NHS London

Pressure Surge Planning and Management Arrangements

2010/11

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Document History

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1.0 Introduction

1.1 Key to the success of local system management during times of increased pressure (not just winter), including the triggering of appropriate escalation plans, will be a robust planning process for pressure surges. This document and the accompanying Emergency Department (ED) Capacity Management and Closure Policy v3 (ED Policy) are released to support London's NHS in preparing its pressure surge management (formerly winter planning) for 2010/11.

1.2 The paper sets out the high level trigger points and escalation activities, which should be in place across all London trusts – this is not intended as an exhaustive list and there will be many more locally tailored to individual area needs. These relate to activities associated with keeping patients flowing through Emergency Department's (EDs), and preventing the need to request a re-direction or closure of an ED. The triggers and escalation activities should be reflected in all local planning, and are not restricted to winter based increases in demand – they may occur at any time of year, and the NHS in London needs to be able to deal with this effectively.

1.3 The planning process, which for the most part will involve a review of previous plans and the tailoring of adjustments, built upon learning from previous years will be followed by an assurance exercise. This exercise will be led by sectors who will want to assure themselves, through evidence provided by local trusts and PCTs, that the guidance and activities outlined in this paper, have been incorporated into local planning.

1.4 The paper includes direction on the high level management arrangements to be in place across London to ensure that a systematic approach is taken to pressure management. It is recognised that sectors will want to supplement this with more detailed local arrangements. This guidance should be read in conjunction with the Emergency Department Capacity Management and Closure Policy v3.

1.5 In previous years, there has been considerable variability in the timeliness and application of some of the escalation measures listed in this paper. One of the reasons for this has been a lack of timely and comparable management data to support the decision making process. The implementation of the Capacity Management System (CMS) will provide real-time data to support the implementation of escalation actions, not only during the winter, but year round. It is vital that acute trusts ensure that the data is kept up to date, thereby enabling appropriate management decisions to be taken, across the sector.

The use and effectiveness of CMS in supporting pressure surge management will be kept under review, in order to ensure that any changes or improvements which need to be made to the processes can be made in a timely fashion in order to maximise the benefits.

1.6 In producing this document, the guiding principle has been to maintain local management discretion to take escalation actions relevant to the local situation whilst ensuring that all possible escalation activities have been enacted before a re-direction or closure is requested.

1.7 For the purposes of the enacting of this document, a re-direction or closure of an ED is defined as:

- **Re-direction – self presentations* and all blue lights** still accepted.**
- **Closure – self presentations* and all blue lights** not accepted.**

*Ambulatory patients for co-located WICs or MIUs would in most circumstances continue to be accepted, except infrastructure failure.

** For the purposes of this document, a "blue light" is defined as an ambulance borne patient of sufficient criticality to warrant the use of the ambulance's blue lights on the inbound journey to the ED, where the ED Department will have been pre-alerted to the patient arrival.

Section One

Triggers and Escalation Actions relating to Emergency Department (ED) Re-directions and Closures

2.0 Triggers and Escalation

2.1 The triggers and escalation activities are designed to maintain local management discretion to take escalation actions relevant to the local situation whilst ensuring that all possible escalation activities have been enacted before a re-direction or closure is requested.

2.2 The triggers set out in section four are a combination of factors, suggested by different NHS organisations. Some will have information collected and populated by acute trusts onto CMS. Data or information to support other triggers, including weather conditions or the number of calls to LAS will be linked to CMS pages by the Emergency Bed Service (EBS). Organisations will need to check this information regularly to ensure that they are aware of external factors which may affect them in the near future. The process by which this regular checking will happen should be clear in pressure surge management plans.

2.3 Formal re-direction of the LAS (i.e., agreed by the sector) or closure of an ED due to **capacity issues** should be the last action taken, not the first. The measures set out at section six should have been taken by all trusts before a request is made to the sector for a re-direction. Unless the situation has reached the point where there is the potential for harm to patients, any trust requesting a re-direction, who has not undertaken the actions listed, should have their request denied.

Note: Re-direction or closure due to technical infrastructure failure will continue to be handled separately under section eight of the ED Policy.

3.0 Visibility and Management of Building Pressures

The level of pressure being experienced will be visible to the sector, both from CMS scores, and conversations with trusts. Sectors will be able to determine if there is a need to trigger co-ordinated escalation actions and whether the actions taken are having an effect.

3.1 Unless there has been a sudden surge in activity which could not be anticipated, requiring the consideration of a re-direction if the unit is overwhelmed, the request for a re-direction or closure should not come as a surprise to the sector. It should become clear over a period of time that re-direction may need to be considered if all other actions are not having the required effect.

4.0 Trigger Points – individual organisation

All acute trusts should ensure that the following major trigger points are included in their plans, with actions prepared to mitigate against their impact.

4.1 Increased Demand

- Weather: – After a drop in temperature (to daytime maximum of four to five degrees and night time temperatures below freezing over a two to four day period) there is a known rise in attendances. This occurs three to five days later for cardiovascular conditions and 10 to 12 days later for respiratory illnesses. (See note 1)
- LAS activity – Overall call volume above 3000 calls per day and CAT A calls above 950 calls per day (if continues for 2 consecutive days, will indicate A&E departments coming under pressure.) (See note 1)
- Patient attendances or admissions through A&E reach higher than the daily expected norm under seasonal conditions (will be trust specific, baseline and tolerances will be expected to be specified in local pressure surge plans).

4.2 Decreased Supply

- Bed Capacity: (individual trusts approaching or reach levels of bed availability outside of the planned for norms under seasonal conditions – baselines set in pressure surge plans and agreed by sectors).
  - Critical Care beds (including PICU).
  - General beds (including paediatric).
- Discharges:
  - DTOCs reach 5 more than the normally accepted level
  - Overall predicted / confirmed discharge volumes are below the known threshold for daily discharges required to meet seasonal bed requirements.
- HCAIs – beds / ward closures due to D&V etc. (See note 2)

4.3 Waiting times

- Performance against four hour operational standard falls to 95% for more than 2 - 3 days.
- Significant risk of patients waiting more than 12 hours in the department for admission.

4.4 Staffing

- Staff – actual or predicted staff sickness, absenteeism or vacancy levels reach a point at which provision of safe, effective care for patients is likely to be compromised. (Baseline to be specified by trusts in local plans. Not collected as part of CMS, will need to be monitored by internal trust processes).

Note 1 - Data not specifically collected as part of the CMS tool, but EBS will ensure that weblinks to the information are available and up to date on CMS.
Note 2 - numbers of beds (not wards) closed is collected on CMS

5.0 Trigger Points – Sector and London level

These are included under Section Two – Management Arrangements

6.0 Escalation Actions (see end of document)

The actions listed in the checklist at the end of this paper are not intended as an exhaustive list, but are the main ones which should have been taken prior to any trust asking for a re-direction or closure of the ED. There are numerous other actions, including increased staffing in minors, extended use of the discharge lounge etc., which can be implemented to help manage pressures.

The actions are not listed in an order of priority, and may need to be deployed in groups or singularly, dependant upon the level of pressure being experienced or the efficacy of previous actions taken and the rate at which the pressure is growing.

Section Two

Management Arrangements

7.0 Overview

The purpose of this section is to set out the management arrangements for London in 2010/11 in relation to pressure surges associated with seasonal weather conditions on NHS services. This sets out the agreed roles and responsibilities for the sectors and NHS London, (including the arrangements should it be necessary to move to pan London command and control of the NHS).

In local pressure surge plans, NHS organisations, including sectors, will need to provide in hours and out of hours contact details. Trusts should note that sectors should be the first point of contact for discussions regarding capacity related re-direction or closures of EDs – in accordance with the ED Policy. Capacity related requests should not be directed, either in hours, or out of hours, to NHS01. **Only if an ED closure is required, due to an infrastructure failure, should contact be made directly with NHS01.**

8.0 Roles and Responsibilities

8.1 Sector

- To manage the sector response to pressure surges (on behalf of the SHA), on a day to day basis (both in and out of hours).
- To keep in touch with the day to day situation across the sector and be aware of any developing issues.
- To ensure that a complete picture of the pressures across London are available through the timely updating of the CMS system.
- To be aware of the measures taken by trusts to address the pressure increases and ensure they are activated in a timely manner in order to ensure a swift countering of the pressures.
- To broker agreements across the sector (and with other sectors if possible) to ensure that mutual aid is available if required to re-balance pressures.
- To liaise with LAS over pressure levels, including authorising re-directions from ED departments where necessary, under the ED Policy (both in and out of hours).
- To advise the SHA if there are actions which need to be taken, requiring SHA approval or brokerage, especially where these will affect trusts or organisations outside of London.
- During periods of central command and control, to ensure that the actions requested or endorsed by NHS London are carried out on the ground in a timely manner, and to escalate to NHS London any problems encountered in enacting those decisions.
- To keep NHS London informed through the provision of additional briefings which may be required in order for the SHA to manage the developing situation and to keep the DH informed.
- To ensure that all partner organisations are working effectively together to ensure that patient services are maximised.
- To overcome any barriers to this co-operation across the sector, and escalate to the SHA if this is not possible.
- To brief bordering sectors on any issues which may impact their own management of pressure surges, including notification of ED re-directions or closures which will see LAS traffic re-directed to beyond the sectors own border.

8.1.1 Specific Actions to ensure the above:

Sector at Green

- Maintain normal day to day relationship with trusts, PCTs and the SHA.

Sector at Amber

- Ensure that contacts occur with acute trusts and PCTs on a daily basis to keep abreast of developments. These do not need to be additional calls etc, but can be ones which are likely to occur naturally during the course of working business relationships.
- Hold weekly conference call with sector organisations to ensure that a sector wide view of the pressures is understood, and share any concerns / actions relating to upcoming events.

- Trusts under pressure will, in consultation with the sector handle the consequences of pressure increases, according to their own internal escalation plans. If pressures continue to rise, the sector will need to provide co-ordination and direction on the availability and scope of mutual aid.
- To brief NHS London (senior performance managers) on an informal basis if required on upcoming situations.

Sector at Red or Black

- Sector to hold daily conference calls with relevant partner organisations, and provide system management and leadership.
- Keep NHS London (senior performance managers) informed of the picture across the sector, on a daily basis, providing a high level brief of actions being taken and the next steps as appropriate – e.g., the next intended set of escalation activities to be used, if the previous set have not rectified the situation. This will involve a daily phone call between sectors and senior performance managers at the SHA. A note of the conversation, typed contemporaneously by the sector representative, and emailed to the SHA at the end of the call, will ensure that an agreed record is maintained for assurance purposes.
- To convene additional conference calls to discuss pressure increases as required, ensuring that all participants are aware of the arrangements in a timely manner.
- If two or more sectors report level four (Black), or three or more sectors report level three (Red), NHS London will take a view, following discussions with sector Chief Executives / MDs, and dependent upon the causes and likely duration, as to whether to invoke central command and control arrangements. If this step is taken, NHS London will co-ordinate multi sector or pan London actions, overseen by NHS Gold, until such a time as the pressure levels have returned to more acceptable levels, and control can be returned to sector level.

8.2 NHS London

- To be aware (senior performance managers) of the day to day picture of pressures across the NHS in London once the upper limits of amber and above on CMS are reached.
- To provide advice to the sectors on the handling of escalating situations, if requested.
- To brief surrounding SHAs if pressures in London are likely to impact outside the Capital.
- To brief the DH on any issues likely to attract media attention through pressure surge conditions, participating in DH weekly winter conference calls.
- To enact command and control arrangements if pressure levels cross agreed thresholds, in order to ensure that actions across London are taken in a co-ordinated and timely manner, to ensure that patient safety remains uncompromised.
- To ensure that Emergency Preparedness team (via NHS01) within NHS London are kept abreast in a timely, manner of any developing situations, which they may need to take into account during a major incident.

9.0 Capacity Management System (CMS)

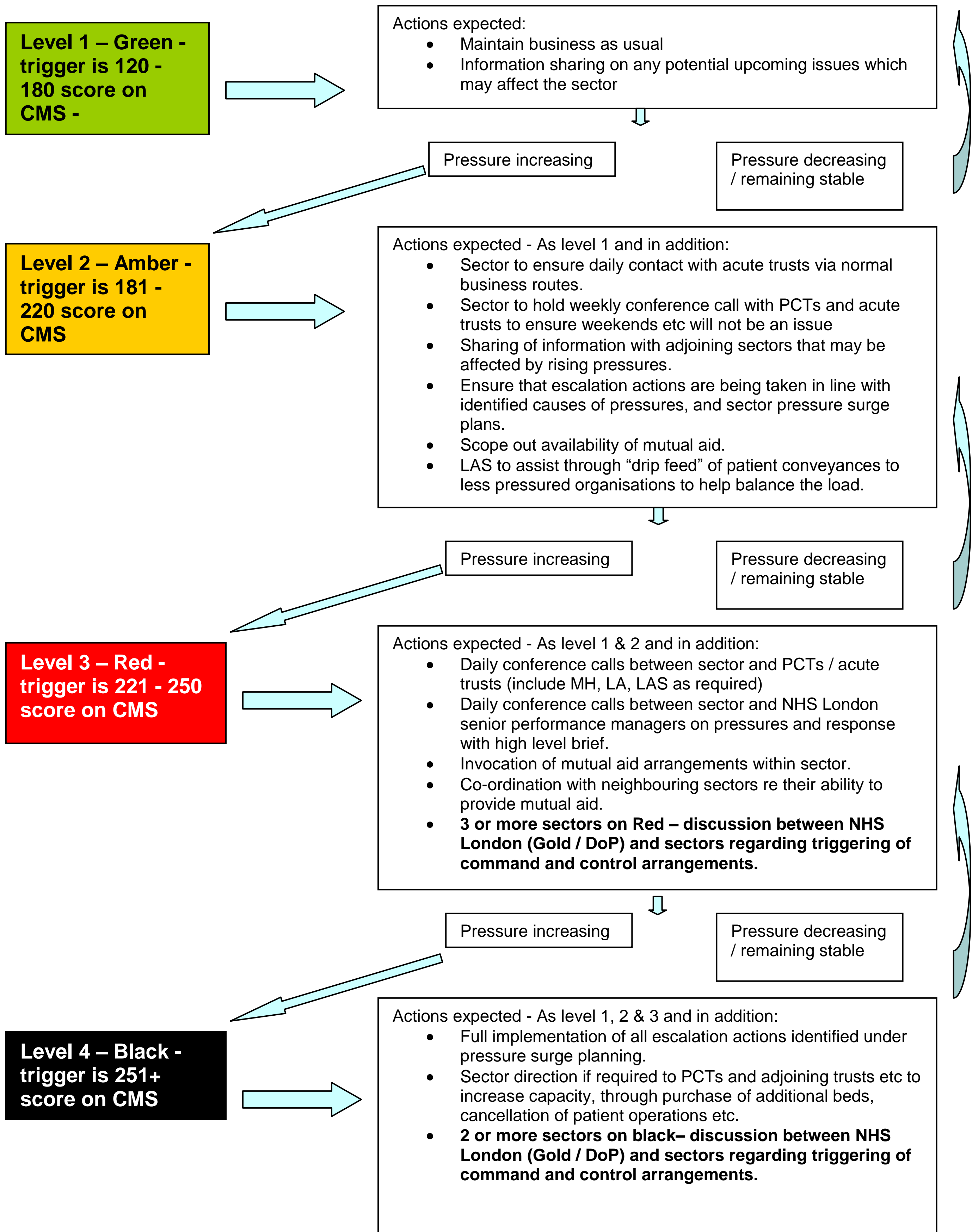
9.1 The system will provide a near real time view across the Capital of the relative pressures being faced by acute trusts, across a range of indicators.

9.2 It is extremely important for all trusts to complete the data, including Foundation Trusts, so that a complete picture of pressures across the capital can be formed and jointly acted upon. If trusts do not keep the information up to date, it will be assumed that they are not experiencing any pressures, and are in a position to offer mutual aid, including taking re-directed patients.

9.3 Acute trusts will still be required to complete the Department of Health daily winter Situation report (Sitrep).

9.4 Update schedules for CMS will be agreed and published to the Service following trial use by early adopters in August 2010.

10.0 Escalation levels and actions



Note – Pressure scores associated with the RAG levels (see coloured boxes), are based on those used elsewhere in the country and will be confirmed once calibration with the early adopters is complete, by end of August 2010. It will be possible for acute sites to indicate their own escalation

status on the CMS screens in the form of a 'traffic light' status - for internal trust use only. This will not, however, form part of the formal pressure assessment at times of escalation – which will use the relative pressure scores to enact escalation processes.

Note: If an ED closure is agreed, due to capacity constraints, this will act as a trigger for the enactment of command and control arrangements in that sector, under the direction of NHS Gold, irrespective of the pressure levels across the rest of London.

11.0 Command and Control Arrangements

11.1 These arrangements have been specifically created for the management of pressure surges such as those attributable to adverse weather conditions. They are designed to enable pan London co-ordination of NHS resources, to cope with a significant increase in pressure, through the use of mutual aid, in order to re-balance the urgent care load being placed on the NHS system, in order to maintain patient safety and access.

Note: Command and control arrangements, in response to pressure surges created by increased activity such as that experienced during either a heat-wave, or winter conditions, differ from those during a major incident.

11.2 Information to support decision making

This will be available through the CMS system, regular briefings from the sectors and twice daily conference calls (see below for suggested attendance), chaired by NHS Gold. The purpose of these calls will be to support collective decision making and information sharing.

11.3 Conference Call arrangements

Once Command and Control arrangements have been invoked, conference calls will initially be scheduled daily at 10.00 and 14.00, but may be varied according to the developing situation. It is likely that calls will also take place over weekends. This will be confirmed at weekday conference calls. Call arrangements, including dial in number and participant codes, will be circulated by NHS London (SM01, Performance Directorate senior performance managers or support staff) to all attendees by email.

Attendee	Responsibility
NHS Gold	Run the "incident" on behalf of the NHS in London
NHS SM01	To provide support to NHS Gold as required
NHS01	To be aware of capacity issues in the event of other emergency situations
Sector MDs (or equivalent)	To provide updates on sector actions, give local direction and leadership, oversee implementation of actions required by NHS London, and liaise with neighbouring sectors regarding potential impacts or actions required
Trust / PCT representatives	To report on the current situation, measures taken and further measures planned. To action SHA requirements as appropriate.
Senior Performance Managers in NHS London	To liaise with sectors outside of calls on progress, additional support required etc
NHS London HCAI Lead	If pressure HCAI linked
LAS Representative	To provide an overview of LAS issues and support to EDs etc.
NHS London Support Staff	To provide general support, advice and note taking, brief DH etc
Others by invitation	To provide ad hoc specific advice as required

11.4 Suggested Agenda

1. Welcome and introductions.
2. Updates against an agreed range of criteria for each trust / sector.
3. LAS update.

4. Update against agreed actions from previous conference call.
5. Look ahead to situation over the next 12 hours and agreement of further actions.
6. Confirmation of next conference call and dial in details.

11.5 Circulation of notes:

- Notes of the meeting will be taken by an appropriate member of the Performance Directorate and circulated to all participants, cc'd to:
- NHS London Chief Executives Office.
- NHS London Communications.
- NHS London Director of Performance.
- Sector Chief Executives.
- NHS01.
- NHS London Head of Emergency Preparedness.
- Bordering SHA's when relevant.

11.6 Briefing of Department of Health / NHS London Chief Executive's Office

Following the conference calls, briefing lines will be agreed with NHS Gold and communicated to DH as appropriate (by either Senior Performance managers or appropriate supporting staff) to keep them informed of the progressing situation. This will be particularly necessary in the event of norovirus outbreaks or the need to close A&E departments due to capacity issues.

11.7 Briefing of surrounding Ambulance Services

The London Ambulance Service will liaise with their counterparts regarding re-directions / closures, on behalf of NHS London and the sectors.

Escalation Actions Checklist

Please ensure that these actions have been taken before contacting the sector to request a re-direction or closure of the ED due to capacity constraints.

Escalation Activity	Completed
Acute trust – managing and reducing demand	
• A&E consultants to be fully deployed to the A&E shop floor.	
• All patients to have initial assessment by registrar or consultant grade, to determine appropriateness of attendance or need for admission – re-direction wherever possible and not life threatening, all admissions to be reviewed and agreed by a consultant.	
• Maximisation of alternative care pathways, prior to arrival of patient at A&E, through telephone triage of all GP referrals for admission, led by consultants (e.g., acute physicians, not necessarily ED consultants – see above) to ensure that admission levels are kept to a minimum, including: o Advising on more appropriate care pathways (e.g., community based) for specific patients or conditions. o Enabling access to diagnostics not normally directly available to primary care. o Re-assurance to GPs about patients on "care of the dying", pathways. o Brokering urgent OPD appointments in other consultant clinics, to avoid unnecessary admissions to hospital etc.	
• GP patients (not calls) sent directly to a ward or Admissions Unit rather than via ED	
Acute trust - Improving supply	
• All inpatients reviewed early in the morning for discharge by consultants before 10am.	
• "Case conferences" between consultants, medical directors and managerial staff to review all inpatients individually and agree appropriateness of continued stay.	
• Opening of all possible extra escalation capacity, private wards etc.	
• 7 day working to ensure continued flow of discharges, access to therapies and diagnostics etc. Tight performance management of ward TTO requests to pharmacy to reduce delays.	
• Maximisation of use of day case and laparoscopic procedures to maintain elective programme, but reduce requirement for beds.	
• Cancellation of all clinically non urgent electives (including private work) / transfer of work to private sector.	
• Consideration given to cancellation of some urgent electives / move of work to other NHS trusts / transfer of work to private sector.	
• Social Services on call managers have been notified of the situation and requested to expedite care packages. Social Services to be in contact several times a day.	
• Inclusion of Social services, PCTs, LAS etc in A&E bed meetings to ensure actions required are understood by the whole system.	
Acute trust - Improving supply - Support Services	
• Pharmacies have been tasked to prioritise TTOs and ensure that medication is dispatched to wards immediately (or discharge lounge if appropriate).	
• Facilities and porters tasked to prioritise cleaning and transfers.	
• Scheduled maintenance has been reviewed, and if likely to impact on capacity	

or patient flow, rescheduled.	
• PTS providers are prioritising patient transfers (discharges) above other work.	
PCT Actions	
• PCT to maximise discharges from community facilities to increase capacity.	
• PCT to purchase extra capacity in community to enable discharges from acute care / prevent patient admissions. Requires full discussion, clarity and agreement between PCTs / trusts prior to the surge to enable swift and responsive spot purchasing where appropriate, supported by locally agreed guidance.	
• Use of community resource (community nursing teams etc) to pull patients from the trusts, if appropriate, including use of intermediate care in-reach to ED and assessment units.	
• Placement of patients "without prejudice" by local PCTs for those patients out of area where external PCTs are not expediting repatriation.	
• Early domiciliary visits to assess urgent care needs	
• PCTs to provide extra GP resource / more hours to WICs, UCCs etc to deal with primary care presentations, enabling A&E to focus on acute presentations.	
• PCT to provide support by contacting OOH and GPs to ensure that only the very sick are referred for admission, and that where possible, conditions are managed in other settings either at home or in community facilities, with PCT support. E.g., OOH providers to provide increased and more rapid visits to patients left at home by LAS crews.	
• Where an outbreak appears to be occurring ie: D&V in a nursing home use a small nurse/Dr team to visit & treat patients in situ, thus preventing admissions – work in liaison with acute trust if more specialised clinical experience required.	
• PCT liaise directly with GP practices where referrals increase inappropriately.	
Staffing	
• Cancellation of staff leave, training courses and re-direction of clinical staff from managerial duties to front line care.	
• Plan local accommodation for staff.	
• Consider supporting staff childcare when schools are closed	
• Staff to be redeployed from around the Trust to support the ED as necessary.	
LAS Escalation Actions	
• LAS to use pressure information on CMS to "drip feed" ambulances to areas of lesser pressure, before a situation develops which requires a full re-direction.	
• LAS, acute trusts / PCTs discuss and agree additional conditions / levels of acuity that can be dealt with via WICS / UCC, to provide more options for LAS crews to convey patients to, other than just A&E.	
Final escalation action:	
• Request to sector for re-direction or for closure of the ED.	