UHL Winter Plan

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Executive Summary

Context

In winter 2016/17, in common with most other acute Trusts, UHL experienced compromised A&E performance, increased numbers of stranded patients and high levels of occupancy. It is essential that as an Organisation we consider the good practice and challenges of 2016/17 to shape actions for 2017/18 winter to ensure we maintain good quality patient care, reduce pressure on staff and deliver the 4 hour transit time performance. UHL has been asked to provide the following system wide assurances:

1. **A full LLR system wide plan** has been completed and focuses on winter resilience planning across the wider health economy
2. **A plan against the below 6 key areas** (From Pauline Phillips National urgent and Emergency Care Director, Dale Bywater NHSI Regional Director and Paul Watson NHSE Regional Director)
   - All patients who are to be admitted have a timely 'Decision to Admit' to ensure they do not need to remain in the ED for any longer than is clinically necessary.
   - Patients are not cared for on hospital corridors.
   - Escalations beds have the necessary staffing and equipment to ensure safe care.
   - 12 hour trolley waits in the ED never happen.
   - Patients do not wait more than 15 minutes in ambulances before being handed over to the hospital.
   - The hospital can manage increasing demand because of flu, norovirus, etc.
3. **NHSI winter readiness self-assessment** (see attached paper)

Questions

- What is the size of the problem?
- What are our solutions?
- What is the remaining risk?

Conclusion

The capacity gap has significantly reduced due to the efficiencies that have been put in place within the CMGs. It is essential that work continues to embed changes in practice and further developments are made to manage surges in demand and decrease variation.

Input Sought

We would welcome the Board's input

- Note and feedback where required on the supporting analysis and high level proposals.
- To approve implementation of actions described within the paper

For Reference

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [No]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Insert here]
4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]
5. Scheduled date for the **next paper** on this topic: [XX/XX/XX] or [TBC]
6. Executive Summaries should not exceed 4 **sides** [My paper does comply]
7. Papers should not exceed **7 sides.** [My paper does comply]

UHL Winter Plan

1. Planning approach 2017/18

This paper summarises how UHL is proposing to respond to increased surges and/or service demands during the winter period.

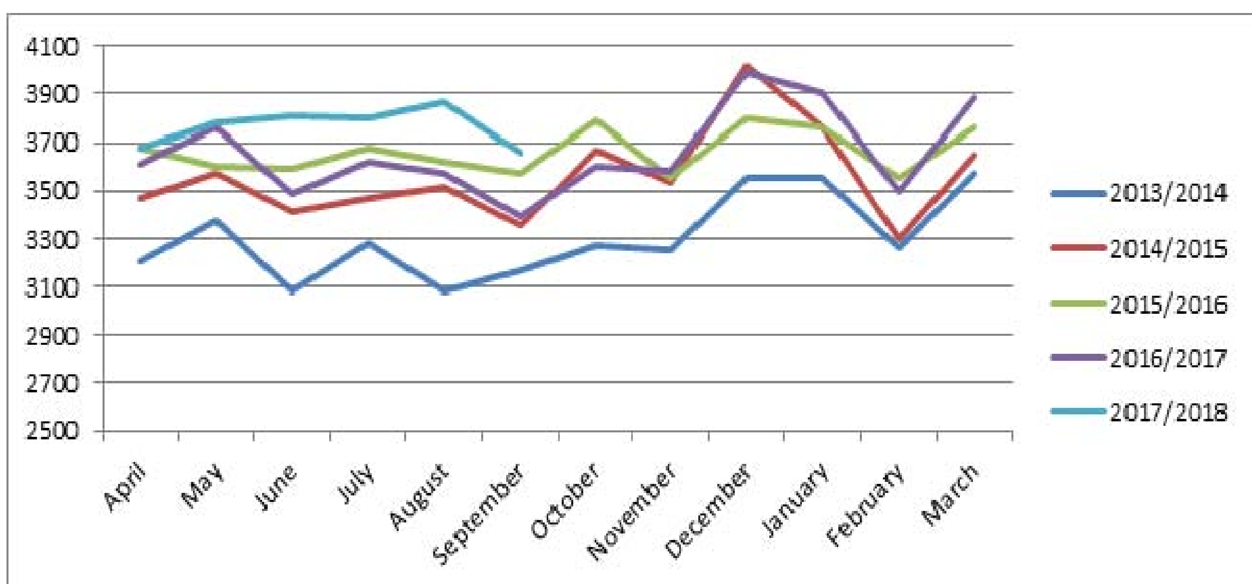
Key factors to consider are:

- ED attendances increased until 2017/18 followed by a decrease in attendances YTD with a forecast of -2% compared to last year (Table 1)
- ED attendances remain relatively static throughout the year with a slight spike in May, November and March
- UHL midnight bed occupancy is approx 90%. ESM is much higher resulting in medical outliers
- DTOC's last year were between 1.8% and 2.9% with an average of 2.4%. This year the average DTOC is 1.8% approximately 25 a day
- Last year the daily number of emergency patients in a bed overnight increased by approx 100 between August and January
- 2017/18 has seen the highest 60+admissions month on month since 2013 (graph 1)
- The bed gap was significantly higher at the beginning of the year (graph 2) and over summer with a 91 bed gap in April decreasing to 31 in September (2017 data)

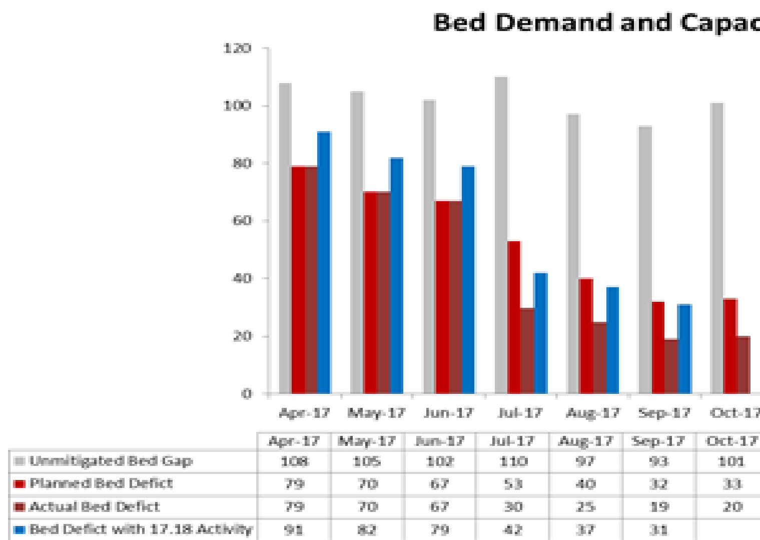
Table 1 UHL ED Attendances (rounded to nearest 100) Type 1, 2 and 3

Year	Total Attendances	Difference	%
13/14	210,800		
14/15	213,400	2,600	+1%
15/16	227,700	14,300	+7%
16/17	237,300	9,600	+4%
17/18 Forecast	232,500	-4,800	-2%

Graph 1 Emergency Admissions (60+ Age) by month and Financial Year



Graph 2 Bed gap based on 17/18 activity



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Unmitigated Bed Gap	108	105	102	110	97	93	101
Planned Bed Deficit	79	70	67	53	40	32	33
Actual Bed Deficit	79	70	67	30	25	19	20
Bed Deficit with 17.18 Activity	91	82	79	42	37	31	

The plan has assumed:
1. No change in system wide plans to deliver decreased attendance and decrease in DTOC's
2. Activity will be similar to last year and that there will be surges in demand

This plan does not contain detailed contingency plans however the below relevant documents are available:
1. Adverse weather policy
2. Seasonal Flu and Pandemic Plans
3. System wide winter plan (attached LLR winter plan

2. UHL winter plan

The winter plan consists of:

- Maximising the efficiency of the existing bed capacity, and achieving as close to 92% occupancy as possible (% to achieve flow based on 2015/16)
- Increasing capacity by creating additional escalation beds (acute or community based), with robust staffing plans to ensure they can be utilised at times of need.
- Managing peaks in demand
- Ensuring efficient discharge including transfer processes from health to social care
- Elective phasing (protection of ITU capacity)
- Robust intelligence on availability of urgent care alternative pathways (UCC, Pharmacy)
- Ensure robust workforce planning
-

The winter plan does not:

1. Provide additional bed capacity due to the lack of staff resource to open additional beds.

3. **Table 2 Predicted bed gap and predicted impact of actions**

		Oct	Nov	Dec	Jan	Feb	March
Beds available		1701	1701	1701	1701	1701	1701
Expected bed deficit			39	24	39	37	37
Gap							
	Action						
5.1	Maximising efficiency of existing bed capacity		0	12	12	12	12
5.2	AMU additional capacity		0	4	4	4	4
5.2	GH additional capacity		0	14	14	14	14
5.3	Managing peaks in demand		0	0	0	0	0
5.4	Ensuring efficient DC		0	1	1	1	1
5.5	Elective phasing		0	0	0	0	0
5.6	Urgent care alternative pathways		0	0	0	0	0
5.7	Ensure robust workforce planning		0	0	0	0	0
	Gap		39	+7	+8	+6	+6

*Gap is based on the whole hospital and is not speciality specific

4. <u>Maximising the efficiency of our existing bed capacity.</u>

Red to Green

This has been the focus of the Organisation of Care (work stream 2) *"An effective and efficient bed capacity"* which is designed to improve the efficiency of medical and cardio-respiratory bed bases (by c. 50 beds) mainly through Red to Green.

During September 2017, the unmitigated gap would have been 93 beds and the Trust planned to have a gap of 32 beds. The actual position reported for September was a gap of 19 beds this was due to improved bed efficiencies in Medicine and Cardio-respiratory. This efficiency can be seen in the LOS improvement (graph 3). Unfortunately this efficiency has been used for the 8% (662 patients) increase in emergency admissions in ESM. Recalculating the bed deficit based on 17-18 activity shows the overall bed deficit (blue bar graph 3) for September as 31 beds.

Graph 3 Average Length of stay in Medicine base wards LRI

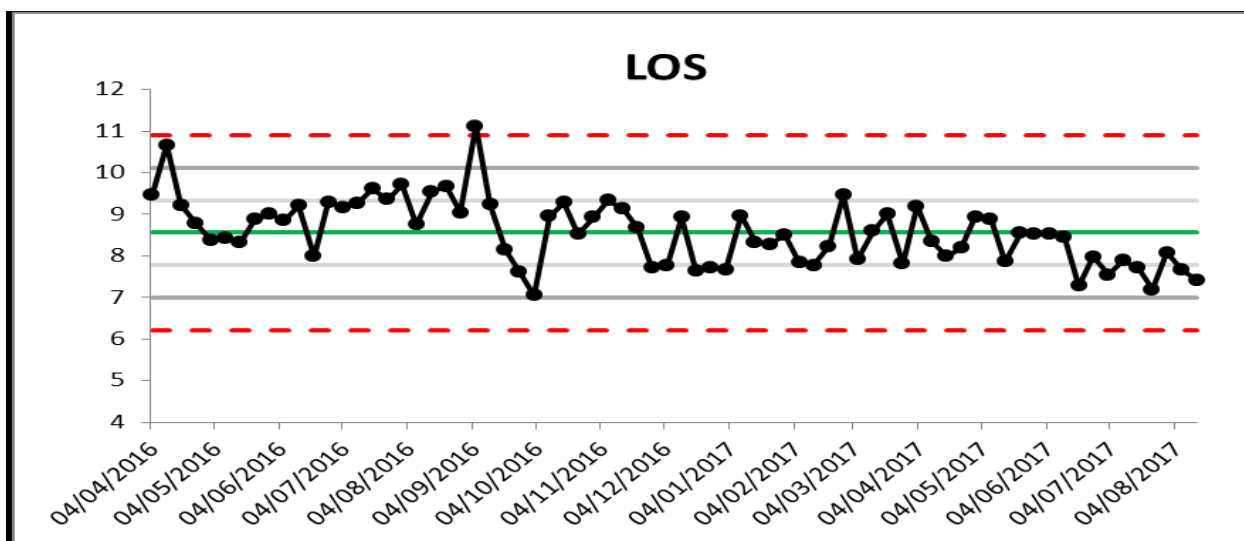


Table 3 Actions

		Deadline	Opportunity
1	Deliver medical step down facility	**December**	
2	Deliver further red to green efficiencies	**1.12.17**	
3	Ensure OD and Transformation capacity is focused on critical areas	**1.11.17**	
4	CMG's own bed occupancy, 4 hr target , ensure business as usual processes are robust, escalation processes are implemented proactively	**In place**	
5	Develop and implement a Frailty pathway	**1.12.17**	**12 beds**
6	Use 'mini-MADE' (Multi-agency discharge events) proactively	**1.11.17**	
7	CMGs ensure actions to decrease >6 day LoS , SAFER is embedded	**1.11.17**	
8	New GPAU to open decreasing conversion to admission	**13.11.17**	

5. <u>Increasing capacity by creating additional escalation beds.</u>

Beds opened last winter as winter capacity are now funded into the baseline and are being run as business as usual. Planned opening of winter escalation beds in December will increase the bed base by 14 at the GGH (4th December and closing by 31st March) and 4 on AMU opening in December. The Additional beds will be staffed and will not compromise staffing / patient care across the Organisation.

As part of the planning process CMGs will be required to ensure they maximise resources to maintain patient flow seven days a week and plan effectively for the predictable peaks in demand at weekends and bank holidays.

Table 4 Actions

		Deadline	Opportunity
1	CMGs to maintain the monitoring of compliance and holding to account (eg in-reach into ED and early acceptance of appropriate patients)	**In place**	**0**
2	ED to request specialist support as early as possible in the patient pathway.	**In place**	**0**
3	Resus capacity must be protected by expediting patients to definitive care.	**In place**	**0**
4	Additional home-care packages to support 'discharge to assess'.	**TBC**	**TBC**
5	Implement 'placement without prejudice'. Patients who have been identified as potentially requiring CHC are discharged to an appropriate out of hospital placement while the assessment and decision is made	**TBC**	**TBC**
6	Ensure trusted assessor is followed at all times	**TBC**	**TBC**
7	Ensure effective and adequately resourced command and control	**TBC**	**TBC**

6. <u>Ensuring efficient discharge including transfer processes from health to social care</u>

Delayed discharges have remained lower than last year (graph 4) and a refocus of actions to ensure this remains in control has already started in medicine.

This is part of Red 2 Green and the development of the Integrated Discharge Team (IDT). Red 2 Green drives the policy of planning discharge in parallel with the acute treatment phase through Estimated Date of Discharge (EDD) planning and the monitoring of the level of stranded patients (LoS >6 days). The IDT attends ward rounds and consolidates the links to social care particularly around complex discharges. These elements will be tested by holding a Multidisciplinary Accelerated Discharge Event (MADE) in early December.

Graph 4 UHL Delayed Discharges April 2017 – Sept 2017

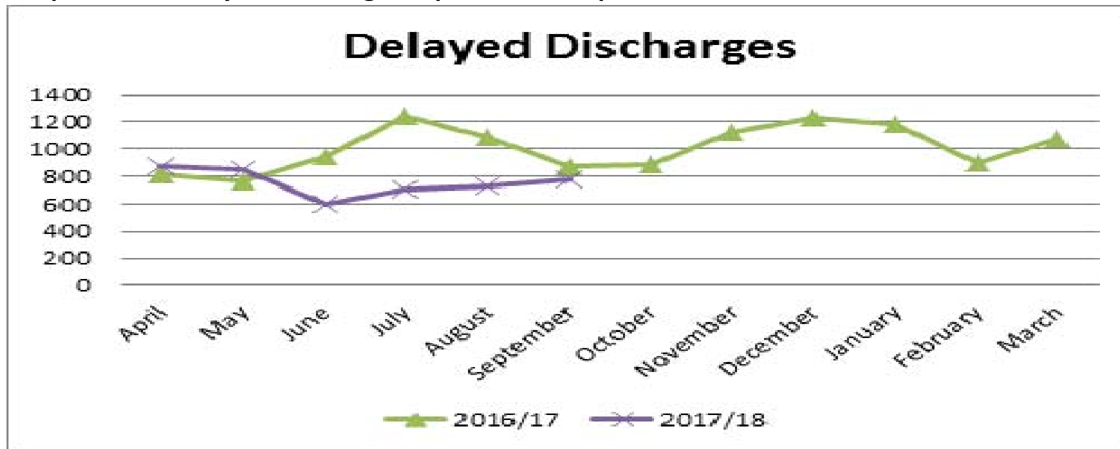


Table 5 Actions

		Deadline	Opportunity
1	Multidisciplinary Accelerated Discharge Event (MADE) in December	**1.12.17**	
2	Embed high Impact Actions to support discharge	**1.12.17**	**1 bed**

7. Elective phasing

The surgical bed owning CMGs and ITAPS have assessed the level of elective phasing possible for the reminder of the year to establish whether it is possible to:

- Increase day case and decrease bed requiring cases
- Increase activity now to mitigate possible cancelations over winter
- Use LGH more to decrease the bed reliance at LRI
- Assess If there are any specialities that can drop activity Dec - Jan and then increase Feb - March

The CMGs were unable to identify any actions that could be implemented to affect the next 4 months however have identified actions which will help next year eg theatre seasonal planning

Table 6 Actions

		Deadline	Opportunity
1	Plan elective / day case to allow maximum activity in none bed requiring cases	**1.12.17**	**0**

8. Robust intelligence on availability on urgent care alternative pathways (UCC, Pharmacy)

The Operational Control Room will be the hub for intelligence on the rest of the health system. The on the day management and liaison with other parts of the system will be enhanced by operational, nursing and medical ‘on day’ management rotas.

9. Ensure robust workforce planning

CMGs will be required to comply with AL processes where shortfalls are identified mitigations will be required to ensure optimal service delivery.

10. Conclusion

A considerable capacity gap remains over the winter period. CMGs are ensuring efficiencies are maximised however the benefits will be small and may only mitigate further potential attendance and admission increases.

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Caring at its best

5. Winter Preparedness

Tim Lynch – Interim Chief Operating Officer

One team shared values

NHS
Improvement

Winter Preparedness Visits
University Hospitals of Leicester

Winter 2017/18

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Staffing

Medical Staffing Arrangements	Description	Outcome/Mitigation
Junior doctor's strike learning	Can the Trust invoke the same level of consultant input for as long as is feasible during the defined above period?	• What is the defined period ? • We will not be able to invoke the same level of Consultant input due to AL (within policy) and the prolonged winter period we had advanced clinical practitioners (nurses) who gave significant support during the doctor's action and the number of these roles have continued to grow over the last 12 months (2017 – 17 new trainees) and new cohort of 12 physicians associates, consultants will be needed to support the development of these roles
Medical job plans	What is being done to maximise the number of PAs available for supporting flow? e.g. • Defer SPAs until Spring/Summer • Convert Clinical Director and Medical Director PAs to clinical for peak period • Ask part-time medics to increase hours for peak period • Suspension of non-safety essential meetings	• CD and MD conversion of PA's will be managed through OPEL and CMG escalation processes • Cancellation of meetings will be managed through CMG and operational command meetings escalation processes • ED – Additional evening and overnight senior ED clinical sessions are being filled over the winter period.
Medical Rotas	To what extent are specialty rotas being changed for the peak period, to create an enhanced robust pool of consultants to be available to go to ED and assessment units 7 days a week, matching resource to demand time	From October 2017 we have implemented a new model of delivery for Acute medicine in ED which has enabled increased senior medical support in ED; this will continue over winter and as business as usual.
Weekend working	Has provision been made to ensure all patients not just new, sick and discharge will receive a senior (ST3+) review daily, 7 days per week	March 2017 7 day service review showed Medicine 87% of patients are seen within 14 hours weekday and weekend Surgery 74% of patients are seen within 14 hours weekday and 73% weekend Respiratory 52% of patients are seen within 14 hours weekday and 50% weekend Geriatrics 74% of patients are seen within 14 hours weekday and 58% weekend The above will be maintained at a minimum over the winter period .
Annual Leave	Is annual leave planning robust, to ensure that minimal leave has been assigned so as not to deplete speciality teams	AL is being monitored through e-roster for nursing staff and through Heads of Ops for medical staff to ensure that AL policies are adhered to.

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Nurse Staffing Arrangements	Description	Outcome/Mitigation
Matrons and Lead Nurses	Have meetings been cancelled to facilitate full visibility on ward areas to support flow	• Each Clinical Management Group has a operation matron of the day who works alongside the manger of the day to oversee flow within their area.
Corporate Nursing Teams	Have all staff in these areas, been redeployed to work in clinical facing areas e.g. wards/ED	• In times of escalation, registered, non-clinical nurses & midwives working in corporate nursing / medical directorates provide support to areas (acknowledging the on-going need to maintain statutory responsibilities (safeguarding / IPC) and to ensure new staff are appropriately trained and supported so they can function as registrants or HCAs • There is now a Silver senior nurse – Head of Nursing, Deputy Head of Nursing or Corporate senior nurse on site overseeing staffing and escalation daily, on site until 9pm and supporting issues by phone until 12md.
Clinical Nurse Specialists	Have clinic commitments been minimised so staff can focus on admission avoidance and reducing LOS through facilitating discharge. Is this practice being followed for community services as well	• Heads of Nursing have reviewed all CNS posts to see what contribution they could make to inpatient care • In-patient based Nurse Specialists (e.g. pain / outreach) have been asked to support in patient areas by instigating specialist treatment plans as opposed to delegating tasks to ward nurses (e.g. changing infusions or dressings / administering first line treatments or interventions) • Team based Nurse Specialists have been asked to work up to one or two clinical shifts month to support wards particularly around discharge pathways. Many of the CNS roles in clinics support admission avoidance and so these clinics continue.
Bank Office	Is there 7 day cover in the bank office to facilitate bank / agency bookings, if required?	• Staff Bank office is open 7 days a week. Monday to Friday 08:30am to 20:00 and Saturday and Sunday 08:30am to 16:00, therefore able to facilitate bank/agency bookings across 7 days.

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Support Services	Description	Outcome/Mitigation
Diagnostic access	Has elective capacity been reduced to accommodate higher inpatient demand – define for what period	• Target turnaround for routine elective diagnostics is 24 hours (7 days a week). The service is performing well against this target and as such is not considering planned reduction in activity over winter. • Decisions to take activity down in extremis will be made in the operational command meetings
Diagnostic capacity	Is sufficient capacity being maintained 7-days a week across all diagnostics to facilitate 'todays work today' including weekends	• Extended CT and MR imaging will be provided at weekends at the Royal and the Glenfield in December. Alongside this teams are working up their plans to ensure results are acted upon in a timely manner • Inpatient hub for reporting has been started to ensure todays reporting is done today.
Therapy availability	Are Therapy staff available to all main ward areas 7-days a week, facilitating a 'todays work today' ethos	• Available 7 days a week on all base wards • The team follow the red to green principles
Pharmacy Cover	Have arrangements been made to ensure pharmacy provision and dispensing is not a barrier to discharge 7-days a week	• Additional resource will be provided at the Glenfield Hospital over winter • Delays will be escalated through red to green and the operational command meetings
Transport	Where transport provision is a known issue have contingencies been made to reduce 'windows' and facilitate early flow	• Portering is a known challenge and a focus of the UHL Scrums to ensure this is rectified ASAP • Hospital transport (TASL) is also a known challenge and is being managed with the CCG

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Capacity	Description	Outcome/Mitigation
Elective stand down	Can the Trust re-align elective capacity for the rest of the year to allow for a full stand down of non-cancer/urgent elective operating for peak provider (Is there available private sector capacity in early January?)	• Theatres and elective holding CMG's are currently reviewing elective activity over winter to establish if any further phasing is possible and to ensure that we have optimised day case opportunities. The results will be available prior to the end of November allowing implementation of any recommendations prior to December
Extra capacity	Have all opportunities been explored to increase capacity that will have an impact on maintaining flow e.g. • Does the trust have a robust full hospital policy which can be safely enacted • Creating seated areas in ED to facilitate Fit2Sit • Co-horting area ready to enact should ambulance delays kick in • Right sized discharge lounge (with capability to take stretcher patients • Additional nursing/ care home & care packages capacity – using extra funding available to local authorities • Using outsourced imaging reading providers, where this is likely to be a constraint to flow • Scheduling clinical nurse specialists and other senior staff on the shop floor during peak demand periods • Can leave rules be reviewed across all critical disciplines – e.g. what are cover levels in Pathology, these need to higher than normal not the same or lower.	• Whole hospital response policy with clear direction on actions to take to increase capacity e.g. cancelation of electives and ambulatory processes • Seated areas are increased during times of escalation and for patients that are fit to sit the waiting areas are used. • A cohorting ambulance escalation area is identified and a policy for when and how to use is available and followed by staff • Additional packages of care can be spot purchased in times of escalation • DRT is available over winter • Outsourcing imaging is not required (see support service slide) • Scheduling additional clinical staff to the shop floor in times of escalation occurs as part of internal ED escalation and the operational command meetings • AL is managed prospectively by the CMG team to ensure adequate shift cover and skill mix. On the day issues and mitigations are managed by the CMG and operational command.
AEC	Is the service compliant with 14hrs a day and 7 day a week delivery and is there resilience within the system to ensure increased demand can be managed across the peak period Is the AEC ring fenced to ensure it will not be bedded?	Yes GPAU 8am – 12 pm 7 days a week

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Leadership	Description	Outcome/Mitigation
Executive Ownership	Is there an executive with operational understanding dedicated each day to the control room / site office to oversee flow that day	• The Director on Call is on call for the 24 hour period. They attend the operational command meetings and will be the escalation point for the Operational Silver Manager and the SMOC out of hours. • The Director on Call will be available on site if required and will remain contactable by phone until 8am.
On-site Silver	Are plans in place to increase on-site silver cover e.g. 10 – 10, 7 days a week	• On site cover has been extended from 13.11.17 • Silver Ops is on site from 9am until 9pm and will remain contactable by phone until Midnight. • The Silver Nursing role will remain on site 12 midday until 9pm and will be contactable by phone until Midnight.
ED Leadership	Is there a senior leader supporting the ED team daily, and does this meet the department demand profile	The following roles support ED: • The Head of Capacity and flow • ED manager of the day • Consultant of the day
System Leadership	Is there dedicated system leadership in place and how will decisions being made to proactively take steps to respond issues as they arise	• ED will manage against agreed targets e.g. time to be seen, time to decision and agreed levels of escalation are in place. • Wards will manage flow against expected and actual beds required • Oversight and organisational priority is run by operational command at 9am, 1pm 4pm and 8pm

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Safety and Governance

Procedures and Processes	Description	Outcome/Mitigation
SAFER	Has the trust undertaken a gap analysis against SAFER bundle and Good Practice on Flow guidance, and taken steps (led by Medical and Nurse Directors) to reduce variation between clinical areas and across days of the week?	• A gap analysis was completed in medicine and respiratory and cardiology in January 2017 prior to go live of red to green • Metrics are collected and reviewed for red to green and used to address any themes for delays and individual patient delays • The SRO for Red to Green as of 1.11.17 is the Chief Nurse to ensure executive oversight and support
Safety huddles and flow meetings	Will there be consultant input to at least the main flow meetings from all core areas – medicine, surgery, trauma, critical care, paeds, O&G, - how are doctors going to help run the hospital in times of stress?	• A safety huddle is in place 7 days a week at the LRI. CMG's have a consultant representative who attends on their behalf
Hospital Full Policy	Is there an up to date verified policy, which all system partners are signed up to	• Yes - Whole hospital response policy
Flu Jab	What % of patient facing staff are vaccinated – how to get to as close as possible to 100%?	
What are reasonable compromises on patient experience to support safety?	Can MSA requirements be relaxed for assessment units?	The following are put in place at times of escalation to ensure safety but compromise patient experience: • Ambulance escalation area • We can mix patients within the ACB as long as patients are level 2 or above and therefore require high dependence care urgently. However once a patient steps down from requiring level 2 care within these facilities if they are mixed this would be reported as a same sex breach to NHS England (no exceptions to this process from an NHSE perspective I guess although we have supported an alternative approach in GSSU). • We never mix within the assessment Units unless in extreme circumstances when on call Director can allow a same sex breach to avoid a 12 hour breach but this is on a case by case basis and we have declared these to local commissioners. Sometimes these are clinically justified but sometimes if commissioners do not agree with our decision we would report as same sex breaches to NHSE. • Clear policies and triggers (via operational command) are in place before these are enacted.
Safety Checklists	What safety checklists does the Trust propose to operate e.g. Bristol checklist, ward checklist, ED safety checklist	• Examples of ward checklists include: Pressure ulcers, falls , waterlow assessments, eobs, IP hand hygiene • Examples of ED checks include ambulance turnaround, time to be seen, time to decision and sepsis

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Emergency Department

Key lines of enquiry	Description	Outcome/Mitigation
Ambulance handover	What operational plans are in place to retain a 15min handover and avoid 1hr plus handover delays	• Ambulance handover policy followed by staff • Ambulance handover escalation area • Senior clinician presence in the assessment area • GPAU to pull appropriate patients out of assessment bay • Fit to sit used • Primary care and injuries to pull patients
Streaming	Is the streaming service fully operational with capacity and operational hours aligned to meet demand	• Yes
Capacity	Where do extra patients reside in the departments, is pressure released in the department through activating the full hospital policy	• Fit to sit using waiting areas • Ambulatory area (blue zone) will be used flexibly • EDU 6 escalation beds
Speciality Input	Is rapid assessment, treatment and decision making available in the ED from speciality departments	• Medicine present • Speciality review target is 30 mins from referral • Patients will go straight to SAU
CDU	Is the CDU managed by the ED Consultants and only used for appropriate care pathways	• EDU at the LRI is managed by Consultants • CDU at the Glenfield is managed by Respiratory and Cardiology Consultants
Confidence Levels	At times of pressure does the department feel it is appropriately supported	• Supported by operational command

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Site Operations

Key lines of enquiry	Description	Outcome/Mitigation
Site Meeting – Attendance	Dependent of escalation level, is there an executive at the site meeting and sufficient senior attendance (including medical) to make decisions	• Operational command meetings are held at 9am 1pm 4pm and 8pm • Representation fro m each CMG (level depends on escalation), Director on call, Silver Manager on call • Meetings are focused on identifying the problems, finding the solution and the CMG's owning and solving the problems
Front Door	Is there a very clear update on the front door position and predictions for the day	• An update on the position plus any issues and mitigations for the day and over night
Oversight	Is a clear picture of the whole site provided understanding surplus/deficit by each areas for the days flow	• The meeting covers the following: • Performance against KPI's • Previous 24 hr performance (9am only) • Current day performance by CMG • Plan for tomorrow • Actions from the meeting and accountable owner, time of delivery, support required etc
Challenge	Are plans challenged e.g., discharge lounge, red day delays and escalated as appropriate	• Plans are challenged by the chair of the meeting and across CMG's • CMG's are rated as red, amber or green depending on their position and actions are aligned to move them towards green
Understanding actions and ownership	Are there tangible actions communicated with defined owners	• Actions are clear with accountable owners and time frames for delivery • Actions by CMG are displayed in the operation command room
Site Plan	Is the meeting ended with an agreed plan to sustain safe flow	The meeting is closed with: • Summary of the status, actions, owners and deadlines • Reminder of the next meeting time and any specific requirements or attendees

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Acute Medical Unit

Key lines of enquiry	Description	Outcome/Mitigation
Assessment	On arrival in AMU how long does a patient wait for initial assessment and is the EDD set at that point	• Medical take is in ED and GPAU so patients have been assessed by medics prior to move • EDD is set on arrival on AMU
Support services	Are in-reach and support services aligned to deliver 'todays work today' on the AMU	• Do not currently have red to green in place • EDD's are managed by the CMG and delays escalated as appropriate in the CMG or in the operational command meeting
Flow	Our wards offering a pre-10am pull to the AMU to ensure early morning capacity for GP and ED admissions	• Gastro and IDU provide a pre 10 am pull to their base wards • ITU review appropriateness for ACB • Acute care specialist nurses, PT and OT are also part of the team
Discharge	Is there a home first culture with support from discharge co-ordinators	• IDT supports AMU ensuring a home first approach
Confidence Levels	At times of pressure does the AMU feel it is appropriately supported and is there executive support embedded	• Supported by operational command meetings

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Ambulatory Emergency Care

Key lines of enquiry	Description	Outcome/Mitigation
Operational hours	Consider hours of access to the service and operation over 7-days	GPAU from 8 am to 12 pm 7 days a week
Area protection	Is the area routinely bedded? And when the area is bedded over night what priority is given to remove the bedded patients	• This area is not bedded in times of escalation • The department is trollies and chairs
Patient appropriateness	What percentage of the medical admissions are avoided through AEC routes? What percentage of patients re admitted to in-patient wards?	
Service Capacity	Are the timescales to initial assessment and medical review aligned to those in ED	• These patients are not on a 4 hour clock • They do report to operational command and flow is monitored • Staff are flexed across ED and medicine if significant pressures are seen in GPAU • Managed closely to ensure it can take throughout the day and it can close at 12 pm

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Surgical Assessment Unit (if applicable)

Key lines of enquiry	Description	Outcome/Mitigation
Assessment	On arrival in SAU how long does a patient wait for initial assessment (ideally within 15minutes) and is the EDD set at that point	The team aim for below 15 minutes to assessment however this is not currently being achieved. EDD is not set in SAU but when the patients hit a base ward.
Support services	Are in-reach and support services aligned to deliver 'todays work today' on the SAU	• The team do not currently follow red to green methodology • SAU will escalate internally to other CMG's if they require additional support • SAU capacity is managed via the operational command meeting and any delays are escalated and managed accordingly
Admissions	Are GP admissions taken directly to the SAU and not via ED	• SAU admissions are direct from GP (Bed bureau)
Discharge	Is there a home first culture with support from discharge co-ordinators	• There is a home first culture • Approximately 50% of patients will go home from SAU
Confidence Levels	At times of pressure does the SAU feel it is appropriately supported	• The CMG will flex staff from the base wards to SAU as required • SAU capacity is considered in the same way as other areas through the operational command meeting

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Wards

Key lines of enquiry	Description	Outcome/Mitigation
Boarding	Are the wards expected to board patients? If so how often does this happen and is it always where there is a definite discharge identified	• Boarding is not acceptable and does not occur • In times of extremis as agreed at operational command safer patient placement (with a risk assessment) may be agreed
SAFER	Are the principles of SAFER operational on the ward: - Daily review by senior decision maker - EDD in place for all patients - Patient pull operational - Focus on pre-noon discharge - Routine review of stranded patients (>6days)	• The principles of SAFER are in place on base wards • Routine review of stranded patients occurs via board rounds plus the weekly medicine stranded patient meeting • There is a focus on pre noon discharge and a discharge lounge first approach to the discharge process • There is a tendency to a push model but with the introduction of the new e-beds system we are moving toward a pull model • The new medicine in reach to ED has enabled a pull system from ED to medicine
Red2Green	Is Red2Green operational with structured resolution of Red days	• Fully operational in medicine • Other CMG's have started work on red to green and use parts of its methodology in some wards
Discharge	Is there a home first culture with support from discharge co-ordinators	• Yes
Confidence Levels	At times of pressure do the wards feel appropriately supported	• CMG's are currently developing their own escalation cards which will include the steps and support they require at each of the OPEL escalation levels • The focus of the operational command meeting is for CMG's to own the problem and find a solution and to identify the support they require

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Discharge Lounge

Key lines of enquiry	Description	Outcome/Mitigation
Capacity	Is the discharge lounge able to accepted seated and bedded patients What are the services operational hours	• The discharge lounge can take seated and bedded patients • It is open from 8 am to 8 pm
Support services	Can discharge summaries and TTOs be completed once patients arrive in the lounge	yes
Transport	Are transport arrangements a barrier to use of the lounge	• We have identified issues with portering which we are currently managing as a priority
Usage	Does the lounge receive patients from the medical wards routinely before 10. If not what are the perceived barriers	• Routinely receives patients before 10 am however we have more to do to increase the number of patients before 10 am
Opportunity	Do the lounge staff feel there is an opportunity to increase the throughput through the area	Yes