ReSPECT

#hellomynameis

West Berkshire System Wide

Winter Resilience Plans

Valuing Patients' Time, Supporting Staff

December 2018-March 2019

CALL 111 when it's less urgent than 999

INTRODUCTION

This plan sets out arrangements to support effective patient flow across the Berkshire West system through partnership working. Of note it supports flow through the Royal Berkshire Hospital (RBH), through a combination of RBH specific actions and those with our system partners to control attendances/admissions to the acute Trust and increase the outflow of medically fit patients safely home from all hospital environments or to an onward care environment. Under the umbrella of ***Valuing Patients' Time*** and ***Supporting Staff*** we will, as a system, strive to:

i) Model and predict activity and support with escalation responses, as appropriate and practical

ii) Safe, high quality care ensuring patients are seen at the right place and the right time, aiming to reduce multiple moves in patients' pathways, whilst maintaining privacy and dignity

iii) Stream as many patients as possible across front door locations to ambulatory care services, wherever it is safe to do so

iv) Treat patients in short stay environments wherever appropriate, supported with proactive discharge processes

v) Target processes and delays in patient pathways and support staff to ensure that patient pathways are advanced each day and that safe discharge plans are implemented

vi) Support staff at times of increased pressure and carefully monitor staffing levels to achieve a balance across all areas

vii) Communicate and escalate with system partners as necessary to support whole system flow

This plan and the progress of the winter period will be closely monitored by an internal RBH Clinical Board and the West Berkshire A&E Delivery Board.

During this period the system will be supported 24/7 by senior clinical and operational teams both on site at provider sites and on call including overnight and at weekend up to Director level. Regular communications will take place daily/weekly throughout the period, including the required reporting up to NHSI.

The plan is set out in the following domains:

1. ADMISSION AVOIDANCE WITH PARTNERS	2. FRONT DOOR PROGRAMME ACROSS ALL SPECIALTIES	3. EFFECTIVE WARDS / IN HOSPITAL PROCESSES
i) Enhanced Integrated Urgent Care 111 service ii) Enhanced access arrangements for primary care services iii) Ambulance Response Programme with a focus on non conveyance and incl Frailty support iv) GP Directory for alternatives to referral v) Community Hospital Voluntary Sector Navigators vi) Mental Health Crisis Resolution Home Treatment Teams providing proactive support to vulnerable individuals vii) Police Street Triage scheme viii) Case management approach to individuals with complex eating disorders	i) Streaming patients on arrival at ED to promote 100% achievement of minors seen and treated within the 4 hour standard ii) ED controls and escalation plan iii) Front Door Huddles iv) Primary Care Streaming v) ED Frailty service vi) Ambulatory Care Pathways vii) Increased Acute Medicine presence in ED viii) Increased capacity in AMU/SSU ix) Enhanced arrangements for referral to all specialties x) Enhanced Mental Health Pathways incl to optimise access to acute beds xi) Red Cross Prevention of Admission to Hospital service	i) Increase in medical bed capacity ii) Maximising Ward/Board rounds iii) Early discharge process – 'Early Risers' iv) Further development of criteria led discharge incl weekend discharge plans v) Tracking/reducing LoS > 7/21 day patients (stranded/super stranded) vi) Internal standards/response times vii) 7 day working incl to maximise weekend discharges viii) Infection control management incl to optimise patient placement/bed management ix) Patient Pathway Co Ordinators x) Outlier management xi) BHFT Mental Health Bed Optimisation Programme xii) Age UK Hospital Befriender pilot xiii) Support to wards to expedite delays and resolve issues xiv) Escalation to external partners xv) Deliver a Difference Volunteers
4. INTEGRATED DISCHARGE & PARTNERSHP WORKING	**5. FLOW MANAGEMENT SYSTEM & COMMUNICATION**	**6. QUALITY & KPI MONITORING**
i) Redesigned Integrated Discharge Team ii) CHS support programme iii) Improved processes for RBH/BHFT bed management and flow arrangements iv) Discharge to Assess/Trusted Assessor v) DTOC system wide reductions in bed occupancy including High Impact Change Model vi) Visible system wide bed management vii) Early Supported Discharge service viii) Weekly senior nursing review of all stranded and super-stranded patients ix) Weekly system wide review of patients who are official delayed transfers of care & stranded/super stranded patents x) Red Cross Extended Stay model	i) Predictors & activity monitoring ii) Bed management & escalation iii) New Operations Centre and Site Management Office iv) Elective management plan v) Safe Staffing plans vi) Support services provision vii) Daily reports & communication tools viii) Daily Ops Meetings ix) Clinical Site Management Hub x) OOH management and escalation xi) System wide bed management system xii) 'Silent Winter' Escalation xiii) System wide comms plan xiv) Weekly ICS/DaSS meeting	i) KPI Dashboard/patient flow metrics ii) Quality Indicators - care group governance iii) Clinical Outcomes incl Harm Assessment iv) RBH Clinical Oversight Board (weekly) v) Berks West A&E Delivery Board vi) 5 national escalation triggers

1. ADMISSION AVOIDANCE WITH PARTNERS

i) Enhanced Integrated Urgent Care (111) service

- Enhanced service with increased clinical input so a higher number of call can be dealt with in the Clinical Hub with no onward referral, direct booking into a wider range of services and clinical review of all ED and low acuity ambulance dispositions

ii) Increased access to primary care services

- Enhanced access arrangements in place 7 days per week delivered through Alliance working across clusters of Practices

iii) GP Directory for alternatives to referral – 'Golden Nuggets'

- Increased access to alternatives to A&E or referral to Acute Medicine incl option to refer to Ambulatory Care
- This will include hot clinics and advice lines such as RACOP, heart failure, jaundice hotline, rheumatology flare clinic, gastro IBD clinic, ENT ARC, rapid access chest pain clinic and falls clinic
- Full directory of all community alternatives to admission including rapid response, hi-tech team providing home based IV service and night sitting

iv) Direct line to Acute Physician at Trust

- Acute Physician to cover referral phone to Acute Medicine to consider appropriate treatment options incl referral to Ambulatory Care

v) SCAS: Ambulance Response Programme (ARP)

- Ensuring the right type of vehicle/response is despatched to meet the patients needs
- Specialist practitioners targeted at low acuity patients to increase non conveyance / reduce attendance at A&E
- Falls and Frailty response service operating at time of peak demand

vi) Frequent attenders programme

- Bespoke treatment plans for cohort of patients identified as potential frequent attenders to A&E
- Anticipatory Care CES in Primary Care requiring Practices to proactively manage and care plan for their most vulnerable patients

vii) RVA/Involve Hospital Voluntary Sector Navigators signposting patients to voluntary sector/community support to maintain wellness and independence

viii) MH Crisis Resolution Home Treatment Teams providing proactive support to vulnerable individuals to prevent crisis

ix) Police Street Triage scheme supporting the police and reducing conveyance rates to Place of Safety and the need to inpatient care

x) Case management approach to those individuals with complex eating disorders

**** Where any of these arrangements identify referral to A&E or Acute Medicine this will be expedited to ensure appropriate early referral****

2. FRONT DOOR PROGRAMME ACROSS ALL SPECIALTIES

i) Emergency Department (ED) controls and escalation plan

- Consultant led Senior Triage Assess and Treat (STAT) for all ambulance arrivals Mon-Fri 10.00-22.00 and Sat-Sun 12-20.00
- On arrival all walk in patients streamed for treatment in ED or Primary Care service
- Deployment of staff to maintain throughput across all areas of the ED so that queues do not build up
- Management of ED patients as ambulatory to achieve discharge from ED wherever safe to do so including:
  - continuation of ED Frailty service as it comes into use
  - increased focus on potential referral to hot clinics/outpatients, advice lines such as RACOP, heart failure, jaundice hotline, rheumatology flare clinic, gastro IBD clinic, ENT ARC, rapid access chest pain clinic and falls clinic
  - a focus on optimising pathways for patient who may not require admission in order bring these to a speedier conclusion/discharge decision
- Closer working with Acute Physicians and POD/ECPOD to agree management of ED patients to Ambulatory Care Unit, Acute Medical Unit, and day treatment options including Battle Day Unit (BDU) – this will include a greater presence in the ED itself
- Timely streaming of critically ill patients to theirAny correct environment (HMU, ICU, CCU, ASU, NOF/HFU).
- Early referral to specialties (ideally within a maximum of 2 hours) and escalation to on call consultant if needed – with use of fast track protocols as appropriate and early referral to SAU
- Escalation by ED consultant/ED coordinator to specialty Matrons in anticipation of any delays in patients being reviewed in ED and site manager out of hours
- Consultant and Senior Nurse coordination of the department to oversee management of patient volumes, allocation of resource, adherence to clinical standards for assessment, treatment and referral and direct actions to achieve ED components of 4 hour pathways and timely handover of ambulance patients.
- As per ED Escalation Plan, incl importance of maintaining separate stream for minors and majors when under pressure.
- Any risk of ambulance holds/volume in ED to be expedited to Directorate Management team/On Call Manager and Director of Operations and/or COO/On Call Director. Decisions to hold ambulances need to be made jointly in this way and not in isolation by ED team incl request for bronze command/halo from SCAS.
- Expediting minors patients: maintaining resource to deal with minors patients in a timely manner to avoid high volumes of patients in ED/ED waiting room and delayed decision making/unidentified clinical risk
- POC testing for infectious diseases, to assist optimum placement of patients mostly particularly those who are a flu risk
- Observation Ward (target typical LoS of < 12 hours) will continue to care for:
  - Patients who require a period of extended care under the ED team beyond 4 hours, pending the outcome of tests and for whom an admission can be avoided.
  - Patients awaiting transport outside the working hours of the Discharge Lounge.
  - Patients who can be managed by the Occupational Therapy (OT)/ED Frailty team avoiding referral into AMU or IP beds, where safe to do so.
  - Where discharge not guaranteed prior to nightfall, but likely next morning, these patients may stay overnight and be reviewed by 1130 am for admission to avoid risk of further overnight stay. Target is one overnight stay.
  - An exception may be mental health patients, who may stay two nights if this is in their best interest, likely pending transfer to an appropriate unit. These pathways will be supported by

proactive escalation throughout each day (adults and children), including to BHFT at Director level, to achieve transfer as fast as possible.

ii) Primary Care Streaming

- GP available 11.00 – 23.00 7 days a week
- Joint governance arrangements between RBFT and Berkshire Healthcare (BHFT)
- Continuous review of number streamed with a view to maximising these either from front desk or triage

iv) ED Frailty Service

- Frailty practitioners working in ED from 8 am to 8 pm, 7 day service
- Role to identify frail elderly and support team to avoid admission to/shorten LoS on Observation Ward and reduce onward admissions to AMU and referral to ECPOD
- Their expertise will maximise the use of community and admission avoidance schemes

iv) Front Door Huddles & Hospital @ Night (H@N)

- **In ED**: **08:00, 15:30 and 21:30** huddles to assess patient volumes, clinical safety and appropriate deployment of staff, to be joined by other specialties where possible
- **On AMU: 08:00** huddle to assess sick patients, early discharges and staffing; **15:00** Consultant Acute Physician with incoming POD to assess the afternoon/evening position and then move across to join ED 15:30 huddle
- **H@N: 22:00** meeting to assess: overall hospital position, support required at front door, management of sick patients and allocation of ward based tasks overnight. All specialties to attend.

v) **Ambulatory Medicine**

- Renewed SOP to be deployed to increase both same day access to Ambulatory Medicine 10.00 am to 22.00 pm and improvements in the processes supporting patients who are asked to attend the following day
- Acute Physician will work across into ED to assist in decision making regarding ambulatory pathways
- At weekends peripatetic ANPs will continue to contribute to this service across the front door and support same day discharge

vi) **Acute Medicine**

- Telephone referrals by GPs will continue to be taken by Acute Physicians to triage to appropriate area and increase use of ambulatory pathways. These will include attendance the next day or direction to ambulatory services such as hot clinics/outpatients, advice lines including RACOP, heart failure, jaundice hotline, rheumatology flare clinic, gastro IBD clinic, ENT ARC, rapid access chest pain clinic and falls clinic
- 'Walk in' GP accepted patients to attend directly to Ambulatory Medicine service
- GP accepted patients arriving by ambulance to attend ED STAT bay for initial assessment and, via discussion with Acute Physician or POD/ECPOD, agree decision as to ambulatory or AMU/specialty pathway
- Closer working between Acute Physicians, ED team and POD/ECPOD to enable decision making earlier in patient pathways and to control/reduce the demand for overnight stays/IP beds, particularly in the evening and at weekends
- Electronic Bed requesting to get right patient in right place first time
- POD/AP huddle at 15:00

vii) Acute Medical Unit / Short Stay Unit support actions

- A new unit to house the Short Stay Unit will be available for handover Friday 21st December
- Reorganisation of Acute Medical Unit (AMU) and Short Stay Unit (SSU) will then take place in 3 stages, subject to the prevailing requirements of bed flow at the time:

- SSU will move into new unit on 23rd December
- 9 closed beds on AMU will reopen 27th December
- a further 16 beds will open 2nd January
- this includes the creation on AMU of an additional 2 HMU beds

- **If prevailing bed pressures require it this timetable will be reviewed in dialogue between Matron for AMU/SSU/DoO for Urgent Care and COO/On Call Director**
- Increased medical cover (Acute Medicine and Interface Geriatrics) has been provided to ensure adequate cover across all these areas and increased presence into ED

viii) **Acute Surgery**

- 7 day Surgical Assessment Unit (SAU) to increase direct admissions to 10pm
- Early decision making in patient journeys and response to escalation from ED
- For patients referred from ED, as early referral as possible and specialty response @ < 1 hour or faster if possible or necessary and speedy transfer to SAU
- To implement, as they develop, the use of electronic referrals from the ED, according to agreed guidance
- Use of ED referral protocol including escalation to On Call Consultant if required to assist decision making

ix) Trauma & Orthopaedics

- Timely attendance at ED for Orthopaedic expected patients
- For patients referred from ED, as early referral as possible and specialty response @ < 1 hour or faster if possible or necessary
- Dedicated Orthopaedic Registrar presence available to ED
- Use of ED referral protocol including escalation to On Call Consultant if required to assist decision making
- High volume response process to be triggered via On Call Consultant

- **Gynaecology**
- Timely attendance at ED for Gynae expected patients
- For patients referred from ED, as early referral as possible and specialty response @ < 1 hour or faster if possible or necessary
- Use of ED referral protocol including escalation to On Call Consultant if required to assist decision making

x) Paediatric Pathways

- New staffing model agreed with Observation Bay staffing now separated from ED, open 7 days a week
- Streaming to Primary Care to commenced in December to be enhanced post triage
- Operational management within ED to ensure escalation managed within department
- Use of ED referral protocol including escalation to On Call Consultant if required to assist decision making

xi) Mental Health Pathways

- Access to CRHTT (Crisis Response Home Treatment Services) 24/7 – BHFT alternatives to hospital admission pathway
- Access to RRT (Rapid Response Team) 8am – 8pm Mondays – Saturdays including bank holidays – BHFT service for children and young people presenting in crisis
- Collaborative and productive relationship with PMS (Psychological Medicine Service) improving mental health liaison including attendance at Daily Ops meeting to identify patient flow issues from Observation Ward and any IP issues
- Bed Optimisation Project working on both bed management (gatekeeping) and creating more capacity within PPH to facilitate better patient flow incl from front door/Obs Ward
- Weekly DTOC Monitoring with a Berkshire West System wide teleconference to drive down inappropriate delays within MH system.
- Weekly Out of Area Patient Monitoring and driving down both acute overspill and specialist placements.
- Community mental health teams will provide assistance with patient discharge and access to community support in partnership with ASC to improve flow from mental health inpatient units
- Access to community mental health services through CPE and local triage into psychiatry, psychology and care coordination
- Access to early intervention services for first episode psychosis via CPE to offer a 2 week referral to treatment service
- Access to IAPT via self-referral, GP referral

3. EFFECTIVE WARDS / IN HOSPITAL PROCESSES

At the Acute Trust:

i) **Daily ward/board rounds -** expediting today and planning for tomorrow, ideally:

ii) **AM board rounds:** to identify sick patients, discharges and next steps

iii) **PM board rounds:** to identify whether EDLs for the current and next day discharges still need completing and highlight this to the medical team

iv) **On ward rounds**, a strong focus on the prioritisation of:

- the sickest patients
- patients ready for discharge/clinically safe to transfer
- active progression of all other patients' pathways
- creation of 'ready to take' and 'sleep easy' bed spaces for key patient groups (for instance NOF bed, HASU, CCU)
- Identify 'early riser' discharge patient
- criteria based discharges, particularly for weekends
- **Ward staff emphasis on:**
  - follow up on actions from ward rounds, to achieve discharges as fast as possible
  - use of the discharge lounge as 'the norm'
  - actions overnight to enable early morning discharges and transfers to the discharge lounge (ward clock)
  - contact with AMU/Short Stay to 'pull' patient to IP from early morning (one before 10)
  - controlled use of side rooms, daily review and designation, supported by the Infection Control team

v) Continued deployment SAFER Bundle across all acute wards

Senior review daily
All patients to have Anticipated Date of Discharge: and work daily on actions to achieve this
Flow: discharge one patient from each ward and admit one patient before 10 known as **Golden Patients**
Early discharge: 1/3 before 12 and 80% by 18:00, plus we need to pull more discharges into the afternoon/early evening – currently 40+ patients leaving 20:00 onwards and then challenge to fill those beds
Review – next steps, **Red**2**Green** every day - especially to avoid over 7 day stays

- Red/Green Board Rounds – positive actions every day - reduce non clinical waits
- Planned sessions with nursing and clinical teams on pyjama paralysis and 1000 days – valuing patients' time
- Internal delays discussed at ops meeting each morning & weekly review of complex pathways

vi) Next Steps on EPR/ Red & Green days for each patient t**racking/reducing LoS > 7 and > 21 days**

- Next steps for all patients pathways are recorded on EPR with internal electronic referrals and tracking of waits
- Targeting daily actions to avoid LoS > 7 days
- Daily 7 day 'stranded' patient report and review, ensure all patients over 5 days are on target with their plans – expedite & escalate issues daily
- 7 day stranded internal target is 230 to maintain flow
- Weekly LoS meetings review of ward performance metrics and complex patients led by Director of Operations and clinical support and challenge provided by the Deputy Director of Nursing, for the Directors of Nursing
- External causes of delays will be escalated via the resilience calls and onward to Urgent Care Operational Group & A&E Delivery Board for more significant issues

vii) Patient Pathway Co Ordination & Enhancing Ward Rounds

- Patient Pathway Coordinators and Medical Support Workers will support the focus on actions every day to advance clinical pathways and discharge pathways
- A key part of this will be to work with ward sisters and multi disciplinary team to maximise the effectiveness of ward round

viii) **Patient Transport**

- Ideally transport to be booked day before discharge or as early as possible for on the day discharges
- Careful consideration regarding stretcher / chair request to optimise impact on resources for ambulance services
- Any risk of cancelled journeys to be escalated to Clinical Site Team and On Call Manager for PTS
- Alpha Care provision will supplement SCAS PTS service

ix) 7 day working

- Weekend Consultant ward rounds and junior team on all medical wards
- Review of criteria led discharge Sat / Sun, by Ward Coordinators
- Huddles at weekends to prioritise consultant work and potential discharges for Monday
- Dedicated Pharmacy Discharge Team comprising of a ward based Pharmacist and a Technician available to support with urgent TTAs on a Saturday and Sunday from 11.00 to 16.00 (This is in addition to the current Saturday and Sunday dispensary service)

- **Infection Control measures and processes:**
  - Outbreak communications as per policy and including:
    - internal staff via face to face, written comms/notices on wards and internal email, Round Up and Weekly Blog
    - external to patients and the public via website and media
  - Visual management at Ops Centre to track bays/wards affected and decisions made on cleaning/opening beds/wards. Bed closures and opening to be approved by Infection Control Lead (or as agreed in the Weekend Plan) or the Consultant Microbiologist
  - Daily review of infection status on EPR by Matrons and proactive management to IC guidelines as a norm
  - Daily update from Infection Control Team, with IC working closely with CSMs and Daily Operations Directors to be clear on bed capacity available/closed
  - Scrutiny of the use of side rooms across the Trust
  - Lead on the flu monitoring for SitRep
  - Ensure the new ward areas comply with the Health and Social Care Act (2008) Code of Practice (2015) and other relevant guidance

x) Outlier management

- The 'outlier buddy' system will continue as follows:

Hunter/Lister – Rheumatology/Endocrinology	Sonning – Elderly Care
Dorrell – Renal	Hopkins – Gastroenterology

- The numbers and spread of outlying patients will be kept under close review, and we will work hard to balance the numbers across the IP wards
- Outlier doctor will be recruited to support the care of outlying patients (subject to resources)
- The DOOs and DoNs will review the escalation plan on a Friday each week with reference to surgical TCIs for Monday, current spread of outliers and staff on medical and surgical wards

xi) Last Day In Hospital: Battle Day Unit (BDU) incorporating Discharge/Stretcher Lounge

- New arrangements will facilitate
  - i) Admission avoidance
  - ii) Last day of care for treatments which could be provided on BDU and release ward beds
  - iii) Last day in hospital for patients discharged from wards and awaiting transport home

xii) Maximising discharge flow: the following will be prioritised:

- Use of BDU Discharge Lounge as the 'norm' from wards
- Identification of 'Early Bird' patients for discharge before 10 (ideally) and certainly by 12 noon
- Early transfer of stretcher patients to Battle Day Unit Discharge/Stretcher Lounge
- Maximum use of Battle Day Unit to offer last day treatments from wards and avoid admission at front door

xiii) Early Bird Programme

Each afternoon during discharge huddle at least one 'early bird' patient to be identified per ward will be identified and highlighted to the BDU discharge team

- An 'early bird' patient means that discharge the next day is definite and the patient will be prepared for discharge overnight by the evening/overnight team
- BDU discharge team will visit wards and discharge with the 'early bird' the process of discharge from the ward for the following morning ideally by 10 am
- Night CSM will support wards to ensure 'early bird' patients and know and actions are being prioritised
- An 'early bird' checklist will be prepared for each patient and placed by the bedside
- Discharge from the ward can be either directly home/to their onward destination or to the BDU discharge/stretcher lounge
- Key actions to enable this to be successful for each patient incl:
  - Any last clinical tasks noted and actionned
  - Transport ordered
  - TTOs ordered and available
  - Relatives/care home informed
  - Night staff to start to support patients prepare for discharge eg washing and dressing, breakfast etc – Care Crew to assist where appropriate
  - BDU discharge team will support wards at the start of each day incl maximising use of the discharge/stretcher to achieve early release of beds
  - Blocks to early discharge will be monitored for the purposes of problem solving

At Community Sites

Standard work adopted across In Patient Units (IPU) to support patient flow:

- All IPUs implement guideline to support systems flow with flexibility of admissions into Berkshire West beds
- All patients have a recorded Intended Date of Discharge (EDD) and work daily on actions to achieve
- Community Hospital Trusted Assessor patient handover in place to streamline referral process
- Daily board rounds in place using red to green principles
- Provide daily sit rep identifying discharges over next 72 hours to facilitate early discharge from RBHFT
- Utilise CHS to support the discharge of self funding patients
- Internal and external causes of delays will be escalated via system resilience calls
- Ward managers and Head of Service will expedite complex discharges and in particularly to assist with the use of the Choice Policy

At Mental Health Sites:

- CRHTT to gate keep all admissions to acute mental health beds
- Weekly system DTOC calls with issues escalated to Locality Directors

- Daily Bed Management meetings with planned discharges declared.
- Daily system updates on mental health bed position within PPH and number of acute overspill beds being used.
- Out of panel funding requests to enable timely transfer to placement
- Use of Section 17 leave to placements to be considered for any patient identified as DTOC or potential DTOCs with BHFT funding
- Use of alternative to admission beds

4. INTEGRATED DISCHARGE & PARTNERSHIP WORKING

i) Discharge to Assess / Trusted Assessor/Hip Fracture Early Supported Discharge

- Hip Fracture Early Supported Discharge (ESD) has been made permanent and will continue to support discharge across orthopaedics / trauma / hip fragility
- Work will continue to to identify ways to increase discharge to assess/trusted assessor across the system

ii) DTOC reductions to reduce bed occupancy & CHS Service

- CHS service will continue to support the discharge of self self funding patients across the system and their families will continue to be benefit from support to identify appropriate nursing and residential care in a timely manner
- Targeted work will continue at DAS/Director of Operations level daily/weekly to reduce blocks in patient pathways
- Adoption of the best practice in the High Impact Change model
- Whole system leadership through weekly ICS/DASS meetings
- Recent winter funding for LAs will be used to actively support the maintenance of current level of DTOC and to support smoothing of pathways to reduce >7 day and > 21 day LoS

iii) Redesigned Integrated Discharge Service

- The redeveloped Integrated Discharge Service will work with all wards to expedite complex discharges and in particularly to assist with the use of the Choice Policy
- This team will work closely with Patient Pathway Coordinators and Ward Sisters on all wards to expedite discharges generally

iv) Community Hospital Bed Management Programme

- Daily Board Rounds to continue to support LoS reductions, reduce bed occupancy and ensure that maximum beds are made available on a daily basis
- Adjustments in community beds to increase (by 3) Neuro rehab and the deployment of a more intensive general rehabilitation model as staffing allows
- A continuation of maximum use of flexible criteria to ensure that community beds are filled – 'no bed left empty' approach
- Improved transfer arrangements between acute and community beds to ensure that beds are fully used in a timely manner and patient transfers happen earlier in the day

v) Mental Health bed management programme

- Daily bed meetings chaired by Directors and attended by inpatients, HTT and Community Teams
- Dedicated locality links for patient flow who attend the PPH site x3 per week
- Bed manager responsible for clinical prioritisation for admission

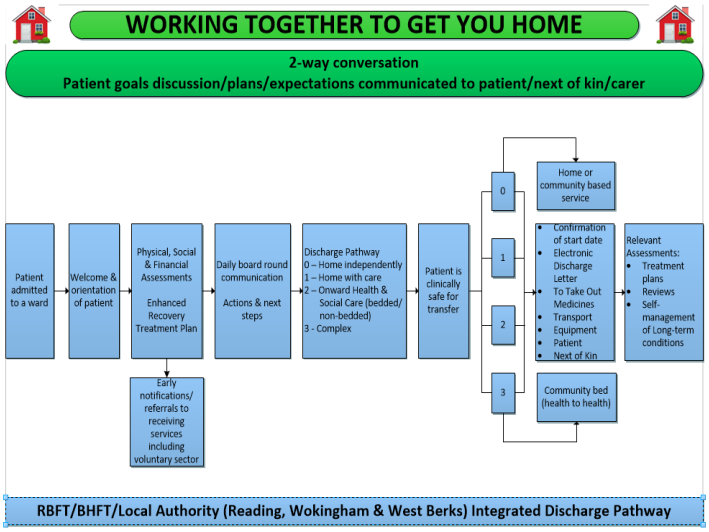
vi) Berkshire wide visual bed management system

- System wide bed management system will be available showing acute and community beds across West Berkshire to improve bed management across the system

vii) **Red Cross Extended Stay model** will support patients at risk of becoming stranded for non clinical reasons

viii) **Integrated Discharge Pathway**

- System wide agreement on principles for effective discharge steps across all settings



5. FLOW MANAGEMENT & COMMUNICATION

i) Predictors and activity monitoring

- Comprehensive predictor tool built into EPR, with 4 weekly review and re-profile against activity
- Daily and weekly review of ambulance arrival times with monthly meeting with SCAS
- GP referral times and number to be reviewed weekly
- GP streaming numbers will be monitored daily and weekly
- KPI dashboard will review key metrics to enable us to 'take the temperature' of the system incl ED attendances, ambulatory, admissions, case mix (resus, majors, minors, GP streaming), LoS in hospital and on discharge, 7 day patients, LoS, bed occupancy

ii) Acute Trust Roles and Responsibilities

Ward Managers/Nurse in Charge Roles & Responsibilities

- To manage and set the standard for the board rounds daily, ensuring that each patient has a plan towards discharge and that EPR is updated and actions are completed in a timely fashion.
  - i) Proactive planning with MDT
  - ii) EDL's /TTO's for any patients being discharged within the next 24-48 hours
  - iii) Referrals completed on EPR
  - iv) Identifying discharges in a timely manner for golden patient
  - v) Ensuring transport booked appropriately
  - vi) Escalation of any delays in the patient pathway that prevents progress to discharge. (Red days to green)
- Ensuring all staff are aware of their role and responsibilities towards flow
- In Sister absence; The ward coordinator should adopt those responsibilities

Matrons Roles & Responsibilities

- Set standards expected to achieve flow through ward areas and ensure staff have capability and support to achieve standard
- Take escalated actions to support ward flow and work with management teams across care groups to resolve

- Raise any 'blocks' that unable to resolve to the DOO responsible for that area for support
- Communicate back to the wards any trust issues/updates regarding patient flow or any other issues that they can possibly support with.
- Ensure capacity is available to meet known demand both electively and non-electively and escalate if insufficient. Work with colleagues to resolve, escalate to site team as required for support.
- Review and ensure that on a daily basis that EPR is kept up to date, if it is not raise with the ward sister/NIC and challenge
- Escalate safety concerns or inappropriate placing of patients to site team for resolution

Clinical Site Manager Roles & Responsibilities

- Daily responsibility for flow using resources appropriately, acts as senior decision maker for all bed capacity issues
- Work forward into ED and AMU/SSU to support effective flow and breach avoidance and in liaison with ward roles to ensure effective flow including identification of 'early bird' patients and timely release of beds throughout the 24 hour period. As resources allow this will be supported by an additional band 8a on a twilight shift
- Manage predictors and flow. Advise Director of the Day and On Call Manager as to an accurate bed state throughout the day, escalating concerns as necessary to enable robust decision making
- Work with teams across the Trust to identify early bed requirements and facilitate right patient right place first time as able
- Work with Directorate teams to analyse capacity requirements and support their escalation planning
- Support the gathering of accurate bed states on EPR and escalate areas of concern
- Work with DoOs on capacity planning using expertise to review plans.

iii) Bed capacity and escalation arrangements:
At the Acute Trust

a) Measures to protect ambulatory and day care areas at the Acute Trust will continue to reduce i) the demands for overnight beds and ii) the options to bed day care areas overnight apart from very exceptional circumstances

b) There will be a continuous drive to control length of stay and maintain current length of stay improvements (4.7 from 5.5 over this summer) and challenge a further reduction of 0.5 days at the Acute Trust and further across all sites across the system

c) Decisions on bed capacity and daily escalation at the Acute Trust will be made via the daily Ops Meetings, to secure a balanced position and safe hospital, utilising the following options:
   a) Continued flexible use of surgical capacity to support medical escalation and the need for medical outliers, taking careful account of the elective demand requirement
   b) Equitable distribution of medical outliers in order to balance workloads and acuity across the medical teams
   c) Wherever possible flex down 12 beds on Burghfield and Mortimer and 8 on Hurley Lodge Plans to be agreed each Friday and reviewed throughout each week..

d) Reorganisation of Acute Medical Unit (AMU) and Short Stay Unit (SSU) in 3 stages, subject to the prevailing requirements of bed flow at the time:
   - SSU will move into new unit on 23rd December
   - 9 closed beds on AMU will reopen 27th December
   - A further 16 beds will open 2nd January
   - this includes the creation with AMU of an additional 2 HMU beds

e) In addition there will be planned swap of Redlands Ward from elective orthopaedics to support emergency flow for a period of 3 week post New Year Bank Holiday (2 weeks open for admissions with a further week to decommission and return to elective orthopaedic work)

f) An additional 2 Intensive Care (ICU) beds are already available which alleviate a proportion of the ICU bed pressures. ICU escalation plan agreed both internally and with ED

g) Point of Care testing in ED to identify patients with potential flu and other key infections in order to inform optimum placement of patients to available beds and minimise the impact on other patients as much as possible.
h) Hurley Ward (potentially flexing into the adjacent Hurley Lodge as required if staffing allows) will deploy a case mix change which will provide improved accommodation and skills concentration for palliative care patients, with physical changes to the ward environment as estates capacity and patient flow demands allows (likely later in Q4)
i) The potential to access last winter's arrangement with Circle to accommodate a number of neuro rehab patients will continue to explored and arrangements confirmed when available
j) A refined and transformed discharge lounge model and increased used of Battle Day Unit to provide admission avoidance and last day of care – all of which is intended to enable beds to be released earlier on in patient wards
k) Bedding day care areas will be actively avoided and only used in absolute extremis and authorised at Executive Director level
l) The moving of 'tomorrow's discharges' will also be avoided wherever possible
m) Should situations develop 'in extremis' decisions will be made at Executive level if any deviation from this plan is warranted including the management of electives (below)
n) **All decisions about the deployment of these bed capacity options will be reviewed and authorised through the daily ops management process and signed off at COO/On Call Director level**

At Community Sites:

o) Daily Board Rounds and resolution of delays in patient pathways
p) Adjustments in community beds to increase (by 3) Neuro rehab and the deployment of a more intensive general rehabilitation model as staffing allows
q) Improved transfer arrangements between acute and community beds to ensure that beds are fully used in a timely manner and patient transfers happen earlier in the day
r) System wide bed management system showing acute and community beds across West Berkshire to improve bed management across the system

At Mental Health Sites:

s) Access to community services within the Wokingham, Reading and Newbury areas to provide community care packages to support early discharge from in mental health inpatient units and support patients in the community

iv) Elective management plan at Acute Trust

- The Trust will work hard to maintain admissions for elective patients, although mindful that sensible adjustments may need to be made in early January. Theatre lists will be constructed as follows:
    a) Treatment of clinically urgent and cancer patients
    b) Maximum use of Day Care beds where appropriate
    c) Protection of Cancer and RTT standards
- Elective admissions will continue be closely scrutinised as part of the daily Ops process and any potential decisions about the need to cancel cases will aim to minimise cancellations wherever possible.
- Redlands will swap its use from elective to emergency capacity for 3 weeks (2 weeks admitting) – patient case mix to be agreed as events unfold as part of daily ops decision making

v) Staffing plans & staffing huddles

At the Acute Trust:

- Staffing levels and recruitment/retention issues will be kept under close scrutiny throughout the winter period
- Also, there is an increased risk of unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus), in addition to adverse weather preventing staff from coming to work – this will also be kept under close review
- Daily nursing staffing huddles will take place each day after the daily Ops Meeting and the prevailing circumstances including the above will be considered as part of decisions re staffing allocations/adjustments

- Nurse staffing levels will then be further monitored by Matrons throughout the day and Senior Duty Nurse at weekends
- A further assessment of nurse staffing levels will take place late afternoon/early evening ahead of the night
- Out of hours safe staffing will be monitored and reviewed by the Clinical Site Team
- Other staffing levels including medical staffing will take place at daily Ops Meeting and throughout each day
- New Medical Rota Co Ordinator will maintain continuous review of medical cover/locum requirement in consultation with Senior Medical staff
- On Call Manager and On Call Director will review and sanction all requests for additional agency and locum booking over weekends and out of hours

At community sites:

- Staffing levels will be monitored daily throughout the winter period by Service Manager and Head of Service
- Staffing escalation process will be followed to ensure safe staffing levels
- On Call Director will sanction agency booking over weekends and out of hours

At Mental Health sites:

- Daily monitoring of staffing within Urgent care pathways
- Staffing escalation process to be followed to Service Manager and Head of Service
- On call Director will sanction additional staffing to meet significant increases in demand.

vi) **Support services**

- Estates, portering and housekeeping to be constantly reviewed and escalated as required at the daily Ops Meeting.
- Portering and housekeeping supervisors will be offered the opportunity to link more closely into the Clinical Site Management Hub once it is established

vii) Patient transport

- Patient transport to be booked in a timely manner and reviewed by SCAS and discussed at daily operational meeting and escalated as required
- Strong emphasis on booking the day before discharge wherever possible, and as early as possible for on the day discharge decisions
- System wide approach to ensure timely discharge and timely release/occupation of beds at all site

viii) On the Day Management @ Acute Trust

- Each day a senior operational manager will take the role of Daily Operations Director and will lead the daily Ops Meetings and keep an oversight of the day taking escalated action as required
- **Daily Ops Meetings will be held in the Operations Centre at 09:30 and 15.00 with an evening huddle at 17.00/17.30 in the Clinical Site Management Hub**
- **These meetings will designate the escalation status of the hospital according to the OPEL framework** and ward escalation boards and intranet will be updated – with the **9.30 meeting** making the key designation at the start of the start of the day
- **The 9.30 meeting** is the key meeting of the day and all specialty areas and key departments are expected to attend and report their position and any issues for which they require support including those that might affect their contribution to the smooth running of the hospital that day.
- The overall position of the hospital will be considered, appropriate information cascaded and agreements made on actions required
- This may include actions required immediately to deal with the circumstances across the front door
- All areas are expected to update the CSM or Daily Operations Director if matters change for their department during the day
- **The 15:00 meeting** will assess the progression of the day and further action to secure a safe hospital going into the evening and overnight.

- **T**his will include an explicit discussion to be regarding the next day's early discharges ie a patient per ward to be discharged/transferred to the Discharge Lounge before 10:00 the next day
- **The 17.00/17.30 huddle** between CSMs, Daily Operations Director and On Call Manager , including Matrons, consider further decision making going into the evening, together with the On Call Director if necessary.
- The key purpose of the evening huddle is to understand issues going into the night and ensure that patient safety, clinical and operational issues are addressed
- **Each Friday at 15.00** a weekend plan meeting will be held, with On Call Managers and On Call Directors attending – this meeting will agree the plan for the Friday overnight period and throughout the weekend. As part of this meeting the DoO/DoN will specifically agree the bed capacity/escalation arrangements.

ix) Clinical Site Management Hub & Operations Centre at Acute Trust

- Once building work is complete the Clinical Site Manager team will establish a new hub adjacent to the new Operations Centre and a new Integrated Discharge Hub. (OT and Medical teams who will continue to be based in the current AMU Night Management Office)
- This set of arrangements, located at the 'crossroads' of the emergency flow will be used to improve communications, forward planning and escalation, working in tandem with co ordinators across all areas and system partners in terms of onward communications
- The new Operations Centre will be used as the focal point for the management of internal and external Major Incidents

x) Communication tools – 'Silent Winter' Approach

- The purpose of the approach is to maximise actions based on trust and reduce the need for repeated communications, meetings and telephone calls
- The Night Management report will be the key means of communication to senior staff on the hospital position at the start of each day – this gives broadly the position across the hospital contributing factors/actions required at the start of day. Moves will be made during the winter to enable ED to directly input into this report before going off shift, which may be assisted by the use of the digital app noted below.
- The Night Management report will be used to flag the bed requirements for ED, and mostly particularly the situation regarding long waiting patients requiring early transfer to wards – Matrons will use this report as the indicator of action required at the start of the day
- Cascade e mail / bleep messages will be used at the start of the day if more immediate actions are required and throughout the day as necessary
- Daily escalation out to system partners will occur supported by the Directors of Operations and Chief Operating Officer
- Across each week there will be a regular review across system partners of patients clinically fit for transfer:
  a) **Monday / Tuesday system wide review** of patient level data, delays and actions to expedite pathways

  b) At Community Sites:
    - Cascade daily escalation email to all services
    - Supply on the day capacity /challenges for community services & Westcall/MIU
    - Twice daily sit rep for beds
    - Weekly review on Tuesday call for patients clinically safe to transfer
    - Friday position for Westcall and MIU going into the weekend

c) At Mental Health sites:

- Cascade daily escalation email to all services
- Supply on the day capacity/challenges for PMS. CRHTT and inpatients
- Weekly delayed discharges meeting with RBH/LA/CCG to support reduc**tion in delayed discharges**

d) At RBH site:

- Tuesday telephone patient level review and action planning with partners
- Wednesday internal ward review and action planning length of stay meeting will review all stranded patients and patients who are at risk of becoming stranded with support and advice from Deputy Director of Nursing/Care Group Directors of Nursing incl on application of the choice policy

e) **Thursday system wide review** to follow up on actions and to expedite pathways and flow ahead of the weekend

xi) Daily System wide flow management, escalation & working with partners

- Monitoring of activity levels will take place daily and throughout each 24 hour period
- The Acute Trust will apply the OPEL framework and ward escalation boards and intranet will be updated regularly
- A system Opel Status will be agreed on a daily basis taking account of all organisations across the system an cognisant of Acute Trust and SCAS performance/triggers
- Regular communication with SCAS to ensure close monitoring of the hospital and system position, with the deployment of HALO support to ED when required
- Regular communication will take place between RBH and BHFT to work in partnership throughout the period to ensure community beds are fully utilised
- Daily/weekly escalation will take place between RBH and all system partners via 'Silent Winter' arrangements
- The Trust and system partners will participate in escalation arrangement designated by NHSE/I
- Ambulance flows will be closely monitored as well as weekly review of handover times with SCAS partners

xii) OOH management and escalation at the Acute Trust

- On Call and overnight/weekend hospital management arrangements will be set out in the Winter On Call Handbook – this will require an on site presence into the evenings Monday – Friday and also across key weekend periods
- The commitments of the On Call Management team will be require adjusted working hours and staff will be supported to achieve this

xiii) Specific Arrangements and Service Plans 17/12/18-19/01/19

- A directory of services will be published w/c 17th December once rotas are fully completed
- This directory and all rotas will be kept under close review and adjustment as needed
- Diary arrangements will be adjusted during this period including the suspension of a number of key meetings to enable additional focus and support to staff to be provided

xiv) System wide communications plan

- A system wide communications plan has been developed with system partners and will be deployed throughout the period to keep patients informed regarding options for care

6. SUPPLEMENTARY ORGANISATIONAL PLANS/POLICIES IN SUPPORT OF THIS PLAN – TO BE ADDED TO THE INTRANET DURING THE PERIOD

RBH

Predictor model
Infection Control Policy
On Call Winter Handbook
Internal Standards
ED Referral Protocol
Acute Medicine/Ambulatory SOP
Bed capacity plan
Mortuary Capacity Plan
Opel Escalation Policy
ED Escalation Plan
Flu Plan
Cold Weather Plan

SCAS

TO BE ADDED

COMMUNITY SERVICES

TO BE ADDED

MENTAL HEALTH SERVICES

Section 117 funding process
OAPS process and access to alternative to admission beds
Winter plan

VOLUNTARY SERVICES

TO BE ADDED

7. QUALITY & KPI MONITORING

i) KPI Dashboard

TO BE ADDED: Trust KPI dashboard incl NHSI recommendations, A&E DB System Dashboard

ii) Quality Indicator Dashboard

TO BE ADDED

iii) Clinical Outcomes incl Harm assessment

- All incidents will be reviewed in accordance to the RBH Incident Reporting, Investigation and Learning Policy (CG553)
- Where appropriate incidents will be reported to external bodies (for example, to the Police/ Care Quality Commission). A full list of notifiable 'Interested Bodies' is available in NHS England's "Serious Incident Framework" (see section 13);
- The Patient Safety Team will ensure lessons learned from incidents are effectively communicated across the organisation; and will ensure there are processes in place for the monitoring and review of the thematic analysis of incidents, and escalating any identified areas of concern during this period.

iv) RBH Winter Clinical Oversight Board

- Implementation of this Board is intended to give additional support throughout the winter period in order that the situation in regard to attendance/admission volumes and any issues of concern regarding staffing, quality and safety and any risk to clinical outcomes are understood and addressed
- Members of this group will include COO, MD and DoN together with senior Care Group leaders. A process for raising concerns to this Board will be implemented as well as thie Board requiring actions to address key issues and concerns.
- This Board will also monitor Weekly ED performance and will examine the reasons for breaches and agree improvement actions.

- Improvement actions will either be those for immediate attention at service, care group or director level or will be fed to Patient Flow improvement Programme which focuses on both the medical and surgical pathways or referral to A&E DB partners for action

v) West Berks A&E Delivery Board

- System wide plan and internal RBFT plan will be kept under scrutiny by this Board and actions agreed with partners as required

vi) The following national triggers will be applied to initiate escalation response:

a. A&E 4 hour performance less than 95% with a particular focus on Trusts whose performance is **below 85% for the previous day**
b. Deterioration of A&E performance of **more than 10% compared with the same day 6 week average**
c. Ambulance delays where more than **five have been delayed for more than 60 minutes**
d. **One or more 12 hour DTA breach** in A&E
e. Increase in **beds closed due to D&V by 20 beds** from one day to the next
f. Any **major patient safety incident**

These triggers will be **standing agenda items** on system calls and systems meeting **any of the five triggers** required to join national escalation calls at lunchtime.