.

Medical admissions by day: Nov 13 – Mar 14



Operational resilience planning template for non-elective care 2014/15

Lead CCG:	North Lincolnshire CCG
Lead acute trust:	Northern Lincolnshire and Goole NHS Foundation Trust

Central Resilience Funding	£1.118m
Marginal Tariff savings to reinvest	tbc- forms part of contract discussions with NLAG
Other funding available locally	
Total non-elective care support funding for 2014/15	**£1.118m**

Section 1: Narrative on local system configuration, key strengths and key challenges

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is the main acute provider for North Lincolnshire. Patients on county boundaries may utilise other acute sites, but the majority of acute activity for North Lincolnshire patients takes place within the Scunthorpe General Hospital site. Overall, NLAG has performed close to the 95% target for discharge or admission from A/E however performance at Scunthorpe General Hospital has been worse that Diana Princess of Wales Hospital throughout 2013/14. Overall performance for 2013/14 was 95.4%, with non-achievement of the target for Q1 and Q3. Both main sites have struggled with bed capacity during the winter period despite having no bed closures due to norovirus. Social Services community teams have experienced higher than normal levels of demand during Q4 in particular.
October 2013 saw the commencement of implementation of the new, integrated urgent care model on the Scunthorpe site. This model, based on best practice, integrates primary care into A/E and utilises ambulatory emergency care pathways and has taken a number of months to achieve full implementation, challenged by the physical constraints of the hospital site. November 2013 saw the temporary centralisation of hyper-acute stroke services on the Scunthorpe site, and whilst numbers of stroke patients per day are low, this move created additional demand on the Scunthorpe site due to mimic stroke patients. Stroke bed capacity has now increased and work in on-going to directly admit stroke patients to the stroke unit, diverting that activity away from A/E into an appropraite setting.
Northern Lincolnshire is currently consulting on the permanent centralisation of stroke services. NLAG reported low levels of cancelled procedures throughout the winter period.
The focus for investment of 2013/14 winter pressures funding was increased community capacity to reduce hospital admissions, however the Trust faced significant challenges in recruitment to a number of these posts which impacted on timescales for implementation.
The Urgent Care Working Group and the Resilience Operational Group are both well established in North Lincolnshire. There is an effective escalation process in place and the operational group convene weekly teleconference calls throughout periods of surge and have a clear escalation plan in place, with high levels of co-operation between health and social care to address pathway issues. We will build on the current structures and processed for 2014/15 to include planned care systems.

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding in 2014/15.
Text in blue italics is provided as examples only and should be overtyped

Ref	Minimum Plan Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Timeframe for Completion	Lead Accountable Officer	Estimated Costs in 2014/15
1	Enabling better and more accurate capacity modelling and scenario planning across the system	Capacity and Demand model developed for each speciality incorporating key service outcomes, 2x Band 7 dedicated operational resilience posts to work alongside the clinical teams	% specialty models in place and agreed	Community wide capacity meets demand	March 2015 for specialties where demand exceeds capacity	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation:NLaG	
2	Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs	Work with YAS as the intelligence Data Tool becomes available. Comprehensive Directory of Service already available within North Lincolnshire, however this will be reviewed and cross referenced with the recent Urgent Care map created by the UCWG. NL CCG will continue to work with YAS to ensure the local DoS is fully utilised by NHS 111 to maximise use of alternative community based services	In place within the contract.	Commissioned services reflect patient needs	Sep-14	Name: Rebecca Bowen Email: Job Title: Senior Delivery Manager Organisation: Y&HCSU	
3	Additional capacity for primary care	Integrated Urgent Care model in place, incorporating GP DOHs service as part of the integrated model. Business case for additional primary care input into Urgent Care Model, in hours	At least 95% patients meeting A/E 4 hr performance target	Increased capacity within urgent care centre, improved 4 hr performance	Nov-14	Name: Collette Cunningham Email: Job Title: General Manager, Medicine, Unplanned Care Organisation:	
4	Improve services to provide more responsive and patient-centred delivery seven days a week	7/7 diagnostics already in place. 7/7 social worker input to be available within hospital site to improve assessment and decision making- funded through BCF. Expand Ward 19 from 5 day ward to 7 days removing the need to transfer patients to an alternative ward if need admission over weekend plus provides additional capacity to support activity surges Expand Ward 19 from 5 day ward to 7 days removing the need to transfer patients to an alternative ward if need admission over weekend plus provides additional capacity to support activity surges	Reduction in non-elective admissions through increased access to social care assessment. KPI to mirror BCF KPI Bed numbers. Increase by 12 by Nov 14	Reduction in non-elective admissions due to improved access to social care assessment across 7 days. Continuity of care is maintained / relieved pressure on medical & surgical beds as patients won't need to be moved at weekend / reduced pressure on A&E as direct access into Ward 19 over the weekend.	Fully embedded 2014-15 Beds open by 01/11/14	Name: *Claire Philips* Email: Job Title: *General Manager, Surgery & Critical Care* Organisation: NLAG	130,000
5	SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda	BCF is central to the strategic plan for North Lincolnshire Unit of Planning. Both plans focus on prevention, early detection and management of ill health, and community based care where appropriate. Unplanned care in an integral part of the BCF implementation plan. The prevention agenda is considered both within this plan and the BCF- there is consistency in the plans and the staff involved to ensure inderdependencies are well recognised and managed	To mirror BCF plan targets. Reduction in non-elective admissions % people still at home 91 days after hospital discharge% people offered rehab and reablement Reduction in number people requiring permanent admission to care home	People are supported to remain independent for as long as possible. Care is provided into the home or close by in the community	on-going	Name: *Caroline Briggs* Email: Job Title: Director of Commissioning Organisation: NL CCG	
6	Seven day working arrangements	7/7 diagnostics already in place. 7/7 social worker input available within hospital site to improve assessment and decision making.	Reduction in non-elective admissions. KPI to mirror BCF KPI	reduction in non-elective admissions due to improved access to social care assessment across 7 days		Name: *Wendy Lowtey* Email: Job Title: Organisation: NLC	
		Increased pharmacy services across 7 days	% reduction in prescribing omission and error / % reduction in length of stay / % reduction in complaints - above focussed specifically on prescribing Increase in Sat/Sun discharges		Operate a pilot through Nov-Mar due to the need for consultation on T&C	Name: *Mike Urwin* Email: Job Title: Organisation: NLaG	129,000
		Increase emergency theatre lists to enable full day lists to operated Mon - Fri with the implementation of a Saturday trauma list	75% of patients requiring surgery for #hip receive surgery on day of, or day after admission	Increased patient experienced, improved theatre efficiency, increased patient access	*Operational by Oct14*	Name: *Claire Philips* Email: Job Title: Organisation: NLaG	100,000
7	Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.	Development of psychiatry liaison serivce (RAIG model) in A/E to address needs to high intensity A/E users . Completion of Experience Led Commissioning work with people experiencing mental health crisis to co-design future services with patients, carers and stakeholder groups by January 2015, incorporating relevant person centred KPIs into contracts for 2015/16. A number of high intensity users are covered by the Proactive Care DES and over 75s covered by local plans for the accountable GP, with practices currently implementing plans to manage these patients, underpinned by patient care plans. This group is also covered by the plans within the BCF for community based, integrated acute care Minors pathway has been redesigned as part of the implementation of the urgent care model during 2013/14.	100% of A/E attendances for self harm are assessed by the RAID team 97% of patients referred to team are managed without requirement for institutional care e.g. residential placement 90% A/E referrals seen within 1 hr 80% of Patients over 65 and managed by the team have a reduction in LoS of 2.0 bed days against current baseline	Improved patient experienced,	Operational Sept-Oct14	Name: *Jon Smith* Email: Job Title: Organisation: RDaeH	300,000
		Recruitment into complex care case co-ordinators to wrap around existing consultant led services and community services. Not specialty specific, patient need specific. To provide one named person for complex patients during their acute phase liaising with community and primary care to ensure continuity of care and appropriate acute length of stay.	100% of complex patients identified on register / 100% of complex patients identified and cared for by the co-ordinator / % reduction in frequent A&E attenders / % reduction in frequent admitters / capture of alternative given.	Reduced length of stay through better co-ordinated care. Improved discharge experience	Pilot Oct 14 -Mar15	Name: *K Wilson* Email: Job Title: Organisation: NLaG	
8	Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand	Top 10 presentations already reviewed and AEC pathway developed- to move to full implementation of these pathways by Dec 14. The acute provider has previously undergone an ECIST review and report (April 2013) and implemented the resulting action plan, including implementation of RAT team and streaming of minors.	% patients managed using AEC pathways - in line with KPIs within service specification	Reduction in avoidable admissions through senior decision making	on-going	Name: *Collette Cunningham* Email: Job Title: *General Manager; Medicine non-elective care* Organisation: NLAG	
9	All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge	Links to Ref 6, Pharmacy 7/7 above as the reconciliation will follow the patient through their acute stay and back out following discharge, also feeds into the discharge summary, ensuring GPs receive accurate and timely information	% reduction in prescribing omission and error / % reduction in length of stay / % reduction in complaints - above focussed specifically on prescribing			Name: *Mike Urwin* Email: Job Title: Organisation: NLaG	
10	Processes to minimise delayed discharge and good practice on discharge	Implement outstanding actions relating to ECIST recommendations for discharge. Expand discharge lounge to 7/7 working, with in-reach into wards to pull through to discharge lounge implement 'Discharge to assess' All non-elective admissions notified to integrated Locality Teams to facilitate discharge planning. Phased plan to increase Discharge Lounge opening hours during the week initially to reflect discharge patterns, with a move to 7 day opening as weekend discharges increase.	50% increase in current weekend discharges (based on Mar - May 14 data, excl paeds and deaths)	Improved A/E performance due to freeing up beds	Operate a pilot through Nov-Mar due to the need for consultation on T&C	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation:NLaG	35,500
11	Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes	The health and care community is moving to implement discharge to assess to ensure people are assessed appropriately within their own environment. Where appropriate, people are offered reablement on discharge, either within a bedded unit if required, or within a community setting. Evaluation of this service shows good outcomes. Performance is monitored within Social Care and within the BCF governance structure. To develop a comprehensive older peoples assessment at the front end, similar to the Paediatric assessment Unit	To reflect BCF plan targets. % people offered reablement on discharge from hospitalN.. people still at home 91 days after hospital discharge/ reduction in adm to care homes			Name: *Wendy Lowtey* Email: Job Title: Organisation: NLC	
12	Cross system patient risk stratification systems are in place, and being used effectively	A risk stratification tool is in place, utilising both primary and secondary care data, however national IG issues prevent full use of this tool at present. The CCG is working with the supplier and GMIC to resolve these issues. In the interim, practices are risk profiling patients based on primary care data. Tool will identify top 3% based on resource utilisation and inform commissioning. Whilst the tool will support use of social care data, this is dependent on the implementation of the NHS number as the single identifier and resolution of national IG issues currnetly experienced.	Top 2% patients at risk identified at Practice and CCG level	All practices implementing care planning and proactive management for at risk patients	Sep-14	Name: *Rebecca Bowen* Email: Job Title: *Senior Delivery Manager* Organisation: North Yorkshire and Humber Commissioning Support Unit	
13	The use of real time system-wide data	Development of read only access of NLaG clinical portal into primary and community care. Enables health professionals to view clinical portal as if on NLaG site including EDD. Requires development costs in 14/15 to deliver from March 15 onwards		Integrated information sharing leading to improved patient care through secure information access	Pilot sites operational by March 2015	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation:NLaG	
					Total costs of all minimum requirement schemes:	*Sum of cells above*	694,500

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total emergency care support funding

Ref	Local Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Lead Accountable Officer	Estimated Costs in 2014/15
1	Development of community support to reduce social isolation and support people to access prevention services	targetted support to people aged 75+ who are or at risk of social isolation which impacts no their health	reduction in over 75s repeat A/E attendances Patient self assessment of independence pre and post intervention	People experience less social isolation and feelsupported to access services	Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£140,000
2	Home from hospital service to support vulnerable people at discharge from A/E and wards, to include handyman element	Negotiate expansion of current contract (LA commissioned)	% patients discharged to usual residence	People are supported at discharge	Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£20,000
3	First responder service	Commission local First Responder service to support ambulance response times, particularly in rurally isolated areas	Acheivement of ambulance targets		Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£30,000
4	Increase in PTS capacity to support discharges	Negotiation with EMAS to secure additional capacity targetted at discharges over an extended working day	% patients discharged on day of booking amb transport	Improved patient flow and improved A/E performance	Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£60,000
5	Expand currently commissioned Handy-person services	Current services commissioned via NLC and Age UK. Need additional capacity to support increase in people managed at home	% patients discharged to usual residence	People are supported to live independently	Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£25,000
6	Additional equipment for Community Equipment store	Service requires additional stock to manage increase in people managed at home and proactive care models	% patients discharged to usual residence	People are supported to live independently	Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£51,600
7	Community bed capacity for those medically fit, but not physically fit for discharge	Agree local criteria and process with LA Spot purchase of care home beds as required for short term stay	Decrease in proportion of people needing long term residential care	People are supported to live independently	Name: Jane Ellerton Email: jane.ellerton @nhs.net Job Title: Senior Manager Organisation: NL CCG	£60,000
8	Contingency					37,000
						£423,600

*please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A	Independent Sector non-acute bed capacity (intermediate care, nursing homes, etc.)	Intermediate inpatient beds were increased from 16 to 30 beds in Jan 2014. work in on-going to increase capacity by reducing length of stay where appropriate. Short -term care home beds were commissioned for a time limited period during 2014. Work in on-going to understand the level of requirement going forward. There is currently approximately 20% vacancy rate across North Lincolnhire Care Homes
B	Other Independent Sector capacity (e.g. healthcare at home etc.)	
C	Voluntary Sector capacity and expertise	Home from hospital is the local commissioned voluntary sector input. Throughout the winter of 2013/14, this service operated under capacity. We are currently assessing potential demand for a redisigned and publicised service as awareness of this service is limited, impacting on activity.
D	Flu vaccination of healthcare workers	
E	7-day a week commencement of new care packages (including over holiday periods)	This is aligned with the BCF plan. Engagement via BCT implementation group, BCF joint board, Integrated Working Partnership and UCWG
F	Improvement in access to psychiatric liaison service teams in A&E	Plan includes a busines case for piloting of liaison psychiatry to reduce A/E attendance for people with mental health problems
G	Collaboration with and development of Children's services	Children's acute pathway redesigned during 2014/15 with revised model to be implemented in October 2014. This will include investment into Children's Community Nursing
H	Engagement with patient representative groups	The resilience plan and BCF plan are directly aligned with the strategic plan. The strategic plan has been informed by Keeping Well and Living Independently- a large programme of public engagement undertaken in 2013

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and that you will commit to attending all SRG meetings (or sending an appropriate deputy when unavailable).

Representative of:*	Name	Email	Job Title	Electronic Signature
SRG Chair\				
Lead Acute Trust				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add rows as aasrsociate

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add rows as appropriate

Non-elective care costings template 2014/15

Section 1: Minimum Plan Requirements

Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Increases in bed capacity	Comments
Enabling better and more accurate capacity modelling and scenario planning across the system						
Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs						
Additional capacity for primary care						
Improve services to provide more responsive and patient-centred delivery seven days a week	£130k- nursing staff				12 beds Fri - mon	Increase in bed capacity for weekends by opening a 5 day ward for 7 days per week. Confirm and challenge regarding skill mix required during August
SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda						
Seven day working arrangements	£100k Surgeons, nursing staff, healthcare assistants and ODAs £129k pharmacy staffing					confirm and challenge required re pharmacy costz
Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.	£300k, baased on October start due to requirements to staff a full team					Confirm and challenge of costs and skill mix required during August/September
Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand						
All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge	£35.5k, nursing and Health care assistants					Skill mix to be confirmed. Based on 2 stage increase. Increase from Oct 14 to 9:30-20:00 opening. From Jan 15 - March 15 open 9:30 - 20:00 7 days per week. Phasing to reflect need to change discharge processes
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	No additional cost- funded via BCF					Focus on preventative care to support people in their own home for longer. Implementation of discharge to assess processes
Cross system patient risk stratification systems are in place, and being used effectively	No additional costs					*Risk profiling tool will focus primary care activty at those most at risk of hospitalisation*
The use of real time system-wide data						
Sub Totals	694,500					

Section 2: Local Plans for Innovation

Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Increases in bed capacity	comments
reducing social isolation	**£140,000**					
First responder service	**£30,000**					**confirm and challenge required on costs/skill mix during august**
home from hospital	**£20,000**					
Increase in PTS capacity to support discharges	**£60,000**			**tbc**		**confirm and challenge required on costs/skill mix during august**
Expand currently commissioned Handy-person services	**£25,000**			**2WTE**		**confirm and challenge required on costs/skill mix during august**
Additional equipment for Community Equipment store	**£51,600**					**Equipment costs only**
Community bed capacity for those medically fit, but not physically fit for discharge	**£60,000**					**confirm and challenge required on costs/skill mix during august**
contingency	**£37,000**					
Sub Totals	£423,600					

Total Capacity Increases*						

* needs to link to capacity plan

Operational resilience planning template for elective care 2014/15

Lead CCG:	North Lincolnshire CCG
Lead acute trust:	Northern Lincolnshire and Goole NHS Foundation Trust

Central Resilience Funding	*£1.118m*
Other funding available locally	
Total elective care support funding for 2014/15	136250 for NLAG

Section 1: Narrative on local system configuration, key strengths and key challenges

Within North Lincolnshire, NLAG is the only acute care provider and the majority of North Lincolnshire population use the Scunthorpe site for elective care. A small number of patients use alternative acute sites including Hull and East Yorkshire NHS Trust, Doncaster and Bassettlaw Foundation Trust and United Lincolnshire NHS Trust. There has been a recent increase in activity in the independent sector,through patient choice, with all these units being outside North Lincolnshire.

The majority of NLAG surgical services are provided on each of the two main acute sites; Grimsby and Scunthorpe. Overall NLAG have achieved targets against referral to treatment , however they are facing challenges within some specialties and are incurring additional costs over tariff to deliver. Specialties experiencing challenges include cardiology, cardiothoracic, neurology and trauma and orthopaedics.The Trust has made significant investments in front line services in the last 12/18 months in particular. The quality of care patients receive is at the fore of service delivery. To sustain both the quality improvements made and further improve 18 week waiting times, the Trust has and continues to make significant investments to ensure compliance across all 18 week measures is achieved. The Trust has a strong track record of delivery across all threse measures however this does come at a cost due to the reliance upon expanding capacity at premium rates to ensure current levels of demand is met. Whilst the current level of demand continues, the Trust is forecasting to incur premium costs above tariff of between £124,000 and £141,500 per month to sustain 18 week performance. These costs will be incurred whilst the longer term sustainable service construct are confirmed and operational. These costs are in addition to the costs quoted to go further and reduce 16 week waiters.

HEYHT performance against the RTT target is lower, and are currently not achieving the RTT targets. The Trust have worked with commissioners to develop a plan to address this, however, this plan will not achieve the RTT target by September and plans to deliver by March 2015. Both Trusts have additional funding allocated to deliver the RTT as part of the latest national allocation to secure achievement of waiting times. this funding is being used ot run additional sessions to clear backlog.

Historically, SGH site have managed winter pressures without the requirement to cancel routine surgical procedures.

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding in 2014/15. More detail on these plan requirements can be found on page 10 of the operational resilience and capacity planning document.

Text in blue italics is provided as examples only and should be overtyped

Ref	Minimum Plan Requirements	Summary of plan to achieve requirement	Timeframes for completion	Assurance Mechanisms	Lead Accountable Officer	Estimated Costs in 2014/15
1	Review and revise the Trusts' 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	Trust lead to spend 2 months full time revising Access Policy and supporting standard operating procedures. Clear timeframes for both completion, and roll out of refresher training to administrative teams regarding the content of the Access Policy. Once review is complete, NL CCG to engage with Primary Care to ensure application of the Access Policy principles and protocols.	31st March 2015	SRG to review Access Policy against national rules and guidance in September.	Name: *Pam Clipson* Email: *pam.clipson@nhs.net* Job Title: *Director of Strategy and Planning* Organisation: NLAGFT Name: Jane Ellerton Email: jane.ellerton@nhs.net Job Title: Senior Manager; Commissioning Organisation: NL CCG	The Trust has increased the level of resource dedicated to monitoring 18 week performance, this has come at a cost and is incorporated within the costs quoted in section 1
2	Develop and implement a RTT training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15	Trust lead to develop bespoke training packages specifically for Clinicians, nursing staff and administration staff foccussing on principles of 18 weeks RTT and how to apply within the Trusts' local systems. Training packages should include, to those whom it applies to, the rules and priciples of the patient Access Policy and PTL management. The Trust has developed an e-learning training package and will be making the training mandatory for specific staff	31st December 2015	SRG to review developed training packages and training roll-out plan to agree assurance. Progress monitored by SRG up to December deadline.	Name: Linda Da Costa Email: linda.dacosta@nhs.net Job Title: Head of Information Organisation: NLAG	The Trust has increased the level of resource dedicated to monitoring 18 week performance, this has come at a cost and is incorporated within the costs quoted in section 1
3	Carry out an annual analysis of capacity and demand for elective services at sub specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16	The Trust is currently refreshing its capacity plans and has placed a focus on those specialties where demand continually outweights capacity. This has resulted in provider and commissioner discussions regarding alternative service configuration.	Core specialties to be completed by March 2015	Action plans shared with CCGs, SRG to to receive	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation: NLAGFT	Costs specific to action plans
4	Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements	Action plans are formulated from the work detailed in question 3 and once agreed with CCGs, mobilisation plans are developed in agreement with CCGs.	Timescales as per mobilisation plan, different for each specialty	Mobilisation plans shared with CCGs, SRG to to receive	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation: NLAGFT	Costs specific to mobilisation plans
5	Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable	Trust lead to develop speciality specific common procedure pathways to inform staff of best practice RTT timelines, and devise robust internal escalation proceedures for when these timeframes are becoming difficult to achieve. Trust and commissiors to develop and agree an external escalation procedure to inform commissioners of upcoming concerns including the plans to address the same.	Ongoing	SRG to ratify pathways and escalation process in September.	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation: NLAGFT	see comment in secton 1
6	'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)	The Trust has commissioned outside consultants to identify areas of inefficiencies and right size capacity within non premium rates, but this work has not been finalised and data is not yet available. The IMAS IST tool was not specifically used	Qtr 3 for output, timescales for actions dependant upon recommendations	Action plans shared with CCGs, SRG to to receive	Name: Pam Clipson Email: pam.clipson@nhs.net Job Title: Director of Strategy and Planning Organisation:NLaG	
7	With immediate effect, review local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses	*Q7 & Q8 merged as identical action required to achieve requirement* Undertake snapshot audit within each specialty against RTT rules to assess compliance with RTT guidance. Audit report to be shared via SRG. Trust to develop appropriate action plan based on audit findings	Audit to be completed by 30th October 2014	SRG to review audit results and resulting action plan in November. SRG to agree subsequent programme of future audits.	Name: *Jane Ellerton* Email: *jane.ellerton* @nhs.net Job Title: Senior Manager Organisation: NL CCG	
8	Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits	Commissioners to be informed of dates of provider internal RTT delivery meetings. Commissioners to attend these meeting periodically, giving notice to the provider on when they intend to attend 7 days in advance.	Ongoing commencing August 2014		Name: Email: Job Title: Organisation:	
9	Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system	Trust to submit weekly RTT PTLs to commissioners, broken down to speciality level. These PTLs will inform the performance discussions at the SRG, allowing focus on those speciality areas where performance is declining, concerntrating on the reasons why, measures required for recovery and trajectories for the same.	To commence from the beginning of August 2014 Ongoing monthly review	SRG to scrutinise performance at speciality level and inform actions and timeframes at monthly meetings.	Name: Linda Da Costa Email: linda.dacosta@nhs.net Job Title: Head of Information Organisation: NLAG	
10	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	Weekly (unvalidated) and monthly (validated) information collected by providers re waiting list size, RTT rates by specialty. NLaG monitor patient waits daily within the clinical divisions, a formally documented weekly meeting is held with each of the teams to work through on a patient by patient basis escalating causes for concern through Trust process	In place and on going		Name: Sarah Coombs Email: sarah.coombs@nhs.net Job Title: Service and Business Development Manager Organisation: NLaG	The Trust has increased the level of resource dedicated to monitoring 18 week performance, this has come at a cost and is incorporated within the costs quoted in section 1
11	Demonstrate how good practice in referral management is being followed	NL CCG Relationship managers are working with practices to understand outliers to reduce inappropriate referrals. This is supported by pathway redesign and implementation of Map of Medicine. Project plan includes implementation of e-refferal through Map of Medicine.			Name: *Julie Killingbeck* Email: *julie.killingbeck@nhs.net* Job Title: *Relationship Manager* Organisation: NL CCG	
12	Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider	NL CCG Relationship Managers to engage with practices to ensure that patient choice is both exersized and supported. Where commissioners are not assured that this is in operation, actions plans will be developed by the practices which clear trajectories for completion and monitoring of the same.	31st August 2014	Report to SRG in September highlighting findings, actions and future recommendations to provide assurance.	Name: Jason Coombs Email: jason.coombs@nhs.net Job Title: Relationship Manager Organisation: NL CCG	
13	Provide assurance during Q2 2014/15 at Board level on implementation of the above	CCG position against RTT standards will be report to the CCG Governing Body as part of the performance report. Concerns around meeting overall standards and within certain specialties are escalated and monitored through the Contract Compliance Board. NLaG produce a monthly performance compliance report which is discussed in detail at the Trust Finance Committee (a sub committee of the Board) Any causes for concern regarding non delivery are then incorporated within escalation reports to the monthly Trust Board.			Name: *Pam Clipson* Email: *pam.clipson@nhs.net* Job Title: *Director of Strategy and Planning* Organisation: NLAGFT Name: Therese Paskell Email: therese.paskell@nhs.net Job Title: Chief Finance Officer Organisation: NL CCG	
				Total costs of all minimum requirement schemes:		*Sum of cells above*

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total elective care support funding and the total costs of the minimum plan requirements, SRGs must present plans to close such gaps such that the minimum requirements are deliverable

Ref	Local Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Lead Accountable Officer	Estimated Costs in 2014/15

	Cardiology pathways	Implementation of cardiology pathways to reduce variation in referrals	Rates of referral to secondary care	consistent pathways for all patients based on clinical indications of need	Name: *Julie Killingbeck* Email: *julie.killingbeck@nhs.net* Job Title: *Relationship Manager* Organisation: NL CCG	
	Gastroenterology	Review of current activity against direct access referral criteria	Gastroscopy activity levels	Reduce activity to within tolerance of comparator group	Name: Rebecca Bowen Email rebecca.bowen2@nhs.net Job Title: Senior Service Delivery Manager Organisation: Y&HCSU	
	Ophthalmology - Glaucoma monitoring service in the community: Will alleviate hospital waiting times.	Finalise training and accreditation requirements for opticians with the consultants. Finalise service specification based on the above.	patients monitored within community service.	18 week wait target met	Name: Rebecca Bowen Email rebecca.bowen2@nhs.net Job Title: Senior Service Delivery Manager Organisation: Y&HCSU	

*please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A	Independent Sector non-acute bed capacity (intermediate care, nursing homes, etc.)	There are approximately 50 care homes within North Lincolnshire including Learning Disabilities Care homes. Across the system there is a vacancy rate of approximately 20-25%
B	Other Independent Sector capacity (e.g. healthcare at home etc.)	There is no other independent sector capacity within NortH Lincolnshire. Elective Independent Sector care is avaialbe outsode North Lincolnshire in Grimsby, Hull and Doncaster
C	Voluntary Sector capacity and expertise	There are a range of services commissioned from the voluntary sector, mainly commissioned by North Lincolnshire council. In developing the plan we have considered how we can build on these existing contracts using non-recurrent funding to test alternative models
D	Flu vaccination of healthcare workers	Providers are developing their own vaccination plans for staff as part of winter planning. These plans are not currently available, but progression of vaccination plans will be picked up via UCWG
E	7-day a week commencement of new care packages (including over holiday periods)	7 day social worker capacity is now avaialbe to support asessment and planning of care packages
F	Collaboration with and development of Children's services	There are plans in place to redsign Children's servcies including the development of a paediatric urgent care assessment unit, and additional investment into children's community services. Funding has already been agreed for this, with services planned to go live in October 14
G	Engagement with patient representative groups	The resilience plan and BCF plan are directly aligned with the strategic plan. The strategic plan has been informed by Keeping Well and Liviing

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and are committed to its delivery

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add/delete rows as appropriate

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add rows as appropriate

Elective care costings template 2014/15

Section 1: Minimum Plan Requirements

Ref	Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Additional Outpatient Appointments	Additional Inpatient/Daycase procedures	comments
1	Review and revise the Trusts' 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							
2	Develop and implement a RTT training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15							
3	Carry out an annual analysis of capacity and demand for elective services at sub specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16							
4	Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements							
5	Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable							
6	'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)							
7	With immediate effect, eview local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses							
8	Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits							
9	Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system							
10	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							
11	Demonstrate how good practice in referral management is being followed							
12	Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider							
13	Provide assurance during Q2 2014/15 at Board level on implementation of the above							
	Sub Totals							

Section 2: Local Plans for Innovation

Local plans for innovation	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Additional Outpatient Appointments	Additional Inpatient/Daycase procedures	Add more columns as required
Cardiology pathways							
Gastroenterology							
glaucoma monotoring							
Sub Totals							
Total Capacity Increases*							

* needs to link to capacity plan