Adults Wellbeing and Health Overview and Scrutiny Committee

1st March 2016

Winter Plan and System Resilience

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1. Purpose of the Report

1.1 The purpose of this report is to provide an update on the management of winter pressures and how the County Durham and Darlington Systems Resilience Group is going to evaluate what the schemes funded over winter to inform planning for 2016/17.

2. Background

2.1 The County Durham and Darlington System Resilience Group (SRG) has overall responsibility for the capacity planning and operational delivery of urgent and emergency care across the health and social care system.

2.2 A number of schemes were funded by the SRG monies to support the healthcare system in its management of pressures. A full list was given to the Health and Wellbeing Board in November 2015. These schemes are all up and running and have given the health economy more robustness over a time of great pressure which is continuing.

3. SRG Resilience Funding 2015/16

3.1 In planning for winter 2015/16 the SRG has taken into account a number of elements:

- learning from local resilience project evaluations;
- outcomes from the regional Winter Debrief event;
- national learning from winter 2014/15;
- current local urgent and emergency care system priorities;
- available resilience funding; and
- contingency arrangements to enable the potential funding of additional capacity, or innovation.

3.2 There was some slippage identified late in 2015 and this was allocated to two schemes. One was a brokerage service which would support the

speedy discharge of patients into a care home. This scheme started in February 2016 and the impact on delayed transfers of care will be monitored via the SRG monthly. The second scheme was to support handovers at the hospitals A&E departments to allow the ambulances to be turned around within 15 minutes. This scheme should be up and running by mid to late February, depending on recruitment of nurses and again will be monitored via the SRG. The total resilience funding available for 2015/16 is £4,681,000 and of this County Durham and Darlington Foundation Trust were given over £2 million. Primary Care received over £1.3 million to provide additional services to target vulnerable patients to prevent admissions.

3.3 In addition, from learning from winter 2014/15 around the Country, NHS England issued eight High Impact Interventions (**Appendix 2**) which are must do's for urgent and emergency care, the achievement of which all SRG's are now being monitored on as part of NHS England's SRG assurance process. The County Durham and Darlington SRG is showing as "implementation underway" for all of these and a more detailed update on progress is due at the February 18th SRG meeting. The winter schemes funds were asked to link to these so progress with implementation is expected and providers will be held to account on this point.

4. Monitoring and Accountability

4.1 The SRG has implemented a monthly monitoring template that providers in receipt of resilience funding, are required to complete and update on a monthly basis to provide the SRG and CCG's with assurance in terms of delivery of planned resilience schemes, actual spend against planned spend and progress towards achievement of key performance indicators. This has been working well and has helped identify slippage as well as give assurance.

4.2 A full and robust evaluation of each scheme will be completed in April 2016 to give the SRG valuable data to support decision making for 2016/17. Key Performance Indicators were agreed for all schemes to ensure that there was a measure of success. A summary of the evaluations can be brought back to a future Board.

5. Management of Winter Surge and Pressures

5.1 All providers were asked, by the NECS Surge Management Team, to revise and review their winter plans, business continuity plans and North East Escalation Plans (NEEP) and these were robustly tested on the 8th of October at a region wide event 'Getting Ready for Winter'.

In addition an SRG level escalation plan was developed which is used at times of surge to ensure all partners are aware of actions that others

are taking at times of pressure. This will be further refined over the coming months to take account of what more primary care can offer but the current working version is attached as **Appendix 3**.

5.2 The NECS Surge Management Team opened the Winter Hub from 1st of November 2015 until 31st March 2016 to provide co-ordination and communication to the health economy over the winter period. This proved very successful last year and has received good feedback from providers and commissioners this year. Consideration will be given to keeping it open to cover the Easter period in 2016.

5.3 The Surge Team co-ordinate and lead daily calls that CCGs and providers dial into to discuss the current pressures, a daily "sit rep" is circulated (**Appendix 4**) which gives an idea of the level of operational escalation each Trust is reporting. The scale of escalation is communicated via a "NEEP" level which is the North East Escalation Policy. This is an agreed unified system of reporting pressures. Actions are taken at each level to help prioritise urgent cases and keep patients safe.

6. Recommendations

6.1 The Adults Wellbeing and Health Overview and Scrutiny is recommended to:

- Accept this report for information

Contact: Helen Stoker, Senior Commissioning Support Officer, North of England Commissioning Support Unit, 0191 374 2751

Kathleen Berry, Commissioning Manager, North of England Commissioning Support Unit, 0191 374 2751

Background papers: None.

Appendix 1: Implications

Finance – Additional funding resource has been provided to support all the projects via SRG

Staffing – Providers in receipt of additional funding to support the projects listed in have been expected to ensure appropriate safe staffing arrangements are in place to support each of their projects

Risk – Contract variations have been put in place to ensure contractual accountability for appropriate use of the allocated funding

Equality and Diversity / Public Sector Equality Duty

Accommodation

Crime and Disorder

Human Rights

Consultation

Procurement

Disability Issues

Legal Implications

APPENDIX 2 – Eight High Impact Interventions for Urgent and Emergency Care

No.	High Impact Interventions
1	No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.
2	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.
3	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4	SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
6	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

Appendix 3 - SRG Level Escalation Plan

County Durham and Darlington SRG Whole System Escalation Action Plan – 2015/16 Draft 1.2 8th January 2016

Level	1 Normal	2 Concern	3 Pressure	4 Severe Pressure	Critical Incident
Definition	Represents a situation where health and social care service are working as normal	Represents a situation where flow issues are being detected in the health and social care economy. Services are starting to implement active management of issues being experienced	Represents a situation where increased flow issues are being detected in the health and social care economy. Management plans are in place with regular review	Reflects the fact that demand for health and social care services is outstripping supply or patient flow is serious impeded by blockages in the system	Any localised incident where the level of disruption results in two organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions
Threshold	Normal operating	• Achievement of NHS constitutional standards at risk – above 95% A&E standard • Surge of activity is above baseline – moderate • Patient flow through the system affected - moderate	• NHS constitutional standards are compromised – above 90% A&E standards • Surge of activity above baseline – significant • Patient flow through the system affected – significant	• NHS constitutional standards are compromised – below 90% A&E standard • Surge of activity above baseline – severely • Patient flow through the system affected – severely	
Clinical Commissioning Group response and actions:					
Teleconference frequency	No call required	As necessary	Daily	Daily/ Twice Daily	NHS England assume control
Teleconference participants	As required	Operational level managers	**Senior Operational managers**	Director level	CEO and Director level
Command and control	CCG	CCG	CCG	CCG	NHS England
Communications	Business as usual	Refer to CCG communication plan	Refer to CCG communication plan	Refer to CCG communication plan	NHS England communications plan

Support Required from Partners

Levels	1 Normal	2 Concern	3 Pressure	4 Severe Pressure	Critical Incident
Action/Support	**Normal multi-agency working**	**Normal multi-agency working but with increased risk**	**Significant risk of services not being able to cope with demand:** ***NB: Support requested at level 2 should be carried forward when at level 4***	**Extra Support required from partners** ***NB: Support requested at level 2 should be carried forward when at level 4***	
Acute	**Communications** • Contribute to Flight Deck as per Regional policy • SitRep reporting • Liaise with NEAS / YAS if a build-up of ambulances is occurring	**Implications for others** • Some GP referrals may be routed via A&E • Trust may be able to offer limited mutual aid **Communications** • Liaise with TEWV to expedite mental health assessments • Liaise with community and	**Implications for others** • The Trust will be unable to offer mutual aid • There will be an impact on NEAS from handover delays and if border control and diverts are required. • It is likely the QE will be approached for assistance. • More GP referrals might have to go via A&E • Increased pressure on TEWV to	**Implications for others** • Ambulance handover delays will affect NEAS • Operational managers may have to cancel attendance at scheduled meetings to deal with operational pressures • Direct access to hospital beds for GP referrals will be impaired • Diverts will be in place	**Implications for others** • Support may be required from other partners, the nature and extent of which to be determined using Major Incident communications processes. **Communications** • Executive lead to communicate

	CDDFT Actions
	• Majors and minors streams in operation
	• Robust plans for all patients waiting more than 2 hours to avoid breaches of the 4-hour standard.
	• Triage appropriate patients to Urgent Care, AMU, Ambulatory Care or Clinical Decision Units
	• Diagnostics requested at triage or as soon thereafter as possible
	• Paediatric patients to go straight to paediatrics for assessment when paediatric front of house is operating
	• Liaise with Specialties to obtain Specialty assessments.
	• Maintain infection control of cubicles
	• S - senior review of all patients before mid-day
	• A - all patients have an expected date of discharge
	• F - flow of patients, wards to pull patients from assessment unit to wards before 10am
	• E - early discharge, 33% of patients from base wards to be in discharge lounge with to-take-out (TTO's) and letter before midday. This requires prescriptions to be issued the previous
		social care services to expedite discharges.
		• Liaise with the QE/NEAS if seeking a divert to the QE.
		
		CDDFT Actions
		• Flex staffing to patient stream most under pressure and escalate any patient safety risks
		• Senior Decision Maker to work down line of ambulances waiting, in collaboration with Nurse Coordinator/ Practitioner to check if patients need to be in ambulance, moving patients to waiting room wherever suitable to reduce backlog/ handover breaches.
		• Heightened level of liaison with Specialties to obtain Specialist assessments, transferring medical patients direct to AMU if a bed is available on the authorisation of an ED Consultant or Registrar.
		• In the event of Specialty beds coming under pressure identify patients who can be guested if the need arises.
		• Ensure up-to-date medical review of all patients who might be suitable for discharge or transfer out of an acute bed.
		• Ensure patients identified for discharge are taken to the discharge lounge as soon as possible.
		• Delays with discharge letter and pharmacy to be identified and to be given priority.
		• Consider whether it is necessary to open a limited number of escalation beds or keep some Assessment unit beds open overnight.
		• Porters prioritise the movement of patients between A&E, AMU, wards and
			expedite mental health assessments; and on community, social and intermediate care services to discharge patients with support.
			• NECS to facilitate mutual aid
			
			Communications
			• Liaise with NEAS if requesting "border control" or internal CDDFT diverts; or if transport delays are holding up patient transfers.
			• Heightened liaison with other services to ensure discharge of all suitable patients
			
			CDDFT Actions
			• Liaise with relevant POD/SOW/Specialty to expedite a medical / surgical assessment for patients who might be discharged direct from A&E, but who need Specialty assessment.
			• For patients who are more likely to need admission, undertake necessary investigations and contact POD/SOW/Specialty to agree action including time-scales. If in doubt about whether a patient is "fit to transfer" to AMU/SAU, the ED doctor should discuss it with the POD/SOW/Specialty Consultant. If the latter is prepared to take responsibility for the decision to transfer, the patient should be transferred.
			• Heightened liaison with Intermediate Care to prioritise ED patients who could be discharged direct with support; and to effect transfers of appropriate patients to Urgent Care and Ambulatory Care.
			• Move low risk patients to waiting room/ corridor to free up cubicle space
			• No more than in 3 resus at any time- Additional patients requiring resuscitation to be diverted to theatre recovery- contact Theatre Coordinator by switch/ bleep.
			• Prioritise all patients who may
				affecting NEAS
				• Other Trusts may be asked for mutual aid
				• TEWV to expedite mental health assessments to avoid unnecessary delays in A&E
				• Increased pressure on community, social care and intermediate care services to discharge patients and provide alternatives to Acute admission.
				• Social Services and CHC staff to participate in Conference Calls
				
				Communications
				• Liaise with NEAS if requesting "border control" or internal CDDFT diverts.
				• If electives are to be cancelled: In-hours: Liaise with booking team to review lists of TCIs for the following day.Out of hours: Liaise with patients directly
				• If mutual aid is required in-hours notify NECS to advise GPs of pressures.
				• Request mutual aid from other Trusts
				• Seek Social Services and CHC staff participation in Conference calls.
				
				CDDFT Actions
				• Robust plans to avoid all potential 12-hour trolley waits
				• Deflect appropriate incoming patients to Ambulatory Care, Urgent Care, Surgical CDU.
				• For patients who might be discharged direct from A&E, but who need Specialty assessment, ask relevant POD/SOW/Specialty for early assessment
				• For patients who are more likely to need admission,
					with CCG/NECS Executive lead or Director on Call.
					• Use communications procedures in the major incident procedure
					• Trust external communication not to attend ED unless there is a threat to life or limb and to make use of walk in centres, urgent care and 111 wherever possible.
					• Conference Calls with Neighbouring Trusts as required.
					
					CDDFT Actions
					• Implement Business Continuity Plans as necessary, keeping apprised of situation and redistributing resources as required
					• Authorise transfer of staff to areas under most critical pressure
					• Consider cessation of non-urgent work (to liberate staff to assist in the critical areas) including:
					  • Electives
					  • teaching to allow teaching fellows/ and students to support in the ED
					  • Consultants on SPA time or undertaking non-critical tasks.
					• Review possibility of higher thresholds for GP referrals to A&E or for acute admission and lower thresholds for discharge.
					• Discuss with NEAS implementation of NEAS Extreme Measures
					• Agree Mutual aid from other Trusts
					• Ensure rigorous data collection/SitReps
					• Request divert of GP referrals or treat and transfer to neighbouring hospitals via CCG

	evening.
	• R - review of all patients with extended length of stay (10-14 days) to have a management plan
		diagnostics to maintain optimum patient flow, as agreed with PFT, A&E and Ward managers.
		• Porters promptly transfer deceased patients to mortuary
		• Domestics prioritise cleaning as directed by Patient Flow and Ward staff
		• In hours, line managers and out of hours Patient Flow authorise additional nurse staffing and Silver Command authorise additional Doctor staffing.
			potentially become 12-hour trolley waits to prevent any breach occurring, escalating to Silver Command if necessary.
			• Pharmacy to prioritise TTOs for dispensing, particularly for patients requiring discharge by hospital transport
			• Consider the need to open more escalation beds, if possible.
			• Consider requesting NEAS to implement "border control" between CDDFT sites
			• Consider and co-ordinate Specialty-level diverts to other CDDFT Sites. Provide details of the divert to NEAS, specifying the Specialty affected and the likely length of time the divert might last
			• Ensure medical teams review all patients thought to be appropriate for early discharge by nurse in charge of ward.
			• Identify and co-ordinate the transfer of patients suitable for guesting.
			• Pharmacy
			  • Advise on appropriate use of FP10 out of hours to support discharge
			  • Out of hours: the on call Pharmacist may be called in on the authority of Silver Command to dispense TTOs for urgent discharges.
			• Commission additional transport if needed
			• Staffing for escalation beds to be sought from less pressured CDDFT sites, from off duty staff , from Bank or, as a last resort, Agency staff.
				undertake necessary investigations and contact POD/SOW/Specialty for advice, agree action including time-scales. If in doubt about whether a patient is "fit to transfer" to AMU/SAU, the ED doctor should discuss it with the POD/SOW/Specialty Consultant. If the latter is prepared to take responsibility for the decision to transfer, the patient should be transferred.
				• Agree internal CDDFT ED diverts and advise NEAS; and seek further assistance from the QE.
				• Open all agreed escalation beds.
				• Ensure up-to-date senior review of all potential discharge patients
				• Ask suitable patients aged 16 - 18 not already in a Paediatric Ward to transfer to paediatrics (patient choice must be respected).
				• Review with DMT/ward staff/matrons potential discharge patients and put in place necessary actions.
				• All Pharmacy prescriptions for discharge patients dispensed expeditiously and transport in place.
				• Liaise with Intermediate Care Plus and RIACT to put urgent care packages in place
				• Transfer all suitable patients to Community Hospitals
				• Agree with Obstetrics which pregnant patients not already on an Obstetrics Ward can be transferred there.
				• Consider with the Director on Call a reduction or cancellation of some or all elective admissions for the following day other than Category 1 (urgent or cancer) cases. NB: The Regional NEEP requires Trusts to have
					• Facilitate increased use of voluntary staff/ chaplaincy staff with suitable pre-employment screening/ e-DBS to support on the transfer of patients to wards and transport home
					• consider where additional space can be opened and staffed to extend the ED outwith the immediate department if necessary
					• Co-ordinate a review and recovery phase after step down
					• Determine if Status Black has been reached.

				taken this step before seeking mutual aid from other Trusts (the QE excepted). In-hours, liaise with booking team to review TCI list for the following day. • Agree with Director on Call whether to seek mutual aid from other Trusts (the QE excepted) or to request regional Conference Calls.	
Community	**CDDFT Actions** • Operation of services prioritised as necessary by operational managers. • Provide routine assistance to "pull" patients from Wards and ED into community hospitals, Intermediate Care or community services.	**CDDFT Actions** • Liaise with acute matrons and Patient Flow to expedite discharge • Review, focus on and implement plans for patients in Community Hospitals who could be discharged to promote timely discharge.	**CDDFT Actions** • Communicate and manage staff shortages and manage supplies. • Consider temporary changes to access criteria and protocols to services. • Plan for possible redeployment of staff and communicate to partners. • Consider / assess availability to open more capacity • Determine with other FT divisions if a major incident of certain aspects of it need to be implemented	**CDDFT Actions** • Prioritise essential services to be maintained and which services can be restricted or suspended. • Additional capacity from cancelled services redeployed in line with competency matrix • Proactive supply requirements identified and ordered • Critical suppliers continue to be checked • Support requirements of acute services. • Discuss mutual aid from external partners	**CDDFT Actions** • Daily briefings with acute services and staff. • Individual patient priority in operation • Mitigation strategies are in place covering deferred services • Communications with patients at risk and not receiving treatment • Resource provision being more channelled towards the requirements of acute services but essential complex community care calls need to be met • All mutual aid will be utilised • Patients will be diverted outside the health economy • Increased reliance on telephone support and the virtual ward • Only critically ill patients will be admitted
Adult Social Care	• All Trusts provide timely comms on potential delays, risks and issues. • Strategic commissioners managing market and ensuring sufficient capacity	• All Trusts provide timely communication on potential delays, risks and issues • Strategic commissioners managing market and ensuring sufficient capacity • Weekly winter pressures call	• Intermediate Care + to allocate more Social Worker to discharge management function • Increase usage of IC+ Time To Think function • Daily/twice weekly winter pressures call	• Teleconference as required • Additional SW in locality teams will support IC+ if needed	BUSINESS CONTINUITY PLAN ACTIVATED
Out of Hours	• Services operating normally to national standards	• Services operating normally but with increased pressure • If 111 is generating unnecessary demand, we will work with commissioners and NEAS to address this. • The shift co-ordinator on	• Less busy Centres accept telephone calls and manage the home visiting to allow busier sites to focus on walk-in patients. • Where walk-in waits are lengthening, following triage, patients to be offered the choice to either wait to be seen, or	As NEEP 3	As NEEP 3

		every site has delegated authority to take corrective actions to maintain performance • Urgent Care GPs will review home visit requests and work with 111 to ensure that home visits are only agreed if essential.	to return later in the day for a planned appointment.		
Primary Care	• Service operating as normal	• Communications between organisations via teleconference and other channels as needed **<u>North Durham CCG Actions</u>** Additional services implemented to support winter pressures include: • Saturday morning opening • Vulnerable peoples service across North Durham (weekends) supporting hospital discharge • GP's to increase in same day appointments (to be discussed with Federations) • NHS 111 DOS updated • CCG on-call rota including emails and contact details in place • Intermediate Care + • Community Matron Service (7 days per week) **<u>DDES CCG Federation Actions:</u>** • Practices to discuss with other Federation lead Practice Managers (Jennifer Wood and Antony White) • Additional Services implemented over winter to support pressures including extra opening times and VWAS service and community matrons • CCG on-call rota including	• CCG to Communicate pressures to GPs in and out of hours via agreed form of words • Contact Practice Managers Council and advise Federation Board • Actions from NEEP 2 carried over to NEEP 3 and 4	• NECS to initiate system wide calls • CCG to initiate public communications as per communications plans • CCG to communicate excessive pressures to GP's and out of hour's with red colour code Other actions to consider • Escalate to Federation Board. • Practice, to notify local FTs of issues of concerns via Surge team • Join Surge calls as requested • Discuss and seek support from neighbouring federations	Actions for discussion with Primary care and Federation Leads, considered as suggestions at this point • Notify local A&Es, DDES and NHS England. • Explore possibility of redirection of patients to A&E or UCC • Possible re-direction of all patients to UCC or A&E • Practice may be closed by CCG/NHS England • GP's to consider stopping all pre bookable appointments and undertake home visiting all day (for further discussion)

		emails and contact details in place • Intermediate Care + **Primary Healthcare Darlington** • Saturday clinic: A&E & UCC both have mobile number to contact the clinic to book on the day appts where appropriate, specific slots are set aside for this. The community matrons and district nurses have also been given the mobile number should they require advice. • Evening Telephone Advice: All non-emergency calls transferred to UCC via 111 between 6pm-10pm Mon-Fri could be picked up by the service. • Hospital to Home: Community matrons and district nurses are able to contact the service GP via DMH switchboard or directly on ward rounds for any advice required.			
Mental Health	• Register for Heat-Health Watch Alerts • Identifying vulnerabilities through Joint Strategic Needs Assessments	• Identification of vulnerable individuals • Work with voluntary organisations to identify at risk • Support care homes to identify vulnerable people and	• Daily/twice weekly surge conference calls reporting by exception • Refer to Trust NEEP Surge level • Support community staff to maintain home visits • Consideration to be given to phoning/contacting high risk	• All existing emergency policies and procedures will apply. • Recovery working group established • Individual organisations operation rooms established 24/7	

	• Identification of vulnerable individuals/communities • Working with at risk individuals' families, and communities to support and put in place protective measures. • Supporting people and young children • Liaise with community groups and voluntary organisations • Pro-active communications education, winter warmth, • Cold weather alerts to be distributed • Working with partners and staff on risk reduction awareness, e.g. flu jabs, information and education	maintain room temperatures • Check vulnerable individuals have enough supplies of medication and food • Weekly surge conference calls reporting by exception • Maintain surge/escalation watch	vulnerable individuals/families on a daily basis • Support care homes to identify vulnerable persons and maintain room temperatures		
Ambulance Service	• Normal operating procedure for PTS and ambulance service	• Awaiting input from NEAS as per email	•	•	

Appendix 4 - Example of Daily Sit rep report

Daily Hospital SitRep Summary - Cumbria and the North East

Monday 8 February 2016

Friday 5 February 2016 08:00 to Monday 8 February 2016 07:59

NHS England

North East Ambulance Service REAP Level 3 - Pressure		Northumbria Healthcare	The Newcastle Upon Tyne Hospitals	Gateshead Health	South Tyneside	City Hospitals Sunderland	County Durham And Darlington	North Tees And Hartlepool	South Tees Hospitals	North Cumbria	Morecambe Bay
	Manually Enter NEEP Level (if required)										
Escalation level	NEEP Level Escalation level	Level 3 Pressure	Level 3 Pressure	Level 4 Severe Pressure	Level 2 Concern	Level 2 Concern	Level 4 Pressure	Level 4 Severe Pressure	Level 3 Pressure	Please Manually Enter NEEP Level	Please Manually Enter NEEP Level
Serious operational problems	Serious operational problems during previous 24 Hours	Yes	No	No	No	No	Yes	Yes	No	No	No
	Remedial Actions being taken	NEEP3 - General pressures, ED waits and bed capacity.	NEEP LEVEL 3	NEEP Level 4 - Bed pressures	NEEP 2	NEEP 2	Neep Level 4. Escalation beds are open. UHND assessement area and Day Surgery open overnight. Appropriate patients moved to Community Hospitals, paediatric 16-18yrs and obstetrics patients moved into specialty beds. POD/SCMs/Intermediate Care Staff focussed on urgent review of patients in ED to avoid admissions. We had 3 A&E diverts:UHND to DMH & South Tyneside and Dmh to UHND	NEEP level 4 - significant pressures experienced through both A&E and admissions, additional beds opened (outside winter plan) Full escalation plans in place. 06/02/2016 The Trust accepted A&E diverts for 1 hour	South Tees Foundation Trust NEEP LEVEL 3	0	0
A&E	A&E closures *Duration (minutes)*	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -
	A&E diverts *Duration (minutes)*	0 -	0 -	0 -	0 -	0 -	3 480	0 -	0 -	0 -	0 -
	A&E - site 1 (All types) *Attendances* *Patients waiting over 4 hrs* *A&E performance (95% standard)*									Cumberland Infirmary 446 101 77.4%	
	A&E - site 2 (All types) *Attendances* *Patients waiting over 4 hrs* *A&E performance (95% standard)*									West Cumberland 290 39 86.6%	
	Trust A&E performance (95% standard)									81.6%	
	A&E attendances (All types)	1710	1225	1009	230	1153	1054	770	1627	736	816
	Emergency Admissions (Via A&E and other)	272	451	211	44	320	591	159	420	169	250
Operations cancelled in previous 24 hours	Urgent operations for second/subsequent time Urgent operations Elective operations									0 0 0	
Non-clinical critical care transfers	Out of an approved critical care transfer group Within approved critical care transfer group									0 0	
Ambulances queuing for longer than 30 minutes	Total *30 - 60 mins* *60 - 120 mins* *> 120 mins*									27 20 7 -	
General & Acute beds - as at Mon 8 Feb 09:00hrs	Total beds available *of which core stock* *of which escalation beds* Total beds occupied	1,134 1,089 45 94.9%	1,816 1,809 7 89.2%	469 425 44 99.8%	337 315 22 89.0%	761 736 25 82.9%	897 861 36 90.2%	607 559 48 92.3%	1,054 1,039 15 98.2%	398 391 7 98.7%	896 896 0 98.7%
	Closed/Affected due to D&V/norovirus like symptoms *of which unoccupied*	0 -	22 100.0%	0 -	0 -	4 25.0%	0 -	8 37.5%	0 -	10 20.0%	0 -
	Unavailable due to delayed transfers of care % of total beds available occupied by DTOC									47 11.8%	
Critical Care beds	Adult Critical Care beds available *of which occupied*	17 70.6%	69 73.0%	12 83.3%	6 83.3%	18 66.7%	21 81.0%	16 81.3%	62 90.3%	9 88.9%	14 100.0%
	Paediatric Intensive Care beds available *of which occupied*	0 -	29 75.6%	0 -	0 -	0 -	0 -	0 -	4 100.0%	0 -	0 -
	Neonatal Intensive Care beds available *of which occupied*	0 -	12 83.3%	0 -	0 -	8 87.5%	0 -	4 50.0%	14 78.6%	0 -	2 0.0%
		Northumbria Healthcare	The Newcastle Upon Tyne Hospitals	Gateshead Health	South Tyneside	City Hospitals Sunderland	County Durham And Darlington	North Tees And Hartlepool	South Tees Hospitals	North Cumbria	Morecambe Bay

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Printed on Monday 8 February 2016 11:02

Daily Ambulance/Community Services SitRep Summary - Cumbria and the North East

Monday 8 February 2016

Friday 5 February 2016 08:00 to Monday 8 February 2016 07:59

NHS England

[redacted] Services/NEAS Daily SitRep Return
[redacted]@nhs.net
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		North East Ambulance Service FT
REAP	REAP Level	Level 3
Serious operational problems	Serious operational problems during previous 24 Hours	No
	Remedial Actions being taken	05/02/16,19:30-20:26UHND diverting to DMH(x2)21:15-22:22UHND deflecting to SGH(x2)UHND diverting to RVI(x2)UHND deflecting to STGH,22:26--00:45UHND diverting DMH(x2)01:25--02:02UHND diverting to DMH(x2).06/02/16,14:00STGH CT scanner down,diverting to SGH(x1),15:51DMH diverting to UHND(x2), 16:30DMH diverting to N.Tees(x1), 19:00DMH diverting to UHND(x2), 19:00UHND diverting to STGH(x2),QEH diverting to STGH(x1)07/02/16,07:00QEH diverting to STGH(x1), 16:50UHND deflecting to SGH(x2),STGH(x2)N.Tees(x1)
Calls Answered	Total 999 calls answered	3,956
Total Incidents (emergencies and GP urgents)	North of Tyne & Gateshead	1,085
	South Tyneside, Sunderland, County Durham and Darlington	1030
	Tees	1110
Cat. Red Performance	Total Category Red Incidents attended	1,992
	of which receiving a response within 8 minutes	56.4%
	Year to Date Category Red 8 min Performance	69.6%
Cat Green	Total Category Green Incidents attended	1,012

Handover Delays		> 30 mins	> 60 mins	> 120 mins
	Northumberland SEC	24	0	0
	Royal Victoria Infirmary A&E	1	0	0
	Queen Elizabeth A&E	34	0	0
	South Tyneside A&E	1	0	0
	Sunderland Royal A&E	6	0	0
	Uni Hospital of North Durham A&E	22	9	0
	Darlington Memorial A&E	22	16	3
	James Cook A&E	2	0	0
	Uni Hospital of North Tees A&E	0	0	0

111 (from 111 daily sitrep - CAD data)	Total 111 calls	7,529
	Ambulance Dispatches	1,115
	Ambulance dispatch as % of calls triaged	16.3%
	Total Calls Referredto ED	438
	Recommended to attend ED as % of total calls triaged	6.4%
Further comments	Media Interest	None
	Patient Transport Service	None
	Staffing	None

		Northumbria Healthcare FT Community services	Newcastle hospitals FT community services	South Tyneside FT community services	County Durham and Darlington FT community services	North Tees and Hartlepool FT community services	South Tees FT community services
NEEP	NEEP Level	Level 1 Normal	Level 1 Normal	Level 2 Concern	Level 1 Normal	Level 2 Concern	Level 3 Pressure
Serious operational problems	Serious operational problems during previous 24 Hours	No	No	No	No	No	No
	Remedial Actions being taken	NEEP 1	NEEP Level 1	None	The answer no to 'Is there capacity available in District Nurse Teams?' is due to the DN teams being very stretched and therefore there is limited capacity at the present time.	None	None
Community beds - as at Mon 8 Feb 09:00hrs	Total beds available	No community beds	30	No community beds	66	No community beds	67
	Total beds occupied		100.0%		77.3%		92.5%
	Closed due to D&V/norovirus like		0		0		0
	of which unoccupied		-		-		-
	Unavailable due to delayed transfers of care		0		9		3
	Number of beds closed due to staffing issues		0		0		0
Community Services Capacity	Is there capacity available in community intensive assessment	Yes	Yes	Yes	Yes	Yes	Yes
	Is there capacity available in virtual wards or equivalent?	Yes		Yes			Yes
	Is there capacity available in District Nurse Teams?	Yes	Yes	Yes	No	Yes	Yes
Further comments	Media Interest	None	None	None	None	None	None
	Staffing	None	None	None	None	None	None

		NDUC - North of Tyne & Gateshead	NDUC - Tees	NDUC - S Tyneside, Sunderland, County Durham and Darlington	GatDoc - North of Tyne & Gateshead		CDD FT OOH services - County Durham and Darlington
NEEP	NEEP Level	Level 1 Normal			Level 2 Concern		Level 1 Normal
Serious operational problems	Serious operational problems during previous 24 Hours	No			No		No
	Remedial Actions being taken	None			Resilience standby called in on Sunday to Blaydon MIU.		None
Incidents in reporting period	Total Incidents	420	218	157	278		2,412
	Attendances - booked	220	102	44	47		498
	Attendances - walk in	0	0	0	79		1,445
	Home visits	48	36	22	35		75
	Telephone	152	80	91	117		394
	Admissions to secondary care ward	15	8	1	8		92
	Referrals to emergency department	19	4	22	10		70
Further comments	Media Interest	None			None		None
	Staffing	None			None		None