Appendix 1
NHS Grampian Unscheduled Care Contingency Capacity Surge Plan

1 Introduction

NHS Grampian has a plan for the delivery of health care over the winter period 2022/2023 described as 'Delivering Unscheduled Care Services September 2022-2023'. As part of this strategic plan and to respond when pressures cannot be managed within our usual business processes, this paper describes the contingency approach to be enacted via civil contingencies. Much of the response demands an approach which is out with normal parameters.

Bed occupancy modelling data indicates that the NHS Grampian system may be overwhelmed by early January with unscheduled care presentations. The expectation at this time is that Grampian Operational Pressure Escalation System (G-OPES) system will have all Level 4 actions enacted. Improvement work in Unscheduled and Urgent Care is suggested via modelling to have a significant impact in improving occupancy levels. However, it is predicted 50 more beds are required in addition to the improvement work in order to keep bed occupancy below 95% (Appendix C).

2 Development of G-OPES and Contingency Arrangements

Whilst we operate the NHS Grampian systems approach to unscheduled care it is essential that we have contingency arrangements when normal business becomes difficult to manage. The G-OPES approach is aiming to create a predictable mechanism for escalation associated with service pressure, meaning that a major civil incident is unlikely to be declared for pressure of this nature. A review of G-OPES levels has been completed to ensure all possible actions are included prior to considering moving into civil contingencies.

Contingency Arrangements Review

Contingency arrangements are used to respond to activity that cannot be managed within usual operational business processes. Due to the enduring pressure throughout the COVID pandemic contingency arrangements became confused. A framework to describe this full range of incident response levels has been developed and considers response levels in the context of impact and the transition from Business Continuity to a Civil Contingencies Response.

3 Trigger for the Unscheduled Care Contingency Capacity Surge Plan

The Unscheduled Care Contingency Capacity Surge Plan (USCCCS) will be initiated by the Chief Executive (or deputy) with advice from the Chief Executive team. The trigger definitions are in place to support decision making and are not intended to be rigidly formulaic / prescriptive. There may be cases where there are exceptions to meeting these criteria, but it is still appropriate to enter the USCCCS Plan.

Consideration of the critical factors described below will stand up the USCCCS Plan:

1. Surge activity is tracking against or above predicted median bed occupancy as per Appendix A.
2. All the G-OPES level 4 actions are fully in place, mutual-aid across the system is in place to balance the pressure as evenly as possible.
3. G-OPES Level 4 is observed in critical Portfolios that impact on acute care hospital beds and cannot be mitigated to a reduced level within 24h.

The data will drive decision making to open either 25 or 50 beds at this time.

N.B. Industrial action in relation to AFC (Agenda for Change) staff terms and conditions may also occur during this time which will impact on AFC staffing levels and Industrial Action contingency plans are in place.

Incident Response Level of High/Very High Impact is expected to initiate this plan.

HOSPITAL High/ Very High **Major Incident**	Major Incident Declared by Hospital A major incident occurs **when the number and rate of presentation of patients or the severity of their injuries exceeds the capacity of normal hospital processes**.	Hospital Major Incident • Activation of Hospital Control Centre (HCC) • Activation of the Hospital Coordination Team (HCT) • Likely to require Corporate Communications response.	Notify EDoC for information and awareness in case of incident escalation or wider impacts. EDoC actions: • Consideration of need for declaration of Board level Major Incident and escalation to Board Tactical/ Strategic response.
BOARD LEVEL High / Very High **Major Incident**	Major Incident *'Any occurrence which presents a **serious threat to the health of the community, disruption to the service,** or causes (or is likely to cause) such **numbers or types of casualties** as to require **special arrangements** to be implemented…..'*	NHS Board level major incident response: • NHS Grampian Tactical Response Team • NHS Grampian Strategic Response • Board Control Centre • Corporate Communications response	EDoC activates NHS Grampian Major Incident Plan. Sectors activate as per NHS Grampian major incident plan. EDoC actions as per NHSG MIP: • Activate/ instruct activation of

		Activation of sector incident response and probable requirement for sector control rooms.	Board Control Centre.

3.1 Strategic aims for the Unscheduled Care Contingency Capacity Surge Plan
The Strategic objectives for NHS Grampian during the Contingency Surge Plan are:

1. Protect life
2. Protect the health and safety of patients, staff & citizens
3. Prevent the escalation of the situation
4. Minimise harm
5. Warn and inform the public
6. Promote self-help and recovery
7. Restore to business as usual as soon as possible
8. Keep staff safe & help them maximise wellbeing

3.2 Stepping down the Unscheduled Care Contingency Capacity Surge Plan
The contingency capacity surge plan will be stood down by the Chief Executive with support from Chief Executive team. The point at which the plan is stood down will be the issues used to trigger the event, namely, demand on the system reflected through G-OPES. All trigger components reflect all parts of the system.

3.3 Other actions associated with declaration of the Unscheduled Care Contingency Capacity Surge Plan
The Board Control Centre (BCC) will be initiated when the unscheduled care contingency capacity surge plan is declared. The aim is to establish the BCC prior to this date to allow some initial preparation and familiarisation for staff who will be working in this team.

4 Timeline for this Plan

Whilst the declaration and standing down of the USCCCS Plan will be determined in real time, the modelling data (Appendix A) being used for planning purposes, suggests that the NHS Grampian system will need to respond in accordance with this paper for a limited period. At the time of writing (01/12/2022), the likely timings of this plan will be:

Based on our model:	Low Scenario Predictions	Median Scenario Predictions	High Scenario Predictions
Start of USCCCS plan	21st January 2023	7th January 2023	7th January 2023
Reduce to 25 surge beds	11th February 2023	11th February 2023	18th March 2023

End of USCCCS plan	11th March 2023	25th March 2023	24th April 2023
Duration of USCCCS plan	50 days	76 days	106 days

The duration of the event has been described considering both national and local models. The indication here is for planning purposes only (remember: model not prediction) and the decisions will be made by the Chief Executive with Chief Executive Team in real time with the evidence of what is happening.

5 Working with Derogations

The anticipated continued demand (based on our modelling data – Appendix A) being placed on the health and care will require all derogations to remain in place (use of non-standard beds, nursing staffing ratios and use of priorities of care).

Many staff have raised concerns about the level of care which they will be able to provide during the periods of high staff absence and high patient demand. The regulators are supportive of professionals working out with their normal scope of practice, a joint statement can be seen in the following links.

NMC (Nursing and Midwifery Council) – Final - CNOs and NMC - Winter Pressures - 16 November.pdf

GMC (General Medical Council)– Winter Regulator Letter - Medical - CMO Scotland.pdf

HCPC (Health & Care Professions Council) – to be published

All professionals, when directed by NHS Grampian to undertake a task during this period, will continue to have indemnity through the CNORIS scheme.

It is recognised that during this time, capacity will be limited, and clinicians will be under significant pressure such that they will be unable to provide what they would consider optimal clinical care. In line with the approach of the regulators, the Nurse and Medical Directors of NHS Grampian recognise this and will support colleagues in this situation.

6 Rationale for Unscheduled Care Contingency Capacity Surge Plan Actions

An additional 50 beds are required to be established when the contingency surge plan is initiated. Demand is expected to increase in four areas – care of the elderly, respiratory, cardiovascular and trauma orthopaedics. There also continues to be an excessive number of delayed discharges in the system.

6.1 Bed occupancy per speciality

Currently some specialities' beds are already over occupied resulting in patients being boarded to another part of Aberdeen Royal Infirmary. Table 1 shows the number of beds per speciality.

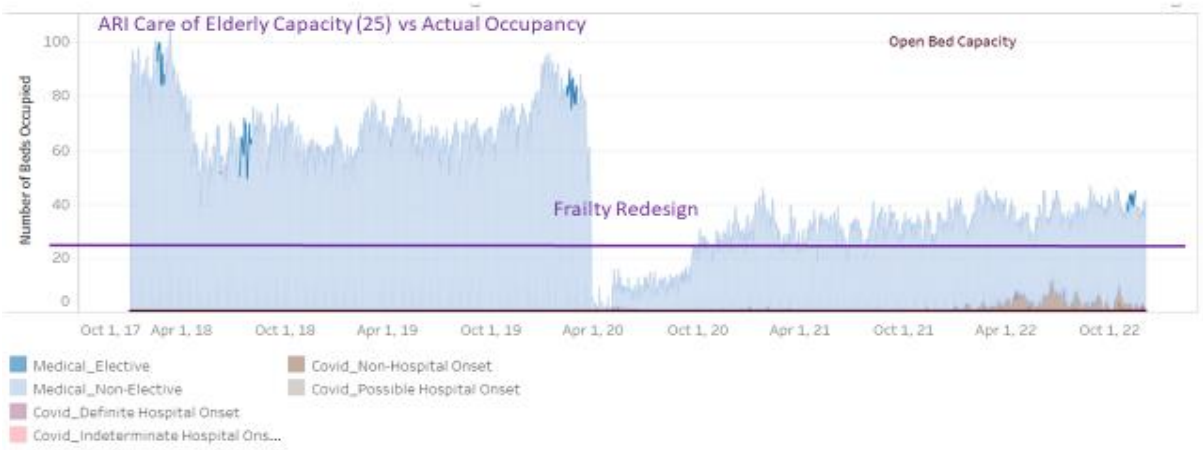
Table 1

Speciality	Ward	No of Beds
Care of the Elderly	102	25
Respiratory	107	30
Cardiology	CCU 106A (10), 109 (30)	40
Cardiology, Cardiology North of Scotland, and Medical Specialty Step-Down	402/403	28 (inclusive of x4 NoS Cardiology beds)

When exploring the data to identify where patients who board originate from, the following three areas experience continuous over-occupancy.

Care of the Elderly Occupancy

From the data presented below, it is evident that the care of the elderly speciality regularly has a need for more than 25 beds in Aberdeen Royal Infirmary.

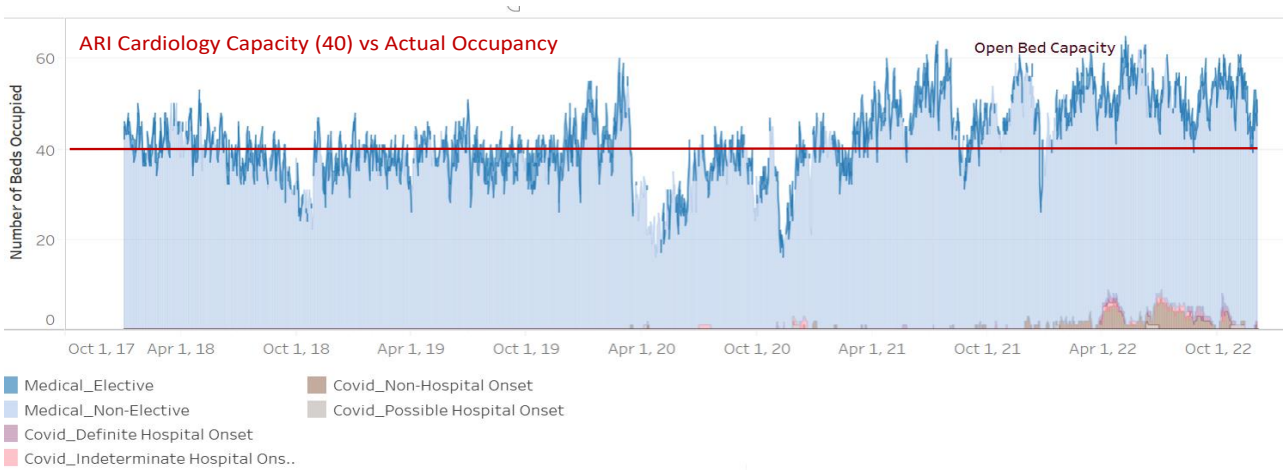


Respiratory Speciality Occupancy

From the data presented below, it is evident that the respiratory speciality regularly has a need for more than 30 beds.

Cardiology Speciality Occupancy

From the data presented below it is evidence that the cardiology speciality has a requirement for more than 40 beds.



The additional patients from these specialities may be included in a cohort in one clinical environment. However, consideration needs to be given to general medical patients boarding in other areas because this displaces medical specialty patients and affects planned care on a daily basis. This also affects how we provide medical workforce.

6.2 Delayed Discharges

There are a significant number of patients with delays in their care pathway in the system who do not require acute hospital care who could be cohorted in one clinical environment.

7 Creation of Unscheduled care surge beds

The aim is to increase unscheduled care bed capacity by 50 beds. 25 will be allocated for patients requiring ongoing specialist medical care and 25 for patients who are delayed on their pathway towards home. The operational plan for these two cohorts will describe the location of beds, the medical cover model and the ward-based care model. The beds will be opened based on the activity data and the tracking against the 'winter scenario models'. The high-level plan for each cohort is set out below:

1. 25 additional beds for patients requiring Medical and Frailty specialist care will be opened in the Aberdeen Royal Infirmary. These will be located either in an unoccupied ward area (Ward 303/304) or through the conversion of a ward(s) space currently used for planned care. The medical management of these patients will remain with the respective specialist medical teams. The ward level care will be provided either by the release of staff from the wider system through the pausing of planned care or through the established ward staff in the situation where this is delivered by the conversion of a ward environment.

2. 25 additional beds for patients who are delayed on their pathway towards home will be provided within the wider Grampian system. These will be located in either in the ARI (Ward 303/304), Woodend Hospital or a Community facility. A model of medical cover is in development, recognising the expertise that Primary Care could bring. The ward-based care team will be drawn from the release of staff from the whole system through the pausing of planned care and corporate services.

8 Risks associated with implementing the surge capacity

8.1 Patient care

At the point where G-OPES 4 is reached and cannot be managed down and the Contingency Capacity Surge Plan is enacted, there are a range of adverse impacts. These include:

People:

- There are significant vacancies across the system and therefore staffing additional beds will post significant challenges across all portfolios. The current predominant status for nursing levels across the system is amber, impacting quality of both patient and colleague experience, and pressure on staffing levels across the system, in all roles, is likely to increase if support is required for additional surge capacity.

- Workforce either working in a new place or delivering care to a different patient population.

Place:

- If the additional capacity comes from sites in either Aberdeen Royal Infirmary or Woodend sites, neither location has modern purpose-built areas which are likely to be available, so the environment for patients will be less satisfactory than if they had been accommodated within the usual footprint for their service.

Pathways:

- Waiting times and treatment time guarantees are significantly challenged across the system and are likely to increase for patients of any service where capacity is converted or reduced to accommodate the surge capacity required. There is no low-level activity to reduce or pause.

- The known impacts regardless of the specific service will include longer individual patient waits, relative increase in waits for others in the same pathway, disruption to complex integrated multidisciplinary pathways, and time expiration of results and evaluations, including risk-benefit assessments.

- Additional delays may precipitate an increase in escalations from primary care due to patient deterioration, direct communication complaints to the service and thus further need for clinical evaluation.

- Delays in addition to those already experienced may adversely affect the stage of disease at future presentation for treatment, escalate the level of intervention required, require greater use of healthcare resource and or reduce the intended value of the outcome.

These impacts are most effectively mitigated by delivering G-OPES actions as aggressively as possible within levels 1-3, thereby deferring activation of the Contingency Capacity Surge Plan. If that plan must be activated, the lowest risk patients will be identified to move using clear standard operating protocols, and the surge areas will be used for the shortest time.

8.2 Financial

Enacting the Contingency Capacity Surge Plan is likely to incur additional costs in the following areas:

- The costs of medical staffing cover.
- Additional Nursing and Allied Health Professional costs if it does not prove possible to realign staffing resource from displaced activities elsewhere to cover surge beds. In this case it is possible that agency staff will need to be used.
- The additional costs in terms of enhancements and out of hours cover that may be required.

The costs will be mitigated by an uncommitted contingency amount within the funding for Unscheduled Care which has already been allocated to NHS Grampian by the Scottish Government.

8.3 Workforce

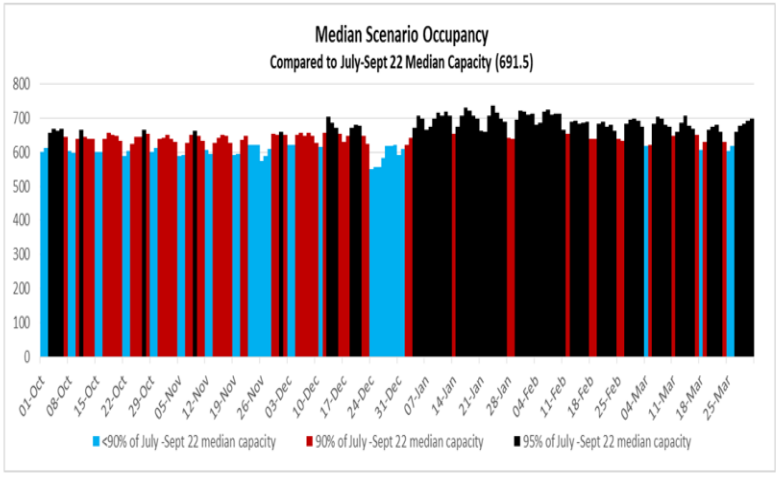
In addition to the significant workforce risks already identified and being managed arising from system pressures and potential industrial action, there are specific risks which are likely to arise if it is not possible to identify alternate location(s) and / or additional staffing capacity;

- Impact on morale and reluctance of colleagues deployed to work in surge capacity areas during the period of the plan. Mitigations include engagement with staff in affected areas during finalisation of the plan; the identification of individuals, and teams where possible, well in advance of any activation that flows from having an agreed plan in place; initiating the Management of the Workforce in a Major Incident Policy to highlight contingent nature of these arrangements.

- Moral injury experienced by colleagues deployed to work in surge capacity areas where this is enabled by a reduction in service levels elsewhere. Mitigations include the prioritisation of clinical psychologist and additional TRiM capacity funded via NHS Charities Together in support of these colleagues; continued expansion of the peer support model based on principles of Psychological First Aid across clinical areas that has been supported by We Care; and the stepping up of a Welfare Group Chaired in Partnership that will identify and identify ways of attending to support needs.

Appendix A - Modelling with no interventions

Original Projections (Median Scenario)



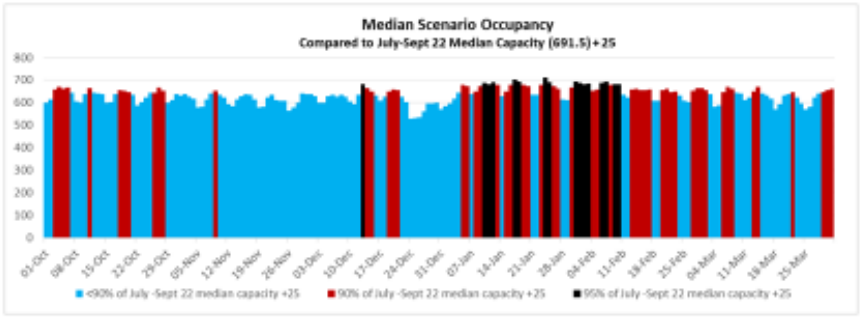
	Oct	Nov	Dec	Jan	Feb	Mar	Total	% of Days
<90%	10	12	11	1	0	4	38	20.9%
90% -95%	15	17	13	5	5	5	60	33.0%
95% +	6	1	7	25	23	22	84	46.2%

- >90% of capacity on 79.2% of days
- >95% of capacity on 46.2% of days

Appendix B - Modelling with improvement changes & 25 additional beds

Cumulative changes: Midnight bed occupancy projections including Hospital at Home Changes, Boarder Management Initiative, Expanded Cath Lab Capacity plus Total Capacity increased by 25 beds

Projections accounting for expanded Hospital at Home Changes, Boarder Management Initiative, Expanded Cath Lab Capacity, Total Capacity increased by 25 beds (Median Scenario)

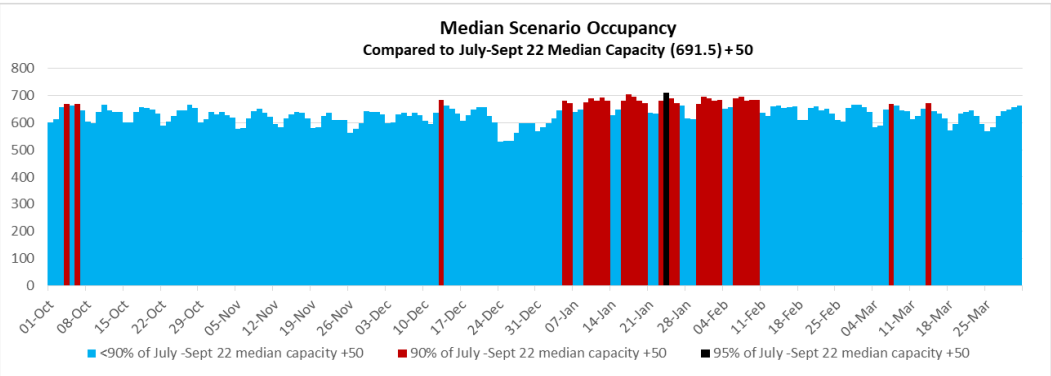


	Oct	Nov	Dec	Jan	Feb	Mar	Total	% of Days
<90%	20	29	26	9	7	20	111	61.0%
90% -95%	11	1	5	13	14	11	55	30.2%
95% +	0	0	1	8	7	0	16	8.8%

- >90% of capacity on 39% of days
- >95% of capacity on 8.8% of days

Appendix C - Modelling with improvement changes & 50 additional beds

Projections accounting for expanded Hospital at Home Changes, Boarder Management Initiative, Expanded Cath Lab Capacity, Total Capacity increased by 50 beds (Median Scenario)



	Oct	Nov	Dec	Jan	Feb	Mar	Total	% of Days
<90%	29	30	31	12	20	29	151	83.0%
90% -95%	2	0	1	17	8	2	30	16.5%
95% +	0	0	0	1	0	0	1	0.5%

- >90% of capacity on 17% of days
- >95% of capacity on 0.5% of days