Portsmouth HealthCare NHS
NHS Trust

WINTER ESCALATION PLANS ELDERLY MEDICINE AND COMMUNITY HOSPITALS

1. Introduction

The following plans relate to both elderly medicine and community hospitals and have been generated on the premise that the beds within theses services relate closely to acute hospital provision. For the purposes of this document it is assumed that Community Hospitals are seen in support of Elderly medicine and PHT except in the case of internal variations in staffing levels.

2. Bed shortages in Elderly Medicine

2.1 Background

Elderly medicine consistently achieves bed occupancy of 90% - 95%. This means that in effect it is functioning at the PHT level 2 on an ongoing basis. Bed shortages in Elderly Medicine may not directly affect PHT and usually the response to these shortages will be managed within elderly medicine, community hospitals and the community nursing service.

2.2 Process

- Elderly Medicine will alert the Community Hospitals, PHT and the nominated executive director.
- Community hospitals will be asked to identify the number of empty beds and the number of patients who could be discharged at short notice.
- Community hospital managers will notify community rehab teams.
- Transfers of patients from elderly medicine to community hospitals will in the first instance be to the patients own locality.
- The next stage will be to identify patients who would be willing to be transferred to a different locality where a bed was available.
- In extremis it may be necessary to transfer patients to other localities without consultation
- If GP beds need to be used Community Hospitals will alert local GP's where necessary
- Patients requiring emergency medical admission will be admitted to PHT in the first instance if there are beds available.

3. Bed shortages in PHT

3.1 Background

Actions associated with this type of escalation will take account of PHT 'Bed Shortage escalation' and for clarity the levels here are those described in the PHT document 211200.

3.2 Process

- PHT will be responsible for notifying its' alert status to Elderly Medicine
- Elderly Medicine will in turn alert the Community Hospitals

PHT announces escalation

	ELDERLY MEDICINE	COMMUNITY HOSPITALS	THERAPY SERVICES
LEVEL 1	• Identify no of empty beds • Notify duty consultant • Consider potential discharges	• Identify no of empty beds • Notify community rehab teams • Consider potential discharges	• OT in A&E
LEVEL 2	• Identify number of possible discharges and action • Cancel planned admissions • Book transfers from PHT	• Identify number of possible discharges and action • Cancel planned admissions • Book transfers from PHT as for 2.2 above	• Support to discharges • Increase OT in A&E
LEVEL 3 **RED ALERT** **See below for detail**	• as above • Identify patients who would agree to go to a different locality. • Admit out of normal working hours to Community Hospitals following an agreed check list	• as above • Alert GP bed GP's to consider potential discharges	• as above

Red Alert

Escalation Level 3

Procedure for Bed Shortage Escalation during Red Alert

Definition of Red Alert:
Total occupancy within QAH, St Marys and Haslar Hospitals of over 100% with trolley waits in A&E of over 12 hours.

- If the pressure on the beds reaches this level Portsmouth Hospitals NHS Trust will inform the Department of Elderly Medicine.
  First contact: Barbara Robinson, Deputy General Manager **Tel:**
  Second contact: Lesley Humphrey, General Manager. **Tel:** Code A
  If neither are available CeCe Green, Nurse Specialist **Blee**

- Deputy General Manager informs:

  a) Service Manager, Community Hospitals, Fareham/Gosport
  Tel: Code A

  - Service Manager, Community Hospitals, Havant/Petersfield
  Tel: Code A

- Each Service Manager to identify the number of empty beds and the number of patients who could be discharged at short notice and declare all available beds to the Admission Office, Department of Elderly Medicine.
  Tel: 023 9228 6919

- Community Rehabilitation Teams will be informed by Community Hospital Managers

- The duty consultant or lead consultant will undertake an assessment of the patients in the acute wards to determine if there is anyone who could be transferred earlier than had been planned.

- Transfers of patients from Elderly Medicine to Community Hospitals will in the first instance be to the patients' own locality.

- The next stage is to identify patients who would be willing to be transferred to a different locality where a bed is available.

- On the days and times that wards in the Community Hospitals would not normally accept transfers the following must take place:

  - The patient must be seen by a consultant or Specialist Registrar on the day of transfer to confirm that they are medically stable and fit for transfer.
  - There must be a transfer letter completed by the doctor and nurse.
  - The patient's current medication chart, care plan, nursing and medical notes must be updated and sent with the patient.
  - Supplies of medication and dressings for 7 days must be sent with the patient.
  - The relatives must be informed.

- If there is a problem following transfer the staff should ring the ward from which the patient has been transferred to clarify or seek information.

- If the patient needs to be seen by a doctor, following transfer, the usual procedure would take place for that unit.

Process when Red Alert is declared out of Normal Working Hours

- Senior Manager on call for Portsmouth Hospitals NHS Trust alerts Senior Manager on call for Elderly Medicine. **Pager:** Code A

- Senior Manager on call Elderly Medicine contacts Senior Manager on call for Community Hospitals who will ascertain bed capacity. **Pager:** Code A

- Patients may be transferred from Elderly Medicine as long as the checklist above is followed.

Process for Referrals of Elderly Patients for Inpatient Admission

As part of the Stage 3 Escalation Policy (Red Alert) the following procedures should be followed when a request is made for admission of an elderly patient. Elderly patients are defined as those who are either very elderly and frail or elderly patients with multiple pathology.

During Working Hours (Monday to Friday 8.30am – 5.00pm)

- If a request is made to the Department of Elderly Medicine for admission, the GP or the medical staff of A&E will be asked, if speaking to a consultant or specialist registrar, might avert the need for admission. If not, the Elderly Care Unit will either arrange admission to one of its beds or, if no beds are available, pass the GP (or A&E Department) onto the Patient Access Unit to arrange admission.

Out of Hours

- If the Patient Access Unit receives a request for admission from a GP or the medical staff of the A&E Department, the Patient Access Unit will ask the GP or A&E if speaking to a specialist registrar or consultant in Elderly Medicine might avert the need for admission. If not, the Patient Access Unit will arrange admission.
- If the referrer agrees that consultation with the specialist registrar or consultant might avoid the need for admission, the referring doctor will be put through to the specialist registrar (or consultant) in Elderly Medicine to discuss the case. If after discussion it is felt that admission is necessary, the GP or A&E Department will be referred on to the Patient Access Unit, who will arrange admission.

4. Bed Shortages Within Community Hospitals

4.1 Background

Generally speaking community hospitals have complements of beds relating to elderly medicine, elderly mental health and general practitioners. These usually require to be viewed independently as the first two are managed centrally across the system and the latter by individual practitioners themselves.
Management of bed shortages in community hospitals will therefore require to take account of client group boundaries, (except in the case of major incident when all available beds in community hospitals would need to be used).

The process outlined below relates therefore to GP beds.

4.2 Process

- The referring GP should be asked by nursing staff to consider the possibility of discharge for one of his/her other patients
- Consideration will also be given to enhanced community support and contact made with community nursing and rehab teams (usually nurse led in consultation with GP's).
- The referring GP should discuss with colleagues their potential to discharge patients.
- Depending on the hospital there may be the ability to have the patient admitted to another ward pending a known discharge taking place, (this would be preferable to the patient subsequently requiring an acute admission).
- The referring GP may contact his/her colleagues in other community hospital to see if they would be prepared to accept the admission.

There may be occasions when **all** community hospital beds are full. Under these circumstances PHT and elderly medicine would be informed that transfers out would be impossible. Other actions might be;
- Contact with social services where delayed discharges are the problem.
- Consideration given to discharge of patients to nursing/rest home beds with enhanced community support.

5. Monitoring

- Named individuals will be identified from each site to co-ordinate transfers
- A named individual will be identified as responsible for co-ordination (usually GM elderly medicine or deputy).
- There will be daily contact between the General Manager or Deputy in Elderly Medicine and the Community Hospitals.
- Senior manager 'on call' arrangements for Community hospitals and Elderly Medicine will be shared.
- Reports will be made to the nominated executive team member daily or as required.

6. Staffing Shortages

6.1 Background

Sickness and absence management are integral components of normal operating procedures. However there may be situations when prevailing circumstances challenge the ability of staff and managers to keep staffing at 'safe' levels. It is likely that a number of different and competing demands will render usual practice in relation to staff shortage ineffectual. Specific contingency arrangements have been agreed for Community Hospitals and EMH services in Community Hospitals which are attached as appendices.

Appendix 1

STAFFING CONTINGENCY ARRANGEMENTS

COMMUNITY HOSPITALS & ELDERLY MEDICINE DISTRICT WIDE (not EMH)

The following arrangements will apply, when circumstances prevail which challenge the ability of staff and managers to keep staffing levels at safe levels. It is likely that a number of different and competing demands will be in force, rendering usual practice in relation to staff shortages of no value.

1. In the normal course of events Clinical managers/nurses 'in charge', will endeavour to cover their areas. The bank/agency guidelines are in normal use and all local resolutions have been considered. The senior nurse and Service Manager will be aware of these issues and monitor them on a daily basis.

2. The introduction of contingency arrangements will be agreed by the Senior Nurse, Service Manager and General Manager in consultation with staff.

3. Introduction of these arrangements will mean that staff and managers have specific concerns regarding their ability to maintain safe staffing levels over a period of time, (possibly due to outbreak of illness, major new developments etc.).

4. The implementation of staffing contingency arrangements will be notified to the nominated executive director and other divisions.

5. **Staffing contingency arrangements (day & night).**

- Cancel non - essential training
- Consider cancellation/suspension of all training
- Review all booked annual leave
- Obtain help from other community hospitals/elderly medicine.
- Ward base Senior Nurse co-ordinators
- Reduce staffing in OPD to minimum levels required to sustain clinics (Community Hospitals only)
- Review day hospital staffing
- Consider combining day hospitals with wards
- An up to date list of staff willing to do overtime to be held by the Senior nurse/service manager.
- Introduce split duties to improve continuity for patients (staff will be asked to volunteer to support this initiative for a time limited period)
- Hours from staff on 'days off' to be considered.

- Contact to be made with community nursing and community enabling service to establish possible support from D/N's and community enabling assistants.
- Contact recently retired qualified staff where appropriate.

6. Monitoring and Review

A system of reporting locally, prior to each period of duty and daily to General Manager/Trust will be established by the Service Manager.

7. Duration

These arrangements will continue for 2-4 weeks in agreement with staff, while other resolutions are considered/planned.

Appendix 2

STAFFING CONTINGENCY ARRANGEMENTS EMH SERVICES FAREHAM AND GOSPORT

The following arrangements will apply, when circumstances prevail which challenge the ability of staff and managers to keep staffing levels at safe levels. It is likely that a number of different and competing demands will be in force, rendering usual practice in relation to staff shortages of no value.

1. In the normal course of events Clinical managers/nurses 'in charge', will endeavour to cover their areas. The bank/agency guidelines are in normal use and all local resolutions have been considered. The senior nurse and Service Manager will be aware of these issues and monitor them on a daily basis.

2. The introduction of contingency arrangements will be agreed by the Senior Nurse, Co-ordinator and General Manager in consultation with staff.

3. Introduction of these arrangements will mean that staff and managers have specific concerns regarding their ability to maintain safe staffing levels over a period of time, (possibly due to outbreak of illness, major new developments etc.).

4. The implementation of staffing contingency arrangements will be notified to the nominated executive director and other divisions.

5. Staffing contingency arrangements

- Cancel non - essential training
- Consider cancellation/suspension of all training
- Obtain help from other community hospitals.
- Contact SJH Bank
- Co-ordinator to discuss cross cover with Service Manager SJH
- Ward base I grade Senior Nurse co-ordinator and suspend other management work as required.
- An up to date list of staff willing to do overtime to be held by the Senior nurse/clinical managers
- Introduce split duties to improve continuity for patients (staff will be asked to volunteer to support this initiative until end Jan 01).
- Hours from staff on 'days off' to be considered.
- A list of community staff will to support inpatient areas is held by Senior Nurse.
- There is agreement that stand alone units will be covered in terms of qualified staff by looking across the service.
- EMH 'clinical on call' nurses are available in an emergency to cover qualified staff duties. (NB sometimes on call and on duty).

6. Monitoring and Review

A system of reporting locally, prior to each period of duty and daily to General Manager/Trust will be established by the Service Manager.

7. Duration

These arrangements will continue for 2-4 weeks in agreement with staff, while other resolutions are considered/planned.