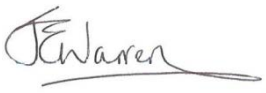
NHS
North Lincolnshire
Clinical Commissioning Group

Date:	11th October 2018
Meeting:	Governing Body
Item Number:	Item 10.3
Public/Private:	Public ☒ Private ☐

Author: *(Name, Title)*	Rebecca Bowen Senior Commissioning Manager Acute Services
GB Lead: *(Name, Title)*	Julie Warren & Dr Neveen Samuel
Director approval (Name)	Julie Warren
Director Signature	

Report Title:
Winter Plan update
Decisions to be made:
For approval

Link to a Strategic Objective?	☐	
Link to a Strategic Risk	☐	

Continue to improve the quality of services	☒	**Improve patient experience**				☒
Reduced unwarranted variations in services	☐	**Reduce the inequalities gap in North Lincolnshire**				☐
Deliver the best outcomes for every patient	☒	**Statutory/Regulatory**				☒
Purpose (tick one only)	Approval ☒	Information ☐	To note ☐	Decision ☐	Assurance ☐	

Executive Summary (Question, Options, Recommendations):

The A&E Delivery Board (A&EDB) provides the strategic leadership and operational links across the health and social care system in Northern Lincolnshire. All partner organisations within the system share co-ordination of planning, integration and delivery of care in order to support the delivery of safe, responsive, effective, high quality accessible services which are good value for money. The A&EDB is supported by work stream groups, each with a nominated Senior Responsible Officer.

The Northern Lincolnshire A&EDB winter plan is attached for approval, and sets out the system approach to maintaining effective delivery of services, mitigating the impact of additional increased activity and acuity pressures during winter, and keeping people safe throughout the winter period.

The plan includes a number of schemes which have been identified as priority areas to support the full unplanned pathway pre hospital, in hospital and for discharge and onward care.

The winter plan and appendices have been signed off by the A&E Delivery board, but with an acknowledgement that they would remain live documents and would be updated to reflect service provision as the schemes detailed come online. This is particularly true of the escalation framework.

During development the plan was costed, and partner organisations were asked to confirm whether identified funding requirements had budgets available and committed. For the majority of the plan schemes this has been confirmed, and there are further conversations ongoing to confirm the funding for the plan in its entirety. For North Lincolnshire CCG a paper was presented to the executive team meeting on 2nd October 2018 asking for approval to continue to commit a proportion of the resilience budget to support delivery of winter. This covers the funding requirements for the CCG elements of the plan.

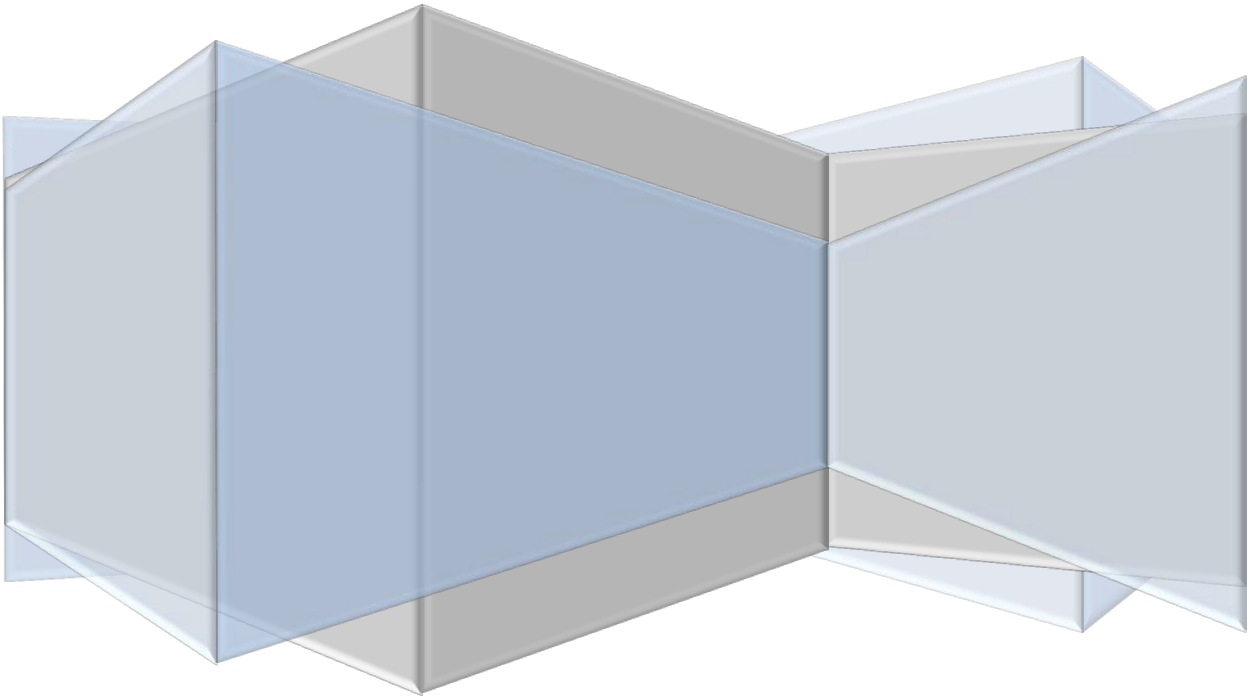
We are required by NHS England to submit the final winter plan by 12th October 2018, and all partner organisations are in the process of taking the plan through their respective governance groups for approval. The CCG Governing Body are therefore asked to support and approve the Delivery Board plan.

Recommendations	1Review the attached Northern Lincolnshire A&E Delivery Board winter plan 2 Approve the content of the plan 3	
Report history	A&E delivery board on numerous occasions, most recently on 4th October 2018 where it was approved as the final version for submission (acknowledging there were further discussions to be concluded around funding).	
Equality Impact	Yes ☐ No ☒	
Sustainability	Yes ☐ No ☒	
Risk	Yes ☐ No ☒	
Legal	Yes ☐ No ☒	
Finance	Yes ☒ No ☐	Proportion of the resilience budget already allocated to support delivery of the winter plan. Approved by Executive team 2nd October 2018

Patient, Public, Clinical and Stakeholder Engagement to date									
	N/A	***Y***	***N***	***Date***		***N/A***	***Y***	***N***	***Date***
Patient:	☐	☐	☒		**Clinical:**	☐	☒	☐	Within A&E Delivery board on multiple occasions
Public:	☐	☐	☒		**Other:**	☒	☒	☒	Partner organisations within A&E Delivery Board on multiple occasions

2018/19 System Winter Plan

Northern Lincolnshire A&E Delivery Board



Version	Date
V13	27/09/18

Table of Contents

DRAFT

1. Introduction

1.1. The Northern Lincolnshire System Winter Pan for 2018/19 sets out the system approach to maintaining effective delivery of services, mitigating the impact of additional increased activity and acuity pressures during winter, providing clarity to the approach to routine inpatient elective work, and to keep people safe throughout the period.

1.2. Link to Emergency Preparedness, Resilience & Response (EPRR) Planning

The Yorkshire & Humber EPRR regional group considers responsibilities and expectations, preparedness and responses for unplanned service disruption and activity surges above and beyond normal variations. Some of the incidents in the scope of EPRR can be winter related such as pandemic flu. Business continuity resilience is also in scope of the overall assurance process. All organisations receiving NHS funds are expected to participate in the regional EPRR group and assurance is led by Local Health resilience Partnerships (LHRP). Emergency services and Local Authorities are linked to this NHS Emergency Planning regime through the Humber Local Resilience Forum (LRF).

The Cold Weather Plan for England is a framework intended to protect the population from harm to health from cold weather. It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately.
It recommends a series of steps to reduce the risks to health from cold weather for:

- the NHS, local authorities, social care, and other public agencies
- professionals working with people at risk
- individuals, local communities and voluntary groups

All organisations are expected to register with the Met Office Cold Weather alert scheme and ensure that there is an organisational cascade process to ensure the alerts and alert levels are recognised and responded to in a timely manner. Further, organisations are expected to review the national Cold Weather Plan for England and consider the recommendations for planning and the fit with the organisations own surge & escalation and/or business continuity planning. The A&E Delivery Board will seek assurance of recognition of and adherence to the requirements of EPRR and Cold Weather planning.

DRAFT

2. Background

2.1. The North and North East Lincolnshire health and care communities have historically operated independently of each other with Northern Lincolnshire and Goole Foundation trust being the only organisation that operates across the two areas. Through the A&E Delivery Board the two communities for the first time agreed to come together and co-produce a single overarching "Northern Lincolnshire" Winter Plan with the Trust through which the pressures that arise across the system over the winter can be collectively managed.

2.2. The organisations in the system are:

- North East Lincolnshire CCG
- North Lincolnshire CCG
- Northern Lincolnshire and Goole NHS FT (including North Lincolnshire Community services)
- East Midlands Ambulance Service
- Core Care Lincs Ltd
- Care Plus Group
- North Lincolnshire Council
- FOCUS
- Navigo
- Rotherham, Doncaster and South Humber NHS trust
- Yorkshire Ambulance Service
- Thames Ambulance Service Ltd
- Amvale
- Safecare

3. Winter 2017/18

3.1. The expectation of heightened senior leadership and ownership for all providers in the system meant that the system appointed three senior responsible officers (SROs) from the acute trust and the CCG's to oversee the planning and operational management and escalation throughout winter. This included:-

- Direct oversight by regional NHSI and NHSE management
- 7/7 daily system, NHSI, NHSE calls and returns by 3 SRO's
- 7/7 daily system by senior leaders in all providers across the system when necessary
- Fortnightly System A&E Delivery Boards chaired by the Trusts Chief Executive

DRAFT

3.2. The plan identified three areas for focus:

- Pre-Hospital
  - Conveyance avoidance pathways – respiratory and falls
  - Primary care streaming
- In-Hospital
  - Ambulatory Care Units
  - Red to green
  - Site Management
- Discharge and Onward Care
  - Trusted assessor
  - Discharge to assess
  - Out of area patient delays

3.3. The system was successful in a winter bid for financial support, receiving £1.5 million made up of £1,054,000 population based share, which contributed to additional ED nursing, on-call manager changes, and a number of other internal trust schemes and £430,000 to support an additional 28 escalation beds across the trust to 31st March 2018.

3.4. The schemes contributed to a bed occupancy plan detailed in table 1 below.

Table 1 – Bed Occupancy/Performance as a result of winter schemes

No of G&A Trust baseline beds	744								
Number of beds required	813								
Shortfall	69								
		Predicted Bed Occupancy		**Actual Bed Occupancy**		Predicted Performance		**Actual Performance**	
Schemes – reduction		Q3	Q4	**Q3**	**Q4**	Q3	Q4	**Q3**	**Q4**
Primary Care Streaming	0								
Trusted assessor and Discharge to assess	45								
Ambulatory Care Units	18								
Red2Green / SAFER	12								
Out of area delays	7								
Ambulance Conveyance avoidance	12								
Total	94								
Surplus	25	103	94						
Escalation and Surge contingency				**90.96**	**92.5**			**90.6**	**83**
Elective Pacing	20	97	88			92	89		
Escalation beds	28	94	85			93	90		

3.5. Overall the system was expected to deliver 90% for both Quarter 3 and Quarter 4, and achieved this in Q3 with 90.6% although Q4 was a more challenging quarter, not just for the local system, but nationally, with a local achievement of 83%. Combining this together however and comparing to the previous year this was an increase for the winter period of 4%, putting NLaG in the top 12 nationally for improvement from the previous year. See Appendix 3 – NLaG Unplanned Care Dashboard.

3.6. In addition to the schemes above, other changes to operational governance and performance framework structure for flow were:

- an increased staffing response for the three weeks over Christmas and New Year
- a revised escalation and surge policy which took into account the updated national system escalation criteria of OPEL, and had clear triggers and responsible owners for actions, that then led into a system escalation
- changes to NLaG management on-call arrangements which gave clarity of bronze (operations site team), silver (senior manager on call), gold (director) responsibilities, 7 day senior management support
- a detailed Sitrep of the hospital operational site position was implemented and shared 6 times a day with key staff across the trust and the system, along with once a day community sit reps.

3.7. Schemes that need further development were identified as follows:

- Conveyance avoidance pathways
- PC Streaming in A&E
- Frailty Ambulatory Unit at DPoW .
- Surgical Ambulatory care at SGH.
- Red2Green and SAFER
- Trusted Assessor and Discharge to Assess

3.8. From 27th December 2017, in response to the National Emergency Pressures Panel (NEPP) recommendation cascaded by NHS Improvement (NHSI) and NHS England (NHSE) on 21st December 2017, the Trust deferred all non-urgent inpatient elective care until mid-January, and a subsequent letter recommending this be extended to 31st January 2018 was also complied with. The Trust mitigated the effect on elective work by increasing day surgery, and planning of lists was reviewed on a daily basis. This resulted in approximately 17% of lists being cancelled on a weekly basis during this period. The position at NLaG was exacerbated by the significant vacancy rates for doctors and nurses, the heightened experience of infection control issues at both sites, the flu numbers, and increased sickness. In addition March experienced two periods of significant weather warnings resulting in snow which saw a further extended period of pressure. Routine inpatient surgery recommenced on 9th April.
The reduction in elective work, enabled flexibility in redirecting staff to support wards and ED and there were no 12 hour trolley waits, unlike the previous year where there were 18. Although the trust received funding for 28 escalation beds, the requirement was more, with an average of 25 open on each site.

4. Lessons Learnt

Additional learning identified in the winter 2017/18 review is as follows:

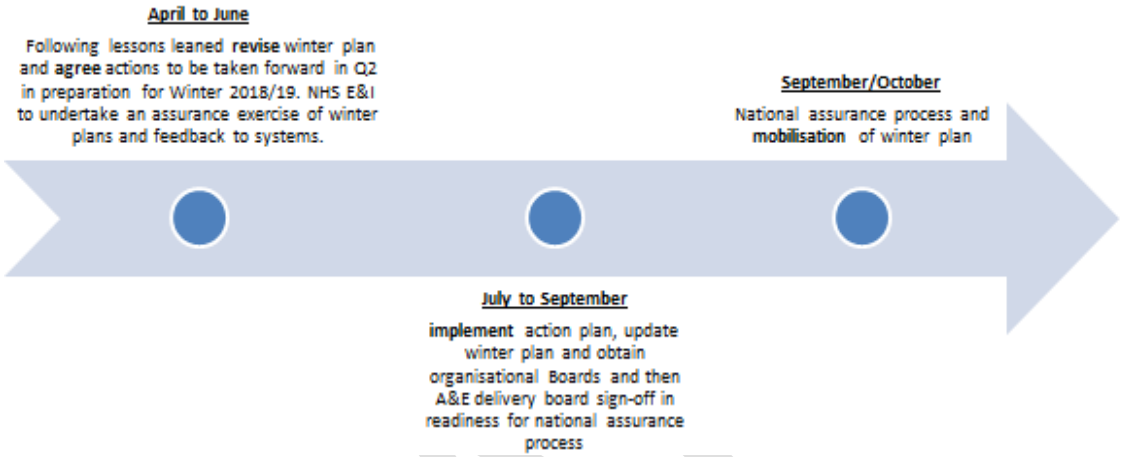
Issue	Learning
Capacity planning/bed modelling baseline needed to be refined further	Review the baseline against plans for 18/19 to help inform impact and ultimately prioritisation of plans.
Frailty was not developed at DPoW	Need to develop the pathway as part of the medical model review, and consider how this can be supported in the community.
Co-locating multi-agency teams in DPOW had a positive impact on discharging patients however this was not achieved at SGH.	Urgent need to create an improved space for SGH operations centre
Difficulty in embedding change during times of high operational pressures	Schemes to be planned, developed and implemented prior to winter.
Nursing workforce pressures	
Wards that had not implemented Red2Green generally had a slower pace of discharges by day and by time of day.	SAFER needs to be fully implemented and embedded ahead of next winter.
Senior community and therapy/social teams reviewing the stranded patient lists impacted on other competing priorities	To embed the stranded review as normal practice with the creation of a multi-agency discharge team whose client base is medically optimised.
Specialty admissions that could be managed in a different way.	To review the medical model and build on ambulatory pathways and consider short stay ward.
The value of patient flow co-ordinators in ward areas was clear, but not substantive in relevant areas.	Chief nurse to review ward establishments.
Primary Care did not necessarily feel part of the System,	Need to be more involved and engaged, with robust input to system management
Comms Strategy regarding public communications was not as effective as could have been	Build a robust comms strategy with high levels of public and patient comms, as well as clear staff comms.

DRAFT

5. Plan for winter 2018/19

5.1 Timelines

In line with the national timeline for sign off of winter plans, this plan will be signed off by the A&E Delivery Board at the meeting on September 20th 2018.



5.2 National Performance

NHS England national planning guidance, (Refreshing NHS Plans for 2018/19, 9th February 2018) states that providers should ensure aggregate performance against the 4 hour standard is at or above 90% in September 2018, and the majority of providers should be achieving 95% standard for the month of March 19. Also Trusts are expected to improve on their performance each quarter compared to their performance in the same quarter the prior year in order to qualify for STF (Sustainability and Transformation Fund) payments.

5,3 Planning Principles

Planning for winter 2018/19 begins in Q1 with effective outcomes in Q4,
.

The plan has been prioritised via a risk assessment into category 1 improvements that MUST be done (shown in red), and category 2 improvements that SHOULD be done (shown in amber/green). See Appendix 4 – Winter Plan Risk Assessment

5.3 System governance and framework for escalation

Winter 2018/19 will see a repeat of the rigorous approach to the operational command and control arrangements designed to maintain operational effectiveness throughout winter, and will continue to be led by three SROs that are the nominated leads for the day to day management of winter.

They will serve two functions:

1. To act as a point of escalation when the system escalates to OPEL three and all appropriate actions have been completed and not resulted in de-escalation..

2. Weekly senior review of pressures, plans and delivery, with exception reporting and escalation into A&E Delivery Board. This will also be an opportunity to review real time data (or as close as possible) to identify changes in demand patterns to make recommendations to the wider SRO group and to A&E delivery board on capacity planning and to make best use of available resource.

The framework for 2018/19 will include a fortified approach to the daily conference calls, and reduce the amount of time spent gathering information through systemwide automation. Where SRO calls are required during periods of escalation, these will include SROs from all partner organisations in addition to the System SROs.

The system wide SROs will work together to best manage staffing levels during what are known to be peak periods of pressure as well as during periods of escalation.

Appendix 1 details the named system wide SROs.

The Escalation Framework (appendix 2) will be reviewed and revised throughout the year to reflect the new services in place as they come online.

In order to manage the number of stranded patients there is already in place a weekly executive level stranded patient meeting, with senior members of staff from health and social care, in addition to the daily operational meeting.

The A&E Delivery board review and manage the system wide Risk Register at each A&E Delivery Board meeting, where it is a standing agenda item.

DRAFT

5.4 Winter Plan Schemes

5.4.1 Pre – Hospital; Integrated Urgent Care

This workstream includes all of the Primary Care and Community service elements that combine in an integrated urgent care system (across Physical and Mental Health, and Social Care), its constituent elements that provide for demand management in terms of providing the right care in an appropriate setting and directly impacting on A&E attendees.

Scheme (Priority)	Summary	Scheme Lead(s)
GP Extended Access (2)	This is a requirement within the LoS reduction mandates, and must be in place by October 2018. The implementation of GP extended access will provide additional capacity for routine and urgent same day appointments in primary care. Access to extended hours for urgent appointments will be integrated into NL/NEL SPAs and is being implemented through GP groups/federations.	NL – Geoff Day (NL CCG) NEL – Sarah Dawson (NEL CCG)
Conveyance Avoidance Pathways (2)	Building on learning from winter 2017/18, community rapid response services will work with EMAS to refine alternative pathways access for EMAS for instances where their clinical assessment indicates that there is not a requirement for conveyance to an A&E department. This will focus on scope and timeliness of response and on education of EMAS crews on access to alternative pathways. The response will focus on use of clinical advice and service access through local SPAs, who will ensure a co-ordinated and integrated response across Physical and Mental Health and Social Care.	NL – Dave Broomhead (NLaG) NEL – Jane Miller (CPG)
Community Urgent Care Capacity (1)	Avoidance of A&E attendance/admissions will be enhanced through the rightsizing of existing SPA/community rapid response services (workforce), through enhancement of preventative and urgent response initiatives for residential care homes and through the implementation of community IV services. One of the LoS reduction requirements is to Prevent unnecessary hospital admissions from Care homes. This will be supported by ensuring that care homes directly access SPA and reduce the number of 999 calls to ensure that all appropriate patients receive an urgent community response to avoid admission. This response will support care homes in managing people's needs as much as possible within the care home setting.	NL – Dave Broomhead (NLaG) NEL – Jane Miller (CPG)
Urgent Treatment Centres (1)	Both Hospital Sites and CCGs will work with provider colleagues to develop an Urgent Treatment Centre (UTC). The UTC model follows the national specification and will be co-located with the SGH/DPoW sites. A proposed enhancement to the national UTC model is that the UTC	NL – Rebecca Bowen (NLCCG) NEL – Jane

	will act as the "A&E front door" in that walk-in attendees would not access A&E services without being assessed in the UTC. It will also be able to attend to some patients who arrive by ambulance. The UTC will be a GP led multi-disciplinary team integrated with acute diagnostics and ambulatory service and builds on the current co-located PCS and GPOOH services and the lessons learned with this year's deployment of nursing and social care staff in A&E departments. Specific site plans will have dependencies on estates and provider configuration and therefore plans will be transitional with full effect by June 2019. In the interim period whilst partners are working to deliver an integrated response within existing A&E departments, they will continue to ensure that: • All patients who are to be admitted have a timely 'Decision to Admit' to ensure that they do not need to remain in the ED for any longer than is clinically necessary. • Patients are not cared for, in non-designated areas • Escalation beds (if any are opened) have the necessary staffing and equipment to ensure safe care • Zero tolerance on 12 hour trolly waits • Patients do not wait more than 15 minutes in ambulances before being handed over to the hospital • Mental Health liaison services are operating from the UTCs, delivering care as part of the integrated teams. • The hospital can manage increasing demand because of flu, norovirus etc	Miller (Care plus group)

5.4.2 In Hospital

In hospital initiatives to improve flow and bed capacity management in the hospital for those who are admitted.

Scheme	Summary	Lead
Ambulance Handover (2)	The trust will continue to work closely with EMAS to improve handover times to minimise the impact that ED overcrowding and pressure can have on releasing ambulance crews in a timely way. This is monitored through the 6 times a day operational sitrep, and ED Ash matrix. The organisations will continue to embed and improve the 'Fit to sit' programme of work, as well as strengthen the identification and communication alerts of the deteriorating patient during he	Ajay Chawla - NLaG

	handover process	
Capacity and demand planning (2)	The trust has agreed with commissioners that maintaining the waiting list position with no deterioration will be the planning assumption for all specialities and all lists. This detailed planning comprises the top 8 high risk specialties as identified in the clinical harm reviews, plus orthopaedics. These detailed plans are the basis of the contracting, commissioning and activity projections for the system. Within this the priorities will remain cancer patients, urgent patients, and a minimum reduction of 50% of the over 52 week waiters. Capacity and Demand plans across the system will consider Monday Surge.	Shaun Stacey - NLaG
Bed modelling – NlaG (1)	Building on the baseline model that demonstrates that if no changes were made to models of care, the trust requires a further 11 beds each year, plus the 50 escalation beds the trust has been using throughout quarter 4. The baseline will be refreshed at the end of Quarter 1. The system will model through proposed service changes to help to inform a right size, and eliminate the risk of corridor care	Shaun Stacey - NLaG
Patient Flow, Escalation and Surge (1)	The Patient Flow/Escalation and Surge policy will be reviewed following feedback from users, and refined further to ensure robust and timely response is clear for all staff. A new operational flow team structure which was reviewed during 2017/18, will be proposed for implementation prior to Q3. This will strengthen leadership of the sites, operational and emergency planning, and increase staffing in a planned way for the predicted peak in activity between the hours of 4 and 8pm.	Claire Hansen - NLaG
Elective Care (1)	To mitigate any impact on RTT performance, all specialties will, where appropriate, front load pathways by switching elective activity to either day case or additional outpatient activity during January and February. NLaG will minimise inpatient routine surgery, and focus on cancer work, and clinically urgent cases post Christmas until the end of February. Demand will be reviewed regularly to ensure that elective activity is programmed in line with capacity and existing pressures. This will ensure that consultants are freed up for decision making and will create capacity for emergencies. In addition all areas will need to ensure a proactive approach throughout the winter period to reviewing elective procedures in order to avoid cancelling patients on the day of admission, which results in both poor patient experience and places further pressure on services to fulfil the 28 day guarantee for last minute cancellation.	Shaun Stacey - NLaG
Revised medical model at DPOW (1)	The revised model will streamline the process of care for non-critically ill medical patients with complex problems, including patients who have medical illnesses but present with conditions where it is unclear as to the need for immediate intervention. The assessment unit will provide the	Dr Stuart Baugh - NLaG

	single portal for entry into assessment for care for all acutely ill medical patients as it does currently. Those that require longer term specialist review will be moved to a specialist ward, however those that require more than an assessment will be moved through to a short stay ward which will have a LOS maximum of 72 hours. This will enable specialty specific bed to remain available for those that are of a higher acuity. It will also contribute to reducing outliers onto surgical wards affecting flow.	
Ambulatory / Frailty (1)	Increasing zero LOS with the objective of a combined surgical, medical and frailty ambulatory unit will be developed throughout 18/19 into one facility, and provide an improved journey for our patients, including GP direct referrals as a matter of course rather than attending ED. This will also support reduction in Stranded patient numbers. The implementation of an integrated approach to delivering UTC standards in ED for winter will also support delivery of routine screening of those over 75 within 2 hours of presentation in ED.	Dr Stuart Baugh - NLaG
Red to Green/SAFER (1)	SAFER actions will be undertaken in the lead up to winter, organising scheduled activity to support early decision making. Throughout winter there will be a step up in the intensity and scrutiny of the 'Red2Green' programme in order to ensure an increased focus on reducing delays. This will support the required reductions in LoS as well as the stranded patient numbers.	Pete Bowker - NLaG

5.4.3 Discharge and onward care

This work stream includes all of the measures that reduce DToCs, improving flow and bed capacity management. It incorporates the measures in the national 8 High Impact Change model for reducing DToCs. Whilst DToCs remain a statutory measure, this work stream includes the key principle of a system wide focus on discharging quickly those who are medically optimised and a shift of their remaining care and assessment needs out of hospital.

Scheme	Summary	Lead
7 day discharge	Development of integrated discharge team across 7 days will ensure timely access to social care assessment and MDT review. Health and social care 7 day working to ensure 7 day discharge, links to trust medical model initiative. In line with the trusted assessor implementation care homes will accept admissions (discharges from hospital) 7 days per week,; for new residents until 5pm and returning residents until 8pm.	Becky Bowen (NLCCG) Andy Ombler (NEL CCG)
Trusted Assessor & Discharge to Assess (1)	At both SGH and DPoW sites, Discharge to Assess pathways will be fully implemented by November. The step-down pathways for moving rehab/LTC assessments from acute beds either home or to a community setting for full	NL - Wendy Lawtey (NLC) NEL – Andy Ombler

	assessment and to receive some elements of care that need not be delivered in an acute setting must be active and resilient and be provided for patients who are medically optimised. Intermediate care will commence within 2 days of relevant notifications, and the system will work towards pre-admission assessments to support early discharge. Development of trusted assessor models to ensure that care managers do not have to come into hospitals and can rely on a trusted assessor.	(NELCCG)
Community Bed Capacity and Virtual Ward	Complex D2A pathways may include a "virtual ward" where community services support patients in their own home whilst still under consultant led care. Home First should be the priority for all patients, However where people are unable to return home for ongoing care, capacity is required to provide an interim step down for patients who are medically optimised who would otherwise remain in a hospital bed. In conjunction with the D2A and Trusted Assessor processes, this will have a direct impact on Super-stranded patient numbers and DToCS for Intermediate Care pathways, and the ultimate aim for the system is to achieve zero DToCs and target 90% of medically optimised patients being discharged within 24 hours. Note that step-down bed capacity may also be used as step-up capacity to avoid admissions, and appropriate clinical pathways will need to be developed to support this.	David Broomhead (NLaG community) Jane Miller (Care plus group)
Out of Area Patient Delays (2)	At both SGH and DPoW sites there are delays in securing out of area team assessments and repatriations for Lincolnshire patients. These delays are not reflected in DToC performance for the Northern Lincolnshire system but have a notable impact on NLaG bed capacity, especially at the DPoW site which receives some 20%+ of it's unplanned admissions from Lincolnshire. This year the system will work with the Lincolnshire providers in developing robust and timely information and actions.	Andy Ombler (NELCCG)
Transport (2)	The system are reviewing some elements of the patient transport service requirements to ensure they are fit for purpose in peak periods.	Jane Ellerton (NLCCG)

KPI's for each scheme are being updated via the SRO framework using an agreed highlight report template

Escalation and Surge Contingency:

The schemes throughout the winter plan have been designed to reduce attendances, admissions, and support early discharge. An elective pacing plan has been designed to allow resources to be flexed during the anticipated peak demands. A contingency has been set aside within the trust for supporting with surge that results in high OPEL levels to support ad hoc additional staffing that may be required.

6. Predicted Performance

The schemes in 5.4 above have been modelled to have an impact on bed occupancy and performance as per Table 2 below:

Table 2 – Predicted bed occupancy and performance

No of G&A Trust baseline beds	696				
Increased beds from bed modelling required	11				
Escalation beds required based 2017/18	50				
Total	757				
Shortfall	**-61**				
		Predicted Bed Occupancy		Predicted Performance	
Schemes	Bed reduction	Q3	Q4	Q3	Q4
GP Extended Hours	0				
Ambulance Conveyance Avoidance	4				
Community Urgent Care Capacity	4				
Urgent Treatment Centres	0				
Ambulance Handover	0				
Capacity and Demand Planning	0				
Bed Modelling	0				
Patient Flow/Escalation and Surge	0				
Medical Model	15				
Ambulatory Care (surgical – SGH)	8				
Frailty	12				
Red2Green/SAFER	0				
Trusted assessor and D2A	30				
Community Ward	27				
Out of area delays	7				
Transport	0				
Total	107				

Surplus/Trajectory	**+46**	89	84.6	90.1	86
Escalation and Surge contingency					
Elective Pacing	20				
Escalation beds	20				

7. Christmas, Bank Holidays, School Holidays and periods of increased demand – Increased Response

In order to ensure that acutely ill patients are safe and discharges are delivered over the above periods, additional arrangements will be in place in line with the recommendations outlined from NHSE (26 February 2018) and NHSI (Gateway reference 07804) during 2017/18. These are -

Primary Care:

- Ensure patients are able to access urgent GP appointments on each day between 8am and 8pm, either at their own practice or an alternative, nearby location
- Ensure access to urgent dental care and community pharmacy
- All OOHs services are fully staffed and well sign posted

Community Care:

- Enough community beds open to meet demand and that staffing levels are adequate across the patch
- Number of WTEs working each day is sufficient to maintain safe practices and meet demand across the patch, especially for Community Nursing, Rapid Response and SPAs

Social Care:

- The numbers of WTEs working per day is sufficient to support timely discharges from hospital
- Enough residential and nursing care beds available, which could be immediately commissioned, if needed

Secondary Care:

- Ensure every specialty has a senior decision maker on site and available for rapid review of patients to reduce admissions
- Ensure every patients has a review at the start and end of the day by a senior clinician to facilitate discharge
- Boost essential support services such as diagnostics and pharmacy at the weekends to maximise non elective patient flow
- Adequate social work presence in hospitals to allow assessments to continue and maintain discharge volumes at weekday levels

DRAFT

For these periods the A&E Delivery Board will ensure that it is collectively sighted on the demand capacity profiles for all parts of the system, and will review any gaps in order to mitigate risks.

In addition to this there will be monthly mini-MADE events across both hospital sites scheduled to learn lessons but also to support the increased demand periods.

8. Testing Plans

A number of elements of the overall winter plan will be selected and tested. From a resilience perspective it is proposed that there should be a focus on a specific scenario that applies to both acute trust sites simultaneously and further a focus on the escalation procedures and how this aligns to the OPEL triggers and response framework under the revised system-wide monitoring and reporting arrangements.

9. High Level Risks

The A&E Delivery Board maintains a Risk Register to support the escalation of risks arising within the development schemes in 5.4. Further, a set of high level risks have been identified that are permanent risks and are fixed in the context of the aims of the winter plan. These are as follows:

Key risks	Mitigation
System wide workforce. On-going concerns about staffing risks and ability to mobilise additional staffing may compromise provider's ability to consistently provide services in a timely manner.	System looking at how it can divert capacity from other areas to cover critical gaps (eg GP extended access into Urgent care). Flexible rotas of staff across SGH and DPOW to cover critical gaps. Trusted Assessor and Discharge to Assess implementation will require a reshaping and development of the workforce both in respect of the sustainable activities of the developing Integrated Discharge Teams and the intermediate care/step down capacity required. In the latter, sufficient therapy resources will be need to be modelled to ensure D2A/TA substantially moves therapy assessments into community settings. There are currently significant nursing and medical vacancies across NLaG. This position is being mitigated through the heavy use of agency and bank staff, however if the vacancy gap cannot be narrowed through other substantive recruitment, there are likely to remain risks around the consistency, quality and reliability of care throughout winter. To mitigate against this requirement the partner schemes will provide less reliance on this position. Alternative roles will be explored to support front line services such as anaesthetist, phlebotomist support to ED, nurse practitioner support to rosters etc. On-going assurance of progress with plans to assure rotas, including assessment of annual leave and overtime capacity.

Key risks	Mitigation
Neighbouring system pressure	Close collaboration and communication with colleagues, with sensible approach to boundaries and support, including exploring how OOA patients could be managed within home system
System: Capacity to implement system wide priorities rapidly	Progress and assurance through AEDB and SRO arrangements. ECIP support. Prioritisation of CCG workloads and use of wider PMO resources
System : Finance – costs associated with locum, agency nursing, doctors and additional community and social care response is not affordable within the controlled budget associated with capped expenditure and aligned incentive	Looking at prioritisation of resources from other areas. Development of alternative capacity within the system to mitigate against the premium rates being paid. Escalation of potential costs via this plan
Elective Pacing – risk of elective pacing impacting on elective waiting time performance and potential clinical harm	Deployment of Escalation beds and use of spot purchasing
Severe weather e.g. Snow, Freezing temperatures, Floods, Gales etc. will impact on the service periodically over the period	Adverse weather guidance. Local planning groups planning for the need for winter vehicles in community. LRF plans and coordination with CCG
Flu – below required staff immunisation take-up. Risk that care home staff that are not routinely eligible for free vaccinations might not be vaccinated due to cost implications. Take up of flu vaccinations by vulnerable groups.	Assurance on CQUIN performance. Looking at options for increasing vaccination rates in care home staff groups. Engagement with Primary Care on identification of vulnerable groups for flu immunisation. Communication Plan to include public advice on uptake messages. Public Health to play a leadership role in supporting increased uptake across staff and public.

10 Comms Plan

A Winter Comms Plan has been developed across the A&E Delivery Board health and care economy combining national and local messages through a variety of media channels and approaches.

This Comms Plan is included here:

Draft Winter communications plan v

Appendix 1 – List of Commissioner/Provider SROs

Organisation	Named SRO	Email Address
NLaG Acute	Shaun Stacey	shaun.stacey@nhs.net
NLaG Community	David Broomhead	d.broomhead@nhs.net
NLC	Wendy Lawtey	wendy.lawtey@northlincs.gov.uk
NEL CCG	Helen Kenyon	helen.kenyon@nhs.net
Care Plus Group	Jane Miller	jane.miller5@nhs.net
FOCUS	Joe Warner	joe.warner@nhs.net
NL CCG	Julie Warren	julie.warren3@nhs.net
RDaSH	Graeme Fagan	graemefagan@nhs.net
Navigo	Mike Reeve	michael.reeve@nhs.net
Core Care Lincs	Anna Morgan	anna.morgan4@nhs.net
Safecare	Julie Killingbeck	j.killingbeck@nhs.net
EMAS	Sue Cousland	sue.cousland@emas.nhs.uk
St Hughs	Ashley Brown	ashleybrown@hmtsthughs.org

DRAFT

Appendix 2 – Escalation Framework

Attached separately but will embed when signed off

DRAFT

Appendix 3 – Unplanned KPI Dashboard 2017/18

Unplanned Care KPI Dashboard

Performance (Perf):
G = Achieved or above Trajectory
R = Under Trajectory

Unplanned Care KPI Dashboard

KPI Lvl	Key Performance Indicator	Secondary Indicator	Target	Site	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	12 Months Total	Current Month & Movement		Perf	Trend
	A&E																					
1	A&E performance		90%	Trust	84.7%	78.7%	85.2%	82.5%	83.9%	89.3%	87.4%	91.5%	92.5%	87.9%	86.1%	83.4%	79.6% ↓	85.6%	15-Apr-2018	84.2% ↑	R	
				DPW	82.9%	70.3%	77.9%	73.1%	74.8%	86.6%	84.2%	89.5%	90.3%	83.2%	83.1%	75.9%	72.9% ↓	80.1%		81.7% ↑	R	
				SGH	82.6%	81.8%	88.8%	87.5%	88.8%	89.4%	87.5%	91.4%	92.9%	90.1%	86.3%	87.1%	82.4% ↓	87.8%		86.7% ↑	R	
				GDH	99.9%	99.9%	99.9%	99.7%	99.9%	100.0%	99.9%	99.9%	100.0%	99.6%	99.7%	99.9%	99.9% ↓	99.9%			G	
		Comments:	...																			
	A&E admission conversion rate		TBD	Trust	20.8%	20.9%	19.6%	19.3%	20.3%	20.6%	21.2%	22.1%	23.1%	24.6%	25.9%	25.4%	24.4% ↓	22.2%	15-Apr-2018	25.8% ↑		
				DPW	22.9%	23.5%	21.9%	22.0%	23.6%	22.1%	22.4%	25.7%	26.6%	27.4%	28.5%	28.4%	26.8% ↓	24.9%		25.3% ↓		
				SGH	24.1%	23.4%	22.3%	21.6%	22.7%	24.3%	25.2%	24.1%	24.5%	26.9%	28.3%	27.9%	26.3% ↓	24.8%		26.3% ↑		
				GDH	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.7%	0.2%	0.2%	0.5% ↑	0.1%				
		Comments:	...																			
1	A&E - % of patients assessed within 15 minutes from arrival in ED		TBD	Trust	34.5%	32.0%	39.0%	37.2%	38.6%	36.7%	32.6%	42.4%	46.7%	42.5%	41.7%	39.9%	37.9% ↓	38.9%	16-Apr-2018	40.6% ↑		
				DPW	23.8%	18.0%	22.3%	27.6%	27.3%	27.6%	28.4%	41.5%	45.7%	39.3%	40.2%	34.1%	32.4% ↓	31.9%		33.8% ↑		
				SGH	36.0%	35.7%	44.7%	38.7%	42.7%	37.6%	28.7%	36.1%	41.7%	39.1%	37.1%	40.3%	38.6% ↓	38.4%		46.8% ↑		
				GDH	69.5%	71.5%	80.2%	67.4%	63.4%	67.7%	66.7%	72.1%	75.5%	71.6%	72.5%	63.1%	62.5% ↓	69.6%		0.0% ↓		
		Comments:	...																			
1	A&E - % of patients reviewed by clinician within 60 minutes from arrival in ED		90%	Trust	76.1%	72.2%	78.0%	78.3%	79.0%	81.8%	80.2%	86.7%	86.6%	83.0%	81.8%	80.3%	76.1% ↓	80.3%	16-Apr-2018	79.5% ↑	R	
				DPW	62.4%	51.1%	57.1%	60.3%	62.4%	65.8%	65.0%	77.5%	78.1%	69.9%	72.0%	67.1%	61.1% ↓	65.5%		65.2% ↑	R	
				SGH	84.0%	85.3%	92.7%	90.2%	90.3%	93.1%	90.1%	92.3%	91.7%	92.6%	87.7%	89.5%	86.1% ↓	90.1%		92.8% ↑	G	
				GDH	97.9%	99.0%	98.9%	98.7%	97.6%	98.4%	99.1%	98.4%	99.5%	98.0%	99.3%	96.3%	97.5% ↑	98.4%		0.0% ↓	R	
		Comments:	...																			
	Medical Ambulatory Care																					
2	Number of patients admitted to Medical Ambulatory Care	Admissions and transfers into Ambulatory Care	TBD	Trust	210	159	171	189	172	165	289	411	402	469	472	374	435 ↑	3,708	14-Apr-2018	154		
				DPW	0	0	0	0	0	6	122	202	186	232	223	182	195 ↑	1,348		57		
				SGH	210	159	171	189	172	159	167	209	216	237	249	192	240 ↑	2,360		97		
		Comments:	...																			
2	Patients discharged from Medical Ambulatory Care rate		TBD	Trust	16.7%	18.9%	18.7%	15.3%	18.0%	21.2%	23.9%	17.3%	16.4%	15.8%	15.3%	16.3%	15.9% ↓	17.2%	14-Apr-2018	16.9% ↑		
				DPW	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	28.7%	18.3%	18.3%	16.8%	15.7%	17.6%	18.5% ↑	18.6%		26.3% ↑		
				SGH	16.7%	18.9%	18.7%	15.3%	18.0%	20.1%	20.4%	16.3%	14.8%	14.8%	14.9%	15.1%	13.8% ↓	16.4%		11.3% ↓		
		Comments:	...																			
	Surgical Ambulatory Care																					
2	Number of patients admitted to Surgical Ambulatory Care	Admissions and transfers into Ambulatory Care	TBD	Trust									39	80	112	98	70 ↓	399	14-Apr-2018	40		
				DPW									39	80	112	98	70 ↓	399		40		
				SGH																		
		Comments:	...																			
2	Patients discharged from Sugical Ambulatory Care rate		TBD	Trust									25.6%	28.8%	24.1%	26.5%	35.7% ↑	27.8%	14-Apr-2018	25.0% ↓		
				DPW									25.6%	28.8%	24.1%	26.5%	35.7% ↑	27.8%		25.0% ↓		
				SGH																		
		Comments:	...																			
	Primary Care Streaming																					
2	Activity Volume Transfers Patients streamed to co-located UTCs or other GP-led services		TBD	Trust	18	50	2	282	306	245	279	481	668	635	669	558	552 ↓	4,727	16-Apr-2018	200		
				DPW	6	43	2	282	306	245	279	447	450	424	378	318	339 ↑	3,513		142		
				SGH	12	7	0	0	0	0	0	34	218	211	291	240	213 ↓	1,214		58		
		Comments:	There were an additional 30 patients streamed in December that haven't been recorded in the system.																			
2	Activity Volume Transfers 4 Hour wait breaches in co-located Primary Care led streaming service		TBD	Trust	1	1	0	8	13	2	10	11	14	1	5	2	2 ⇨	69	16-Apr-2018	1		
				DPW	0	1	0	8	13	2	10	11	10	1	1	2	1 ↓	60		1		
				SGH	1	0	0	0	0	0	0	0	4	0	4	0	1 ↑	9		0		
		Comments:	...																			
	SAFER: Red to Green																					
2	Emergency average length of stay		TBD	Trust	5.4	5.2	5.1	5.1	4.9	4.7	4.7	4.7	4.4	4.4	4.5	4.8	4.8 ↑	4.8	15-Apr-2018	4.8 ↑		
				DPW	5.9	5.7	6.0	5.8	5.5	5.1	5.1	5.2	4.9	4.6	4.8	4.9	5.1 ↑	5.2		5.2 ↑		
				SGH	4.7	4.5	4.2	4.1	4.0	4.2	3.9	4.0	3.7	4.0	4.0	4.4	4.3 ↓	4.1		4.4 ↑		
		Comments:	...																			
2	Medicine emergency average length of stay		TBD	Trust	7.9	7.8	7.7	7.6	7.0	6.9	6.6	6.2	6.2	5.8	5.9	6.6	6.5 ↓	6.7	15-Apr-2018	6.6 ↑		
				DPW	10.0	9.4	10.0	9.5	8.5	8.4	7.4	7.0	7.2	6.4	6.5	7.2	7.2 ↑	7.7		7.3 ↑		
				SGH	6.1	6.2	5.8	5.7	5.4	5.4	5.2	5.3	5.0	5.0	5.1	5.7	5.5 ↓	5.4		5.9 ↑		
		Comments:	...																			
2	Stranded patients (7 days)		TBD	Trust		409	334	337	335	313	372	316	309	361	341	369	377 ↑		16-Apr-2018	363		
				DPW								195	180	209	177	194	199 ↑			188		
				SGH								107	116	135	142	151	153 ↑			153		
				GDH								14	13	17	22	24	25 ↑			22		
		Comments:	Month end snaphot information presented.																			
	Frailty																					
2	Admission avoidance: % of total Frail elderly patients who meet criteria	Seen by FEAST Chair Team	TBD	SGH	13	10	12	9	20	20	30	36	42	21	31	30	45 ↑	306	Mar-18	26		
		Admission Avoidance			100.0%	100.0%	100.0%	88.9%	95.0%	90.0%	93.3%	94.4%	92.9%	95.2%	77.4%	76.7%	77.8% ↓	88.2%		76.9% ↓		
		Comments:	...																			
2	Number of frail elderly patients assessed by FEAST team on a daily basis	Monthly shown currently	TBD	SGH	185	194	152	192	155	170	147	192	184	124	179	144	167 ↑	2,000	Mar-18			
		Comments:	Data for the last month is updated mid-month due to the extracts process from SystmOne and so may not be complete.																			

Appendix 4 – Winter Plan Risk Assessment 2018/19

WINTER PLAN RISK ASSESSMENT 2018/19

Impact / Consequence

Likelihood of Success	None (1)	Low (2)	Moderate (3)	High (4)	Certain (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25

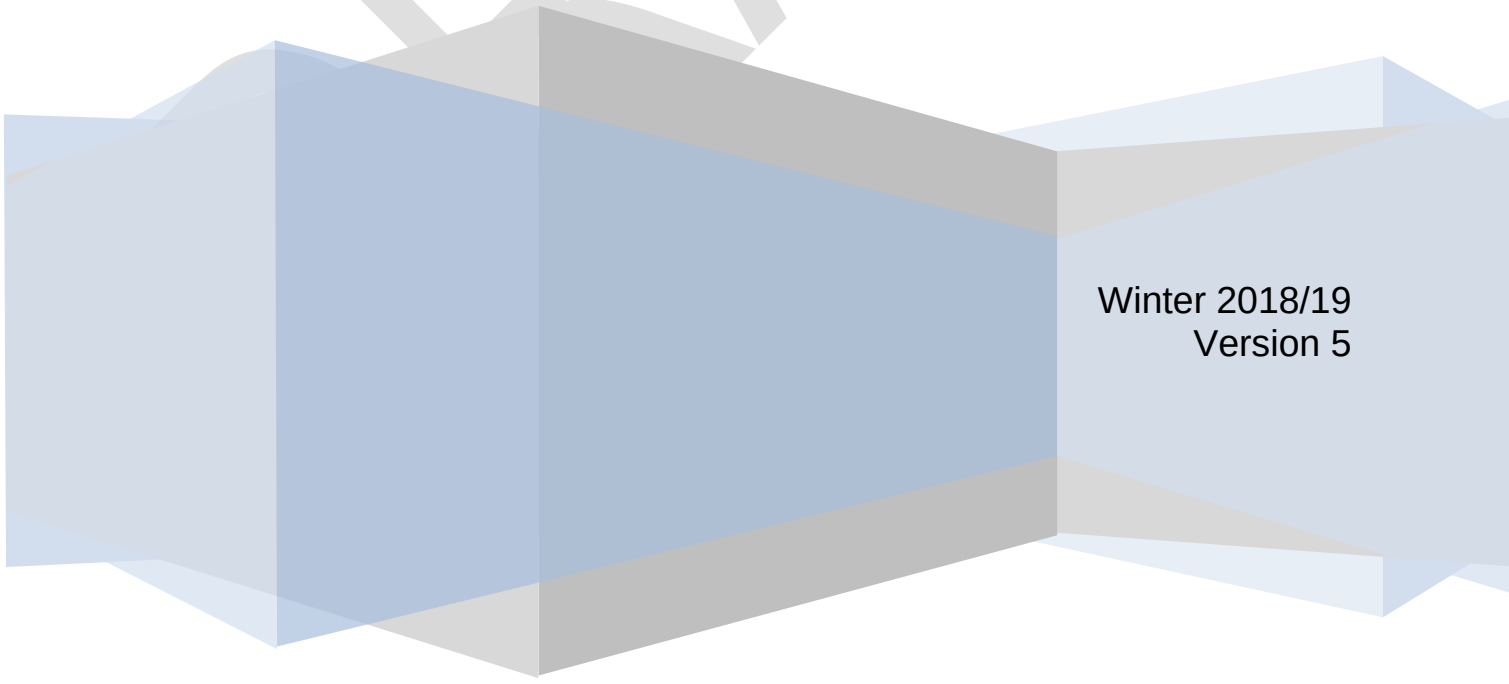
RISK	Green – Risk Score 5-19	Very low	Yellow – Risk Score 20-34	Low	Orange – Risk Score 35-44	Moderate	Red – Risk Score 45-70	High

		Reduce attendances at ED	Improve 4 hr ED performance	Reduce admissions through ED	Improve bed availability	Reduce LOS	Total
Pre Hospital	GP Extended Hours	Possible (3) Low (2)	Rare (1) None (1)	Rare (1) None (1)	Rare (1) None (1)	Rare (1) None (1)	10
	Conveyance Avoidance Pathways	Possible (3) Low (2)	Possible (3) Low (2)	Possible (3) Low (2)	Rare (1) None (1)	Possible (3) Low (2)	25
	Community Urgent Care Capacity	Likely (4) Moderate (3)	Possible (3) Low (2)	Possible (3) Moderate (3)	Possible (3) Moderate (3)	Likely (4) Moderate (3)	48
	Urgent Treatment centres	Certain (5) Certain (5)	Likely (4) High (4)	Rare (1) Low (2)	Rare (1) None (1)	Rare (1) Low (2)	46
In Hospital	Ambulance Handover	Rare (1) None (1)	Likely (4) High (4)	Rare (1) None (1)	Rare (1) None (1)	Rare (1) None (1)	20
	Capacity and Demand Planning	Rare (1) None (1)	Rare (1) None (1)	Rare (1) None (1)	Rare (1) None (1)	Rare (1) None (1)	5
	Bed Modelling	Rare (1) None (1)	Likely (4) High (4)	Rare (1) None (1)	Certain (5) Certain (5)	Likely (4) High (4)	59
	Patient Flow	Rare (1) None (1)	Certain (5) High (4)	Rare (1) None (1)	Likely (4) High (4)	Likely (4) Moderate (3)	50
	Elective Care	Rare (1) None (1)	Likely (4) High (4)	Likely (4) High (4)	Certain (5) Certain (5)	Possible (3) Low (2)	64
	Revised medical model	Rare (1) None (1)	Likely (4) High (4)	Likely (4) High (4)	Likely (4) High (4)	Likely (4) High (4)	65
	Ambulatory /Frailty	Rare (1) None (1)	Likely (4) High (4)	Likely (4) High (4)	Likely (4) High (4)	Likely (4) High (4)	65
	Red2Green / SAFER	Rare (1) None (1)	Likely (4) High (4)	Likely (4) High (4)	Likely (4) High (4)	Likely (4) High (4)	65
	Escalation Beds	Rare (1) None (1)	Likely (4) High (4)	Rare (1) None (1)	Certain (5) Certain (5)	Rare (1) None (1)	44
Discharge & Onward Care	Trusted Assessor and Discharge to Assess	Rare (1) None (1)	Likely (4) High (4)	Rare (1) None (1)	Certain (5) Certain (5)	Certain (5) Certain (5)	68
	Community Ward	Rare (1) None (1)	Possible (3) Moderate (3)	Rare (1) None (1)	Certain (5) Certain (5)	Certain (5) Certain (5)	61
	Out of area - patient delays	Rare (1) None (1)	Possible (3) Moderate (3)	Rare (1) None (1)	Certain (5) Low (2)	Certain (5) Low (2)	31
	Transport	Rare (1) None (1)	Possible (3) Moderate (3)	Rare (1) None (1)	Certain (5) Certain (5)	Possible (3) Low (2)	42

DRAFT

Northern Lincolnshire A&E Delivery Board Escalation Framework 2018/19

DRAFT



Winter 2018/19
Version 5

Document Change History

Version	Date	Comments
1	29/08/18	Becky Bowen – Draft triggers and actions
2	05/09/18	Incorporate MH comments and NLaG detail
3	19/09/18	Incorporate AEDB member comments
4	26/9/18	Incorporate further feedback from A&E DB on 20/9/18
5	27/09/18	Incorporate NELCCG and NLaG comments

DRAFT

1 Introduction

The A&E Delivery Board (A&EDB) provides the strategic leadership and operational links across the health and social care system in Northern Lincolnshire. All partner organisations within the system share co-ordination of planning, integration and delivery of care in order to support the delivery of safe, responsive, effective, high quality accessible services which are good value for money. The A&EDB is supported by work stream groups, each with a nominated Senior Responsible Officer.

This framework has been developed by the North and North East Lincolnshire A&E delivery board to ensure a consistent approach and better management of system wide escalation, improved planning and preparation for winter 18/19 and clarity of expectations from all partners within the wider system. The content is based on the national Operational Pressures Escalation Level (OPEL) Framework.

2 Aims of the framework

The key aims of this framework are:-

- To provide a set of escalation triggers for services and mitigating actions each service should take when the system declares a specific OPEL level.
- To set clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures.
- To facilitate a whole system proactive response to surge pressures across any health or social care provider which may impact on service provision and adversely affect patient experience, safety and outcomes. This will include a focussed approach to supporting any single area of provision in escalation, regardless of the system wide OPEL level. This will include mutual aid across service providers of the same type, but importantly a shift in focus to any area under pressure. For example if the pressure is seen in Primary Care, consideration will be given as to how community and acute services can help General Practice support people at home, and if the pressure is in acute, how system partners can support discharges and flow etc.
- Support formal de-escalation

3 A&E Delivery Board Escalation Process

The CCGs, in partnership with organisations across the North & North East Lincolnshire A&E DB footprint, have developed this Escalation Framework, which details the agreed triggers and reporting of different levels for surge and escalation across the system.

Each organisation has identified triggers for determining their own OPEL level and actions to complete when **the system** has declared a specific OPEL level. These triggers and actions are based on the national framework, with local additions. There will always need to be very specific actions undertaken when any provider or service declare OPEL 3 in order to support that individual service and deliver de-escalation.

3.1 Daily system management and winter reporting arrangements

During winter 17/18 there was a daily call in place whenever the system was at OPEL 2 or above. This was to enable all partners to clearly understand the current system level and manage appropriate responses, and to support required regional and national reporting of winter pressures.

For winter 18/19 the information collection and sharing process has been automated meaning that before 10am every day a system sitrep will be shared with all system partners. This will set the

DRAFT

system OPEL level that day. Review of this daily Sitrep will highlight any isolated areas of pressure, and will allow all partners to focus their support to ensure it is most effective. The system sitrep will also support the daily national exception reporting processes.

System Call:
Held every Monday and Thursday at 10am whenever the system sitrep sets the system OPEL level as 2. ***All system partners are required*** to dial into the call ***and each organisation will be represented by a senior member of staff able to make decisions and ensure delivery of the agreed actions for their organisation***. Where required a 2pm call will also be held.

At OPEL level 3, daily calls will be implemented to ensure agreement and delivery of every appropriate and possible action, focussed on the areas of need to support de-escalation.

A&E Delivery board SRO call:

Held at 11am on any day where the system has declared an OPEL level 3 or more and where the agreed actions have not supported de-escalation. SRO discussion will agree further mitigating actions with implementation timescales.

NHS England regional winter call:
Held every Monday and Thursday at 12pm. CCGs to provide update on performance, system pressures, mitigating actions and plans to support any de-escalation required.

Exception Reporting:

TBC – awaiting NHS England instruction

System OPEL determination:
The System OPEL level will be determined by taking each service area OPEL level and using an algorithm to reach a System level OPEL.

DRAFT

A&E Board escalation and de-escalation plan 18/19 – Organisation specific

Escalation Level	OPEL 1	OPEL 2	OPEL 3	OPEL 4
Definition	**Low pressure** Demand is broadly at expected levels and being managed effectively. Resourcing is satisfactory and there are no concerns regarding delivery of patient safe care. Performance is broadly in line with trajectory expectation. All relevant actions are being taken to maintain OPEL one and no formal system response currently required.	**Moderate pressure** There is a moderate level of pressure and a suggestion that routine service arrangements might be inadequate to cope with demand. There has been a deterioaration in performance, escalation actions have been taken in response, and a system response is required in order to support de-escalation and prevent further escalation.	**Severe pressure** The system is experiencing Severe pressure and service can no longer be maintained withint routine service arrangements. Implementation of special procedures not previously employed is required.	**Extreme pressure** across A&E Delivery Board area, and the system is unable to provide safe patient care across all aspects of service delivery, or has insufficient capacity despite all prior measures. There is a risk of service failure, all available escalation actions taken and potentially exhausted, extensive support and intervention is required.

System wide response	• OPEL levels and pressures reported to automated system wide sitrep.
	• Standard operations maintained.
	• Maintain whole system staffing capacity assessment
	• Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases
	• Active monitoring of infection control issues
	• Maintain timely updating of local information systems and facilitate production of System SITREP
	• Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken
	• Proactive public communication strategy e.g. Stay Well messages, Cold Weather alerts
	• Maintain routine active monitoring of external risk factors including Flu, Weather.
	• If any organisation is reporting an OPEL 3, the system response to support that organisation will be considered and actioned. These will vary depending on the area of pressure and support required, and will be specific to address the area of provision requiring support for example (but not limited to):
	  • If the pressure is within a trust site bed base partners will support with discharges and flow.
	  • Where pressure is in A&E Departments, Primary Care access to rapid consultant opinion could be facilitated to support decision making in order to avoid attendances etc
	  • Where pressure is within Primary Care, community service and consultant support to primary care would be explored.
	  • Where Mental Health services
		• Twice weekly 10am system calls implemented at declaration of OPEL 2 until de-escalation to OPEL 1.
		• Actions completed to support de-escalation focussed on the areas of pressure within the system
		• If any organisation is reporting an OPEL 3, the system response to support that organisation will be considered and actioned. These will vary depending on the area of pressure and support required, and will be specific to address the area of provision requiring support for example (but not limited to):
		  • If the pressure is within a trust site bed base partners will support with discharges and flow.
		  • Where pressure is in A&E Departments, Primary Care access to rapid consultant opinion could be facilitated to support decision making in order to avoid attendances etc
		  • Where pressure is within Primary Care, community service and consultant support to primary care would be explored.
		  • Where Mental Health services are under pressure, mutual aid between providers across the board, and sharing of bed capacity could be facilitated.
		  • Local Authorities experiencing significant pressure due to provider failure might require support from community services to care for those affected.
			• Daily 10am system calls implemented at declaration of OPEL 3 until de-escalation.
			• Actions completed to support de-escalation focussed on the areas of pressure within the system
			• 11am SRO calls where all actions deemed necessary at 10am, cannot be implemented
			• 2pm system call where all agreed action implemented and no de-escalation
			• In addition to focussed support to those areas in heightened escalation there will also be a focus on those areas that would support early de-escalation. For example, if the trust sites are under severe pressure, in addition to front door and discharge support, there will be a focus on attendance and admission avoidance such as support to Primary Care to ensure rapid specialist opinion and community support to keep people at home.
			• Careful consideration will be given to determining which cohorts of staff across the system can be usefully deployed to support the areas most pressured.
			• Review of upcoming events such as Protected learning time, with consideration as to whether these can be postponed/stood down.
				• All previously agreed actions completed focussed on the specific areas of pressure within the system.
				• System-wide communications to update regularly on status of organisations (as per local communications plans)
				• Provide mutual aid of staff and services across the local health and social care economy
				• All Training cancelled and annual leave cancelled where possible.
				• Stand-down of level 4 once review suggests pressure is alleviating
				• **Post escalation:** Contribute to the Root Cause Analysis and lessons learnt process through the SI investigation

DRAFT

	are under pressure, mutual aid between providers across the board, and sharing of bed capacity could be facilitated. • Local Authorities experiencing significant pressure due to provider failure might require support from community services to care for those affected.			
Organisation	**Acute Hospital**			
	Triggers	**Triggers**	**Triggers**	**Triggers**
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLGFT)	• Demand for services within normal parameters • Hospital sites OPEL 1 • Capacity predictor < - 30 at 08.30 • Capacity predictor > + 10 at 16.30 • No staffing issues identified • No technological difficulties impacting on patient care • Specialist units/beds/wards have capacity • Infection control issues monitored and deemed within normal parameters • ED OPEL 1 • First assessment within 15 minutes • Seen by clinician within 60 minutes • Ambulance handover within 15 minutes • Imaging and lab requests concluded within 60 minutes • DTA within 120 minutes • Speciality response within 30 minutes • ED waiting times are able to be maintained within 4 hours unless a clinical exception	• Insufficient discharges to create capacity for the expected elective and emergency activity • One or more Hospital site OPEL 2 • Capacity predictor > - 30 at 08.30 • Capacity predictor 0 to +10 at 16.30 • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services • Capacity pressures on NICU, and other intensive care and specialist beds • Level 2 Public Health England cold weather watch/ Heatwave alert • Critical care beds are full, although there are some in the network • Infection control issues are located in one area in a ward • Unable to meet repatriation requirements within 24 hours • ED OPEL 2 • First assessment not achieved within 15 minutes despite moving staff resource • Seen by clinician is > 60 minutes • Ambulance handover > 30 minutes • Imaging and lab requests taking more than 60 minutes • No speciality response within 30 minutes • Patients waiting more than 60 minutes for a bed post DTA • ED waiting times are challenging but no more than 5 patients have breached since midnight	• Actions at OPEL 2 failed to deliver capacity • One or more Hospital site OPEL 3 • Capacity predictor > - 45 at 08.30 • Capacity predictor 0 to – 10 at 16.30 with a mitigation plan to achieve predictor 0 • Patient flow significantly compromised • Medical equipment delays or failure causing delays for a number of other patients • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Serious capacity pressures escalation beds and on NICU, and other intensive care and specialist beds • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 2 hours • Level 3 Public Health England cold weather watch/ Heatwave alert • Ambulance handover is delayed over 60 minutes • Patients have to wait to be seen by a doctor for between 2 and 3 hours • Critical care beds are full and there are none inside the network • Infection control issues are emerging in more than one inpatient area • Unable to meet repatriation requirements within 48 hours • ED OPEL 3 • First assessment wait > 30 minutes • Seen by clinician wait > 2 hours • Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) • ED waiting times are challenging and more 5 patients at any one time have breached in the department • Ambulance handover is delayed over 60 minutes • Patients have to wait to be seen by a doctor for between 2 and 3 hours	• Actions at OPEL 3 failed to deliver capacity • One or more hospital sites at OPEL 4 • Capacity predictor > - 55 at 08.30 • Capacity predictor > - 10 at 16.30 and mitigation plans will not achieve a predictor of 0 • No capacity across the Trust with all escalation beds used and patients waiting admission and the number of expected discharges is less than current demand • Emergency care pathway significantly compromised • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Infectious illness, Norovirus, Severe weather, and other pressures in Acute Trusts • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 4 hours • No critical care beds available with Yorkshire & Humber Network or neighbouring networks • Infection control issues are occurring in multiple ward areas • Unable to meet repatriation transfers requirements within 72 hours • Level 4 Public Health England cold weather watch/ Heatwave alert • ED OPEL 4 or Major Incident declared • Ambulance handover is delayed over 120 minutes • ED waiting times are challenging and more than 5 patients have breached in the department and there are no management plan able to be enacted • First assessment wait > 30 minutes • ED patients are unable to be seen by a doctor within three hours

DRAFT

	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Named individuals across Local A&E Delivery Board to maintain whole system coordination with actions determined locally in response to operational pressures, which should be in line with business as usual expectations at this level • Maintain whole system staffing capacity assessment • Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases • Active monitoring of infection control issues • Maintain timely updating of local information systems • Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken • Proactive public communication strategy e.g. Stay Well messages, Cold Weather alerts • Maintain routine active monitoring of external risk factors including Flu, Weather.	• Undertake additional ward rounds to maximise rapid discharge of patients; Snr decision makers involved. • Clinicians to prioritise discharges and accept outliers from any ward as appropriate • Implement measures in line with trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place • Notify CCG on-call Director to ensure that appropriate operational actions are taken to • Maximise use of nurse led wards and nurse led discharges • Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases • Communicated with partner organisations regarding pressures, e.g. GP visits to care homes and mental health in-reach etc. • Reallocate A&E resource to highest need	• ED senior clinical decision maker to be present in ED and on wards department 24/7 • Contact on-take and ED on-call to inform of system pressures • Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Enact process of cancelling day cases and staffing day beds overnight if appropriate. • Open additional beds on specific wards, where staffing allows. • ED to open an overflow area for emergency referrals, where staffing allows. • Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages • Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases. • Consider ambulance deflect • Ensure HALO is supporting in ED and utilise fit to sit • Stand down all training and meetings and redeploy staff • Reallocate specialties to in reach into the ED department • Utilise orthopaedics to review minor patients • Utilise corporate response team clinical and nonclinical to support pressures • Ensure pharmacy are based in ED, and admitting wards • Consider cancelling routine outpatients • Cancel specialist nursing activity • Extra primary care support in ED • Critical care staff to ED • Outpatient staff to ED • Deputy directors to support in Ops centre • Increase telephone support to GPs to facilitate rapid access to specialist opinion to support primary and community care to keep people at home. • Implement emergency clinics to support rapid OP appointments to support admission avoidance.	• All actions from previous levels stood up • ED senior clinical decision maker to be present in ED and consultant teams on wards / department 24/7 • All consultants in and on the floor • Contact on-take and ED on-call Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical senior clinical decision makers to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7 • Consider ambulance divert • Enact Full Hospital Capacity Protocol • **An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG and neighbouring trusts to agree a divert.** • **Ensure HALO is in ED and cohort patients, utilising fit to sit** • **Stand down day cases to divert staff** • Explore private hospital support for electives or staffing • Patients to move between sites for theatres • Community nursing support for wards • Medical Director and Chief Nurse to be based in Ops centre
	Ambulance Service			
	Triggers	**Triggers**	**Triggers**	**Triggers**

DRAFT

East Midlands Ambulance Service (EMAS)	• REAP 1 • Demand less than 5% forecast • Performance triggers subject to national Review post ARP • Abstractions up to 5% • Handover up to 5% over 60mins • 111 pass through 2-5%+	• REAP 2 • Demand 5-10% forecast • Performance triggers subject to national Review post ARP • Abstractions 5-10% • Handover 6-10% over 60 mins • 111 pass through 5-8%	• REAP 3 • Demand 10-15% forecast • Performance triggers subject to national Review post ARP • Abstractions 10-15% • Handover 10% over 60 mins • 111 pass through 8-10%	• REAP 4 • Demand 15%+ forecast • Performance triggers subject to national Review post ARP • Abstractions 15% + • Handover regularly breaching 60mins • 111 pass through 15%+
	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Standard Operations Maintained • Routine escalation/partners calls attended twice weekly • Contribute to System wide SITREP	_naru_reap_plan_nov_15.pdf Needs to be updated		
	GP OOHs and PC Streaming (UTC Capacity)			
	Trigger	**Trigger**	**Trigger**	**Trigger**
Core Care Lincs and Safecare (GP OOHs Services and PC streaming)	• Full service delivery. All OOHs and PC streaming/UTC shifts fully covered.	• Demand increased up to 20%, Delays in seeing patients, increased number of home visits. • Minor operational service delivery incidents or environmental conditions which offer operational inconvenience but are not expected to create significant effect on service delivery level and can be presently managed by local management and staff but need to be continually reviewed for potential escalation.	• Demand increased by 40%, frequent delays in seeing patients, increased number of home visits. • Any operational/environmental condition or clinical event which has reduced the capacity to provide expected service delivery and may have the capacity to escalate to an operational failure situation. • Any short term or intermittent failure of service delivery from telephony or Information technologies, both hardware and software, which Id considered to have the potential of escalating to operational failure situation condition.	• Demand increased and depleted workforce. • Serious incident/environmental condition causing significant failure of any operational service delivery activity at any site. • Long term failure of service delivery Telephony or Information Technologies, both hardware and software. • Severe loss of key service personnel or logistical support through loss of support vehicles, fuel deprivation or extreme weather. • Severe failure of service delivery due to overwhelming clinical events.
	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Standard Operations Maintained • Routine escalation/partners calls attended twice weekly • Contribute to System wide SITREP	• Capacity increased in line with demand (All Service clinicians not just GPs) • Consider support to pressured system partners, for example but not limited to: • Diversions from A&E • Supporting community services • Where required business continuity plans implemented and impact communicated system wide. • Contribute to System wide SITREP	• Capacity increased in line with demand (All Service clinicians not just GPs) • Consider support to pressured system partners, for example but not limited to: • Diversions from A&E • Supporting General Practice, but increasing capacity in OOHS and considering starting the service provision to cover some of the in hours period or by supporting primary care in A&E/UTC • Increase capacity to support general practice where appropriate and necessary, by increasing the number of bookable primary care appointments in hours in the A&E Department/ UTC • Supporting community services • Where required business continuity plans implemented and impact communicated system wide. • Contribute to System wide SITREP	• Ensure any agreed system actions from Level 2 & 3 are implemented. • Support Level 4 management and engage in de-escalation plan implementation • Where required business continuity plans implemented and impact communicated system wide. • Contribute to System wide SITREP
	Mental Health Services			
	Trigger	**Trigger**	**Trigger**	**Trigger**

DRAFT

Navigo Rotherham Doncaster and South Humber NHS Trust	Services operating as normal no disruption	• Limited acute bed availability or reduced acute staff levels, but managing demand • Increased demand or reduced staff levels in community, but not impacting on ability to provide services. • Liaison services not available on hospital sites (SGH once in place) • Increased demand into Crisis teams that is being managed short term • Delays in the provision of services due to availability of Local Authority mental health provision (eg MHS assessments and AMHP availability)	• Significantly reduced acute bed availability or ability to staff all beds due to staffing levels, with patients being routinely accommodated out of area. • Liaison services not available on hospital sites (SGH once in place) • Increased demand into Crisis teams that is not able to be managed. • Significantly increased demand or reduced staff levels in community, impacting on ability to provide services. • Significant delays in the provision of services due to availability of Local Authority mental health provision (eg MHS assessments and AMHP availability)	• Demand increased and depleted workforce. • Serious incident/environmental condition causing significant failure of any operational service delivery activity at any site.
	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Standard Operations Maintained • Routine escalation/partners calls attended twice weekly • Contribute to System wide SITREP	• Expedite rapid assessment for patients waiting within another service Increase support and/or communication to patients at home to prevent admission • Focus on medically optimised patients within acute settings, to facilitate rapid discharge • Contribute to System wide SITREP	• Capacity increased in line with demand where possible • Further consideration of support to pressured system partners, for example but not limited to: • Increased support to A&E and acute physical health wards where appropriate • Supporting community services • To review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission • Where required business continuity plans implemented and impact communicated system wide. • Contribute to System wide SITREP	• Ensure any agreed system actions from Level 2 & 3 are implemented. • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible • Support Level 4 management and engage in de-escalation plan implementation • Where required business continuity plans implemented and impact communicated system wide. • Contribute to System wide SITREP
	Social Care services			
	Trigger	**Trigger**	**Trigger**	**Trigger**
North Lincolnshire Council FOCUS Lincolnshire County Council	• Social services able to facilitate appropriate support arrangements for people in the community and discharges from acute care and other hospital and community based settings	• People in the community and / or acute settings waiting for social services capacity • Adult social care services experiencing moderate pressure in more than two or more of the following areas or significant pressure in one of the following areas: 1. Demand 2. Staffing levels HSWTs (integrated discharge teams) 3. Out of Hospital resources becoming	• Adult social care experiencing severe pressure on services • Social services unable to facilitate care packages, discharges etc • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • A contracted provider service is failing and immediate supportive action is required to maintain people's safety.	• Adult social care is **unable to safely fulfil** its statutory duties in respect of assessment and provision of services • Adult social care has received notification that its current status is negatively impacting on other external organisations' ability to deliver their services.

		stretched with limited capacity *residential home capacity* *Domiciliary care capacity* *CST/ IC@Home* • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)		
	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Standard Operations Maintained including discharge to assess and trusted assessor pathways • Community referrals responded to appropriately • Expedite support arrangements • Ensure all people waiting within another service are provided with appropriate services as an alternative to avoid delays where appropriate. • Maximise use of IC and re-ablement/ intermediate care beds. • Routine escalation/partners calls attended twice weekly. • Routine attendance at Stranded Patient meetings. • Contribute to System wide SITREP	• Social Services escalate to on-call managers to expedite care packages and placements • Clear discussions with all patients in conjunction with Health partner to ensure all patients waiting within another service are provided with appropriate services as an alternative to avoid delays and understand that hospital is not a choice. • Where possible, increase support and/or communication to people at home to prevent admission. • Re-direct resource where appropriate to support screening and assessment to ensure discharge from hospital • Proactive presence in pressured areas to in reach and maximise discharges or prevent admission to hospital. • Focus on people within acute settings, to facilitate rapid safe discharge where social care input is required. • Focussed stranded patient reviews • Contribute to System wide SITREP	• Manager presence on site within trust to support discharges. • Further increase support to service users at home in order to prevent admission, working with partners where appropriate. • Ensure close communication with Acute Trust, including senior on site presence • Ensure adequate capacity within social care SPA functions (NL- Gateway to care, NEL- SPA. Lincs - Brokerage) to further support admission avoidance and facilitate alternative solutions where appropriate to do so. • Where there is provider failure, available resource will be diverted to support ie council residential and home support services. • Alert Lincs system functions (re-ablement, brokerage, and care homes) of increased levels of pressure • Contribute to System wide SITREP	• Senior Management team involved in decision making regarding use of additional resources. • Senior Managers to decide what functions can be stepped down in an emergency. However statutory functions for the council cannot be compromised. • Service manager, linking closely Head of Service, & teams will prioritise quick wins to achieve maximum flow, for people needing support within the community or supporting ED regarding prevention of admission & turn around. Identification via board rounds and links with discharge team & therapists. • Service Manager/Head of Service to monitor escalation status, taking part in teleconferences as required. • Support Level 4 management and engage in de-escalation plan implementation • Where required business continuity plans implemented and impact communicated system wide. • Alert LCC commercial team to pressures and increase LCC staffing to NLaG sites • Contribute to System wide SITREP
	Community Services			
	Trigger	**Trigger**	**Trigger**	**Trigger**
Care Plus Group **NLaG Community**	Services operating as normal no disruption or significant gaps in rotas	• Patients in community and / or acute settings waiting for community care capacity • Reduced discharge liaison and locality co-ordinator capacity (integrated discharge teams) • Lack of medical cover for community beds • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services • Unplanned slots being used to fulfil planned visits due to capacity • Level 2 Public Health England cold weather watch/ Heatwave alert	• Community capacity full resulting in reduced service delivery in any area. • Unable to take new referrals • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • More than one area with infection control issues • Level 3 Public Health England cold weather watch/ Heatwave alert	• No capacity in community services and unable to manage existing workload • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) that is at a level that compromises service provision / patient safety • Level 4 Public Health England cold weather watch/ Heatwave alert
	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Standard Operations Maintained including discharge to assess and	• Escalation information to be cascaded to all community providers with the intention of	• Community providers to support additional ward rounds in acute hospitals	• Ensure all actions from previous stages enacted and all other options explored and

DRAFT

	trusted assessor pathways • Routine escalation/partners calls attended twice weekly • Regular attendance at stranded patient meetings • Contribute to System wide SITREP	avoiding pressure wherever possible. • Increase capacity and clinical input to calls in SPA • Maximise use of re-ablement/intermediate care beds and ensure D2A pathways are supported • Intermediate tier to bring forward discharges to allow transfers in as appropriate. • Intermediate tier to liaise with Social and Healthcare providers to expedite discharges from intermediate tier • Community service proactive presence in trust pressured areas to in-reach to maximise discharges. • Community matrons to support hospital at home services to prevent admissions and support discharges • Focus on medically optimised patients within acute settings to facilitate rapid discharge • Focussed stranded patient reviews • Contribute to System wide SITREP	• Review admission and treatment thresholds within Rapid Response teams in community and SPA to create capacity to support conveyance and admission avoidance where possible. • Community providers to expand capacity wherever possible through additional staffing and services, including support to primary care and where possible move all services to 7 day services • Review caseloads and redeploy staff to vulnerable areas if safe to do so. • Risk assess and postpone routine visits based on risk assessment, eg VitK injections, QoF Bloods, catheter etc. • Ensure all remaining staffing resource is distributed to manage high risk patients • Increase domiciliary support to service users at home to prevent admission. • Contribute to System wide SITREP • Review all training and meetings and redeploy staff • Initiate spot purchase beds in conjunction with commissioner	utilised • Ensure all possible capacity has been freed and redeployed to ease systems pressures • Support Level 4 management and engage in de-escalation plan implementation • Where required business continuity plans implemented and impact communicated system wide. • Contribute to System wide SITREP • Nurse managers to work clinically • Review caseloads to prioritise red flag patients. • Stand down routine therapy visits and redeploy staff to critical areas. • Stand down routine clinics The following clinics would continue on the basis that staff do not have the relevant skills to support OPEL 3 / 4 • Dentistry • Podiatry • MSK
	Primary Care – General Practice			
	Trigger	**Trigger**	**Trigger**	**Trigger**
General Practices/ Federations/ Networks	• GP attendances within expected levels with appointment availability sufficient to meet demand	• GP attendances higher than expected levels • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services (core and extended access) • Increase in respiratory infection and Flu in registered population	• Significant increase in attendances or requests for urgent appointments. • Significant, unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on ability to see same day and urgent appointments and impacting on extended access • Significant increase in respiratory infection and Flu in registered population	• Unexpected reduced staffing numbers and or increased demand to such levels that patient safety is at risk due to delays, or where patient have to access other services such as A&E. • General practice closure.
	Actions for system level 1	**Actions for system level 2**	**Actions for system level 3**	**Actions for system level 4**
	• Standard Operations Maintained • Routine escalation/partners calls attended twice weekly • Contribute to System wide SITREP	• Where possible and where not already in place, increase number of telephone consultations using other HCPs in addition to GPs • Where capacity allows, GPs to work with community services to support their registered higher acuity patients in the community. In particular support care home residents by providing clinical assessment • Prescribe prophylactic antibiotics for at risk patients with respiratory conditions where not already in place • Alert GPs in practice to escalation and consider alternatives to ED referral be made where feasible (diversionary pathways) working with system partners. • Contribute to System wide SITREP • In period of cold weather alerts to routinely review respiratory patents to make sure have mitigation actions in place	• Engage practice GP services and inform them of rising operational pressures and to plan for recommending alternative care pathways where feasible and safe • Where capacity allows, GPs to work with community services to support their registered higher acuity patients in the community. In particular support care home residents by providing clinical assessment • Use other HCPs as alternatives to GPs for routine (QoF) clinics, or cancel QoF clinics to allow for increased same day appointments • Use practice over 75 co-ordinators to support high risk patients • Contribute to System wide SITREP	▪ Ensure all actions from previous stages enacted and all other options explored and utilised ▪ Ensure all possible actions are being taken on-going to alleviate system pressures • Contribute to System wide SITREP
	North & North East Lincolnshire CCGs			

	Trigger	Trigger	Trigger	Trigger
CCG's	• No Business Continuity Plans invoked • GP attendances within expected levels with appointment availability sufficient to meet demand • No expected events or circumstances likely to impact on services • Cold weather/Heatwave Level 0-1 - Normal Conditions	• More than 1 organisation Business Continuity Plans invoked • GP demand unable to be met by ordinary increase in appointment availability for 48 hours • Actual or forecast loss of more than 1 service for 24 hours – primary, acute, Community or mental health services • Anticipated events or circumstances likely to impact on services • Cold weather/Heatwave Level 2 - Severe weather or Heatwave is forecast	• More than 1 organisation Business Continuity Plans invoked • GP demand unable to be met by ordinary increase in appointment availability for 96 hours • Actual or forecast loss of more than 1 service for 24 hours – primary, acute, Community or mental health services • Anticipated events or circumstances likely to impact on services • Cold weather/Heatwave Level 3 - Severe weather or Heatwave action required.	• Several organisations Business Continuity Plans invoked • GP demand unable to be met by ordinary increase in appointment availability for > 7 days • Actual or forecast loss of more than 1 service for 7 days – primary, acute, Community or mental health services • Significant loss in staff numbers where this will result in inability to meet forecasted demand • Actual event or circumstances likely to impact on services. • NHSE/external support for mutual aid requested • Cold weather/Heatwave Level 4 – Major Incident – emergency response
	Actions	**Actions**	**Actions**	**Actions**
	• Dial into twice Weekly NHSE teleconference call 12 noon on Mondays and Thursdays • CCG Winter Leads to chair system calls with partners • Facilitate collection of data to populate the System Sitrep for circulation	• Co-ordinate communication and escalation across the local health economy. • CCGs instigate joint twice weekly call with Health & Social Care partners in order to:- - Assess current risks and pressures - Identify scope for mutual support - Agree actions required - Assess risks of further escalation • CCGs to brief wider partners including NHSE as required. • Facilitate collection of data to populate the System Sitrep for circulation.	• CCGs to instigate joint daily call with Health & Social Care partners and SRO calls as required in order to:- - Proactively lead the A&E Delivery Board response to pressure surges on a day to day basis 24/7 - Assess current risks and pressures - Identify scope for mutual support - Agree actions required - Assess risks of further escalation - Actively plan further contingency arrangements - Ensure NHS11 DOS is kept up to date in respect of any changes to Community capacity CCGs to inform wider partners, including NHSE and the public of the current system-wide status and recommend alternative care pathways. • Facilitate collection of data to populate the System Sitrep for circulation	• CCGs to notify NHSE of the system-wide alert status and involve them in decisions around support from beyond local boundaries. • CCG to instigate joint twice daily calls with Health & Social Care partners and SRO calls or meetings in order to:- - Proactively lead the A&E Delivery Board response to pressure surges on a day to day basis 24/7 - Assess current risks and pressures - Identify scope for mutual support - Agree actions required - Assess risks of further escalation - Actively plan further contingency arrangements - Ensure NHS11 DOS is kept up to date in respect of any changes to Community capacity CCGs to inform wider partners, GPs, NHSE and the public as necessary Facilitate collection of data to populate the System Sitrep for circulation
A&E Delivery Board	Coordination of Calls/Actions and updates to NHSE	Coordination of Calls/Actions and updates to NHSE	Coordination of Calls/Actions and updates to NHSE	Coordination of Calls/Actions and updates to NHSE

DRAFT