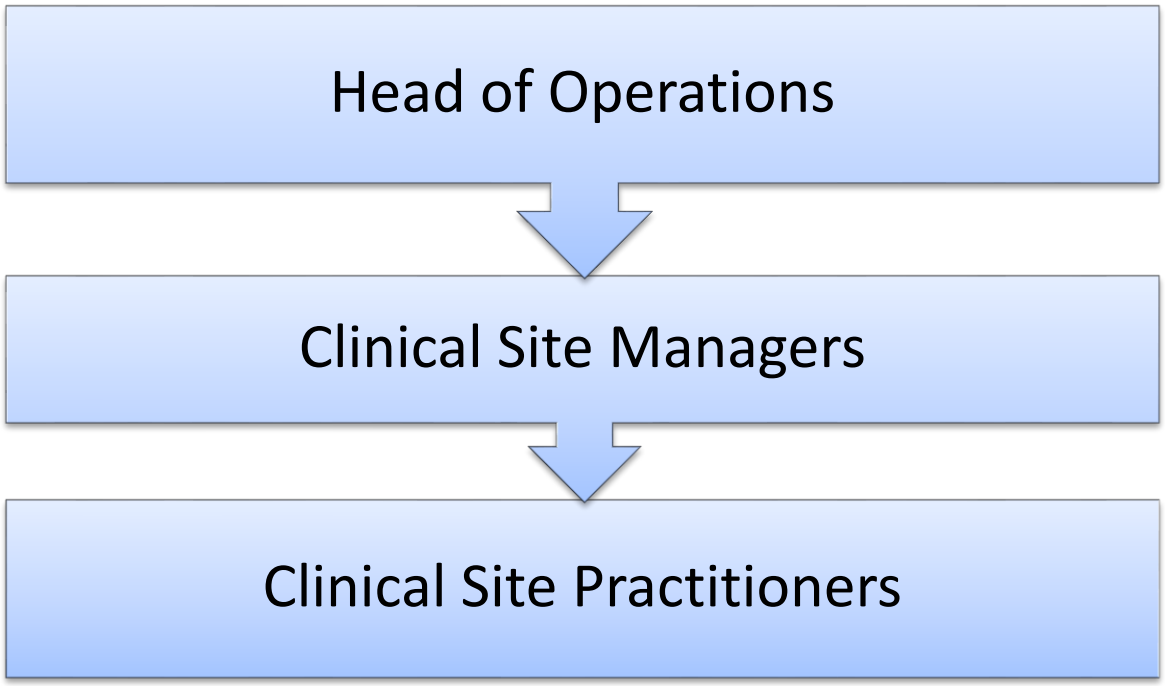
University Hospitals Birmingham NHS
NHS Foundation Trust

Ops Centre Service Description

Head of Operations July 2018 – Review V1

Ops Centre Service Description

1.0 Team Structure



1.1 Role of Head of Operations

The Head of Operations on a day to day basis will be the key individual operationally ensuring the safe and timely flow of patients through the unscheduled care pathways achieving performance and quality targets overseeing the work of the Clinical Site Team. An overview of the requirements of scheduled care will be required.

The Head of Operations will provide visible and proactive leadership to the Operations Centre taking responsibility for operational planning and decision making to achieve patient flow performance and quality targets and holding to account non achievement of agreed targets and plans.

1.2 Role of Clinical Site Managers – Band 8a

The role of clinical site manager is crucial to ensuring that patients are admitted to hospital in a timely and appropriate manner and that beds, specialist advice and intervention are available as and when needed. The CSM will work closely with senior colleagues in A&E and divisional capacity team as a pivotal part of the Urgent Care Team they will co-ordinate out of hour's hospital activity as well as acting as the on- site manager during these times.

1.2 Role of the Senior Clinical Site Practitioner – Band 7

In collaboration with the Clinical Site Manager the Senior Clinical Site Practitioner will assume responsibility of maintaining and upholding agreed standards of care for patients,

relatives and staff in direct contact with the Team as part of their pathway. The Senior Clinical Site Practitioner will work collaboratively with the Clinical Site Manager to ensure the Trust has a robust response to staffing and capacity management requests and in the absence of a more senior colleague, take responsibility for managing the team and delivery of service.

The Senior Clinical Site Manager out of hours will drive the management of the Hospital @ night system, allocating roles throughout the H@N team by triage and prioritisation of 'jobs' raised.

1.3 Role of Clinical Site Practitioner – Band 6

The Clinical Site Practitioner's coordinate, supervise and collaborate with the multi-disciplinary team to facilitate seamless, effective and integrated care to the critically ill and acute pain patients throughout the trust. At night the Clinical Site Practitioner works collaboratively with the Clinical Site Management team to ensure the Trust has a robust response to staffing and capacity management requests.

2.0 The Operations Centre

Location: Ground floor QEHB

Contact Ext 16158

ED Dashboard = http://charon/MainDashboard/Reports.aspx?reportID=281

Bed Viewer = http://ceto/24-7/default?mode=day

SMA = http://ceto/sma/login

Hrlydischarge=
http://charon/Reports/Pages/Report.aspx?ItemPath=%2fPICS_Report%2fPICS+Discharge+Summary

2.1 The Operations Centre Meetings

The purpose of the meeting is to provide a forum to feedback a concise situation report of the hospital status. The focus must be to maintain flow from ED by creating capacity within the assessment areas CDU, SAU, RDU and AOU. The Site meeting will be supported by the use of the Automated Bed meeting template and when necessary the Site Management Allocation system.

Time: Daily at 09:00hrs, 12:00hrs and 16:30hrs. The frequency of these meetings is dependent upon the escalation status of the hospital, further meetings may occur at 14:30hrs and 18:00hrs.

Out of Hours the Clinical Site Manager will lead at 10pm site situation meeting with the Clinical Site Practitioners on duty with email correspondence to the Senior Manager, Duty Director on call, Head of Operations and Chief Operating Officer.

Representation:

Clinical Site Manager (Chair), Head of Ops, Site Practitioner, Division A Capacity Manager, Division B Capacity Manager, Division C Capacity Manager, Division B Capacity Manager, ED representative, ITU Coordinator, WMAS NEPT Discharge Coordinator.

Further representative to the meeting will be determined against the escalation status of the hospital and may include the following representatives Infection control, facilities, QEHB@Home, Discharge Hub, Divisional Matrons, Directors of Operations, Divisional Directors, Associate Directors of Nursing, Chief Operating Officer.

Agenda:

- EMS status;
- ED attendances since midnight, wait to be seen time, number of breaches, and breach reasons;
- ED patients awaiting a bed, speciality breakdown, speciality escalation;
- Total take numbers per division and number of critical care emergency admissions;
- Elective activity, outstanding and deferred;
- Assessment area capacity availability now, later and query for CDU, SAU, AOU;
- CCU, ITU, 306, Burns capacity available now, later and queries;
- Access beds: Stroke, critical care, #NOF, cardiac surgery, Burns;
- Outliers which includes all patients in ambulatory and Wellcome capacity with potential for repatriation or discharge
- Critical care flow including started status of cases against the bed booker/ theatre starts
- Utilisation of the Discharge Lounge
- Community bed availability and identified transfers out
- CAD- review of ambulance arrivals, delays, further expected patients
- RCDM/Trust expected patients
- Recovery delays
- Divisional plans/ review of plans
- Infection control updates
- Review of capacity beds via ward viewer

Agenda Friday 16:30hrs:

All the above in addition:

- Elective activity and forecast emergency activity for the weekend;
- Divisional plans for the weekend – must include plans to close predicted gap between admissions and discharges;
- Additional capacity;
- Planned Critical Care bed booker patients
- Trust expected patients;
- Staffing plans.

- Any planned events within the region that have a potential to impact on site, including planned outage of systems with contingency plan in place.

The Clinical Site Manager will document agreed actions and plans relating to Capacity and Demand on the Site Meeting Report. All actions should have the name of the person responsible for delivering the action.

The Clinical Site Manager will ensure decisions are made that will strategically support capacity and flow over the medium term, and not just during the current shift.

2.2 ITU Flow:

Daily at 07.00hrs the Clinical Site Manager will review listed patients on bed booker and identify appropriate beds against swaps or empty beds which will enable the Critical Care Coordinator to determine which cases can be started immediately against agreed transfers.

07.45hrs a Critical Care Operational meeting will take place in Area A's seminar room, all patients to be transferred out, all planned Bed Booker patients, potential admissions to Critical care from either base wards or ED, IHT's and potential for transplants will be discussed with plans discussed to create appropriate capacity to meet forecast demand.

Further discussions will take place at each bed meeting to create further capacity to support both patients listed on the Bed Booker and also emergency capacity. Where there is a clinical query or clinical prioritisation needs to take place, the Divisional Capacity team will liaise with necessary speciality team medical and nursing.

At weekends the Clinical Site Managers will aim to create capacity against required emergency demand and planned Bed Booker patients and maintain the demand to specialities such as Liver, Neurosurgery and Cardiothoracics.

2.3 TCI's:

The number of divisional TCI's will be discussed at each bed meeting and the divisional capacity teams will lead on the allocation and management of these patients in hours. Out of hours, the Clinical Site team will work with ward teams to accommodate identified TCI's. If any elective patients cannot be accommodated the plan should be discussed with the On Call Manager and Duty Director on Call, no patients should be cancelled unless direction given by the Duty Director. When cancellations take place or change in plan, such as patient to attend the Admission Lounge, the Clinical Site team will email the relevant divisional operational team. Where there are issues to create appropriate capacity out of hours, this should be discussed with relevant speciality team in an attempt to identify further discharges to accommodate patients or to prioritise listed patients further.

Key Target:

- <1% of elective admissions cancelled on the day of admission or later by the hospital for none clinical reasons.

2.4 Access Beds:

The Clinical Site Manager will agree a plan with Divisional Capacity team to maintain access capacity for the following:

a. 1 Shock Room on the Burns Ward;
b. 1 #NOF bed in Trauma (SOP #NOF);
c. 1 Stroke bed (Stroke Operational Policy);
d. 1 Cardiac Surgery bed on 306;
e. 2 CCU beds;
f. 1 critical care Access bed;
g. Assessment capacity on AOU – must not be converted into beds;
h. Assessment capacity on CDU;
i. Assessment capacity on SAU (SOP);
j. RCDM expected patients (Bed 36 SOP)
k. Assessment capacity on RAU

L. **Management of Ward 625**

- A rolling TCI list will be submitted to the weekend folder on a Friday by 5pm. The rolling list will have different types of treatment and the ward team will identify the most appropriate patient for the bed
- Ward 625 capacity should be maintained for Haematology flow which will include TCI's and repatriation of patients throughout the Trust including ITU.
- More often than not there is a Band 6 in charge who fully understands patient priority against bed availability and should maintain this plan.
- No patient should be cancelled or flow stopped without a conversation with the Haematology Consultant on call, there is significant risk to patient's pathway by cancelling these patients. At a weekend there are 2 consultants who attend site both Saturday and Sunday, both can be contacted via switch and must be should there be any change in plans
- If capacity is available at 4.30pm Monday to Friday It should be used to:
    a. Support the rolling TCI list
    b. Support the emergency 'take' for haematology
    c. Repatriate outlying haematology patients

2.5 Additional Capacity:

The Clinical Site Manager will determine appropriate patients to move into available Wellcome or Ambulatory capacity to support necessary specialities.

2.6 EMS:

The following schema will be used to help communicate the escalation status. This is based on a numbered scale that reflects the level of risk to patient safety and the extent to which patient experience may be compromised. The escalation status refers to Trust sites only.

This status setting applies to adult acute bed capacity.

A single escalation status will be set for the QEHB (QEHB and Heritage site).

At any one time, the site would be on an escalation status ranging from 1 to 4. This escalation status will be reviewed at periodic intervals by the Clinical Site Manager in conjunction with the Head of Operations.

The Clinical Site Manager will review the Escalation of the Trust at least twice a day- before 09:00 and before 16:30. Additional updates will be made to the EMS level where appropriate. The Clinical Site Manager will seek approval from the following before increasing the Escalation level.

Level 1	• No Escalation required
Level 2	• Head of Ops during working hours • Clinical Site Manager Out of hours
Level 3	• Head of Ops during working hours • On Call Senior Manager Out of hours
Level 4	• COO / Deputy COO during working hours • Duty Director on call Out of hours

Trigger	1	2	3	4
Expected capacity Vs expected demand in the next 24 hours	Capacity > Demand	Capacity deficit of <120	Capacity deficit between 120 and 240	Capacity deficit >240
Beds in assessment areas	Less than 80% occupied	80% to 100% occupied	No assessment area for a minimum of 3 hours	No assessment area beds for minimum of 7 hours

Planned additional bed capacity	On standby	Open and less than 80% occupied	Open and more than 80% occupied	Open and full; unplanned capacity in use
Critical Care capacity	<80% occupied	80% to 100% occupied	100% occupied; planned over flow areas in use	As for (3) plus potential transfers identified-unresolved
Elective activity for the next 24 hours	Proceeding as planned	Up to 10% elective and urgent inpatient activity cancellation	Up to 90% elective and urgent inpatient activity cancellation	Greater than 90% elective and urgent inpatient activity cancellation
Medical outlier	Less than 6	6-12	12-36	>36
Infection control measures	No loss of admission capacity	Partial or whole ward closed due to Infection control measures	More than one ward closed due to Infection control measures	Whole Hospital closed due to Infection control measures

2.7 Weekend Plans:

All weekend plans must be submitted into the weekend shared folder by 1730hrs on the Friday, by Divisional Capacity teams following review and categorisation of all TCI's, Divisional Staffing plans for the weekend including any outstanding bookings for both Nursing and Medical Staff must be discussed at the Friday 1630hrs bed meeting and submitted into the Weekend shared folder.

If there has been an identified event taking place in the region, Local Health Resilience plans will be shared with the Clinical Site Managers, On Call Manager and Duty Director on call for this period of time by the head of Operations or the head of Emergency Planning and Resilience.

2.8 Trust Policies

The Clinical Site Manager must ensure that key policies and procedures are being adhered to. Specific examples include:

- Trust Site Escalation Policy

- Bed Declaration Policy
- Full Capacity protocol
- Professionals Standards for referrals between ED, CDU, SAU, ITU and Specialities.

3.0 ED Flow:

The Clinical Site Manager will ensure flow in ED and AOU is being tracked by the ED Coordinator and that there is clear communication about issues that may lead to patients being in ED for longer than 4 hours. Key targets:

- No patients stay longer in ED than 12 hours from decision to admit to discharge from ED
- 95% of ED attendances to be seen, treated and discharged within 4 hours
- Average time from decision to admit in ED to transfer out of ED below 60 minutes.
- Average time to treatment in ED <60 minutes

The Clinical Site Manager will support in resolving issues that may delay a patient's pathway in ED as required.

The Clinical Site Manager must report to the Senior Manager on call any patients that have been in the department for 8 hours from decision to admit, a plan should be identified to prevent further episodes of 8hours DTA's.

The Clinical Site Team will work with divisional capacity teams to have a robust plan to avoid any patients breaching 12 hours from decision to admit, and track this plan to ensure that it is delivered appropriately. Out of hours the site manager will resume totally responsibility to action plan to prevent 12 hours DTA breaches, updating both the Senior Manager on call and the duty director on call.

The Clinical Site Manager will maintain an accurate list of patients waiting for beds, or waiting for internal transfer, including DTA from ED.

12 hour clock starts ticking:	On whichever is the later of: a) Decision to Admit time. Note this is the time documented in the patient's clinical record of a formal decision to admit to an inpatient bed. This should be a Trust clinician who has admission rights. Please do not use referral time as the specialty may decide an admission is not necessary. *Or* b) Treatment completion time. Some patients may have a decision to admit but continue to receive necessary treatment in the A&E department for a period of time afterwards, eg patients being actively treated in resus or patients completing an infusion of drugs before they can be transferred to a ward. In this instance the 12 hour clock should start upon completion of treatment. For patients who require admission to an offsite mental health bed, we have recently received written confirmation that any

	RAID DTA should be confirmed as accepted by Forward Thinking Birmingham. The 12 hour clock should therefore commence when FTB have documented their acceptance of the RAID recommendation for admission.
12 hour clock stops ticking:	On admission to a Trust inpatient ward or when transport arrives to collect the patient for transfer to another provider. The clock may also stop when a patient leaves A&E for theatre or if the patient leaves A&E in order to have a procedure or investigation en route to being admitted to a bed.

3.1 Tracking of RAID patients:

Patients presenting to ED and requiring a RAID assessment who are not suitable to transfer to PDU will be referred to and assessed in ED by the RAID team. When a 16-25 year old has been reviewed by RAID and it has been determined an admission is necessary. RAID will request a Psychiatrist on call to review the patient who will agree or disagree with the initial assessment. If the Psychiatrist decides the patient needs admission that is when the Decision to Admit (DTA) clock starts. A request for a bed is made by RAID to forward thinking Birmingham to Forward Thinking Birmingham who is managed by Hunter Combes, referrals are submitted via fax, and both form 1 and form 2 should be sent. Hunter Combes do not accept referrals overnight and only start looking for a bed from 9am onwards.

Prior to referral submission if the patient requires sectioning under the Mental Health act AMPs will need to attend ED to complete the assessment of the patient and complete relevant section papers.

Clinical Site team will liaise with RAID to confirm form 1 and 2 have been submitted and the time of submission.

If no bed is identified and a threat a patient will exceed 12hrs from DTA, the Clinical Site Manager will escalate to the Senior Manager on call. Duty Director on call also by now should be aware and advise. The NHS England duty manager must be contacted.

If no bed is found for over a 24hours period the Duty Managers for NHS England and Forward Thinking Birmingham should be asked to attend site to make a plan by the duty director.

If bed found and safe and secure transfer required site team to call Prometheus, details re patient transfer to be emailed to Group Manager ED and Head of Operations for invoicing on next working day.

There is an expectation that a timeline of all logged calls is kept, this will potential inform the RCA required by the Regional Capacity Team

Refer to BSMHFT Decision Tree for Mental Health Pathway

4.0 Urgent Care Intelligent Centre:

The Clinical Site Manager will liaise with UCIC 3 times a day to discuss the following

- Number of patients in ED
- Number of patients waiting admission
- Capacity availability within assessment areas
- Wait to be seen in ED

No breaches against decision to admit will be discussed with UCIC until a full RCA has taken place by the divisional team and declared as a breach by Head of Performance.

Adhoc the Clinical site managers may request support from UCIC in the following way

- Under times of extreme demand in ED a message is sent out to Katie Rd and 111, and contact with WMAS for intelligent conveyancing of patients to ED's

5.0 WMAS Hospital Desk:

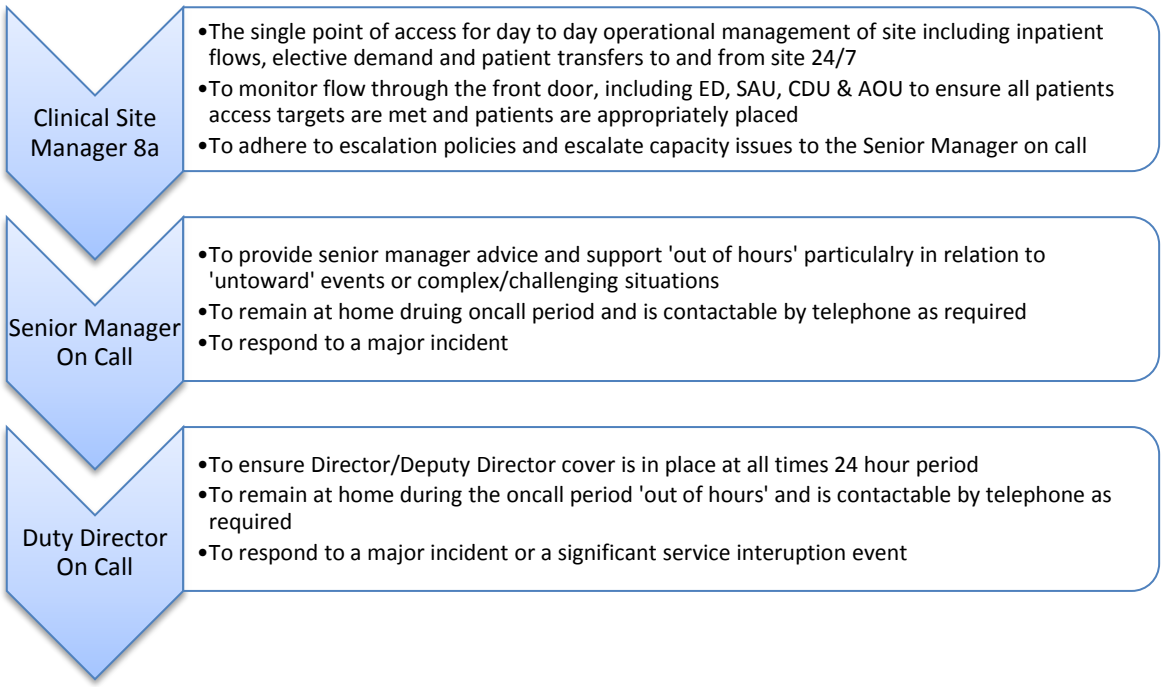
The Clinical Site Manager will liaise with the Ambulance Controller (SOC Controller) if ambulance handover delays arise (over 30 mins = £200 fine, over 60 mins = £1000 fine and a RCA). The Ambulance Controller will normally call the on call manager via switchboard to discuss the situation. The SOC Controller can be reached on 01384 246373.

The Clinical Site Manager will request a HALO attends site, this request is driven due to numbers in ED and expected demand onto site.

5.1 None Emergency Patient Transport:

The clinical site manager will escalate throughout the day any issues identified re NEPT discharges from the Trust, to the WMAS Discharge Coordinator. NEPT will be discussed at each bed meeting, with representation from the WMAS Discharge Coordinator at 9am, 12.30pm and 4.30pm. The WMAS Discharge Coordinator will leave an updated patient list with times of expected journeys with the Clinical Site Manager after the 4.30pm bed meeting. Issues identified out of hours that need to be escalated to Sliver Command NEPT must be done so by the Clinical Site Manager – a list is maintained in the Ops centre folder.

6.0 On Call Arrangements:



6.1 Purpose of the Senior Manager On Call:

- To ensure senior manager cover for the Trust is in place at all times
- To provide senior manager advice and support ‘out of hours’, particularly in relation to ‘untoward’ events or complex/ challenging situations
- To respond to a major incident

During the out-of-hours period it is the responsibility of the Clinical Site Manager to inform the Senior Manager on call of any operational issues that are of a concern. The Senior Manager, in discussion with the Clinical Site Manager, will determine if all processes are being carried out as agreed; it is then the decision of the Senior Manager on Call as to whether they need to attend the hospital. Should the decision be to attend, the Senior Manager should report to the Operations Centre for a full briefing of the situation from the Clinical Site Manger. The option is available if needed for a conference call to be arranged with relevant parties.

In the absence of the Senior Manager on Call due to ‘late’ sick call the Clinical Site Manager will assume the role.

6.2 On Call Rota’s

The following On Call Rota’s are held within the Ops Centre Folder

- On Call rota all specialities submitted by switch board daily
- Speciality teams includes identified Consultant for all specialities
- On Call Managers rota – identifies Duty Director, On Call Manager, Site Lead, and Divisional Capacity Leads.

7.0 Ops Centre – Setting up a conference call:

When a decision is made to hold a conference call, the relevant staff members should be notified of time and reason of call and information required. If Consultants are to be included in the conference call, ideally the call should be planned for an hours' time to allow site the time to contact all necessary consultants. It should be agreed the Duty Director on call who will chair the meeting. Switch board will contact relevant staff following direction from the Clinical Site Manager

The Clinical Site Manager will act as host and set up the conference phone in the Operations Centre, staff on site have the option to attend the Operations Centre or dial in as a participant.

- Dial in number 02083222619
- Host pin 2526716
- Participant pin 2309844

8.0 Acceptance of Section Papers on Behalf of the Trust:

When patients are sectioned under the Mental Health act in inpatient beds the Clinical Site Manager will accept the Section papers on behalf of the Trust. At the same time they will populate within the PICs system details relating to the patients Mental Health Section status.

RAID duty phone 07876398578

Oleaster bed manager (PDU) 0121 301 2098
Forward Thinking Birmingham 0300 300 0099

9.0 Police Condition Checks:

All Police enquiries to the Clinical Site Manager. They can be reached via switchboard. The CSM's will maintain an up to date spread sheet in the Shared Ops centre folder re condition check requests and information given.

10.0 Staffing:

10.1 Nursing

Senior Divisional Nursing teams will put plans in place to cover shortfalls that may occur during out of hours working and will update the Nursing Staffing Dash board and the site team to reflect this. Plans will be submitted via email to the clinicalsitemanagers@uhb.nhs.uk by 16.30hrs. Where a plan has not been achieved an email will be sent by the Clinical Site Manager to the relevant divisional nursing team.

Out of Hours the Clinical Site Managers will put into place any actions as identified by Divisional Nursing teams and any further actions required to maintain safe staffing levels across the site. The Nurse Staffing dashboard will be updated as and when the site team make adhoc changes to staffing.

The clinical site team will authorise any ad-hoc requirements via Allocate in the absence of divisional nursing teams.

QEHB+ team will email the Clinical Site Managers daily re the RMN bookings.

If there are incidence around non-compliance regarding staffing moves requests made by the CSM's the CSM will submit an email to the necessary Head of Nursing for investigation.

10.2 Medical

Any gaps in medical staffing out of hours, is managed by the Clinical Site Manager.

The Clinical Site Manager will submit requests for shift cover using the TemRe system. The Clinical Site Manager will ensure locum CVs are shared with, and authorised by, the relevant Consultant on call. The CSM will email apporpiate divisional operational team for awareness.

Divisional management teams must send an email, with a plan to the clinical site management team where there is a shortfall in speciality cover.

10.0 Major Incident/ Service Interruption Management:

The Clinical Site Manager will assume the necessary role to set up and run either a Major Incident or Service Interruption event to the Trust until the Duty Director attends site. Training of the Clinical Site team will be provided on the following

- Major Incident – Delivered by Head of Emergency Planning and Resilience
- Service Interruption - Delivered by Head of Emergency Planning and Resilience
- Counter Terrorism – Trust Security Management Specialist

http://uhbhome/emergencies.htm

11.1 Major Incident (Major Incident Response Plan)

http://uhbhome/Microsites/Policies_Procedures/assets/MajorIncidentResponsePlan

Video 'How to Setup Command and Control' and 'Capacity Manager'

11.2 Mass Casualty (Mass Casualty Plan)

http://uhbhome/Microsites/Policies_Procedures/assets/MassCasualtiesPlan.pdf

11.3 Business Continuity Escalation Procedure

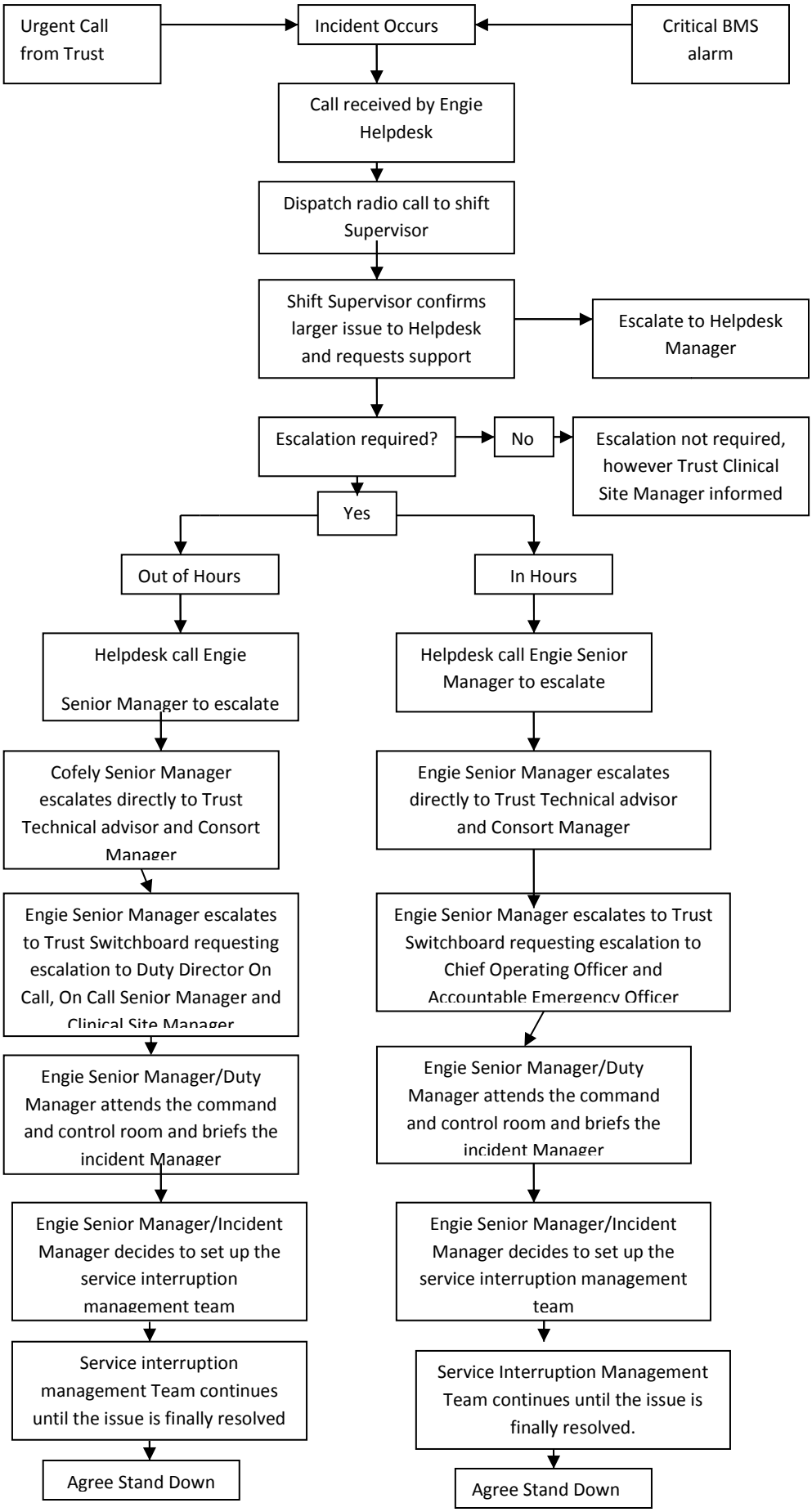
In the event of a service interruption immediately refer to the appropriate service interruption action plan. (action plans held within Share point)
http://qehbportal/emergencyplans/Wiki%20Pages/Home.aspx

A service interruption is an event or situation which

- Threatens the service, personnel, buildings or the organisational structure of UBH: and
- Requires special measures to be taken to respond to the interruption and to restore normality.

The Clinical Site Manager Must:

- Assess the severity of a significant service interruption and determine whether the business continuity plan should be implemented
- Assume the role of the incident manager, having overall responsibility for planning and implementing the Trust's operational response to a significant service interruption
- Convene and chair the service interruption management team (SIMT)
- If necessary Liaise with the On Call Manager and Trust Duty Director with the Trust's response to the service interruption.


Urgent Call from Trust
Incident Occurs
Critical BMS alarm
Call received by Engie Helpdesk
Dispatch radio call to shift Supervisor
Shift Supervisor confirms larger issue to Helpdesk and requests support
Escalate to Helpdesk Manager
Escalation required?
No
Escalation not required, however Trust Clinical Site Manager informed
Yes
Out of Hours
In Hours
Helpdesk call Engie Senior Manager to escalate
Helpdesk call Engie Senior Manager to escalate
Cofely Senior Manager escalates directly to Trust Technical advisor and Consort Manager
Engie Senior Manager escalates directly to Trust Technical advisor and Consort Manager
Engie Senior Manager escalates to Trust Switchboard requesting escalation to Duty Director On Call, On Call Senior Manager and Clinical Site Manager
Engie Senior Manager escalates to Trust Switchboard requesting escalation to Chief Operating Officer and Accountable Emergency Officer
Engie Senior Manager/Duty Manager attends the command and control room and briefs the incident Manager
Engie Senior Manager/Duty Manager attends the command and control room and briefs the incident Manager
Engie Senior Manager/Incident Manager decides to set up the service interruption management team
Engie Senior Manager/Incident Manager decides to set up the service interruption management team
Service interruption management Team continues until the issue is finally resolved
Service Interruption Management Team continues until the issue is finally resolved.
Agree Stand Down
Agree Stand Down

12.0 Fire:

A member of the clinical site management team, usually the Clinical Site Practitioner will attend all fire calls in the QEHB and Heritage building. The role is to confirm with security representative there

- Need for further assistance from the fire service or not and the call may be stood down.
- Determine the need for evacuation of environment and put evacuation plans into process

http://uhbhome/Microsites/Policies_Procedures/assets/FireSafetyPolicy.pdf

13.0 Media Enquires:

The Clinical Site Manager should direct all media enquiries to the Communications Manager on call. They can be reached via the switchboard.

14.0 Access to Medical Records:

Please refer to: On-Call Managers guide to dealing with Police requests for patient information or medical records.

15.0 Clinical Incidents Out of Hours:

The Senior Manager on call will be contacted by the Clinical Site Manager to inform of such an incident, which will offer appropriate advice and confirm actions have taken place as necessary and inform the Duty Director of such an incident. Dependent upon severity of the incident there may be a need to inform the Chief Nurse or Medical Director, this decision will be taken by the Duty Director. There may be a need to contact the relevant speciality consultant on call for further information.

16.0: Infection Control

Out of hours if an outbreak is suspected, a ward or beds can only be closed after discussion with the on call Microbiologist, the Clinical Site Manager should initiate this discussion and initiate any actions that are agreed within this discussion with the relevant ward team. This should be clearly documented within the bed meeting template.

In hours if an outbreak is suspected review of suspected outbreak will be led by the Infection Prevention and Control team (IPC) in conjunction with the senior divisional nursing team, a further out break meeting may be convened in the Ops centre led by IPC.

The Clinical Site Manager will populate within the bed meeting template and EMS of ward closures only once confirmed by IPC/Microbiology.

17.0 Withholding Treatment Procedure:

http://uhbpolicies/assets/WithholdingTreatmentProcedure.pdf

The Clinical Site Manager will lead on this process according to the Withholding Treatment procedure and will escalate as necessary to the Senior Manager. There is a live link to With Holding Treatment tracker within the Ops Centre folder.

18.0 Human Resource Procedures:

All HR procedures and policies can be found on the Trust Intranet.

http://uhbpolicies/category.htm?category=Human resources

Appendices 1; ROLES AND RESPONSIBILITIES – CAPACITY – DIVISION D

Time	GSM/DSM	Lead
8.00AM – 8.30AM	Ensure Update from Neuro/TNP/AOU/Hands received	Matron • Bed Collection
8.30am	**GSM attend Pre-Meet** • SMAs validation	**Matron/Lead attend Pre-Meet** • Beds (now/later/queries) • Outliers – inter divisionally and Trust wide • TCIs including WADM agree send/hold • ITU/ED requiring allocation • Transfers and Aeromed • Email SMT positon Escalate – SMT as required
9.00am	• Hold capacity phones • Confirm discharges and use discharge lounge to create early beds • Confirm patients have arrived for TCI • Create access beds	**Bed Meeting** • Update Divisional position Escalate- ADN if upping required
9.30am	Actions from Bed meeting	Hand over actions from bed meeting to GSM/DSM
9.30am – 11.30am	• Allocate (am) TCIS • Allocate agreed ITU-Liaise with Div A with times agreed – 4 hour target • Allocate ED pts and transfer within 4hr target • Chase query beds • Liaise with SAU • Ensure outliers reviewed by Consultant Escalate- Lead • Any issues with converting queries to actuals • Capacity issues	• Liaise with DSM and GSM • Manage own usual workload as required Escalate – SMT as per criteria
11.30am	**Pre-Meet** • Outstanding TCIs/ED/ITU • Discuss Transfers in and out list • Update SMA	**Pre-Meet** • Chair pre-meet to discuss GSM/DSM list • Record number of discharges • Cross reference with ward view beds and allocation Escalate – SMT as per criteria
12.00pm	• Bed Meeting at Lead discretion • As above	**Bed Meeting** • Update site team as to current position Escalate - ADN if upping is requested, SMT as per criteria
1.45	• Update Lead	
2.00PM		**Bed Meeting as required** • **Request Wellcome capacity if needed**
2.30pm – 4.00pm	• Allocate (pm) TCIs and any outstanding (am) • ITU transfers agree times • Allocate ED pts and transfer within 4hr target • Confirm further discharges and queries • Identification pts to outlie into to create capacity • Update SMA • Chase query beds • Identify predicted discharges next day	• Liaise with DSM/GSM • Chase update from Neuro/TNP/Hands re transfers • Email SMT position Escalate to Site if capacity issues
4.00pm	**Pre-Bed Meeting** • Update position • Discuss Transfers in and out list	**Pre-Meet** Confirmation of patient allocation Ensure Ward view is updated for all wards in Division D Agree potential to outlie Escalate – SMT as required
4.30pm	**Bed Meeting**	**Bed Meeting –** • Plans for outstanding admissions • Plan for emergency capacity for night • Next day TCIs
5.00pm-5.30pm	• Complete actions for the Day • Compose handover (includes transfers in and out/TCIs/ITU bed booker) template • 17.30 send handover to site team	• Oversee all actions are completed for Division • Communication with site team for handover

6.00pm		**Additional bed meeting if requested**

Key tasks

NOF/MTC/shock room/AOU beds to be available throughout the day

Monitor Oceano throughout the day and plan for ED admissions communicating with wards when allocating ED patients into beds

ED Breaches document to be updated by DSM/GSM on daily basis

Update SMA

Ensure ward view is updated

Appendices 2: Division D Bed State Form

Division D - Bed State Form

Outliers	Ward	Now	Later	queries	TCIs	ITU	A&E	Discharges	Comments
	408								
	410								
	410 NOF bed								
	412								
	407								
	409								
	411								
	BU								
	BU shock								
	622								
	AOU (Recliner)								
	YPU / 623								
	624								
	625								

A&E Admissions (numbers names and wards allocated)

CDU pts (names & speciality)

Others patients who need to come in or out

Appendices 3: **Division B Capacity Report**

Date: **Time:**

	Now	**Later**	**?**	**Bed Allocations/Usage**	**WADM TCIs**	**Ward TCIs**	**Emergency Board**	**ITU out**	**Outliers**
SAU (620) 13195									
Renal Surgery (302) 13198									
Renal Medicine/Surg 13030 (303)									
Vascular/UGI (305) 15139/15230/13082									
Cardiology (304) 13197									
Cardiac Surg (306) 13199									
Liver (726) 17308									
GI MED / Liver (727) 17309									
Colorectal (728) 17310									
Total									
QEHB CCU Capacity 12562									

Available Beds	Now		Queries	ITU	Number already Allocated

Expected Pts=	Now		Later		Query		
SAU (4 recliners and 4 trolleys)	Clinic		TCI without allocated beds		TCI with allocated beds		
Speciality Patients for wards	Div B		Div D				
RAU Trolleys x2	Now		Later		Query		

Appendices 4; Division B ITU discharges

Date

ITU area	Patient Name	Ward	Level	Comments	Time declared fit	Time agreed at	Reason not taken

Available Beds	Now	Later	Queries	Today's ITU Transfers	No Sent to D/L	BEDS 4 CDU		
						M	F	SR
513 (36) Multi Spec								
514 (10) Geriatrics								
Stroke Unit (26 on 514)	Access:							
515 (36) Respiratory & GIM								
516 (36) Respiratory & GIM								
West 1 Geriatrics & GIM								
West 2 Geriatrics & GIM								
(H/B)								
(B/V)								
518 (36) Acute Med								
517								
411(10)								
Edgbaston Med : Other								

WARDS	Queries				Number of beds used already in the day by CDU or other transfers			Staffing issues for night shift	Co-coordinator
	BED	initial	Time	Reason	CDU	ITU	WARDS		
513									
514									
515									
516									
518									
HB									
B/V									
West 1									
West 2									
Edgbaston									
517									

This document will be held in the Ops Centre and reviewed yearly, next review due June 2018. If there is significant change in process review will take place adhoc.