Reporting to:	TRUST BOARD, Thursday 26th September 2013
Title	TDA Winter Planning Assurance
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Lead - Ian Donnelly, Assistant Chief Operating Officer (Unscheduled Care)
Previously considered by	
Executive Summary	The Trust Development Authority [TDA] requires the Trust to complete and submit a winter operational plan and assurance template which has to be signed off by the Trust Board by 30th September 2013. The TDA will use the submitted winter operational plan and completed template to gain assurance that the Trust has planned to deliver sufficient capacity based on assessed activity.
Strategic Priorities ☐ Quality and Safety ☒ Healthcare Standards ☐ People and Innovation ☐ Community and Partnership ☐ Financial Strength	**Operational Objectives** HS1 Ensure bed capacity meets demand supported through wider health partnership solutions HS2 Improving the timely flow of patients from admission to discharge HS3 Deliver all key performance targets
Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☒ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☐ Clear Clinical Service Vision or we may not deliver the best services to patients ☐ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☐ Achieve a Financial Risk Rating of 3 to be authorised as an FT
Care Quality Commission (CQC) Domains ☐ Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well led	**Outcomes**
☐ **Receive** ☐ **Review** ☐ **Note** ☒ **Approve**	**Recommendation** Trust Board is asked to APPROVE the Trust's winter planning assurance submission to the TDA

Demand & Capacity (3)

Workforce

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•Could the Trust provide details regarding your winter staffing plan and how this aligns to predicted demand for services?

The Trust made a decision prior to confirmation on monies being made available via any additional funding being released; that it could not rely on Agency or Bank to support winter and to improve quality we would start recruitment in the Summer for HCAs and Nurses to support a trust pool.

Nursing

❑The Trust is currently recruiting to all Nursing and Health Care Assistant posts, through values based recruitment. This includes recruiting more nurses and HCA than vacancies to substantively recruit a pool of staff to cover short notice absence and increased activity during winter. The additional numbers support all identified escalation areas and a surplus to cover Enhanced Patient Support and sickness.

Doctors

❑The Trust is recruiting additional medical staff for ED and doctors for escalation areas to ensure prompt review.

❑ED consultant workforce recruitment ongoing. No suitable applicants following recent advert for 2 additional Consultants.

ACP/ENP Grade

❑The Trust appointed 9 Physician Assistants last year which provide support to key medical wards including escalation areas.

AHP/Specialist

❑Through winter planning the need to ensure appropriate clinical support services therefore extra Pharmacists and Therapists are identified in the winter plan to support effective discharge and cover additional escalation beds.

❑Therapist teams are working with the community therapist teams to ensure joined up working in planning a scarce available resource. Proposal to fund up to an additional 40 sessions of therapy input per site to be worked flexibly mirroring the additional demand from escalation areas and ED which will include weekends and bank holidays.

Delivery

Delivery (1)

Effective models of Care.

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•Could the Trust describe its models of care / access standards in the following areas:

- ED
- Acute Medicine
- Inpatient bed base
- Confirmation of provision of Ambulatory Emergency Care
- Access to diagnostics / pathology

A review of demand against available work force was carried out in assessment areas to ensure that capacity matches demand, this has been completed and resulted in some changes

- **ED**
  - Level 1 ED at both sites open for 24 hrs
  - 24 hrs consultant cover
  - Consultants presence till 8 pm over week days
  - Trauma unit at RSH site
  - Middle grade presence 24 hrs
  - CDU at RSH (9 beds)
  - Streaming of minor and major patients
  - ENP support
  - Hospital Full Protocol
  - ED admitting rights
  - DTA Standards
- **Acute Medicine**
  - 24hour admission on both sites
  - Consultant led service (acute physicians supported by speciality physicians)
  - Consultant on shop floor 12hrs a day, seven days a week
  - AMU/Short Stay Ward/ Ambulatory care services (total bed base 40)
- **Ambulatory Care**
  - Pathways in place for ambulatory care and admission avoidance
  - Ambulatory care service on-going Monday to Friday on both sites
  - Ambulatory care supported by physicians assistance
- **Diagnostics/Pathology**
  - 24hr access to x-rays
  - 24hr access to CT
  - MRI access Monday to Friday 9-5
  - 24hr access to Consultant Radiologist
  - 24hr access to pathology services
  - Priority to discharge dependent diagnosis over routine.

Delivery (1)

Effective models of Care.

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  - ED
  - Acute Medicine
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Please see Appendix 1 for an assessment of compliance with best practice in effective approaches in urgent and emergency care.

- Bed Base
  - 24/7 Clinical Site Capacity with a new clinical site lead nurse manager on each site
  - AMU/SAU at RSH and AMU at PRH
  - Stroke Thrombolysis Pathway with full access to all CT requirements
  - Trauma Centre at RSH
  - Full medical bed base bed with 7 day working across Acute Med and Gen Med on each site
  - Full H@N practitioner Service
  - Full H@W practitioner Service
  - Full NIV service and COPD
  - Cardio pathways' to Cardio Net work pathway for PCIs
  - Full Surgery list to maintain RTT
  - Additional outsourcing of Day case to Nuffield as part of service deliver in times of escalation
- Surgery
  - 24hour admission at RSH with transfer protocol to RSH from PRH
  - Consultant led service
  - Consultant on shop floor 12hrs a day, seven days a week
  - SAU/Short Stay Ward/ Ambulatory care services
  - Day case area used as overnight stay area for surgical patients

Delivery (2)

Seasonal Flu/ Pandemic Flu and Norovirus

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust provide an outline of the Trusts updated Flu, Norovirus and infection outbreak management plans, including when the plans were updated or are proposed to be updated? It would be appreciated if the Trust could provide copies of the above plans when submitting?
- Could the Trust set out its plans for staff flu vaccination including a trajectory?

- **Governance**
  - Infection outbreak and performance indicators are reviewed and assured by the Board via the Quality & Safety Committee (Q&SC) and the Infection Prevention Control Committee
  - Infection outbreak and performance metrics are reported and reviewed to Q&SC via a dashboard
  - The Board is assured of any risks and mitigation associated with infection outbreaks via the Q&SC
  - Board executive leadership is delivered via the DIPC and Director of Quality & Safety
- **Winter assurance**
  - The Trusts Norovirus and infection outbreak management plan is current (July 2013) and due for revision in June 2015 (APPENDICES A & B)
  - The Trusts major outbreak management plan (incorporating ward closure) is current (March 2013) and due for revision in March 2014
  - Norovirus education is included in all statutory training
  - The profile and social marketing for preventing infection outbreak is commenced at key times during winter (from September) and includes staff newsletters, communication banners in main entrances of wards for visitors
  - The Trusts flu plans are currently being reviewed with an expected completion date of October 2013.
  - An internal task and finish group led by the DIPC have developed a plan since June 2013 to implement the Trusts flu vaccination campaign to maximise staff flu vaccination coverage
  - The plan is to deliver flu vaccination immunisation at every opportunity to healthcare staff, administer the vaccine at every opportunity and record the number of staff immunised
  - The Trust has secured confirmed delivery of flu vaccine to enable an immunisation target of >75% of frontline staff

Delivery (3)

2013/14 Christmas/ New Year arrangements

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•Given the way Christmas and New Year Bank holidays will fall in 2013/14. Could the Trust provide assurances that robust arrangements are in place to cover the Christmas/ New Year period, including specifically a workforce plan for this period covering 21st December 2013 through to 5th January 2014.

Clear direction to all areas has been made to ensure that we have a full and robust workforce plan and cover for the BH periods, this includes all grades being in all specialities ensuring a robust plan to maintain normal working:

Includes but not exhaustive:

- ❑ ED consultant cover on the BH and full cover as per normal arrangements
- ❑ Full speciality cover with on call cover for BHs
- ❑ Full Ward Cover
- ❑ AL policy ensuring consistent cover across all specialities including support services
- ❑ Pharmacy cover during whole period with on call cover for BHs
- ❑ Pathology cover as per normal working
    - ❑ Blood Sciences - 24 hour cover will be available on site in Blood Sciences at both RSH and PRH
    - ❑ Microbiology – 24 hour cover will be available in line with normal arrangements
- ❑ On call management teams in place
- ❑ On call Exec team in place
- ❑ Site teams working between BHs ensuring site safety and flow
- ❑ Funding for Occupational Therapy and Physiotherapy cover for all weekends and bank holidays across this period as part of the winter plan.
- ❑ Radiology will have robust staff rotas in place to cover the Christmas/New Year period allowing the provision of a 24/7 Radiology service

Governance

Governance (1)

Governance Structure

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•How the board will review and formally approve the winter resilience and influenza plans?

•Can the Trust describe the accountability framework in place to manage winter performance and how the Board will hold the Executive team to account.

Performance – Governance

- **Trust:**
  - Winter Planning
    - Pre –Winter Started June 2013
      - Fortnightly winter planning and action meeting will continue throughout winter
      - Highlight updates on actions weekly
      - Financial planning meeting weekly ensure costs follow action plans, any service unable to deliver finance redirected to support additional plans
  - Operational Meeting
    - Winter planning discussed at Operational meeting to confirm on track
  - Executive Weekly review

- **External - Health and Social Economy**
  - Winter planning meeting initially every fortnight then monthly attended by CCGs and LA
- **Internal and External Sign off of the winter plan**
  - Exec Board Sign Off - September
  - Assurance at Urgent care Network Board by CEO and AO group with Sign off September
- **Board Governance**
  - Sign off at Trust Board of winter resilience and influenza plans
  - Monthly report on effectiveness of the Winter Plan to Trust Board as part of the Integrated Performance Report.

Governance (2)

Daily management and escalation

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•Can you set out the process of daily / weekly performance and capacity management and your escalation process? this should also include the metrics you use to support this?

•Can you describe the process for engaging external partners in the escalation process?

Daily

- ❑ Daily bed/ site safety meetings on each site x 3 per day
  - ❑ Attendance On Call Manager, CSM, Matrons and dependant on escalation Consultant support
- ❑ Site Status Sheet to allow daily planning with available capacity and projection for the next 24 hrs
- ❑ Fit to transfer list of all patients' who are medically fit for transfer but are delayed within the acute trust, this is sent to all our partners across health and social care
- ❑ Ward view flagged discharged and potential distributed daily
- ❑ Daily performance sent to Health and Social Care partners' at 0700 Hrs daily on pervious days performance
- ❑ Site Escalation levels distributed twice daily or if pressure dictates more frequent
- ❑ Development of Site Dash board with a private company to manage key performance indicators real time

Weekly/Monthly

- ❑ Performance reports including RTT
- ❑ ED KPIs including quality
- ❑ Nurse based ward metrics / KPIs including discharge
- ❑ RTT weekly challenge and confirm

Policies

- ❑ 2 new policies in place:
  - ❑ Speciality review in ED guide lines with timings
  - ❑ Full capacity protocol
- ❑ Reviewed and update Escalation policy and action cards

Governance (3)

Quality & Patient Safety

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):
Ensuring patient outcomes and experience do not deteriorate during winter pressures is a key challenge:

- What governance arrangements are in place to ensure Quality & Patient Safety is not compromised during winter period? Could the Trust outline these arrangements?
- Could the Trust describe what plans are in place to ensure operational standards are maintained consistently throughout the year e.g. A&E and Acute Medicine Clinical Quality Indicators, referral to treatment times, cancer operational standards, HCAIs.

- ❑ **Governance**
  - ❑ Quality and safety performance indicators are reviewed and assured by the Board via the Quality & Safety Committee (Q&SC)
  - ❑ Quality and safety indicators are reported and reviewed to Q&SC via a dashboard and includes patient experience, nursing, safety incidents and infection prevention metrics
  - ❑ The Board is assured of any risks and mitigation associated with increasing system pressure via the operational risk group and clinical governance executive
- ❑ **Winter assurance**
  - ❑ "Board rounds" are undertaken daily where the plan of care for every patient is reviewed by a consultant to identify problems and delays to maintain momentum.
  - ❑ During times of increased pressure quality and safety is discussed and assured at every bed meeting
  - ❑ Corporate ward rounds undertaken by corporate nursing to gain assurance of safety and quality during times of increased pressure
  - ❑ Key areas of pressure observed by corporate nursing such as A&E, AMU, Escalation wards and warded patients to gain assurance of quality and safety
  - ❑ Senior nursing forums discuss and remind staff to consider "safety pauses" to maintain quality and safety for patients during pressures of demand and capacity
- ❑ **Performance**
  - ❑ Site Team including a site lead nurse manger to support capacity
  - ❑ 24 hr Clinical Site Manager with a specific remit in delivering safe patient flow and maintain performance
  - ❑ Daily review of FTT and site delays
  - ❑ Site capacity meetings 3 times a day
  - ❑ JONAH in support of patient escalation
  - ❑ Daily report on ED 4 hour performance
  - ❑ Monthly Integrated Performance reports to Operational Performance Group meeting and Trust Board

Governance (4)

Additional Investment

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•Could the Trust give a clear outline of the areas where additional resources would be targeted. The investments need to evidence the contribution to the Trusts capacity to deliver and sustain quality care.

The trust and the social and health economy have received £4 million worth of additional investment this is split out as follows:

- ❑Split between commissioning bodies as follows
  - ❑ 39.94% Telford and Wrekin CCG
  - ❑ 60.06% Shropshire CCG
  - ❑ SaTH direct funding: £1,241,887 (31%)

The plans will enable the Health and Social Care partnerships in development of a range of services that include physical beds but also include staff to support patients' in funded beds or within their own homes', the range of schemes will ensure we maintain patient flow.

- ❑The developed plans financially are split as follows:
  - ❑ Improving health and social care - £1,270,779 equates to 31.77%
  - ❑ Surge capacity - £1,369,320 - equates to 34.23%
  - ❑ Enhanced staffing for hospitals - £1,359,901,equates to 34%

❑The £1.2M funding is targeted at ensuring all escalation areas are adequately staffed with permanent staff, additional staffing in ED, 7 day working and outsourcing of day case activity to protect RTT.

Governance (5)

Stress testing the plans

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•Could the Trust explain the process to stress test the plans and how will lessons from this testing be including in the winter plan?

As part of the winter planning group a confirm and challenge will be carried out to ensure the plans proposed match the expected demand and short term surges. This will include:-

- ❑ A Table top exercise where all plans will be tested
- ❑ Review of each action plan within each organisation to ensure on track will be conducted by the CCG as the area lead for all plans
- ❑ Exec challenge for internal plans will commence during October

Any additional lessons from the confirm and challenge or as part of weekly conference calls will enable us to modify the plan. The trust winter plan is a live document and as part of the challenge process it is modified and tested on an ongoing basis.

Governance (6)

Risk management

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- What are the key risks / challenges currently regarding winter planning?
- Have they been placed on the corporate risk register?

- ❑ Insufficient in patient bedded capacity within the trust due to no physical ward space being available
- ❑ Norovirus and Flu pandemic will exceed available isolation and inpatient capacity requiring site lockdown
- ❑ Inability to fully recruit the following
  - ❑ ED Consultants – we have a gap of two even though recruitment on-going
  - ❑ Nurse Staffing recruitment still does not bridge the gap between vacancies and availability Recruitment on-going.
  - ❑ Insufficient pull from the community to reduce the fit to transfer list creating capacity needed within the trust daily
- ❑ Flu Outbreak

The Trust has placed this on the risk register and have attempted to mitigate the risks as follows:

- ❑ Lack of delivery from partners on their element of the Winter Plan including withdrawal of current service provisions.

Risk register:

- ❑ Consultant recruitment is on-going, we recently placed one applicant and will continue to recruit, additional middle grade presence is used to cover the gap
- ❑ Nurse recruitment
  - ❑ A recent drive has resulted in the trust employing 26 additional HCAs through value based recruitment
  - ❑ An advert and a new recruitment drive is underway to recruit qualified nurses, we are also looking at international markets
- ❑ Plan in place to create 60 beds within the community to support pull from the trust, to assist in reducing LoS and time from medically stable to discharge
- ❑ Norovirus and Flu plans are being reworked to support the Trust with the community

Governance (6)

Risk management

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- What are the key risks / challenges currently regarding winter planning?
- Have they been placed on the corporate risk register?

❑What will Be different at SaTH this winter?

- ❑More robust internal Winter Plan;
- ❑New protocols in place;
- ❑Permanent staffing of escalation areas rather then reliance on agency nurses;
- ❑New operational team structure including Site Capacity Lead Nurses;
- ❑Improved Patient Flow processes in ED and Discharge Planning (ATOS workstreams);
- ❑Whole Health Economy working.

Partnership

Partnership

Partnership Working

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

•What arrangements are in place with the Urgent Care Board and key health economy partners?

To support the area wide health and social economy, the CCGs have set up the Urgent Care Board.

This is further supported by the following:

- ❑Fortnightly Winter Planning Meeting
- ❑Monthly Operational Performance Group Meeting
- ❑Daily Communication with Health and Social Care Providers
- ❑New Health Economy-wide dashboard designed to provide live update of ED and SaTH information
- ❑Planned Weekly Conference Calls
  - ❑Additional Conference Calls may be needed/used dependant on Escalation level of the Trust
- ❑Agreed Escalation and Surge Plan across the whole health and social care economy
- ❑Named Contacts for Each Organisation in time of escalation and pressure

Effective Approaches in Urgent and Emergency Care

The table below highlights a cluster of good practice tactics that have been proven to reduce bed occupancy, cost and harm events, while increasing the satisfaction of front line clinicians and the rest of the team.

Priorities within Acute Hospitals	Self-Assessment	RAG Rating
1. There should be early *senior* review of *all* patients along *all* parts of the pathway		
The Emergency Department		
- Implement RAT[1] for 'majors' patients	Cannot implement now with the present number of consultants and middle grades, but can happen at certain times. More consultants are being interviewed this month and middle grades. Once they all are appointed can do this regularly **Therapy** We have an Extended Scope Practitioner Physiotherapist working in ED at RSH but not PRH with minor musculoskeletal injuries on a see & treat basis including training in acute MSK injuries for junior doctors in ED. Patients are followed up either in ED Clinics or in the Physiotherapy Dept therefore receiving prompt and effective treatment. PRH ED would also greatly benefit from this service as it allows medical staff to concentrate on other patient groups presenting to ED and majors.	A
- Implement See and Treat[2] for patients with minor injuries and illnesses.	Happens most often, however at times of high demand within resus staff can be pulled to support this area	G A
- Reduce or eliminate triage[3]	Cannot completely eliminate triage as there is lack of man power to see patients as they come. Triage acts as a safety net currently	A
- Ensure that there is effective departmental co-ordination of activity	In place between Nursing and Doctors	G
Assessment Units / Acute Medical Units		
- Implement consultant-led rolling ward rounds[4], or RAT. Avoid batching patients to be seen on 'set piece' ward rounds	Happens on Mon-Thursday at both sites till 8 pm. To make it work all days need more acute physicians Gynae small numbers in assessment area	A
- Ensure consultant presence is available seven days a week and into the evenings	In place Consultant presence in gynae 5days per week	G

- Establish clear pathways for patients requiring specialist care, so they can be cared for in the most appropriate setting as quickly as possible[6]	Poor flow impedes the pathway created.	**A**	
- Set up dedicated, multidisciplinary health, therapy and social care teams based in the unit	In place Mon-Friday only **Therapy** This was achieved during the time of the Frail and Complex Project (December 2012 to June 2013) however now there are only SaTH therapist (OT and Physio) remaining who are covering ED referrals, AMU and CDU funded via non-recurring monies from SC CCG with funding still to be confirmed from T&W CCG. Winter planning needs to build on the learning from the Frail and Complex Project and re-create these multi-disciplinary multi-agency teams. PRH has the benefit of the Home from Hospital Team for the therapists to refer patients for earlier supported discharges.	**A**	
Specialty Wards			
- Ensure that a consultant sees all patients, and their care plans are confirmed, within 2-3 hours of admission to the ward[7] (or a *maximum* of 12 hours if admitted 'out of hours'), and sooner if the patient's clinical need requires it.	Consultant presence 8 hours Monday to Friday across gynae All in patients on specialty wards have a specialty consultant review 5 days per week. All new, sick and fit for discharge patients have a specialty consultant review 7 days per week	**G**	
- Each patient should be discussed daily (including at weekends) with the responsible consultant[8]	7/7 ward rounds consultant lead As above. Patients who are stable and not expected to be discharged may not be fully discussed at weekends depending on level of demand	**A**	
- Ward managers need to be supernumerary to coordinate and drive care	Ward managers are 40% supernummery, we have a dedicated team to support discharge and support best practice on wards	**A**	**G**

Priorities within Acute Hospitals	Self-Assessment	RAG Rating
2. Maintain the momentum of care – there should be a *senior* review of every inpatient's care plan *every* day		
- Every patient must have a consultant approved care plan in place within 12 hours of admission at the latest	There is no consultant presence in gynae at WE (save ward round) In place across Medicine and Surgery, new Rota being discussed with Medical colleagues	A
- Care plans must include an expected date of discharge (EDD)[9]	Use of EDD is improving and better use of predictive planning with confirm and challenge is enabling this to be improved	A
- EDDs should be set by the consultant in charge and only changed with her/his permission	Derogation for earlier discharge to nurses/junior docs	A
- Care plans must include 'criteria for discharge'[10] Empower the multi-disciplinary team to discharge when criteria are met (particularly at weekends), rather than waiting for senior medical confirmation	Not formally recorded but events lead discharge is primary method used Planning is in place that supports nurse facilitated discharge with check list, a trial concluded on the wards is working	G
- There should be daily, early morning 'board rounds'[11] by a senior clinical decision maker (normally a consultant) to ensure that the care plan is on track	In place Monday to Friday and cover at weekends to ensure patients' discharges' take place. Patient discharge planning for the weekend ensures that we maintain discharges daily	A
- Schedule main ward rounds for the mornings, and see potential discharges first, so that beds are freed as early as possible.	Restructure of the board and ward round on-going to deliver the following order • Sick • Discharge • remainder	A
- Develop 'one stop ward rounds'[12], where tasks such as writing TTOs and filling request forms are completed before the round moves into the next patient (avoid batching work to the end of the round)	As part of the development of the ward round and the check chase challenge this will support timely discharge	R

Priorities within Acute Hospitals		Self-Assessment	RAG Rating	
3.	**Get patients on the right pathways – manage patients in 'flow streams'**			
	Emergency Department			
-	Establish 'protected streaming' – create separate streams for minors and majors, with dedicated staff, processes and coordination	Happens at RSH and intermittently at PRH mainly due to the way the department is built	A	G
-	Create processes to ensure that the majors stream is not halted by a full resuscitation room	Escalation plan in place	G	
-	Avoid acting as the default arrival point for referrals that do not require resuscitation or stabilisation (e.g. most GP or clinic referred patients) – these patients should by-pass ED and go directly to assessment / acute medical units or specialist beds	In place ,but at times when other areas are full this happens	A	G
-	Ensure senior decision makers[13] in high volume specialties are available to attend the ED within 30 minutes of referral	ED Operational policy in place, but the policy mentions review within 1 hr	R	
-	ED should have direct admission rights using agreed protocols	Policy being written awaiting implementation	A	R
-	Establish ambulatory emergency care[14] streams to avoid unnecessary overnight stays	Care in place for certain conditions	A	
-	Consider establishing Clinical Decision Units offering observation medicine (with LOS <12 hours) and ambulatory emergency care	In place at RSH and no space and work force available at PRH	R	G
	Admissions			
o	Stream by length of stay and care needs:	Patients are placed onto wards by clinical speciality, frailty and needs	G	
-	*Assessment capacity* should be 'sized' for patient stays of no more than 12 hours, after which patients should enter appropriate flow streams.	Cannot implement currently for all patients due to block in flow out of the hospital, community capacity is insufficient to support AMU deliverable metrics	A	
-	Provide *short stay capacity* for patients with an anticipated length of stay of up to two midnights (assessment and short stay capacity is usually co-located in acute medical units)[15].	Capacity created but it is full most of the time with inappropriate patients Gynae - Short stay closes at 7.30pm Acute Medicine Short stay on both sites nd Surgery at RSH	G	
-	Further streams should be to *specialist beds* (for complex speciality patients requiring >72 hour stays), beds for patients with *complex discharge* needs (e.g. the frail elderly) and *catastrophic illness* (e.g. critical care and stroke patients).	Streams are present but the flow problem impedes this pathway	A	

-	Ambulatory emergency care should be provided where appropriate.	Available for a limited period only- can improve with increased staffing level	**A**
o	Minimise handovers between consultant teams and maximise continuity of care – a ratio of more than one handover per admission beyond ED suggests poor practice	If the flow is well this happens Gynae - Senior handover of care every 24 hours	**A**

Priorities within Acute Hospitals		Self-Assessment	RAG Rating
4.	**Work together systematically and predictably – implement internal professional standards**		
o	Response standards should be agreed for *the whole pathway* and cover time to:	Agreed standards in place with Speciality review currently being agreed for delivery in September	G
-	Assessment, including investigations	Pathology does not batch any urgent or routine requests from the ED and Turnaround times are audited from the time they arrive in the laboratory until the time the result is authorised by Telepath. Radiology ensure ED and patient discharges from wards are prioritise to support timely flow	**G**
-	Treatment	Treatment of clinical conditions are taken as part of normal ward reviews, doctors use PSAG and seek advice for speciality input	**G**
-	Review	Patients' are seen and reviewed as required and in a timely manner, delays to review are escalated	**A**
-	Referral	Patients are referred as requested	**A**
-	Discharge	Discharge planning is variable across the trust, however Shropshire have large delays in moving patients' to the next setting	**A**
o	Agree and implement single assessment processes to reduce duplication	This was achieved for ED, AMU and CDU patients via the Frail and Complex Project – see note above However across the health and social economy multiple ase4ssmenst are still required	**A**
o	Simplify referral processes, rather than using them as mechanisms to 'hold back' work	This was achieved for ED, AMU and CDU patients via the Frail and Complex Project – see note above Referral process follows national guidelines for discharge	**G**

o Use metrics to measure performance and the impact of improvement initiatives.	Pathology turnaround times - Working within the limitations of the technology available, we will achieve the following : U/E/LFTs: 85% within 1 hour Coagulation/ DDimer: 90% within 1 hour Troponins: 80% within 90 mins	**G**
5. Plan and manage capacity to meet demand		
- Develop an agreed escalation protocol that has input from all relevant stakeholders	The internal SaTH escalation plan and action cards has been reviewed and updated and is in line with the LHE escalation plan and action cards	**G**
- Use a tool to predict the expected number of admissions – if anticipated admissions exceed expected bed availability, escalate early!	PSAG and SQL predictions report in use	**G**
- Each specialty and supporting department should plan to match capacity to demand	On call consultant and team for each area manage flow and along with a number of other interventions such as Bed Bundle, FFT list etc, the aim is for capacity to be matched to daily demand wherever possible	**A**
- Implement effective bed management, equipped with real-time information, and rigorous processes	Greater rigour is now in place to monitor EDD, delays in transfer, C&D figures and early escalation etc.	G
- Staffing rotas should be designed to match demand profiles	Staffing is reviewed at ward level for nursing and issues escalated to the CSM daily. Medical staffing issues are pre empted and plans to address put in place at the rota review meeting each week at 08.30 on a Monday morning.	A

Priorities within Acute Hospitals	Self-Assessment	RAG Rating
6. Manage variation in discharge planning[16]		
- Minimise in-day bed swing[17] by maximising morning discharges – set targets to maximise discharges by a locally agreed 'check-out' time	In place will be performance managed during September	**A**
- Consistently prioritise activities associated with discharge (except where there is urgent clinical need) in order to reduce length of stay[18]	All therapists attend board rounds and meet mid-morning to co-ordinate their work targeting patients who can go home that day to ensure discharge happens.	**G**

-	Manage frail elderly people assertively to avoid in-hospital de-compensation with associated prolonged stays[19]	See notes on Frail and Complex Project above, this will be reintroduced during Winter 13/14 with a focus on Reablement within 72 hrs	**A**
-	Ensure services required for discharge are accessible at weekends	Across each site we have this however health and social economy this is limited	**A**
-	Avoid 'batching' in diagnostics and support services (see note 5 below)	We do not batch in diagnostics	
7.	**Avoid unnecessary overnight stays – implement ambulatory emergency care**		
-	Download and study copies of the Directory of Ambulatory Emergency Care for Adults and the 'how to' guide from the NHS Institute website.	We have ambulatory care in place supported by a DART on one site, this is improving al the time and increasing the zero day LOS	**G**
-	Ensure senior clinical decision makers are available to decide on the need for admission	patients' are admitted to specialties and are only admitted when accepted by senior decision makers, if admitted to AMU/SAU overnight, all patients' are reviewed for post take and will/could be discharged at this stage. patients' with on-going Social or health care needs who do not need admitting may be admitted whilst waiting for external support/provision	**A**
-	Ensure ambulatory emergency care is available for all patients who meet the criteria	Ambulatory services are provided across each site, insufficient workforce does not deliver a 7 day a week model	**A**
-	Ensure access to timely investigations to support clinical decision making	AS part of the assessment and ward process	**G**
-	Create responsive alternatives to admission:	Working with health and social care partners' admission avoidance schemes are in place for a proportion of patients	A
	Urgent clinics	Patient can be discharged and returned for all urgent clinics with an appointments some clinics are available on the day	G
	o Community based assessments	Current only at T/W patienst remain in hospital for assessment	A
	o Community support for urgent treatment at home and in residential and nursing homes	SaTH and SCHT therapists plan to continue to develop their integrated working practices from the learning of the Frail and Complex Project in order to progress with a discharge to assess model for as many patients as possible.	A

End notes

1 RAT is 'Rapid Assessment and Treatment'. It is employed to manage 'majors', most usually those arriving by ambulance, or hot admissions to assessment units. A senior medical decision maker (usually an ED consultant or acute physician) will rapidly assess the patient on arrival/admission and determine what investigations and immediate treatment are needed. 'Door to doctor time' should be measured; best practice is a 30 minute standard.

2 'See and Treat' is typically used to treat patients with minor injuries and illnesses. Following registration, patients wait to be seen by a clinical decision maker (e.g. an ENP or consultant in emergency medicine) without going through any intermediate stage (such as triage). They are then seen and treated by the decision maker. It should be noted that so called 'minors' may have serious conditions that require prompt and effective treatment. See and Treat helps identify these patients early, as well as dealing with less serious conditions quickly.

3 Triage is a process where patients are seen by a clinician (e.g. a nurse or sometimes a GP) who carries out a preliminary assessment to determine their clinical priority. Some hospitals use sophisticated assessment systems, such as 'Manchester Triage', while others use streamlined assessment tools. Triage typically takes between 2 and 10 minutes per patient, who then queue for definitive treatment. ECIST recommends that wherever possible, triage is eliminated from the pathway, as it creates additional queues and ties up clinical resources that could otherwise be used to treat patients. Evidence suggests that triage only adds value where the triaging clinician initiates diagnostics or treatment (see: *Reducing Attendances and Waits in Emergency Departments*, 2004, section 4.3.2, Cooke, M. et al).

4 A rolling ward round (or 'continuous ward round') is where all patients are seen by a senior doctor (normally a consultant) shortly after their arrival on the ward. More traditional models, where rounds take place at set times/days, delay decision making and create workload spikes for junior doctor, nurses and supporting departments, which are not easily absorbed.

5 'Batching' is where jobs or events are delayed and carried out in groups/batches at a later time. While some batching is useful (e.g. elective operating lists), other batching can lead to delays to discharge (e.g. batching the writing up of TTOs until the end of a ward round or day) or care (e.g. the twice weekly ward round).

6 Some hospitals have established 'specialty in-reach', where specialists actively visit assessment units to 'pull' appropriate patients into specialist wards or provide advice to optimise short stay episodes of care. This approach should be used with caution, as it may lead to batching or inefficient use of specialist time. Best practice is rapidly to identify patients requiring specialist care and to transfer them to specialist wards where they receive an early review by a decision making clinician.

7 This time standard should be determined locally, as part of the process of agreeing 'internal professional standards' (see section 4). ECIST recommends the earliest possible *consultant* review of all admissions (we suggest within 2-3 hours of admission between 8am and 8pm, and a *maximum* of 12 hours if the admission is 'out-of-hours', and much sooner if the patient is not responding to treatment as expected. Out of hours, all patients should receive an early senior review, by an ST3 level doctor or equivalent, within 1 hour of admission, followed by discussion with the consultant if the patient's care plan remains undefined and/or the patient is not responding to treatment as expected). We also strongly recommend that patients are seen again the following morning by the admitting consultant. See *RCS Emergency Surgery. Standards for Unscheduled Surgical Care February RCS 2011,* and, *RCP UK Consensus Statement on Acute Medicine, November 2008,* for the minimum standards recommended by the Royal Colleges. Also see NCEPOD *Emergency Admissions: A journey in the Right Direction*? (2007)

8 Best practice is daily 'board rounds' where the care plan of every patient is reviewed every day by a consultant to identify problems and delays in order to maintain momentum.

9 An Expected Date of Discharge (EDD) represents a consultant's clinical decision in relation to when a patient will be clinically ready for discharge from the hospital. It should not include any allowances for non-clinical delays (an EDD missed for non-clinical reasons is sometimes expressed as EDD+1, EDD+2 etc to indicate an avoidable delay). We recommend that consultant permission is required to change an EDD, as the need to change it should only occur where recovery is not as anticipated.

10 Ensure that consultants define and record in the notes, clinical and functional criteria necessary for each patient's discharge, and then hold multi-disciplinary team members accountable for progress against those goals daily - for example at a ward or white board round. These criteria should be realistic and allow for continuing recovery at home following discharge.

11 A 'board round' is a rapid review of progress against the care plan, typically involving the consultant, his medical team, the ward manager and therapists (and sometimes a social worker). It is usually held by a wards 'at a glance' white board. The aim is to ensure that momentum is maintained and deteriorations identified and managed promptly.

12 One stop ward rounds are where most tasks that have been identified as necessary (e.g. the writing up of TTOs or the ordering of a scan) are completed before the round moves onto the next patient. This avoids the 'batching' of tasks and consequent delays. It can be useful to use a 'COW' (computer on wheels) as an enabler. Team working is essential - leaving all the tasks to the most junior doctors is not team work. See: http://carebydesign.org/checklists/ for a useful ward round check list and other guidance.

13 A senior decision maker is a clinician who can establish a diagnosis, define a care plan and discharge a patient without routine reference to a more senior clinician.

14 See the NHS Institute's *The Directory of Ambulatory Emergency Care for Adults,* 2010. Ambulatory Emergency Care can be delivered by A&E consultants in a CDU (Clinical Decision Unit) and/or by physicians in acute medical units or dedicated ambulatory care units.

15 For a more detailed discussion, see *Acute Medical Care: Report of the Acute Medicine Taskforce*, 2007 and our paper on *Unscheduled Care Pathways* at www.nhsimas.nhs.uk/what-we-can-offer/intensive-support-team/

16 See *Ten High Impact Changes for Service Improvement and Delivery*, Change 3, Modernisation Agency, 2004 and *Ready to Go? Planning the discharge and the transfer of patients from hospital and intermediate care*, DH 2010

17 'In-day bed swing' is a term used to describe the fluctuation of the bed occupancy level of a hospital across a single day. Typically, hospitals become full from late morning due to the inflow of elective and emergency admissions, with occupancy easing from the later afternoon/early evening when discharges have peaked.

18 *Simulation of patient flows in A&E and elective surgery. Discharge Priority: flows in A&E and elective surgery*, Allen A, Cooke M, Thornton S, University of Warwick

19 Older patients with care and/or support needs (rather than acute care needs), should receive a multi-disciplinary assessment from a dedicated team within two hours of arrival in A&E, with a view to arranging suitable home based services and avoiding admission to an assessment unit. Patients who are admitted, but show signs of frailty (such as malnutrition, cognitive impairment or if they have an existing care package), should receive a geriatric assessment and case management support during their hospital stay to reduce their risk of prolonged hospital stay. See: D. Harari et al, *The older persons' assessment and liaison team* etc, 2007, www.ageing.oxfordjournals.org

Appendix A

Infection Prevention & Control Policy

Norovirus

V5

Version:	V5
Approved by:	IPCC
Date approved	
Ratified by	Hospital Executive Committee
Date Ratified	
Document Lead	Specialist Infection Prevention Control Nurse
Lead Director	Director of Infection Prevention and Control
Date issued:	
Review date:	June 2014
Other related policies:	Major outbreak policy incorporating ward closures Standard precautions policy Hand hygiene policy
Target audience	All clinical staff

Document Control Sheet

Document Lead/Contact:	emilia.chrusciel@sath.nhs.uk
Document ID	
Version	V5
Status	Final
Date Equality Impact Assessment completed	May 2012
Issue Date	July 2013
Review Date	June 2015
Distribution	Available on SATH Intranet. Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words	Norovirus, outbreak,
Dissemination Plan	Circulated via Ward Managers Band 7 meeting, Link Nurse, inclusion in Statutory training. All policies will be emailed to Ward Managers / Departmental Manager when updated.

Version history

Version	Item	Date	Author	Status	Comment
V2		18/8/09	Karen Barber	Draft	Presented to STICC subject to minor changes see 3.18
V3		21/9/09	Patricia O'Neill	Final	Changes made see 3.18
V3.1		19/7/10	J Pritchard	Final	Replaced Chlorine Dioxide To Chlorine releasing/detergent combination agent (Tristel Fusion)
V3.1		27/1/11	J Pritchard	Final	Review date changed to yearly. Duties and responsibilities updated.
V4			Debbie Link		Action card added. Link to D&V Outbreak forms added in points 4.4 and 4.9. Replaced Tristel Duo with Tristel Jet. Further advice added for vomit and faecal spillage in point 5.4 Added Algorithm for closure of bays or other clinical areas
V4.1			Jan Heath	Final	Added definitions for cohorting patients and bay closures. Added algorithm for opening/closing clinical areas. Updated aims and purpose of policy. Approved at STIPCC V5
V5			E Chrusciel	Final	Added The stool Tool as appendix, Added Outbreaks forms as appendix. Added links to policies and forms in the body of the policy.

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1. Action Card

INFECTION PREVENTION & CONTROL ACTION CARD

Management of patients with diarrhoea and/or Vomiting, including Norovirus and Clostridium difficile.

Inform Relevant parties of D&V outbreak		• Patients presenting with Diarrhoea & or vomiting must be isolated • If 2 or more patients develop unexpected/unexplained diarrhoea &/or vomiting, this must be considered to be a possible outbreak of infection • Notify Bed Manager, IPC Team, Ward Domestic, Domestic Supervisor • IPC Team will advise about ward closure. Out of hours contact on call microbiologist
Restrict Access to all non essential Staff		• Ensure ward restriction blind is in situ to inform visitors to ward that they are aware of the outbreak • Ensure Enteric precaution signs are positioned on patient beds and side room doors • Essential staff should continue to visit the ward (eg OTs, Phlebotomists, Social workers etc) • Nurses and Health Care Assistants should not work in other clinical areas part way through their shift
Provide Information and Advice to Patients & Visitors		• Visitors must be aware that there is restricted visiting & the ward has an outbreak • Request visitors do not visit other patients on the ward or elsewhere in the hospital • Visitors symptomatic in the previous 48hrs should not visit • Provide patients & visitors with information leaflets • Encourage visitors to carry out hand hygiene with soap & water • Ensure patient's own food, including fruit, is stored away inside their locker
Care of Patients with Symptoms		• Request a review of the patient (s) by a member of the medical team • Maintain an accurate record of symptoms on a stool/vomit chart and report to nurse in charge • Provide facilities to carry out hand hygiene after toileting and prior to mealtimes • Ensure the patient is adequately hydrated • Ensure no anti-motility agents or aperients are given until infection is excluded • Consult with patient about disposal/home laundering of their own clothing if this has become heavily soiled. Provide patient with dissolvable washing bags
Specimens		• Enure all patients who are symptomatic with diarrhoea have a stool specimen taken • Send a stool specimen to the laboratory for testing (request C&S, Virology & C.difficile) & document in nursing records • If patient has had a +ve C diff result please don't take a 2nd specimen • Don't send more than 2 specimens • Don't send if obvious cause for diarrhoea (pt on laxative had enema etc) • Don't send blood or mucus
Follow Trust Policy		• Implement Trust Policy: • D&V –management of affected patients & staff • C.Difficile Policy • Norovirus Policy • Patient Placement & Movement Policy * Isolation policy
Cleaning		• Inform ward domestic and domestic supervisor • Implement enhanced environmental cleaning with chlorine releasing agent • Ensure patients environment (locker/table etc) is cleaned daily with Chlorine releasing/detergent combination agent (Tristel Fuse) and commodes are cleaned with Tristel Jet and after any episode of diarrhoea in the patient environment • Vacuuming/buffing should not take place on affected wards during an outbreak

2. Document Statement

The aim of this policy is to ensure that Healthcare workers are aware of the guidance for the care and management of patients with potential, or confirmed Norovirus. The policy also provides advice for staff that develop diarrhoea and/or vomiting.

The purpose of the policy is to:-

- Minimise the risk of cross infection to patients, staff and all other service users
- Ensure compliance with National Guidelines for the management of Norovirus
- Ensure staff have relevant information to carry out appropriate infection prevention and control procedures

This policy applies to **all staff** employed by the Shrewsbury and Telford Hospital NHS Trust, and also to **all visiting staff** including tutors, students and agency/locum staff. Every member of staff has personal responsibility to ensure they comply with this policy.

3. Overview

3.1 Norovirus is the most common cause of gastroenteritis in England and Wales. This highly infectious virus, can affect patients and staff, with a range of symptoms, most characteristically the sudden onset of vomiting and or diarrhoea. However, there may also be other symptoms associated with the disease, which include myalgia, headache, abdominal pain and low-grade fever.

Cases and outbreaks can occur at any time of the year but are commonest in the winter months.

3.2 The duration of symptoms can range from 12 - 60 hours, but is characteristically 24-48 hours. The incubation period is usually 24 – 48 hours but can be shorter. Outbreaks and repeated reintroduction/appearance of new patients and staff with symptoms is common in the epidemic period. There are a range of different strains but little is known about immunity. However, people do not generally achieve long term immunity following exposure. Norovirus is common in the community and in all residential accommodation including schools, nursing homes, hospitals and other institutions.

4. Definitions

The following definitions apply in this document:

Norovirus
Norovirus is an RNA virus. (A virus is a micro-organism containing either DNA, or RNA). It is an important pathogen causing sporadic cases and outbreaks of gastroenteritis (winter vomiting disease) (Goller et al.,2004 cited in Gould and Brooker, 2008)

Outbreak
An outbreak is defined as the occurrence of 2,or more cases of the same infection, or where the number of infections is more than would normally be expected (Wilson, 2007).

Cohorting the same category patients
Means caring for patients that are; All symptomatic possible or confirmed cases together or, all exposed asymptomatic patients together, or all non-exposed patients together.

5. Policy Detail

5.1. Mode of Transmission

5.1.1 The virus is easily transmitted from one person to another through the faecal-oral route. It can be transmitted by contact with an infected person; by consuming contaminated food or water or by contact with contaminated surfaces or objects, especially in areas where people vomit. The infectious dose is very low, swallowing as few as 10 - 100 virus particles may be enough to cause illness.

Infectivity begins a few hours before onset of symptoms. Patients/staff and visitors remain infectious
for up to 48 hours after symptoms have subsided. However, if they relapse and symptoms reoccur they will remain infectious for a further 48 hours.

5.1.2 Outbreaks are very disruptive as they can reduce staffing levels when staff are affected and generate considerable additional work in caring for unwell patients.

6. Management of Norovirus (see Action Card)

6.1. If patients need to be admitted, they need to be isolated in side rooms or in a bay with other affected patients.

6.2 Carry out a risk assessment of patients who are suspected of having viral gastroenteritis and contact the Infection Prevention and Control Nurses (IPCN).

6.3 An outbreak is two or more cases of the same communicable disease that exceeds the normal numbers (see Infection Control Major Outbreak Policy Incorporating Ward Closure, SaTH Internet). http://intranet/infection_control/Infection_control_policies_and_related_information.asp

6.4 The decision to close beds/ bays/wards is made by the IPC nurses or Consultant Microbiologist (see **Appendix A - Algorithm for Closure of Bays, or other Clinical Areas.** Once the decision is made, the affected bay/ward should remain closed to admissions until patient have been asymptomatic for 48 hours (see **Appendix B Reopening of closed bays or other closed areas**).

Please find Outbreak forms in appendix C, staff can also access the D&V Outbreak forms via the Intranet
http://intranet/infection_control/d_v_outbreak_form.asp

6.5 The IPC nurses will assess the situation and provide regular updates to the ward and the Trust, until the ward can safely reopen.

6.6 If all patients can be accommodated in single rooms on the ward at the onset of an outbreak do so, but **DO NOT transfer patients** to an unaffected ward in order to isolate patients in single rooms.

6.7 It is sensible to cohort same category patients together in the same bay and clean the vacated bay with Chlorine releasing/detergent combination agent (Tristel Fuse) to reduce viral contamination.

6.8 Do not cohort exposed asymptomatic patients with non-exposed patients unless it is 48 hours after their last exposure, and of course, they have remained asymptomatic

Patients who have been exposed to Norovirus but are asymptomatic, can remain in the same bay as those who are symptomatic to Norovirus.

6.9 Avoid transferring or discharging patients to other wards or health care settings until they have been asymptomatic for 48 hours. If there is a clinical need to move a patient to another ward or hospital, the necessary infection prevention and control precautions needs to be adhered to.

6.10 A stool chart needs to be commenced and maintained whilst the patients are symptomatic http://intranet/Library_Intranet/documents/infection_control/D_V_outbreak_forms/Bristol%20stool%20chart.pdf

6.11 If a risk assessment does not indicate any other reason except norovirus for a patient to have diarrhoea (please see appendix C 'The Stool Tool') a stool sample needs to be obtained promptly (specimens contaminated with urine can still be sent to the laboratory). Norovirus must be requested on the form, or it will not be looked for. The IPC Nurse will inform the Lab that a specimen, or specimens are being sent for Norovirus testing.

6.12 Any necessary investigations/procedures/treatment of patients must continue if the patient's condition dictates this. If ward or department is unsure contact, the IPC nurses for advice.

6.13 Patients on a closed wards must not be transferred or discharged to other wards, other hospitals or residential/care homes. If there is a clinical need to move a patient to another hospital, this needs to be discussed with the IPC nurses.

6.14 Patients can be discharged to their own home.

6.15 Food that has been exposed to aerosolised norovirus (during vomiting) will be contaminated by the virus. Therefore, it is sensible to avoid having exposed food such as fruit that can not be peeled on the ward during an outbreak.

6.16 It is the nurse in charge responsibility to inform domestic services of daily Tristel cleans until outbreak has been declared over. The cleaning must be completed using Chlorine releasing/detergent combination agent (Tristel Fuse), paying particular attention to normal general cleaning regime and cleaning toilet areas. Vacuum cleaning and buffing floors during an outbreak is not recommended as it may re-circulate the virus from the environment.

6.17 Advise relatives and visitors of the outbreak prior to them entering the ward and ensure they are aware of the potential risk of acquiring norovirus as a result of their visit. Limit visiting of non-essential staff /visitors and emphasise hand hygiene. Ensure patient and visitor information leaflets are available.

6.18 Visitors must be advised not to visit if they have had symptoms within the past 72 hours. Young children or debilitated visitors need to be discouraged from visiting.

6.19 In the case of a major outbreak of Norovirus/ward closure with large numbers of beds lost to admissions, the major outbreak policy will be utilised. The IPC team will instigate a Serious Incident (SI) report and the Public Health England will be notified

7. Nursing Care

7.1 Gloves and aprons need to be worn for contact with an infected patient, when dealing with body fluids, contaminated linen and during cleaning (see Infection Control Standard Precautions Policy, SATH Internet.)
http://intranet/infection_control/Infection_control_policies_and_related_information.asp

7.2 Hands must be decontaminated with soap and water following contact with an affected patient, or environment and after removing gloves and apron (see Infection Control Hand Hygiene Policy, SATH Intranet). Alcohol hand gel is not advisable as oppose to hand washing in outbreak situation.

7.3 Vomit and faecal spillage must be cleaned up promptly. Wearing Personal Protective Equipment,(PPE) cover and envelope in disposable paper towels. Decontaminate area with chlorine releasing agent/detergent combination (Tristel fuse). Remove PPE. Wash hands with soap and water.

7.4 Horizontal surfaces, and furniture near the soiled area should be cleaned at least daily with Chlorine releasing/detergent combination agent (Tristel Fuse) to disinfect hard surfaces.

7.5 Contaminated linen should be placed carefully into red alginate bags and then into red Terylene bags appropriate as per guidelines for infected linen, available on intranet: http://intranet/Library_Intranet/documents/infection_control/IC_ursing_nformation/LINEN_SEGREGATION_Aug%202011.pdf

7.6 Ensure all commodes and toilets are cleaned between use with Chlorine releasing/detergent combination agent (Tristel Jet).

7.7 Thoroughly clean ward with Tristel Fuse before re-opening.

7.8 Unless contaminated, curtains do not need to be changed before re-opening of the ward.

8. Staff Advice

8.1 Under normal staffing circumstances, if staff develops diarrhoea and vomiting the member of staff should go off sick, and not return until they have been asymptomatic for 48 hours.

8.2 Minimise movement of staff between affected and unaffected wards.

8.3 Members of staff who have worked in an affected area should preferably not work in unaffected areas of hospital for 48 hours.

8.4 Essential agency, medical, and physiotherapy staff should preferably only work on affected or unaffected wards during an outbreak. However, this should not be at the detriment of the patients or the department and if this is unavoidable, affected areas should be visited last. Detailed advice can be obtained from the IPC nurses.

9. Review process

This policy will be reviewed annually unless there are significant changes at either national policy level, or locally.

In order that this document remains current, any of the appendices to the (policy/ guideline / procedure) can be amended and approved during the lifetime of the document without the document strategy having to return to the ratifying committee.

The compliance and effectiveness of this policy will be monitored through audit and outbreak management.

10. Duties

10.1 Chief Executive

The Chief Executive has overall responsibility for ensuring infection prevention and control is a core part of the Trusts governance and patient safety programmes.

10.2 Board
The Board has collective responsibility for ensuring assurance that appropriate and effective policies are in place to minimise the risks of HCAI's.

10.3 Chief Operating Officer
Ensuring that sufficient and appropriate information is available to aid decision making and performance management at all levels. Review performance against plan on regular basis ensuring that appropriate action is taken where necessary. Ensure there are robust systems of internal control that support the achievement of national Trust policies, aims and objectives.

10.4 Director of Quality and Safety / Chief Nurse
The Director of Quality and Safety / Chief Nurse is responsible for ensuring there are robust systems in place to improve performance in relation to Infection Prevention and Control.

10.5 Director of Infection Prevention and Control (DIPC)
It is the responsibility of the Director of Infection Prevention and Control to oversee the development and implementation of infection prevention and control policies.

10.6 Infection Prevention and Control Team (IPC)
It is the responsibility of the IPC team to ensure this policy is reviewed and amended at the review date or prior to this following new development in asepsis.

10.7 Centre Chiefs
Ensure that IPC is considered and monitored as part of the clinical governance structure within the centre and that any action plans are implemented

10.8 Centre Clinical Governance Leads
Receive and review performance information on infection control and report key findings to the Centre Board.

Discuss and review performance information on infection control with Nurse Managers at monthly meetings & promptly escalate to Centre Chief and Centre Manager issues of immediate concern or where help and support is needed.

10.9 Centre Lead Nurse or Practitioner
Receive and review performance information on infection control and report key findings to the Centres.

Discuss and review performance information on infection control with Nurse Managers at monthly meetings & promptly escalate to Centre Chiefs, Clinical Governance Leads and General Managers issues of immediate concern or where help and support is needed.

10.10 Nurse Manager/Matrons
Ensure that they are fully aware of the Trust's HCAI action plan and priorities, especially where they apply to their area of responsibility. They report monthly to the Clinical Manager on compliance with infection control practices and audits.
Ensure effective communication systems are in place to disseminate key messages for Infection prevention & control to all staff within their area of responsibility & ensure details of infection control activity are discussed, recorded, and actioned at monthly ward / department meetings.

10.11 Ward/Department Managers
Ensure that staff are aware of this policy and have access to the appropriate resources in order to carry out the procedure appropriately.
Ensure staff attend Essential Learning in Infection Prevention and Control.

10.12 Healthcare Personnel
Ensure they have read and are familiar with this policy and adhere to the requirements.

10.13 Head of Facilities

Ensure that there is a high level of cleanliness throughout the Trust, they will be the nominated lead for cleanliness, accountable for achieving the key objectives of the Operational Cleaning policy and monitor compliance with the policy.

10.14 Management Responsibilities

Ensure that their staff including bank, locum staff etc are aware of this document and that it is adhered to at all times.
The practices detailed in this policy will be monitored in conjunction with the isolation of patients' audit. Results will be reported to relevant committees.
This policy applies to all staff employed by The Shrewsbury and Telford Hospital NHS Trust, and also to all visiting staff including tutors, students and agency/locum staff. Every member of staff has personal responsibility to ensure they comply with this policy.

10.15 Infection Control Link Nurse

Ensure they have read and are familiar with this policy and adhere to the requirements.
Act as a resource and role model for infection control issues in the clinical area (in conjunction with the Infection Prevention & Control Team IPCT.
Disseminate new information from IC Link meeting including new policies at ward/department meetings.
Take responsibility for completing staff hand hygiene assessments inline with Trust policy.
Participate in audit/surveillance in own clinical area (in conjunction with IPCT) and feed back findings – maximum 4 per year.

11. Equality Impact Assessment (EQIA)

This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group.

12. Monitoring of this document

The monitoring of compliance of this policy is an integral part of the trust governance and audit arrangements. The practice detailed in this policy will be monitored by audit and review if serious incidence occur.

13. Further Information

CHADWICK PR, BEARDS G, BROWN D, et al. (2000) on behalf of the PHLS Viral Gastroenteritis Working Group. *Management of hospital outbreaks of gastro-enteritis due to small round structured viruses*. Journal of Hospital Infection; 45:1-10

GOULD, D. BROOKER, C. (2008) *Infection Prevention and Control. Applied Microbiology for Healthcare.*Basingstoke:Palgrave Macmillan.

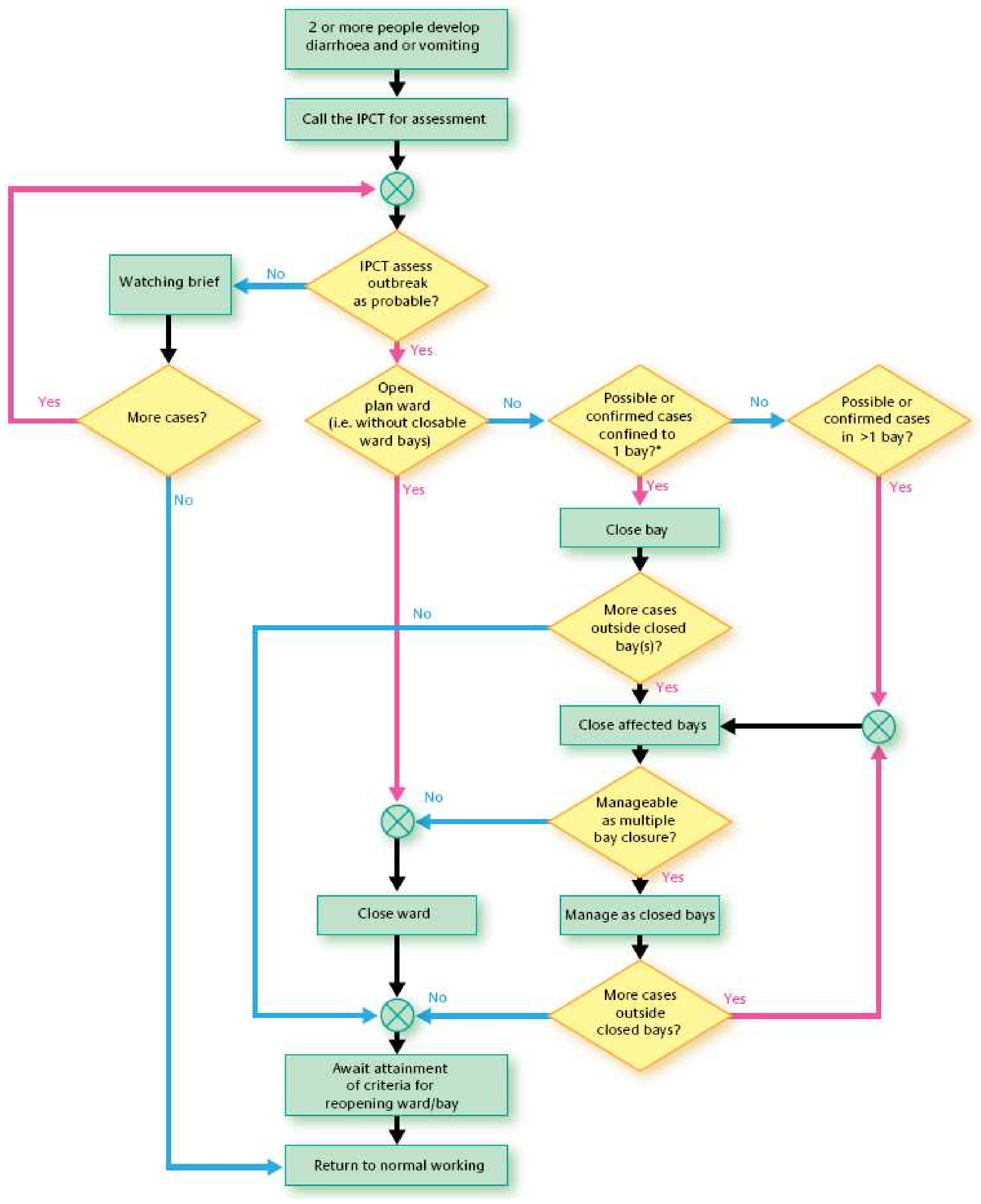
MCCALL J, SMITHSON R. (2002) *Rapid response and strict control measures can contain a hospital outbreak of Norwalk-like virus*. Communicable diseases and Public Health 2002;5:243-6.

WILSON, J (2007). *Infection control in Clinical Practice*. 3rd Edition. London. Balliere Tindall.

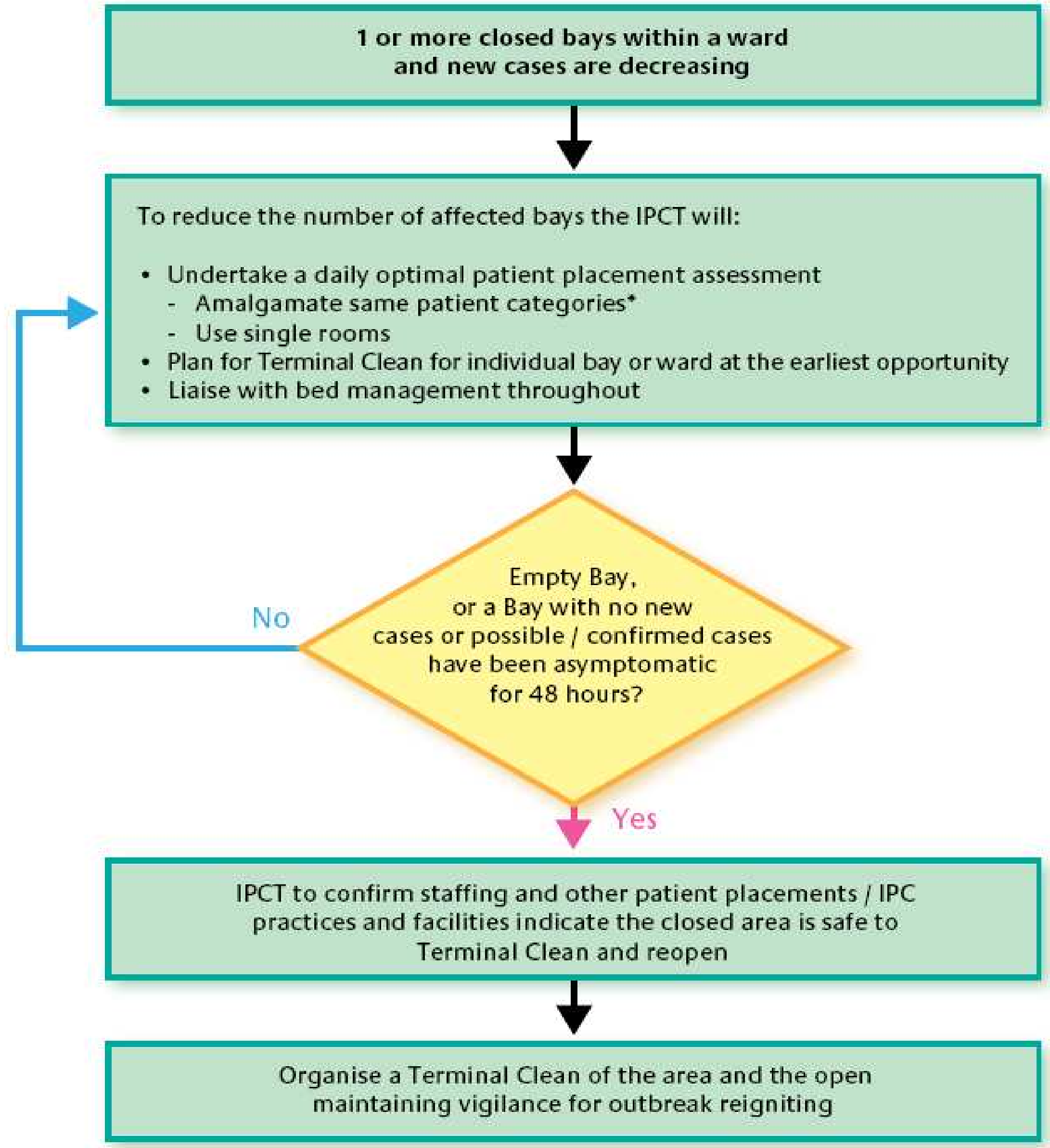
Click on link to review Guidelines for the management of Norovirus outbreaks in acute and community health and social care settings
http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317131647275

14. Appendices

Appendix A – Algorithm for Closure of Bays or other Clinical Areas



Appendix B – Algorithm for reopening of closed bays or other closed areas



*Amalgamating the same category patients means caring for patients that are: All symptomatic possible or confirmed cases together or, all exposed asymptomatic** patients together, or all non-exposed patients (non-exposure in the ward, or within the past 48 hours anywhere) together.

- Do not amalgamate exposed asymptomatic patients with non-exposed patients unless it is 48 hours after their last exposure and of course, they have remained asymptomatic
- Exposed asymptomatic patients can remain in the same bay where exposure to the possible or confirmed norovirus cases occurred, i.e. with the possible or confirmed cases, but should not be exposed to new cases
- **confirm ongoing decontamination of exposed asymptomatic patients environments prior to sharing accommodation with non exposed patients

Appendix C: Outbreak form

MONITORING FORM FOR GASTROENTERITIS OUTBREAK

(PLEASE COMPLETE A FORM DAILY FOR INFECTION CONTROL TEAM TO REVIEW)

WARD:	
DATE:	

FOR THE DAILY MONITORING OF PATIENTS AND STAFF WITH DIARRHOEA, VOMITING, ABDOMINAL PAIN & PYREXIA. THIS FORM RUNS FROM 12 MIDNIGHT TO 12 MIDNIGHT. USE A NEW FORM FOR EACH 24 HOUR PERIOD.

ENTER PATIENTS NAME FOR EACH EPISODE OF DIARRHOEA AND/OR VOMITING AND PLEASE REMEMBER TO TIME & DATE WHEN LAST INCIDENT OCCURRED

Patient Name & Age	**Bed**	**Diarrhoea** (date & time)	**Stool spec** (date & time)	**Vomiting And/or Abdo pain**	**pyrexia**	**Comments & Staff initials**
EXAMPLE Jenny Bloggs	**S/R 1**	**08.30am**	**Sent 8.45am 6/3/03**		**37.9**	**On IV antibiotics**

IF YOU HAVE A NUMBER OF FORMS IT WOULD BE HELPFUL IF YOU COULD NUMBER THE PAGE:

MONITORING FORM FOR GASTROENTERITIS OUTBREAK
CONTINUATION SHEET

Patient Name & Age	**Bed**	**Diarrhoea** (date & time)	**Stool spec** (date & time)	**Vomiting And/or Abdo pain**	**pyrexia**	**Comments & Staff initials**

Appendix D: The stool Tool

The Shrewsbury and Telford Hospital

NHS Trust

The Stool Tool

Before you send a sample ask yourself this........

Is there a reason WHY the patient may have loose stools?

Don't send a sample if:

- It is normal for the patient to have loose stools
- If the patient has recently had laxatives or an enema
- If the patient is constipated with overflow
- If the patient is a known C diff infection or carrier, **DO NOT SEND FURTHER SAMPLES,** discuss with Microbiologist if the patient is symptomatic.

If the patient is passing type 6 or 7 stools and there is no reason WHY the patient may have loose stools

THEN SEND A SAMPLE!!

If a patient has been admitted with loose stools you MUST send a sample within 48 hours

If your unsure then contact the Infection Prevention and Control Team

Infection Prevention & Control Team May 2013

Appendix D – Patient and Visitor Information Leaflet

You can get further advice and information by:

- Asking the Ward Sister or Clinical Nurse Manager
- Asking to speak to a member of the Infection Prevention & Control Team
- Visiting or contacting the **Patient Advice and Liaison Service (PALS).** PALS will act on your behalf when handling patient and family concerns. They can also help you get support from other local or national agencies. PALS, is a confidential service
- **Royal Shrewsbury Hospital** Tel: 0800 783 0057 or Tel: 01743 261691
  Princess Royal Hospital Tel: 01952 282888

Other sources of information about health and health care:

- NHS Direct is a nurse-led advice service run by the NHS for patients with questions about diagnosis and treatment of common conditions
  Telephone: 08454647
  Website: www.nhsdirect.nhs.uk
- Equip is a website established by the NHS in the West Midlands. It signposts patients to quality health information and provides local information about support groups and contacts
  Website: www.equip.nhs.uk
- Patient UK provides leaflets on health and disease translated into 11 other languages as well as links to national support/self help groups and a directory of UK health websites
  Website: www.patient.co.uk

This leaflet is provided for your information only. It must not be used as a substitute for professional medical care by a qualified doctor or other health care professional. Always check with your doctor if you have any concerns about your condition or treatment. The Shrewsbury and Telford Hospital NHS Trust is not responsible or liable, directly or indirectly, for ANY form of damages whatsoever resulting from the use (or misuse) of information contained in this leaflet or found on web pages linked to by this leaflet.

Information Produced by: Infection Prevention & Control Team
Last Updated: June 2012 - Due for review: June 2015
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Patient & Visitor Information

A guide to Norovirus

Norovirus is a frequent cause of diarrhoea and vomiting (D&V) in the community and the commonest cause of outbreaks of gastroenteritis in hospitals.

How is it spread and what are the symptoms?

- Norovirus is found in the faeces and vomit of the infected person. Therefore when people vomit or have diarrhoea the virus may be spread into the environment and settle on surfaces and patient equipment. It can also be passed on by physical contact or contaminated items.
- The symptoms of norovirus often begin suddenly and include nausea, vomiting and / or diarrhoea. Some people may also have a raised temperature, headache and aching limbs.
- Symptoms normally last between 12 and 72 hours, although most people make a full recovery within 24 and 48 hours
- Please inform a member of the nursing staff if you develop any of these symptoms.

What is the treatment for norovirus?

- There is no treatment for norovirus, apart from letting the condition run its course. Antibiotics do not work because they fight bacteria and not viral infections.
- If you develop the symptoms associated with the norovirus you should drink plenty of fluids to prevent dehydration.
- A specimen of the diarrhoea will be sent to the laboratory for testing to confirm if the norovirus is present.
- Once the illness is over no further action is necessary and your treatment will continue as before.
- Protective clothing such as gloves and aprons will be worn by the staff providing direct patient care.
- To prevent further spread of the virus, all staff, patients and visitors must wash their hands thoroughly with soap and water.
- Please remember IT'S OK TO ASK our staff to clean their hands.

Will I need isolation?

- If you develop diarrhoea and vomiting you may be looked after in a single room or in an area with other patients with the same symptoms.
- The ward may be closed to new admissions.
- You should have as few visitors as possible. All visitors to the ward will need to gel their hands on arrival to the ward and wash with soap and water on leaving. Hand washing with soap and water needs to occur after any patient contact or contact with the patients environment.

How can the spread of the virus be prevented?

- Hand hygiene is very important. Washing thoroughly with soap and water after using the toilet and before eating food is essential.
- Soft fruits should not be left on your locker or table. This is because they could be potentially become contaminated with the virus and if consumed by patients and visitors it can cause symptoms.
- Soiled nightwear should be sent home daily for laundering. The staff will provide you with laundry bags, which are placed directly into the washing machine. (Instruction leaflets for these bags are available from the nursing staff).

Is norovirus a risk to my family and visitors?

- Norovirus could be a risk for your visitors. Children, the elderly or those with immune systems which are not functioning well may be particularly susceptible to catching the virus and should avoid visiting during an outbreak.
- Friends and relatives who are unwell or have had diarrhoea and vomiting in the last 48 hours must not visit. This will reduce the amount of patients affected by the illness.
- If you have any concerns regarding visiting during an outbreak please speak to the nurse in charge of your care who can contact the Infection Prevention & Control Team if necessary.
- To prevent spread of the infection to other patients within the hospital, visitors should avoid visiting other wards and departments.

Can I be discharged home with active symptoms of norovirus?

- Yes if you are medically fit and feel that you will be able to manage then the team will support your discharge home.
- We would recommend that you carry on with the recommended precautions detailed above.

Appendix B

Infection Prevention and Control Policy

MAJOR OUTBREAK POLICY INCORPORATING WARD CLOSURE

Version:	V4.1
Approved by:	IPCC
Date approved:	19/03/13
Ratified by:	HEC
Document Lead	Debbie Link
Lead Director	Dr Patricia O'Neill
Date issued:	March 2013
Review date:	March 2014
Other related polices:	MRSA IPC Policy. Clostridium difficile IPC Policy. Influenza IPC Policy Diarrhoea and Vomiting, Management of affected Patients and Staff IPC Policy.
Target audience:	All Clinical staff

Document Control Sheet

Document Lead/Contact:	Debbie.Link@sath.nhs.uk
Document ID	
Version	V4
Status	Final
Date Equality Impact Assessment completed	September 2012
Issue Date	March 2013
Review Date	*March 2014*
Distribution	Available on SATH Intranet. Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words	Major, outbreak, ward closure

Version history

Version	Item	Date	Author	Status	Comments/ Key Changes
V3		April 2010	D Snooke	Final	No changes to content. Policy format edited.
V3.1		Nov 10	J Pritchard	Final	Duties and Responsibilities – DLN and NM's added
V4		Aug 11	D Snooke	Draft	No major changes to contents
V4.1		Aug 2012	Debbie Link	Final	Grammar and updated references. Updated to new format Approved at IPCC 18.09.12

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1. Overview

Antibiotic-resistant bacteria and serious outbreaks of infection in both hospital and community have attracted widespread publicity in recent years.

The aim of this policy is to outline the responsibilities and the lines of management and communication which are essential for rapid control of such outbreaks. This policy also includes advice on handling smaller outbreaks and covers the protocol for ward closure which may occur in major or more minor outbreaks. (Appendix 1). It should be read in conjunction with other infection prevention and control policies relating to the microorganism causing outbreaks e.g. MRSA, Clostridium difficile, Influenza, etc. Also the Diarrhoea and Vomiting, Management of affected Patients and Staff IPC Policy (click on link below to access policies)
http://intranet/infection_control/Infection_control_policies_and_related_information.asp

2. Definition

An outbreak of infection is defined as the occurrence of two or more related cases of the same infection, or where the number of infections is more than would normally be expected (Wilson, 2007).

The severity of an outbreak is graded according to several factors:

- The number of patients affected
- The type and virulence of the organism
- The resources available and necessary to control an outbreak
- The media interest.

3. Roles and Responsibilities

Chief Executive
The Chief Executive has overall responsibility for ensuring infection prevention and control is a core part of the Trusts governance and patient safety programmes.

Board
The Board has collective responsibility for ensuring assurance that appropriate and effective policies are in place to minimise the risks of HCAI's.

Director of Infection Prevention and Control (DIPC)
It is the responsibility of the Director of Infection Prevention and Control to oversee the development and implementation of infection prevention and control policies.

Infection Prevention and Control Team (IPC)
It is the responsibility of the IPC team to ensure this policy is reviewed and amended at the review date or prior to this following new development.

Divisional Lead Nurse
Receive and review performance information on infection control and report key findings to the Divisional Board. Discuss and review performance information on infection control with Nurse Managers at monthly meetings & promptly escalate to Divisional Director and

Divisional General Manager issues of immediate concern or where help and support is needed.

Nurse Manager/Matrons
Nurse Managers/Matrons should ensure that they are fully aware of the Trust's HCAI action plan and priorities, especially if they apply to their area of responsibility. They report monthly to the Divisional Lead nurse / Service Delivery Manager on compliance with infection control practices and audits.

They should also ensure effective communication systems are in place to disseminate key messages for Infection prevention & control to all staff within their area of responsibility & ensure details of infection control activity are discussed, recorded, and actioned at monthly ward / department meetings.

Ward/Department Managers
It is the responsibility of managers to ensure that staff are aware of this policy and have access to the appropriate resources in order to carry out the procedure appropriately. It is also the manager's responsibility to ensure staff attend Essential Learning in Infection Prevention and Control.

Staff
It is the responsibility of staff to ensure they have read and are familiar with this policy.

Head of Facilities
It is the responsibility of the Head of Facilities to ensure that there is a high level of cleanliness throughout the Trust; they will be the nominated lead for cleanliness, accountable for achieving the key objectives of the Operational Cleaning policy and monitor compliance with the policy.

Management Responsibilities
It is the responsibility of ward/department managers to ensure that their staff including bank, locum staff etc are aware of this document and that it is adhered to at all times.

This policy applies to **all staff** employed by The Shrewsbury and Telford Hospital NHS Trust, and also to **all visiting staff** including tutors, students and agency/locum staff. Every member of staff has personal responsibility to ensure they comply with this policy.

4. Recognition of an outbreak

An outbreak of infection should be suspected if:

- **Two** or more patients develop similar symptoms over a short period of time e.g. diarrhoea and vomiting, sore throat, influenza-like tracheitis, wound or skin infection
- Microbiology reports that may show an increase in the number of isolates of a single species
- The Occupational Health Department notices an increased incidence of a specific infection in staff.

Occasionally a major outbreak may be declared after a single patient has acquired infection in hospital e.g. Legionella, or if a particularly hazardous pathogen is isolated e.g. avian influenza, diptheria.

5. Notification of a suspected outbreak

Responsibility for reporting a suspected outbreak lies with both the clinician responsible for the patients and the nurse in charge of the unit.

(See appendix 2 for managing an outbreak within office hours and appendix 3 for managing an outbreak out of office hours)

5.1 Suspected outbreaks of infection should immediately be reported to one of the following:

- The DIPC
- The Matron for Infection Prevention and Control
- The Infection Prevention and Control Nurse (IPCN)
- A Consultant Microbiologist in the Shrewsbury and Telford Microbiology Laboratory (via hospital switchboard out of hours)

5.2 Ward staff must isolate affected patients as soon as possible to prevent and control the outbreak. They must also send appropriate specimens to the laboratory for examinations.

Precise details of individual patients and staff and when their symptoms started should be recorded. Name, unit number, age, symptoms and the date they started will be required and the outbreak monitoring form should be used to record these details (Appendix 4)

5.3 If it has not been possible to isolate the patient a datix form will be completed by the ward staff, detailing the processes taken to access isolation facilities

6. Investigation of a suspected outbreak

Suspected outbreaks are initially investigated by the Infection prevention and Control Team and reported back to the DIPC

7. Minor Outbreak

- Usually characterized by similar signs and symptoms affecting people in one area and may occur over a period of days or weeks

- Small outbreaks of infection most commonly due to Norovirus or C difficile, occur in all hospitals from time to time, and are routinely recognized, investigated and controlled by the DIPC and the IPCNs in conjunction with microbiological, medical and nursing staff.

- They may require actions including additional cleaning regimes and ward closure, but do not usually require convening a major outbreak team unless they are causing major disruption.

8. Major Outbreak

Generally this is characterized by similar clinical signs and symptoms affecting a significant number of people (e.g. 10 or more patients and or staff) in one unit ward. However an infection may be considered major either due to the number of cases, or because of the seriousness of the disease.

8.1 Only in certain circumstances will a major outbreak be declared. These are:

- A risk of spread to the community
- A risk of mortality or major morbidity
- An infection resistant to all antimicrobials
- A need for control measures requiring disruption to services, or control measures that require major cost and manpower

9. Declaration of a Major outbreak

The decision to implement the Major Outbreak Plan will be taken by the Trust's DIPC or in their absence another Consultant Microbiologist, but may also be taken by a Health Protection Agency Consultant in Health Protection or their deputy.

If the outbreak is on such a scale that additional hospital beds may be required, the Medical Director of the trust and the Chief Executive or duty Hospital Manager should be informed so that arrangements can be made to divert or cancel admissions or discharge in-patients.

Major outbreaks should be declared as a Serious Incident (SI) according to the normal Trust procedure.

10. Ward closure

Ward closure may be required in both minor and major outbreaks where the risk of infection to new admissions is high and the risk cannot be reduced by routine infection prevention and control measures e.g. hand washing, isolation nursing or cohort nursing. The infection prevention and control team (IPCT) in consultation with the DIPC will advise that the ward is closed.

11. Activation of the major outbreak plan (see appendix 5)

Details relating to the activation of the major outbreak plan, and setting up the outbreak meeting are detailed in Appendix 5

11.1 Initial procedures required for the management of a major outbreak

The Infection Prevention and Control Team will initiate infection control procedures to include:

- Isolation nursing
- Case finding
- Data collection
- Diagnostic and screening microbiological tests.

12. Management of patients after an outbreak (see appendix 6)

Issues to be considered in the management of the patient during and after an outbreak are detailed in appendix 6

13. Additional supporting measures (see appendix 7)

Information relating to additional supporting measures are detailed in appendix 7.

14. At the end of the outbreak

The DIPC is responsible for ensuring that the incident is officially closed and that the control measures introduced to contain the outbreak i.e. ward closure, are withdrawn except for those control measures necessary for a particular individual. The environment should be decontaminated appropriately.

15. End of the outbreak

At the end of the outbreak the Outbreak Control Team (OCT) will meet to:

- Review the experience of all those involved in managing the outbreak
- Identify any shortfalls encountered and highlight areas which worked well
- Review the outbreak plan based on information obtained form the above
- Produce a written report for the Trust, which will include recommendations for changes in procedures to prevent a recurrence.
- Formulate a press release, if thought necessary.

16. Report to the Trust Board

The Director of Infection Prevention and Control will be responsible for the provision of interim information to the Trust Board and for a formal report at the conclusion of the outbreak.

17. Equality Impact Assessment (EQIA)

This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group.

18. Further information.

. Department of health, (1995) HSG (95) 10: Hospital Infection Control-Guidance on the Control of Infection in Hospitals. London. DH. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4017852

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HSG (93)56 Public Health: responsibilities of the NHS and the roles of others.

19. References

Wilson, J (2007). Infection control in Clinical Practice. 3rd Edition. London. Balliere Tindall.

Ayliffe, GAJ et al (2000). Control of Hospital Infection: a practical Handbook. London, Arnold. Pp 22-23

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19. Appendices

Appendix 1

PROTOCOL ON WARD CLOSURE FOR OUTBREAKS OF INFECTION

Ward closure may be required in both minor and major outbreaks where the risk of infection to new admissions is high and the risk cannot be reduced by routine infection control measures e.g. hand washing, isolation nursing or cohort nursing. The Infection Prevention and Control Team (IPCT) will advise that the ward is closed. Ward closure will only occur after careful consideration and full risk assessment by the IPCT. The decision to close a ward will be made by the IPCT in consultation with Clinical Nurse Managers, Ward Managers and appropriate Clinical Site Manager.

Risk Assessment
Factors influencing consideration of ward closure are: -

- Risk status of patients to be admitted e.g. elective orthopaedic surgery, vascular implant surgery.
- Number of cases
- Virulence, morbidity and mortality rate of infection
- Availability of alternative facilities
- The risk of infection to others
- The ability of others to combat infection e.g. Neutropenic status of patients
- The potential adverse risk from isolating the individuals with infection

The following staff will be informed that the ward is closed, the reason for this and the anticipated duration of the closure

- Chief Executive
- Director of Operations
- Centre Cheifs
- Centre and Busniess Managers
- Deputy Chief Nurse
- Associate Director of Nursing
- Medical Director
- Director of Stratergy
- Estates
- Catering
- Director of Communications
- Matron
- All Ward Managers
- Clinical Site Managers
- HPA
- PCT
- All other relevant deparments

Roller blinds are displayed at the entrance of both hospitals detailing ward closures .The affected wards will also use a roller blind to advise staff and visitors of the precautions required given the particular outbreak It is the responsibility of the nurse in charge to make sure that a ward closure notice roller blind is used at the entrance/exits to the ward and that all the relatives have access to an information leaflet. Leaflets on various infections are available on the intranet under Infection Prevention and Control.

The IPCT will help ensure staff introduce control measures and initiate any necessary investigations.

Where appropriate an IPCN will visit the ward every weekday in order to assess the ward and provide daily infection prevention and control advice. Out of hours the consultant microbiologist on call can be contacted via switchboard for URGENT advice.

If closure involves disruption of services then a major outbreak meeting may be needed, but advice will always be given to duty management on initial action. A meeting will always be convened if the consequences of the infection are serious, or multidisciplinary action is required. The meeting must be held quickly and attendance must take priority over other work.

Transfer/Discharge from Closed Ward

For the duration of the ward closure, patients must not be transferred to other wards, community hospitals or residential/care homes without consultation with the IPCT

Only essential procedures should be carried out on the symptomatic patients. Remember a patient's treatment must not be compromised. If internal transfer is necessary e.g. X ray department, Intensive Care or Theatre, then ensure that both infection control and the receiving unit are aware of the situation and that a risk assessment has been performed by the infection control team.

Clinical Staff

Ideally nursing staff should not be moved to other areas, or to other duties outside that area whilst it is closed, without consultation with the IPCT.

Visiting staff e.g. Physiotherapists, Occupational Therapists, Phlebotomists should still continue their services to the ward. If possible the affected ward should be the last to be visited.

Visitors to Closed Ward

Visitors may contribute to an outbreak of viral gastro-enteritis and therefore should be advised not to visit if they are symptomatic or have had recent contact with someone who has had diarrhoea and/or vomiting.

If it is deemed necessary for a patient to have visitors, this should be restricted to immediate family only.

Re-opening a Closed Ward

Before re-opening to new admissions, effective environmental decontamination is required.

Reopening the ward or bay should only be by agreement with the Infection Prevention and Control Team.

This printed version may be out of date. You should refer to the SaTH intranet for the most up to date copy this policy

Appendix 2

IN HOURS FLOW CHART FOR MANAGING OUTBREAK

Outbreak of infection - *(2 or more cases of alert organisms e.g. D&V, MRSA, C-diff, ESBL, H1N1)* ensure infection control nurses are notified

|

Duty consultant microbiologist will be informed by the IPCN

|

Infection Prevention & Control Team will assess information and advise action

(The Infection Prevention & Control Team will decide if ward should be closed)

|

Infection Prevention & Control Team will inform the Clinical Site Manager about all ward closures. A copy of the outbreak report will also be sent to the on call Clinical Site Manager.

|

In the event of a major outbreak, the Director of Infection Prevention and Control will request an outbreak committee

|

Outbreak will be monitored and appropriate action taken

(The Infection Prevention & Control Team/outbreak committee will decide when the ward can be re-opened)

|

A report will be written at end of a major outbreak by the Infection Prevention & Control Team and will be submitted to the Infection control committee and ward manager.

|

Details of the outbreak will be discussed at the next clinical governance for the Centre

Appendix 3

OUT OF HOURS FLOW CHART FOR MANAGING OUTBREAK

Outbreak of infection -
(2 or more cases of alert organisms
e.g. D&V, MRSA, C-diff, ESBL, H1N1)
Inform the on call consultant microbiologist

|

Consultant Microbiologist will assess information and advise action. Ward will inform Clinical Site Manager of advice given
(The microbiologist will decide if ward should be closed)

|

Clinical Site Manager will commence the outbreak monitoring form which is available on the intranet. The Consultant Microbiologist will be contacted if further advice is needed

|

The next working day the Consultant Microbiologist should inform the Infection Prevention & Control team of the outbreak. The ward should also phone the Infection Prevention & Control Team for ongoing advice.

|

Outbreak will be monitored and appropriate action taken
(The Infection Prevention & Control Team will decide when the ward will be re-opened)

|

In the event of a major outbreak, the Director of Infection Prevention and Control will request an outbreak committee

|

A report will be written at end of a major outbreak by the Infection Prevention & Control Team and submitted to the Infection control committee

|

Details of the outbreak will be discussed at the next clinical governance for the Centre

Appendix 4

MONITORING FORM FOR GASTROENTERITIS OUTBREAK

(THIS FORM NEEDS TO BE COMPLETED BY THE WARD STAFF FOR INFECTION PREVENTION AND CONTROL TEAM TO REVIEW)

WARD:	
DATE:	

FOR THE DAILY MONITORING OF PATIENTS AND STAFF WITH DIARRHOEA, VOMITING, ABDOMINAL PAIN & PYREXIA. THIS FORM RUNS FROM 12 MIDNIGHT TO 12 MIDNIGHT. USE A NEW FORM FOR EACH 24 HOUR PERIOD.

ENTER PATIENTS NAME FOR EACH EPISODE OF DIARRHOEA AND/OR VOMITING AND PLEASE REMEMBER TO TIME & DATE WHEN LAST INCIDENT OCCURRED

Patient Name & Age	**Bed**	**Diarrhoea** (date & time)	**Stool spec** (date & time)	**Vomiting And/or Abdo pain**	**pyrexia**	**Comments & Staff initials**
EXAMPLE Jenny Bloggs	**S/R 1**	**08.30am**	**Sent 8.45am 6/3/03**		**37.9**	**On IV antibiotics**

Appendix 5

Setting up the outbreak control team and meeting.

The DIPC, or in the case of a community centered outbreak, the Consultant in Communicable Disease Control (Health Protection) will convene an outbreak control meeting. In the absence of the DIPC for a hospital centered outbreak another consultant medical microbiologist may deputise.

The DIPC will inform the Chief Executive and seek their nomination for executive officer to the DIPC for the duration of the outbreak. The nominee will be a senior manager (e.g. director of operations, medical or centre chief). The nominee must attend all meetings of the Outbreak Control Team (OCT).

The DIPC will manage the outbreak with the assistance of the Chief Executive or his/her nominee and will arrange a meeting of an Outbreak Control Team at the earliest opportunity. Members of the group must be of sufficient seniority to make decisions and implement actions on behalf of the department or organisation which they represent.

The Chief Executive's nominee may be the Operations, Medical or Clinical Director.

The core Committee will comprise the following and all must be involved:

- The DIPC (Chairman)
- Director of the Microbiology laboratory and other consultant microbiologists or clinical scientists
- A Consultant in Communicable Disease Control from the Health Protection Unit (CCDC)
- The Matron for Infection Prevention and Control
- The Infection prevention and Control Nurse (IPCN)
- Chief executive or nominated senior manager (see above)
- Clinical Nurse manager
- Appropriate Centre Lead Nurse/Practisioner
- Appropriate Centre Chief
- Appropriate Centre Manager
- Member of Clinical Risk Team

At the DIPCs discretion, the following staff may be added to the team;

Internal staff:

- Consultant medical staff from affected service
- Secretary for the affected area
- Occupational Health doctor or nurse
- Estates and Works Department representative
- Pharmacist
- Catering manager
- CSSD, Supplies, laundry, cleaning managers
- Trainee SpRs in microbiology or public health medicine
- Head of comms or deputy

External staff:

- Director of Public Health or deputy from the local PCT
- Community infection control nurse or deputy
- Local Authority Chief environmental Health Officer or deputy
- A regional epidemiologist and other HPA and CDSC staff
- An infectious disease physician
- Sister in charge of any containment isolation facility
- Other specialists

If an invited member is unable to attend, a deputy with executive authority should be agreed with the DIPC.

In the interests of a need for prompt and effective action, the DIPC may choose to act with a small or core team, but should ask for additional help from the Trust Chief Executive if required, or dissatisfied with the expertise locally offered.

The Outbreak Control Meeting will be chaired by the DIPC, who will direct and co-ordinate the management of the outbreak. Initially the nature of the outbreak should be explained and the meeting will then discuss appropriate actions which may involve affected patients and staff, unaffected patients staff and visitors, the operation of the directorate/trust and environmental investigations.

The chairman will ensure that all communications required are considered including:

- Notifying the CE or deputy of relocation requirements for patients who require containment isolation or cohort nursing
- Establishing a list of planned actions and named persons responsible for them. These persons carry these as personal responsibilities and must attend subsequent meetings to report back. This responsibility may only be passed on after discussion with the Chairman.
- Preparing written information for affected patients, other patients and staff as required
- Drafting a press release and briefing document for the CE.
- The head of the comms department will act as contact point for the media up to the next meeting. Where public alarm may be generated the CCDC has responsibilities for public statement and any division of responsibility for public briefing should be agreed in the outbreak meeting.
- Fixing an agreed time, date, venue and attendees for the next meeting of the OCT

The DIPC has operational responsibility for ensuring that all decisions of the outbreak control team are implemented quickly, appropriately, and should liaise with and appropriately delegate executive action to the Chief Executives nominee.

The CCDC has the responsibility on behalf of the PCT and OCT for informing the general public where there is public alarm, particularly in the event of fatalities

The Chief Executive's nominee is responsible to the DIPC for ensuring that other managers act as required and that appropriate resources are deployed. The manger is responsible for minuting and agreeing full minutes of each meeting of the Outbreak Control Team and the preparation and dissemination of internal and external communiqués agreed by the Chairman.

Members of the Outbreak control Team must take all necessary steps:

- For the continuing clinical care of patients during the outbreak
- To meet needs for additional resources in managing the outbreak including additional supplies, medical, nursing, and support staff.
- To investigate, control, and review action lists and progress in the outbreak
- To provide clear instructions and information for staff including ward and support staff
- To consider the need for outside help and expertise and arrange this
- To nominate one person to make statements to news media for the duration of the outbreak
- To agree information arrangements for patients, relatives and visitors
- To communicate with DH, Regional Director of Public Health, DPH, Pacts, CDSC and reference laboratories
- To define the end of the outbreak and evaluate and communicate lessons learnt
- To prepare a preliminary report, ideally within 48 hours, interim reports and a final report.

Appendix 6

Issues to be considered in the management of the patient during and after an outbreak.
The OCT will consider the following at each meeting:

a) General Points

- What is the definition of a case or contact and how many cases are there.
- The likely cause and circumstances of the outbreak and whether it is point source or continuing.
- Whether an epidemiological investigation and case control study is required.
- Is there community involvement and what CCDC action is required.
- Is an incident room required?
- Are food/water/infusion products/supplies/other environmental source likely to be implicated? Have they been removed as continuing sources of the outbreak and have appropriate environmental samples been taken or secured?
- Are engineering investigations required?

b) Patients

What is the extent of the outbreak now?

- When, and to which wards, were the affected patients admitted/transferred prior to diagnosis?
- Which wards/rooms are the affected patients in now?
- Do they need to move, and if so, where to?
- What isolation rooms or wards are required?
- Should further beds be cleared for further cases and if so where and how?

What may be the extent of the outbreak in the future?

- Who are the patient contacts who may be infected or colonised?
- Do patients contacts need to be traced and samples taken?
- What samples should be taken from contacts or affected patients, when and by whom and are additional laboratory staff needed to take them or process them?
- Are legal proceedings for corporate killing or negligence likely and is a chain of evidence or independent laboratories needed to process the samples?
- Do patient contacts need follow-up if discharged and what is the follow-up?

Can spread to other patients be limited through contact management?

- Should the ward to be closed to admissions? See appendix 5 for Protocol on Ward Closure
- Should routine admissions to the whole hospital be restricted?
- Have all contacts been identified - back to admission date or into the community?
- Do contacts still need to be traced/cultured?
- Should the ward suspend transfers of all patients to other wards/hospitals including isolation facilities and other single rooms or segregated bays.
- Should affected patients be discharged home or to other accommodation and how can this be expedited?
- Should the affected patients be moved, and if so, where to?

- What accommodation is available for infected patients in the hospital?
- Can unaffected contacts be discharged home, or sent to other wards/hospitals, or cohorted with, or separate from, affected patients through containment isolation until proven to be pathogen negative?
- Do contacts need follow-up if discharged and if so of what sort?

Can spread to other patients be limited through reducing infectivity?

- What immediate investigation or treatment of patients is required?
- What immediate treatment or prophylaxis is needed for patient contacts?
- What immediate treatment or prophylaxis is needed for staff contacts?
- Who will arrange the above?
- Has disinfection or equipment change been put in place?
- Do catering arrangements need to be modified?

c) Staff

What are the requirements for staff management?

- Who are the staff contacts who may be infected or colonised?
- Are any staff infected and who is undertaking their treatment?
- Do staff contacts need to be traced and samples taken or investigations undertaken?
- What samples should be taken from staff, when and by whom and are additional laboratory staff needed to take them or process them?
- Are legal proceedings for corporate killing or negligence likely and is a chain of evidence or independent laboratories needed to process the samples?
- Do staff contacts need follow-up if on leave and what is the follow-up and who will carry it out?
- Are staff transfers from the ward to other wards permitted?
- Should staff who care for affected patients be segregated from staff that are not contacts?
- Are additional staff who have not been in contact (medical or nursing) required on the ward?
- What precautions are needed for staff's personal protection in clothing, equipment, immunisation or immunity testing?

d) Supplies

- Are there adequate stocks of antibiotics, vaccines, laundry, supplies in the hospital/on the relevant ward?

e) Communications with staff, relatives and patients.

- *What should patients, contacts, relatives, and staff be told?*
- What have patients and their relatives been told already?
- What should affected and contact patients be told?
- What should affected and contact patients relatives be told?
- What should patient non-contacts and their relatives be told?
- What should affected staff and staff contacts be told (including consultants, junior doctors, nursing staff, physiotherapy/Occupational therapy/Porters/Cleaners and Domestics/Others)?

f) What instructions should be given to the hospital switchboard re enquiries
External staff including:

- Ambulance staff
- GPs
- CE of trust and adjoining trusts
- PCT DPHS and CEs
- West Midlands RDPH/Regional Office/HPA regional lead/regional
- Microbiologist
- DH/CMO/HPA Chief Executive or Chairman
- ID consultants
- Trust Board
- HPA CDSC/CPHL Laboratory of Hospital infection or other consultants
- Neighbouring DHAs/Microbiologists
- CE of District Council or Chairman of Health Committees
- What advice should be given to staff about risk of transmission to relatives in the incubation period or when infected and are any staff relatives at special risk?.

Appendix 7

Supporting measures in the control of an outbreak.

The OCT will consider at each meeting the action list from the previous meeting. The DIPC should then brief the meeting on any new cases/carriers/operational constraints and his/her assessment of requirements for further actions or communications.

Points to be considered thereafter include:

General Points
The investigation for a source to the outbreak and whether this source of infection will continue to lead to new cases.
Whether an epidemiological investigation and case control study has accurately defined risk factors and further populations at risk.

Specific areas of assistance

Environmental investigations and control
- Director of Public Health Laboratory or other consultant microbiologist.
- Estates and Works Department representative
- Local Authority Chief Environmental Health Officer or deputy

Microbiological examinations of patient samples
- Consultant microbiologist
- Clinical scientists

Epidemiological investigations
- Consultant in Communicable Disease Control [CCDC] from the Health Protection Unit
- Regional epidemiologist and other CDSC staff

Control of admissions to unit or hospital
- Chief executive or nominated senior manager (see above)
- Medical Director
- Appropriate Divisional director – Need to discus with PON
- Consultant medical staff from affected service

In-patient and contact screening and movement
- The Trust DIPC
- The matron for infection prevention and control
- The Trust Infection Control Nurse [ICN]
- Ward nursing manager
- Clinical nurse manager (CNM)

In-patient treatment and protection
- Appropriate clinical director
- Consultant medical staff from affected service
- Infectious disease physician
- Pharmacist

Notification of specific general practitioners if patient is discharged
- Consultant medical staff from affected service

Notification of Ambulance Control if patients have to be transferred.
- Ward nursing manager
- Community infection prevention and control nurse or deputy

Community care of patients, contacts and the public.
- Consultant in Communicable Disease Control [CCDC] from the Health
Protection Unit
- Director of Public Health or deputy
- Community infection prevention and control nurse or deputy

Control of staff movement
- Ward manager supported by the clinical nurse manager
- Centre Lead Nurse/Practisioner
- Medical Director
- Chief executive or nominated senior manager (see above)

Staff (including Bank, Agency, Leavers and staff on Leave) screening, treatment, and protection
- The Trust Infection prevention and Control Nurse [IPCN]
- Ward nursing manager
- Occupational Health doctor or nurse
- Pharmacist

Exclusion of staff
- Clinical nurse manager
- Medical Director
- Human Resources manager
- Occupational Health Doctor or nurse

Cleaning, disinfection, sterilisation, or discarding of equipment & additional sterile equipment/ other CSSD requirements
- CSSD manager

Additional supplies of protective equipment and disinfectants
- Supplies officer

Supplies of bed linen
- Laundry manager

Supplies of drugs and vaccine *or specialist immunoglobulin supplies (from the local Health Protection Laboratory or Collaborating Laboratory)*
- Pharmacist

Additional cleaning
- Domestic Services Manager

Catering reorganisation and food/water related liaison
- Catering Manager

Outbreak minutes, records and meeting venues and preparation of communications including incident rooms, help lines, other dedicated phone lines, press releases

- Chief executive or nominated senior manager (see above)
- Secretary for the affected area
- Head of comms
- The trust DIPC
- Consultant in Communicable Disease Control [CCDC] from the Health Protection Unit
- Director of Public Health or deputy
- The external communications checklist may include:
- Hospital switchboards
- Ambulance staff
- GPs
- CE of PCT
- Directors of Public Health, PCTs
- CE, Chairman of Trust, Trust Board
- CE and Chairman of Sath
- RDPH and Regional Chairman
- Director of Field Services HPA
- DH (Duty doctor, CMO/Deputy CMO)
- Regional Microbiologist & Director regional HPA laboratory
- Director of Reference Services HPA
- Director of Hospital Infection Research Laboratory
- Neighbouring microbiologists/PCT DPHs
- Neighbouring Hospital CEs
- Local Authority CEHO/CE

Paper 5ii

Reporting to:	TRUST BOARD, Thursday 26th September 2013
Title	Local Health and Social Care Economy Winter Plan
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Debbie Kadum, Chief Operating Officer
Previously considered by	
Executive Summary	A summary of the plans to utilise the additional winter funding that has been made available across the local health and social care economy is attached. The detailed plan is subject to sign off from the Secretary of State.
Strategic Priorities ☐ Quality and Safety ☒ Healthcare Standards ☐ People and Innovation ☐ Community and Partnership ☐ Financial Strength	**Operational Objectives** HS1 Ensure bed capacity meets demand supported through wider health partnership solutions HS2 Improving the timely flow of patients from admission to discharge HS3 Deliver all key performance targets
Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☒ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☐ Clear Clinical Service Vision or we may not deliver the best services to patients ☐ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☐ Achieve a Financial Risk Rating of 3 to be authorised as an FT
Care Quality Commission (CQC) Domains ☐ Safe ☒ Effective ☐ Caring ☐ Responsive ☐ Well led	**Outcomes** 6: Cooperating with other providers - People should get safe and coordinated care when they move between different services.
☐ **Receive** ☐ **Review** ☒ **Note** ☐ **Approve**	**Recommendation** Trust Board is asked to NOTE the Local Health and Social Care Economy Plan

LOCAL HEALTH AND SOCIAL CARE ECONOMY WINTER PLAN

On Tuesday, 10 September 2013, the Secretary of State for Health, The Right Honourable Jeremy Hunt, announced additional winter funding totalling £250 million to be allocated across fifty-three Acute Hospital Trusts in England identified as being at the highest risk for non-achievement of the A&E 4 hour 95% target this winter.

SATH was identified as one of the Acute Trusts to receive additional financial support along with nine other Trusts across the Midlands and has been allocated £4 million.

In order to receive his funding we have had to develop detailed plans outlining how the money will be spent to support patient care and achieve the A&E target.

The plan is divided into 3 areas:

- Improving flow between health and social care;
- Surge capacity;
- Enhanced hospital funding.

An additional 69 beds outside of SaTH will be available as follows:

- 36 beds – combination of intermediate care, care home and specialist dementia beds;
- 24 spot purchase beds;
- 9 enablement schemes.

At SaTH, we will have 16 beds available and are finalising plans to outsource a proportion of day surgery to the Nuffield to protect elective activity should it be necessary to utilise the day surgery unit as escalation capacity.

The plan has been agreed by all of the Local Health and Social Care Economy Chief Officers and submitted to NHS England and is subject to sign off by the Secretary of State.

SaTH's proportion of the £4M is £1-2M and will be used to staff all escalation areas (nursing, doctors and AHP's), cover increases in non pay due to the opening of escalation areas and fund the day surgery activity at the Nuffield Hospital.

Monitoring of the plan is to be agreed by the Chief Officers once the funding has been confirmed.

This plan is supplemented by the Telford and Wrekin/Shropshire/Powys Local Health and Social Care Economy Surge and Winter Capacity Management Plan which has been submitted to the Area Team and is awaiting final sign off as well as the Trust's Internal Pressure Plan.

Debbie Kadum
Chief Operating Officer