NHS
North West London

Capacity Management System (CMS) – Overall Hospital Activity (OHA) Frequently Asked Questions

Below are queries that have been raised in response to the request to provide baseline data for CMS and from face-to-face meetings and training sessions with Acute Trusts. They are organised into the following sections, with the definitions from the training packs included for completeness:

1. OHA Set-up – Baseline Data Gathering
2. OHA Operational Management – Overview Screen and Notes Updating
3. OHA Operational Management – Bed Status Updating
4. OHA Operational Management – Other Updating
5. OHA Information Sharing, Reporting and Escalation
6. Definitions

Please note that we expect to have the above information and the Pressure Surge and ED Policies available online, via a link from the CMS website once it is 'live'.

1. OHA Set-up – Baseline Data Gathering

Q: Could we be clear what we mean about trolleys? Most of us have CDU/MAU or even SAU but most of these are beds not trolleys, do we include these under this heading or not?
A: Under this heading please include all trolleys as well as any beds that are being used for assessment and not for admitted patients.

Q: What is the rationale for including Neonatal and Paeds beds under general bed stock as we cannot admit anyone to these, why are Paeds beds not separate?
A: Neonatal and Paeds beds are to be included as per the nationally agreed definitions. You can see a copy of this at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/index.htm

Q: You have not included anything regarding Paeds ED or UCC which are now often co-located, how is this data captured?
A: Any Paeds ED figures should be included in A&E if it impacts on pressure. The only circumstances that would require a separate data set are where the Paeds ED is actually a separate access point. CMS are working on setting up separate access points for co-located UCCs, please provide the data for this separately in the interim.

Q: How do we deal with separate elective sites, i.e. where a site (under another hospital) has acute capacity but does not have an A&E access point?
A: If the site has bed capacity, please just provide bed stock for it and the site will appear as a 'child' of the main ('parent') site.

Q: We have 6 beds in our CDU, the template has a column for CDU trolleys but the guidance note states that A&E observation needs to be excluded – can you clarify?
A: This column should include all trolleys as well as any beds that are being used for assessment and not for admitted patients.

Q: Do we include in G&A bed count:

- **q:** Infection control ward?
- **a:** Yes
- **q:** Rehabilitation beds?
- **a:** No
- **q:** Stroke unit
- **a:** No
- **q:** Mon – Fri elective ward?
- **a:** No, but this should be included in escalation number if it is open for anything other than electives
- **q:** Palliative Care Unit?
- **a:** No

Q: What does Ext stand for?
A: This is the extension number for the access point

Q: Can mental health be included in a separate area with its own score?
A: No, mental health patients should be classified as others are according to their dependency.

Q: Can ITU be included as access point
A: No, ITU / step down is incorporated within beds. Intensive Care is being addressed as a separate module for Critical Care to be adopted nationally.

Q: Is waiting room data captured?
A: Data in majors and minors should cover this. Patients who have not been triaged should not be included.

Q: Has the currency for UCCs been agreed? How will this be reflected within the CMS tool and what happens if this is not operational 24/7?
A: This is currently under consideration by the project team.

Q: When will the critical care module be operational for London?
A: This is still under discussion.

2. OHA Operational Management – Overview Screen and Notes Updating

Q: OHA Notes – is it possible to pull off a report to show an audit trail of the notes that have been input?
A: Unfortunately not - this field is free text and in common with most web based systems is overwritten by the last entry.

Q: Will we be able to view the algorithms?
A: The algorithm was put together by a group of nurses from an acute hospital in Surrey approx 10 years ago to reflect capacity in their hospital. Given that CMS is a national system it is not possible to change or customise these specifically for London.

Q: Will the colour column on the overall screen be used to indicate the NHS London escalation level?
A: Yes.

Q: Is there a maximum number of characters that can be used for the free text boxes?
A: Yes, 1000 characters – but please note that text box notes are expected to be clear, concise and contextual so that the Overview screen remains easy to read.

Q: Following a dummy run, one of the sites found that when the dependency of patients was changed ie from dependency 1+ to 2 the overall pressure remained the same. Is this usual?

A: We will only get a true response when the correct access point information has been added for **all** hospitals.

Q: Is the overall pressure impacted by the frequency of update?
A: You can update as often as you wish – the overall capacity will reflect any updates made.

Q: Will sites be able to see what the LAS are doing during a divert/closure, e.g. which sites they are conveying to instead?
A: Not currently, although there are plans to enable this sort of information to be available in the future.

3. OHA Operational Management – Bed Status Updating

Q: Can baseline G&A bed stock be amended?
A: Baseline bed stock can be amended in some circumstances after necessary agreement but any short term / temporary changes to bed stock should normally be captured in 'bed closures'.

Q: Can we identify where beds are closed for infection control etc?
A: Not specifically, number of closed beds is captured as a general figure covering all. CMS is in place to identify pressure scores, therefore the detail behind these elements is not necessary. However, the notes field can be used to provide further context to bed closure information.

Q: Will all access points have access to the bed status screen?
A: Yes – transparency is important.

Q: When looking at the repatriation part of the Beds screen, should the figure reflect repatriations that have been completed or those waiting?
A: Repatriations that are waiting.

4. OHA Operational Management – Other Updating

Q: Do we have a national/pan-London definition for outliers or should Trusts employ their own definitions here?
A: Not to our knowledge – this does need to be agreed pan-London.

Q: Is there an example of best practice regarding the operational management of this system from sites that have been using CMS previously?
A: This has been explored, however each region operates the system in a different way, reflecting local needs. Once CMS is implemented pan-London, we will have a clearer understanding of our own operational management needs and an opportunity to influence future system development.

Q: In the A&E module, sometimes due to increased demand and lack of available space, Trusts have reported that they sometimes transfer their majors into their minors dept as they run out of resus space. How will this type of shift be reflected in the system?
A: If the patient is under A&E they will appear under A&E figures despite temporary relocation. It is important to report patient dependency information regardless of where the patients are actually sited in the ED.

Q: Is the level of patient acuity picked up within CMS and how will this be reflected?
A: CMS is about capacity, rather than acuity, and uses the dependency information entered for each Access Point to reflect the resources currently allocated to patients.

Q: What are likely to be the login names allocated? We would prefer individual logins as use of generic login names is against our policy.
A: CMS is a national system and we have adopted the national login policy. This means that a set of generic names is set up for each hospital, each one reflecting hospital name and access point. As

each login will be used by different people, it will be important to change the password information and keep it secure.

5. OHA Information Sharing, Reporting and Escalation

Q: Will CMS replace the current requirement to submit a London Critical Capacity Form to the LAS on a 2 hourly basis?
A: CMS reporting will remove the need for trusts to complete the Critical capacity forms and Emergency Bed Service (EBS) will no longer do the ring-rounds to get this information.

Q: Can we share information with Trusts across border?
A: Yes and this is encouraged. This will need to be brokered over the coming weeks by sectors, acute hospitals and the local health economies concerned. The central CMS implementation team will initiate this process with sectors shortly.

Q: Is there potential for CMS to link into current internal reporting systems such as Cerner?
A: CMS are working with Connecting for Health colleagues to look at this option

Q: Can a trend analysis be produced across Sectors?
A: Yes. A reporting suite is currently in development.

Q: Is there a helpdesk number?
A: A helpdesk number will be displayed on the system in due course.

Q: Who owns the data that is held in the system and who will take responsibility for any FOIs?
A: The wider health economy owns the data. A reporting suite is being constructed, but in the meantime CMS can run reports for FOI requests if required.

Q: Can you develop an interface with the other systems being used across departments, so that information can be updated automatically?
A: There are future plans to do this.

Q: Could CMS provide a list of reports that they run/can run and frequency of them? Also, what reports can the Trusts run themselves?
A: This is currently under development.

Q: Is there any chance of talking to out-of-London trusts who have been using the system for many years?
A: There is a CMS user group that meets regularly. In addition, we will find out if there is a chance of talking to an 'expert user'.

6. Definitions

6.1. General Definitions

TERM	DEFINITION
A&E or AE	Accident & Emergency – NB includes Paeds, unless this is a totally separate access point with its own reception, etc.
Access point	A unit in an Acute hospital where patients go to be assessed, before being admitted or sent home. For CMS purposes, does not include WiCs or UCCs that are not co-located or operating 24/7
ACP	Appropriate Care Pathway, part of the Directory of Services in CMS
CMS	Capacity Management System
Dependency	For CMS purposes, reflects the type of patient and the level of resources they require – see 6.3. NB Do not use the DH patient dependency definitions
DoS	Directory of Services, part of CMS
DTA	Decision to admit to hospital
EAU	Emergency Assessment Unit
ED	Emergency Department
MAU	Medical Assessment Unit (NB CMS does not cover Medical Admission Units)
OHA	Overall Hospital Activity, part of CMS
SAU	Surgical Assessment Unit (NB CMS does not cover Surgical Admission Units)
TCI	To come in date, or the fact that someone is due to be admitted to hospital
UCC	Urgent Care Centre – to be included as a separate access point in CMS, it must be co-located with A&E and operating 24/7

6.2. Bed Status Screen Definitions

Bed Status Definitions

These figures to be updated at least every two hours
Enter the number of patients for **whom a bed has not been allocated**

DTA in A/E - patients at present in A&E, with a decision to admit
DTA in MAU - patients at present in MAU, with a decision to admit
DTA in SAU /SEU / ESU - patients at present in SAU or equivalent, with a decision to admit
Patients still awaiting a bed (over 4 hrs, under 8 hrs)
Potential 12 hr breaches still awaiting a bed (over 8 hrs, under 12 hrs)
Actual 12 hr breaches still awaiting a bed
Routine elective TCIs waiting at home – as SITREP definition
Urgent elective TCIs waiting at home – as SITREP definition
SITREP breaches (over 12 month waiters and over 28 day rule) waiting at home
Elective patients cancelled on the day – patients due to come in today, cancelled today
Elective patients admitted on the day
Out Patient / Day Case patients requiring inpatient bed with a decision to admit
ITU / HDU – step down to acute bed
Patients in internal escalation areas, or overspill beds, or private sites/areas
Outliers in funded G&A beds
Repatriation – OUT to tertiary or other acute sites – Click Update to enter figures
Repatriation – IN from tertiary or other acute sites – Click Update to enter figures
Potential number of discharges today
Bed Available – number of beds available for patients to access
G&A Declared bed stock – Pre-set and cannot be changed. Defined as 'Number of general and acute NHS hospital beds open and staffed: include all in-patient beds on wards open overnight that are **not** maternity, mental illness or learning disabilities. Also include critical care beds and cots in paediatric and neonate wards, but **exclude** "well baby" cots. Include medical assessment units but **exclude** beds in A&E observation units and day case units and **exclude** residential beds. Use KH03 definitions.'
Number of beds closed – the number of G&A beds on the declared bed stock which are temporarily unavailable (staff shortages, infection control, etc) **and which are empty**.

NB If there is a **permanent or long-term** change to the G&A Declared bed stock, please inform your local CMS Manager.

6.3. Access Point Screen Definitions

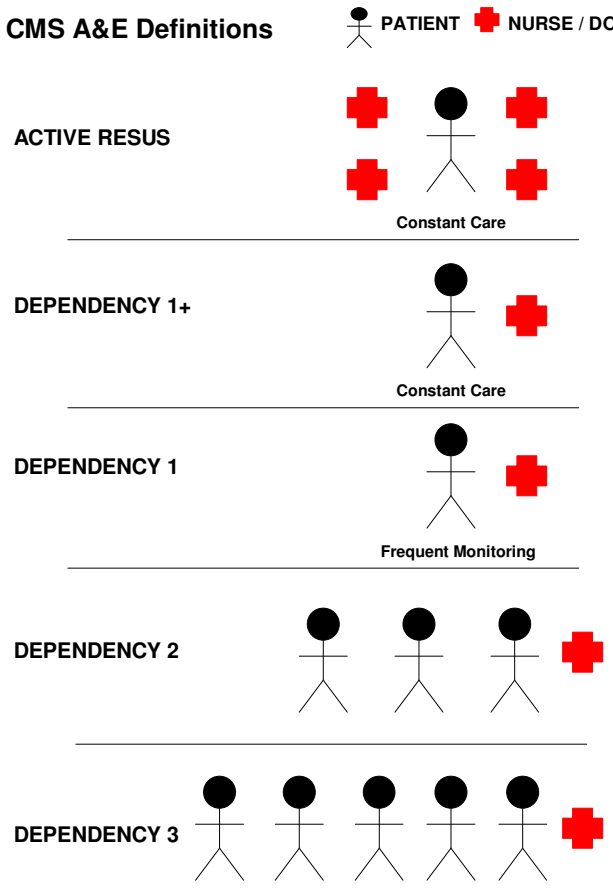
Patient Criteria for Access Point Departments

These figures to be updated <u>at least every two hours.</u>

As activity in the department increases,
it is in the interest of your department and your hospital
to update more frequently

Count the number of MAJORS patients in your department, including patients waiting for a major trolley and patients who have been moved within the department due to lack of capacity.
DO NOT INCLUDE minor injury patients

Classify patients according to the categories below:



Patients **actively** undergoing resuscitation, with Crash Team or Trauma Team in attendance

NB When Active Resus is completed, please reclassify the patient as soon as possible

Dependency 1 patients occupying a resus bay due to lack of capacity in majors, who are **not** undergoing Active Resus

Patients on a trolley/bed who cannot move at all and require full nursing care and assistance

Patients on a trolley/bed who are able to move; can reach for drinks, etc; can walk with assistance

Patients who can care for themselves and are independently mobile; including patients on chairs

(Continued overleaf)

Also enter:

Qualified clinician short	Number of **qualified** clinical staff short of normal shift complement
Patients still in care of ambulance crews	Enter the number of patients in ambulances or on ambulance trolleys awaiting handover to your department
GP urgent referrals expected, including patients still at home	Enter the number of GP referrals expected in the department but not yet occupying a trolley/bed – including patients still waiting at home; patients en route to hospital; and patients in a waiting area. Do not include patients who have been diverted to another department (e.g. you are in MAU and the patient has gone to A&E)
No. of hours wait to see a qualified practitioner/clinician	The time displayed in minors to indicate the likely wait to see a doctor/other A&E professional
No. of minors patients in majors	This is for information only – it does not affect the algorithm. It can be used to record patients transferred in from a co-located UCC that has closed for the night
No. of minors patients in minors	This is for information only – it does not affect the algorithm. It can be used to record patients in a co-located UCC that is not a separate access point

6.4. Scoring System Definitions

These figures are processed through a complex algorithm to produce the scores which appear on the Overall Hospital Activity screen. These scores are not a simple matter of counting patients and trolleys, but are designed to reflect the pressure on the department in a way which allows it to be compared with other departments of different sizes, resources and staffing.

In order to do this calculation, the system holds data which is not visible on the screen, because it is changed only infrequently. This data has been collected from you, and will be checked regularly by the Capacity Managers to ensure that the calculation is based on your current resources. This data consists of:

- the number of resuscitation trolleys in the department
- the number of major trolleys/beds in the department

NB If there is a **permanent or long-term** change to these figures, please inform your local CMS Manager so that the algorithm can be updated.