

Trust Board Meeting: Wednesday 12 November 2014

TB2014.117

Title	Out of Hours Cover 'Care 24/ 7' Project - Update
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Status	For information
History	This is an update on progress against the Action Plan for Out of Hours Cover approved by TME on the 27 February 2014.

Board Lead(s)	Mr Paul Brennan, Director of Clinical Services			
Key purpose	Strategy	Assurance	Policy	Performance

Executive Summary

1. The Trust Management Executive received a report on the the review of out of hours cover across the OUH NHS Trust on 27 February. TME agreed an Action Plan for delivery at Appendix 1 (Action Plan updated to reflect specific site based issues).

Risk Summit meetings were held with staff from across the organisation to identify the key issues and potential solutions related to the delivery of care in the out of hours period. The key themes were incorporated into the work streams within the 'Care 24/ 7' project.

An update on progress against the Action Plan was provided to the TME at its meeting on 12 June 2014.

2. The project evolved into its site based implementation phase in July 2014. A revised structure was put in place with an overarching Project Board, which is led by Dr Jon Westbrook. Site based Project Teams, (each led by a Clinical Lead), report into the Project Board which in turn reports into the Transformation Steering Group.

The site based implementation has been split into three phases the first of which is the at the Horton General Hospital under the leadership of Dr Graham Walker. The timeline for implementation of the first phase of the Care 24/7 HGH is the 27 October. Inevitably this project is raising a number of issues that require use of formal organisational change processes and strategic decision making in order to bring about the changes required. Those issues include:

- Consultation with junior medical staff and operational managers on changes to shift times and job description to support the out of hours model.
- A decision on the role of the Critical Care Unit at the HGH.
- The role of the Therapies teams out of hours and funding to support increased input.

3. The inaugural meeting of the Churchill Phase 2 Project Team meeting took place on 2 October 2014, led by Dr James Gilbert. The issues raised by staff are similar to the HGH although appear to be present more potential risks to patients e.g Transfer protocols not being used, gaps in medical staff cover between 5pm – 9pm. For this reason the Churchill issues (documented in the Action Plan at Appendix 1) are being escalated within the project for swift resolution. Actions taken to date are:

- Background data collection has taken place to inform decisions in relation to the staffing model for out of hours. The Project team meetings will occur every two weeks to review and resolve the cover issues. It is anticipated that the staffing model adopted at the HGH could also be used on the Churchill site.
- A proposal for centralised management and coordination of the rotas has been submitted to the Transformation Steering Group for approval at the end of October.
- A formalised handover will be put in place by the end of October using the Handover Guidance established through the Project, once agreed through the

Clinical Governance Committee mid October.

4. Progress has also been made in the following areas:

- Improved access to pharmacy out of hours and at the week end has been established through the provision of Winter Pressures Funding.
- Radiology have a system for remote review of images in place to provide improved access to a radiology opinion out of hours.
- An operational protocol for the HGH out of hours team has been approved. The protocol will form an appendix to the Corporate Bed Management Policy. This can be used as a template for the Churchill protocol.
- A communications hub has been found for a formalised evening handover to take place on the HGH site. The room requires a small investment of funding to support access to screens to review information relating to individual patient details and ED activity. This handover hub is also a requirement for the Churchill site.

5. **Recommendation**

Trust Board is asked to recognise the progress made within the 'Care 24/7' project to the end of September 2014 and to note the proposed timescales within the revised Action Plan as approved by Trust Management Executive.

Out of Hours Cover

1. Purpose

- 1.1. A paper was presented to TME on the 27 February 2014 to improve the Out of Hours Cover across all sites within the OUH and to agree that the timescales proposed for delivery are acceptable. An update on progress against the Action Plan was provided to TME at its meeting on 12 June 2014. This paper provides a further update on progress against the Action Plan, and proposes revised timescales where appropriate.

2. Background

- 2.1. The report submitted to TME in February made recommendations to improve the safety of clinical services across the OUH in the out of hours periods 17:00 – 08:00 week days, week ends and during public holidays.
- 2.2. Following approval of the Action Plan in February 2014, a series of consultations with the MDT's across the organisation was undertaken. These were held with stakeholders over a period of three months and included Risk Summits and work stream meetings focussing on a 'Nerve Centre' to promote effective communications, 'Workforce' and 'Logistics'. The consultation was used to engaged the MDT's involved in the delivery of out of hours care and to further validate the issues raised.
- 2.3. The Action Plan has been updated with progress and also incorporates specific site based issues for resolution.
- 2.4. If resolution can be found to challenges as they arise, it is anticipated that the Care 24/ 7 Project will deliver all of its objectives within a ten month timeframe up to February 2015. The dates for completion within the Action Plan have been changed to reflect this.

3. Progress Report

- 3.1. In July 2014, the consultation period was completed and the Work Streams were disbanded. The membership of the overarching Project Board was reformed in preparation for Care 24/7 role out across each site. The Project Board is led by Dr Jon Westbrook (Divisional Director for NOTSS) supported by site leads for each of the hospital sites involved in the project. Dr Graham Walker (Consultant anaesthetist) is leading the Horton General Hospital (HGH) phase 1 roll out (up to the end of September). Mr James Gilbert (Consultant Transplant Surgeon) is leading phase 2 roll out at the Churchill Hospital. There are two consultants to be interviewed for the Nuffield Orthopaedic Centre and John Radcliffe sites during October 2014.
- 3.2. The Patient Safety Academy is providing support to the project, holding focus groups with staff and conducting observational studies to inform the model of cover put in place.
- 3.3. The areas of work under the headings below were agreed in the stakeholder consultation meetings and have been used as a template for the project roll out. Progress made at the HGH site using these principles is as follows:

- 3.3.1 Mapping exercise (HGH): A detailed activity mapping exercise was undertaken. The mapping task is cumbersome due to the paucity of good quality information available on rotas and staff involved in those rotas, out of hours task requests and lack of ownership for out of hours activity. Despite the difficulties the project has collated adequate to enable an understanding of the demands, in terms of workload. The information is being used to make an assessment of input required from the out of hours team. Key aspects of this assessment and subsequent proposed changes include:

4. New and Changing Job Roles

- 4.1. At the HGH this has demonstrated that the bleep 500 (linked to the Operational Managers) is used infrequently and that there is a lack of confidence in what the role has to offer in terms of clinical input. However, it clearly has an operational function in maintaining patient flows which is extremely valuable. It is important that this aspect is maintained in the new Clinical Coordinator role. It is proposed that the role of the Operational Manager out of hours will become a more clinically oriented role called the site Clinical Coordinator. This role is pivotal in providing leadership and expertise to support both clinical and operational decision making out of hours. A proposal is in the process of being produced and presented to staff by the end of October. The proposal will form the basis for organisational change with those staff involved.
- 4.2. At the HGH it has been proposed that the shift hours of the Medical Registrar and Operational Managers have been brought forward and the attendance of those staff at the Handover meeting mandated. Both of these actions require consultation with staff with one months written notice. Medical staff have already been given notice. The Operational Managers and NNP's proposal is in the process of being written with the intention to consult with staff in October.
- 4.3. A Clinical Support Worker has been introduced into the model to support clinical activities such as phlebotomy. Requests for routine clinical input such as phlebotomy, iv resiting and taking ECG's etc are reported as constituting up to 40% of the requests made of the out of hours team. This role is not currently funded so is incorporated into the model as an aspiration. The benefits are that the medical staff time would be released for other direct patient care activities which could be expedited and would provide flexible capacity for the Clinical Coordinator when the operational workload is under pressure.

5. Handover Process

- 5.1. Evening Handover meetings out of hours are not held regularly, often with sparse attendance and a lack of clarity of what is to be discussed. There is a lack of leadership in the meetings and the Operational Manager does not attend. The model developed (see Appendix 2) will bring all of the key staff on duty out of hours together. A register of attendance will be taken, possibly using swipe of the security identification card, as is the case for the Grand round meetings. This will allow clinical leads to follow up on management of any lapses in attendance.
- 5.2. A standardised format and guidance for Handover has been written and agreed through the Care 24/7 Project Board (Appendix 3). The Handover Guidance will be presented to the Clinical Governance Committee in October for ratification.

- 5.3. Central coordination of the out of hours model through the Handover process will deliver the following benefits: creates an out of hours community of staff to support each other, provides an awareness of the activities required and provides opportunities for the triage of that workload to the most appropriate staff which will promote teamwork.

6. Operational Protocol

- 6.1. A draft operational protocol for the out of hours team at the HGH is attached at Appendix 3. The protocols built for each site will become appendices to the Corporate Bed Management Policy.
- 6.2. The operational protocol supports the referral of out of hours requests (except for medical to medical staff requests and 222 calls) to the Clinical Coordinator who will triage the requests and refer to the most appropriate team member.
- 6.3. There was agreement that a daily IP review should take place however this need not always be undertaken by a consultant and will be incorporated into the Operational Protocol for each site.

7. Role of IT and Support Systems

- 7.1. The triage of clinical requests into the out of hours team will be managed using a manual process unless a technological solution can be identified. The process will be administered by the Clinical Coordinator.
- 7.2. EPR is not currently being used to support handover across the Trust however this is being explored within the project. The proposal to use EPR has not been well received by users. There is at least one bespoke system in use on medicine for handover which may provide an alternative if EPR cannot be utilised as a first line. The Guidance for Handover contains a proforma which can be used if electronic solutions are not found.

8. Changes to Service Provision and Pathways

- 8.1. An agreement on the role of critical care at the HGH and its functionality is required as there is currently confusion between clinical teams in relation to accessing critical care support out of hours. Fewer than 60 ventilated patients per annum pass through the unit which presents a challenge in terms of viability of the unit for provision of level 3 care. A meeting will be arranged to discuss this issue as part of the Critical Care Strategy project led by Dr Julian Millo.

9. Metrics to Measure Success

- 9.1. Baseline metrics have been established for the HGH and include: Number and grade of incidents out of hours, readmissions to AICU and staff satisfaction. This information will be correlated through the Patient Safety Academy within a formal evaluation and feedback process.

10. Project Progress Trust Wide

- 10.1. The Care 24/7 intranet web site has been set up to keep staff fully informed with the progress of the project.
- 10.2. The weekend out of hours on call plan was implemented via the Switchboard team and has received very positive feedback with comments from a number of consultant staff that the availability of the on call plan enabled them to expedite patient management plans in urgent situations. The plan provides the contact details for all of the staff available in key roles supporting the activity of the Trust out of hours and can be used as a quick reference guide for those on duty and on call.
- 10.3. Access to pharmacy out of hours has been enhanced following allocation of Winter Pressures funding.
- 10.4. Access to in patient echocardiography out of hours has been supported for implementation on the JRH site following allocation of Winter Pressures funding. It is anticipated this will not come on line until appointment into posts in November.
- 10.5. Radiology have enhanced access to a radiology opinion out of hours through establishment of a remote access process.
- 10.6. The work of the project will continue to be supported by the resources within the Transformation Programme and a dedicated Project Manager was appointed at the end of August.
- 10.7. Roll out of phase 2 at the Churchill Hospital commenced on 2nd October with the inaugural meeting of the Care 24/7 Phase 2 Churchill Project Team. The Action Plan at Appendix 1 has been expanded so that items specific to each of the sites can be tracked through to completion.

11. Conclusion

- 11.1. The 'Care 24/ 7' project is a major project bringing together staff from across the OUH's clinical services to address the issues which were outlined within the paper presented to TME in February 2014
- 11.2. The structure for delivery by February 2015 is established with input from Trust Executives and clinical staff from across the organisation. The Project Board will be accountable to the Trust Management Executive for delivery providing monthly progress and exception reports as part of the project monitoring structure.

12. Recommendation

- 12.1. The Trust Board is asked to recognise the progress made within the 'Care 24/7' initiative to date, and to note the proposed timescales within the revised Action Plan as approved by the Trust Management Executive.

Mr Paul Brennan
Director of Clinical Services

October 2014

Report prepared by: Belinda Boulton, Associate Director of Clinical Services

Appendix 1 Action Plan

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
1	Visibility of the medical rotas within some services needs to be improved to inform the OOH's cover Trust wide	There is no central repository of rotas within the Trust and it is therefore difficult to identify gaps	Submit all rotas for upload to DRS except for Anaesthetics (jnr Dr and consultants)	All rotas uploaded to DRS except for the Anaesthetics rotas which are maintained on a separate system.	Complete
2	There is a lack of clarity on how to gain access to a senior medical opinion on the Churchill site 0900 to 2100.		Identify a mechanism for guaranteeing access to a medical opinion. Define a process and communicate across medical teams	Asst Medical Director has met CD's to discuss the increased input to the rotas. There are resource implications currently being identified to extend cover Clinical Directors in Renal/ Chest Medicine/ Oncology and Infectious Diseases to progress as part of the Care 24/ 7 Churchill Phase 2 Rotas Review	Complete October 2014
3	The HAN rota on the Churchill site is not maintained as 'live' and is	There is no central coordination of the HAN rota. Where there are gaps e.g	Identify a central coordinator for the HAN rotas	Clinical Director for Ambulatory Services	

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
	not visible to those staff who need it.	due to sickness it is not clear who was on the rota previously and who the staff are that can be contacted to fill the shift. It is often left to the OSM or junior Dr themselves to fill the shifts at the last minute.	Identify a process for identification of staff available on the rota. Identify administrative processes for upkeep of the HAN rota (all of the above should be incorporated into the Out of Hours Operational Protocol.	A proposal to introduce central coordinators and use of the DRS real time software system is being presented by the Assoc Director of Clinical Services to the Transformation Steering Group.	October 2014
4	There is a lack of clarity about roles and responsibilities in relation to out of hours cover within the HAN process	There are no ratified policies in place for HAN on any of the clinical sites. This leads to confusion and frustration for the staff involved.	Review the need for cover on each site and bring together the requirements, processes, roles and responsibilities within an overarching Trust policy.	Policy review commenced 3 rd Feb 2014. The policy will be written as part of the Care 24/7 Project Review of NNP role arranged for 11 Feb to involve Matrons and Ops Team – Assoc Director of Clinical Services	Draft protocol for agreement for HGH site complete Sept 2014. This can only be finalised once the consultation period with staff has completed at the end of October 2014. Complete – revised job description out to advert to fill a vacancy at the HGH. The job description may

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
				would bring significant benefits at minimal cost. A decision is required on whether to include a CSW role in the model. Assoc Director of Clinical Services is Coordinating this information for feed back to the Director of Clinical Services	
7	The evolution of services on some sites and reconfiguration of services (HGH and Churchill) has led to an increase in inter hospital transfers between sites.	There is resource identified at the HGH to act as an escort service for sick patients transportation between sites however this appears to be inadequate. This issue was also raised on the Churchill site in the context of sick patients being transferred with poor work up or poor documentation*(point 8). Additional resource to aid transfer and communication would be beneficial.	Assess information available on numbers of transfers and assess skills/ resources required to resolve issue Devise protocols for transfer with associated documentation	Protocol for Inter Hospital Transfers From An Assessment Area (draft circulated for agreement 10/02/14) Policy to CGC in June for ratification Asst Medical Director	Complete June 2014 check

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
				for ED.	
8	The handover processes across sites do not meet the standards set within the DoH Modernisation Agency guidance published in 2004:	Need to identify the following within the handover process: Staff required to attend, who takes the lead a designated area for handover and formalised process for the handover plus the communication cascade, triage of calls and delegation of activities	As part of each site policy review/ assess who should attend the handover, what time and where it is held, lead for each handover, communication process detailing clinical information requirements, ensure robust bleep system to aid communication is in place	Handover Guidance paper submitted to CGC for ratification in October 2014. Assoc Director of Clinical Services	Complete pending approval through CGC
9	A focus group held with junior medical staff highlighted that patients are transferred to the Churchill Hospital without a management plan and on some occasions are not fully clerked.	The workload for the HAN team was described as 'busy' but not 'onerous' however it was perceived that patients not fully assessed on their admission to the JR ED resulted in undue pressure on the HAN team at the Churchill once patients were transferred*.	Clarify the processes involved in determining a management plan that is clear, well documented and communicated to the receiving clinical teams	Clinical Director for Emergency Medicine and Ambulatory Services In addition there is a highlight paper going to GCG (SOP for inter hospital transfer following assessment). In October it was	Complete November 2014

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
				found to be the case that patients are being transferred to the Churchill site without a senior review. The Assoc Director of Clinical Services will bring the issue to the attention of the Clinical Lead	
10	There is a perceived lack of integrated working between teams on HAN rotas and amongst consultant teams providing cover	Junior Drs continue to cover their specialities when on the HAN rota and do not provide site wide cover as was intended within the original model set up in 2009 reflecting the DoH Modernisation Agency guidance 2004. Consultant cover out of hours is variable often due to other commitments within their job plans e.g. Some have speciality input which limits their availability for general cover.	Re launch the HAN as a Non Elective Cover Strategy Involve staff at all levels on working groups	First meeting held on the HGH site (called by the Medical Director) to review issues and to highlight actions (Feb 12). A Risk Summit will be called to bring together stakeholders in the HAN to discuss issues and agree actions Interim Medical Director and Assoc Director of Clinical Services	Complete. Complete

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
11	Consultant week end reviews of patients across the Trust in medicine are variable and often only cover new patient admissions and not existing in patients	Patient management plans are not expedited across the week end.	Clinical Directors must devise a mechanism for week end in patient review and to determine the resource impact.	Review commenced at the HGH with the Clinical Lead for Medicine. A revised rota has been implemented. A focus group has been arranged with HAN team members w/c 24 Feb on the Churchill site.	Complete Complete
12	There is a lack of clarity in relation to the role of the consultant anaesthetists and HAN cover across sites.		The Clinical Leads** identified for HAN on all sites must review the role of the anaesthetists with those staff involved with a view to providing clarity on their role within the HAN cover.	Initial discussion took place at the meeting called by the Medical Director at the HGH. The roles of the Anaesthetic staff on each site will be clarified within the model of care agreed. It is envisaged that the Registrar or consultant on site will attend evening Handover however	Complete October 2014

Issue Log	Issue	Gap	Action	Progress and Responsible Lead	Date for Completion
				will not take a lead role due to commitments in critical care of theatres.	
13	The issues related to HAN have been documented within the Surgery and Oncology Risk Register.		<p>Review risk register and confirm mitigating actions and any outstanding issues</p> <p>The outstanding issue for the Division is the potential impact on cover following the relocation of Chest Medicine and Infectious Diseases to the JR site</p>	<p>The review of the specific Churchill based rotas has started with a meeting of the Clinical Leads arranged in October. Gaps in cover will be identified with any associated mitigating actions and costs to the Director of Clinical Operations.</p> <p>Assoc Director of Clinical Services</p>	November 2014

Appendix 2 – Out of Hours Cover Model at the Horton General Hospital

The Nerve Centre of Care 24/ 7 – HGH Model



It is anticipated that this model can be used as a template for use across the Churchill site for Phase 2.

Appendix 3 – Draft Operational Protocol - (can be submitted for approval once the consultation process with staff is complete and any amendments made). The Operational Protocol will become an Appendix to the Corporate Bed Management Policy.

Out of Hours Operational Protocol – Horton General Hospital

Introduction

1. The Care 24/ 7 Out-of-Hours cover model redefines how clinical and operational cover across the Oxford University Hospital sites is provided outside normal working hours. The Out-of-Hours cover model consists of a multidisciplinary night team that has a broad range of competencies and experience to manage a wide range of conditions. A number of teams will be required to cover the distributed geography of the Trust, but the principles on which they are based will be constant. The team will comprise a Clinical Coordinator (CC) (senior night nurse practitioner) and a small team of junior doctors supported by specialist staff on-call from home as appropriate.
2. In order for the team to function effectively, there must be a handover between the day and night staff, morning and evening. The evening handover is particularly important as the oncoming doctors will not be familiar with the patients for whom they are assuming responsibility. This will be conducted as a formal meeting (see Handover Guidance).
3. The purpose of the Out-of-Hours cover team is to review those patients who are already causing concern and to assess and treat those who deteriorate during the night. In addition to routine clinical assessment, 'Track and Trigger' scoring will be used to assist in identifying deteriorating patients. The Out-of-Hours cover team is not set up to complete unfinished, routine tasks that should have been performed in the daytime. It is critical to the functioning of the team that all routine tasks are completed before evening handover.
4. A training and skills competency framework has been developed to support this new service. There will be ongoing audit and risk assessment of the service which will be reviewed at regular intervals by the Out-of-Hours cover Steering Group to provide assurance that it is fit for purpose. The service will be expected to provide both monthly and annual reports of its activities.

Scope

5. This protocol covers the HGH and should be used in conjunction with the overall Corporate Bed Management Policy. This document applies to employees of the Trust, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff.

Aim

6. The purpose of this protocol is to ensure:
 - 6.1. That patients are seen and treated by the most appropriate member of the Out-of-Hours team in an efficient and timely manner.

6.2. Guidance is provided to both the Out-of-Hours team and other hospital staff.

Definitions

7. The terms in use in this document are defined as follows:
 - 7.1. Out-of-Hours – 17:00-08:00 Monday to Friday; 08:00-08:00 weekends and bank holidays.
 - 7.2. Multi-Disciplinary Team (MDT) – Out-of Hours team.
 - 7.3. Track and Trigger – Patient Monitoring Risk Scoring System

Part 1 – Horton General Hospital Out of Hours Protocol

Out-of-Hours Team

The exact make up of the out of hours team in each location within the Trust may change according to changes in the conformation of services and staffing. The following represents the initial conformation at the HGH as of autumn 2014.

- Medical Registrar
- Clinical Co-ordinator (CC)
- Clinical Support Worker
- Medical FY2
- Surgical (Orthogeriatric) FY1
- Medical FY1 .
- Anaesthetic Registrar/ Consultant
- ITU Nurse
- Operational Manager (in hours)
- ED Senior Nurse

Responsibility & Accountability

8. Individuals have a shared responsibility to minimise the Out-of-Hours workload by changing current ways of working and moving non-urgent work from the night time to the extended day.

Clinical Leadership

9. The Registrar for Medicine will lead the clinical team. The CC, will work in partnership with the Medical Registrar and will be the operational lead for the Out-of-Hours team.

Responsibilities

10. The following details the Horton Out Of Hours Team responsibilities.
 - 10.1. The **Registrar for Medicine** will lead the clinical team.
 - Partner with the CC to coordinate care of patients OOH.
 - Leads the evening handover with the CC and allocates tasks to the most appropriate member of the Out-of-Hours team.

- Directs the Out-of-Hours team in partnership with the CC/Operational Lead.
- Directs initial patient management for critically ill patients on wards and provides advice and support for the ED Registrar for any such patients in the ED.
- Informs medical consultant on-call and Consultant Anaesthetist on call for ICU of any ICU referrals/ admissions and potential transfers of critically ill patients.
- Registrar within General Surgery and sub specialties will also inform the on-call consultant of critically ill patients who are admitted to ICU/HDU.

10.2. **Clinical Co-ordinator– BLEEP 500**

- Review ward referrals (calls via Bleep 500) and, refer patients to the most appropriate member of the team.
- Support unstable/ acutely unwell patients identified for admission to ICU until they are able to access HDU/ICU.
- Provide clinical support for level 1 & 2 patients around the various wards/departments.
- Support and supervise ward staff and junior doctors by assisting with appropriate clinical skills.
- Follow up immediate shortfalls appropriately post staff reporting sick (following telephone calls)
- Liaise with and support nursing staff and junior doctors by visiting wards/departments throughout the night on a regular basis.
- Liaise closely with the ED team regarding emergency admissions for ED or the GP Out-of-Hours Base.
- Assist with ward patients who need to transfer to HDU, ICU and maintain safe and rapid transfer during out-of-hours.

10.3. **Clinical Support Workers – BLEEP Enter no** – will work under the guidance of the CC and will undertake tasks delegated by the CC. Healthcare Assistants clinical tasks will include:

- Measurement of vital signs; ie – pulse rate; blood pressure; temperature; respiratory rate, fluid balance chart records.
- Measurement of oxygen saturation.
- Measurement and recordings of weight/BMI.
- Venepuncture – no routine bloods will be performed unless specifically requested by Doctor, including Groups and Holds unless in an emergency.
- Venflon insertion.
- Performing 12 lead ECGs.

- Blood Glucose.
- Urinalysis
- Pressure area care

Handover

11. All members of the Out-of-Hours team will attend the multidisciplinary handover meeting each evening at 20:30 and morning at 09.30 in the Medical Seminar Room.
12. All members of the Out-of-Hours team must attend and sign the attendance register.
13. This is mandatory for all doctors in the out-of-hours period.
14. One of the FY1 doctors will hold all bleeps during the meeting and answer them/take messages. Switchboard will be asked to send only urgent bleeps out. The operating principles will be as per the Trust's Handover Guidance.
15. The clinical leads within the Medical Directorates must ensure that the medical staff covering the out-of-hours period are able to attend the handover at the designated time and remain contactable while on duty until the end of their shift. Regular audit of attendance will be provided on a monthly basis.

Process At Handover Meeting

16. Handover out of hours will take place in the Medical Seminar Room between 20:30-21:00. Attendance at this handover should include:
 - All members of the OOH team (as above) except those in Obs/Gyn and Paeds (see below)
 - Outgoing Medical Registrar
 - Outgoing (5-9 pm) FY1 doctors for surgery, medicine(x3)
 - Outgoing senior ITU nurse
 - Consultant Anaesthetist or Registrar
 - Outgoing Senior Nurse or Registrar from ED
17. The Medical Registrar and CC will coordinate the handover meeting, prioritise and allocate work.
 - Switchboard bleeps attendees as a reminder fifteen minutes prior to the handover
 - General introductions and sign attendance sheet/ swipe card as appropriate.
 - Site and security issues, if any (fire, unsafe or unusable buildings or plant, known dangers to patient or staff security, plus plan to deal with them)
 - Staffing, skill-mix and capacity issues reported by : bed state, ED waits, ICU status; any urgent staffing problems: Plans to deal with above.

- Handover of acutely ill, unstable and newly admitted patients (Flagged patients). Each patient to be handed over in brief, standard SBAR style as specified by Handover Template
- ITU patients should be handed over first followed by medical patients.
- Attendance by Obs/Gyn and Paeds not required but phone check with senior nurse in charge of Labour Ward or Paeds Ward during handover mandatory. Any patients needing to be flagged should be notified to CC during this.
- Outstanding tasks tasks/duties will be summarised AFTER Flagged patients.
- If there is a priority call during handover, all clinical staff covering the crash calls should attend as usual and the CC will continue the handover with remaining doctors.

Handover Attendees Morning Meeting.

- All members of outgoing OOH team
- Medical Reg (Day)
- FY1 doctors (Day)
- Senior Nurse in Admin Charge (Day)
- Operational Manager (Day)

Use of Handover Room

18. The handover room is available as a base for the team during the night for further review as necessary and further delegation of duties as necessary.
19. The CC and Medical Reg will delegate duties post handover to members of the Out-of-Hours team according to who is available and has the competency to carry out the duty. There may therefore be occasions when team members are asked to work outside of their individual specialty.
20. The CC will liaise with medical staff during the night regarding outstanding tasks and ensure appropriate allocation.
21. The nurse in charge of ED and the of acutely ill patients who are being transferred to the ward, so that follow-up investigations are performed on a timely basis.

On-Call Pharmacist

22. An on-call Pharmacist will be available outside normal working hours to deal with emergency/ urgent requests for information and/ or drugs. Contact with the on-call Pharmacist must be made through the night services management structures.

Review Of Speciality Accepted Or Referred Patients

23. Members of the Out-of-Hours team may need to see patients outside of their specialty but working within their level of competence, if asked to do so by the Medical Reg/ CC. Patients see in ED by non-specialty team members will need

review by the relevant FY2 or SpR subsequently. The time frame for this will depend on:

- The clinical state of the patient
- Self awareness of the limits of the non-specialty FY2 own knowledge and ability to recognise critical illness.
- Availability and knowledge base of the senior doctor on duty in ED to give advice for the patient in ED prior to transfer to a ward bed.

Track And Trigger

24. Track and trigger is a physiological scoring system that identifies non-specific deteriorations in patients' condition by assigning a numerical score to routine clinical observations. A rising score implies a deteriorating patient and above a pre-determined threshold, a patient is said to 'trigger'. When this occurs, the nurses recording the patient's observations are expected to call their home clinicians to review the patient: at night they should call the CC or Medical Registrar. Track-and-Trigger is not a replacement for clinical judgment and patients who are causing concern but who have not yet achieved a threshold trigger score should still be referred for review.
25. Reference <http://ouh.oxnet.nhs.uk/RAID/Pages/Default.aspx>

Critical Care Support

26. Patients causing concern should be referred by the nursing staff and/or FY1 doctors to the Medical Reg or CC. These individuals should inform ITU promptly if ITU transfer seems likely, and seek advice from the ICU Consultant Anaesthetist, who should review the patient or organise immediate ITU admission.
27. Patients admitted to ITU should have a designated Consultant in charge of their care, who should be informed of their admission at the time it occurs. If there is any doubt about which Consultant should be in charge of the patient, the Consultant Anaesthetist on call should be the default Consultant until another person has accepted the responsibility.
28. In the event that the Consultant Anaesthetist does not feel able to take responsibility for the patient under the above circumstances, he/she must take responsibility for arranging immediate transfer of the patient to ITU at the John Radcliffe Hospital

Cardiac Arrest calls – NO CHANGE IN PRACTICE. Ext 2222

29. Departments and wards should avoid bleeping medical staff for non urgent requests during the handover meeting as this leads to disruption.
30. Internal referrals between medical staff will go directly to referring specialty from referrer and NOT pass through the CC.
31. External referrals between medical staff will go directly to referring specialty from referrer and NOT pass through the CC.

Training

32. Covered by the Overarching Corporate Bed Management Policy

Monitoring Compliance

33. Covered by the Overarching Corporate Bed Management Policy

Dissemination of Policy to Other Sites

34. Pilot testing of procedures at HGH may lead to changes in the policy. Staff involved in the OOH Team and Handover will vary by site. The strategy of a unified OOH team centred on experienced trainee doctors and highly skilled senior nurses will be applied in all areas. The Template for the Handover meeting will be applied in all areas
35. Recording of the Handover, Task allocation and co-ordination of work will be recorded on the EPR system or the template enclosed within the Handover Guidance. A copy of the task allocation and work undertaken must be saved on EPR or on to the central server. It is the responsibility of the CC to ensure that this administrative process takes place .

Appendix 4 Handover Guidance – This document is being submitted to the Clinical Governance Committee for ratification.

Guidance to facilitate an efficient handover process

Category:	Guideline
Summary:	A guideline to help facilitate efficient handover between the multidisciplinary team and facilitate improved patient safety throughout the Oxford University Hospital NHS Trust
Equality Impact Assessment undertaken:	July 2014
Valid From:	
Date of Next Review:	02 July 2017
Approval Date/ Via:	Approval requested via Clinical Governance Committee
Distribution:	Clinical Divisions, Operational Managers
Related Documents:	Corporate Bed Management Policy
Author(s):	Andrew Harper Peter McCulloch Belinda Boulton
Further Information:	“Safe handover: safe patients” British Medical Association “Acute care toolkit 1: Handover” Royal College of Physicians
This Document replaces:	Not Applicable

Lead Director: Mr Paul Brennan, Director of Clinical Services
Issue Date: 5 October 2014

Introduction

1. This document has been designed to facilitate a standardised handover process throughout the Oxford University Hospital's NHS Trust. This guidance comes as a result of changing working patterns. It is hoped that by applying a standardised model throughout the multi-disciplinary team patient safety will directly benefit.
2. This guidance has been based on the guidance published by the BMA entitled "Safe handover: safe patients" and the "Acute care toolkit 1: Handover" Royal College of Physicians.

Scope

3. This guideline applies to all areas of the Trust and all members of staff directly involved in patient care.

Aim

4. The purpose of this Guideline is to ensure an effective and efficient patient handover between clinical teams.

Responsibilities

5. The Nerve Centre team has generated this guidance. The Chief Executive has overall responsibility for this guideline. The medical director is co-ordinating the efforts of the 24/7 care initiative. All staff involved in the care of patients has a responsibility to use this guideline to improve patient safety and facilitate an efficient handover process

Guidance for effective handover

6. A standardised handover model should be adopted across all sites within the Oxford University Hospitals NHS Trust. We acknowledge that many forms of handover exist throughout the Trust and we aim to provide generic guidance to facilitate this process. The optimal handover process involves verbal and written information that engages multidisciplinary teams, however, we acknowledge that this is not always practical.
7. Effective handover relies on efficient information transfer to or from key members of the multidisciplinary night team (see appendices 1 and 2).
 - 7.1. Each site within OUH is composed of a different collection of key members overseeing care
 - 7.2. A team leader should be appointed to co-ordinate the handover process and introduce any new or temporary members of staff
 - 7.2.1. Locum staff should be given a dedicated induction to enable them to access relevant patient information during their shift
 - 7.3. Involvement of senior clinicians is fundamental
 - 7.3.1. Senior clinicians have a responsibility to direct appropriate management decisions

- 7.4. Members attending the handover session should be protected from clinical distractions throughout the duration of the meeting. Exceptions include emergencies that require immediate intervention or support.
- 7.5. An attendance register of all members attending the handover process will be recorded
8. Handover should take place at the major staff shift changes for the beginning of the normal working day and at the beginning of the period for night cover. This meeting should last no longer than 30 minutes
 - 8.1. Staff attending the handover process should be 'bleep free' and not distracted by clinical duties except for life threatening emergencies
 - 8.2. Staff rotas are co-ordinated to ensure that staff can attend handover during working hours
 - 8.3. Key information generated from handover should be shared across the multi-disciplinary team. This information can be disseminated during board rounds early in the day to enable optimal task management.
9. Handover will take place in a designated hub room within each site (see appendix 1)
10. Handover will be supervised and co-ordinated by a senior clinician. Medical or nursing staff may assume this role
 - 10.1. Handover of patients should be stratified based on assessment of the outgoing team. Priority should focus on patients requiring the greatest clinical attention
 - 10.2. A bespoke and standardised communication system should be used by the outgoing team to verbally discuss patients (see appendix 2).
 - 10.2.1. This incorporates any relevant information associated with a patient that may alter ongoing management, including the agreed ceiling-of-care for a patient should be discussed
 - 10.3. Based on the outgoing teams assessment and handover the incoming team should risk stratify patients
 - 10.3.1. The senior clinicians should co-ordinate the urgency of patient reviews and assign any jobs/patient reviews to appropriate team members
11. IT solutions should enable a record of the handover process to be made and retained in a place and form where it is readily available to clinical staff
 - 11.1. This should provide information on all current inpatients, any accepted and referred patients, an accurate location for all patients, any clinically relevant operational matters (such as ICU bed availability), any information to pass onto the following shift and any patients whose track and trigger score has been deteriorating.
 - 11.1.1 The avoidance of jargon and explanations of abbreviations is essential.

Monitoring Compliance

12. Use of the standardised handover model will be audited across all sites. Compliance with the guideline will be monitored in the following ways.

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Compliance will be measured using a standardised handover audit tool	This will involve prospective data collection primarily through group members	The Patient Safety Academy are responsible for the auditing of the handover process	Every 4 months	The Care 24/ 7 Project Board reporting to the Transformation Steering Group

13. In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:
- Commissioned audits and reviews
 - Detailed data analysis
 - Other focused studies

Results of this monitoring will be reported to the 24/7 care project steering group.

Review

14. This guideline will be reviewed in 3 years, as set out in the Policy for the Development and Implementation of Procedural Documents.

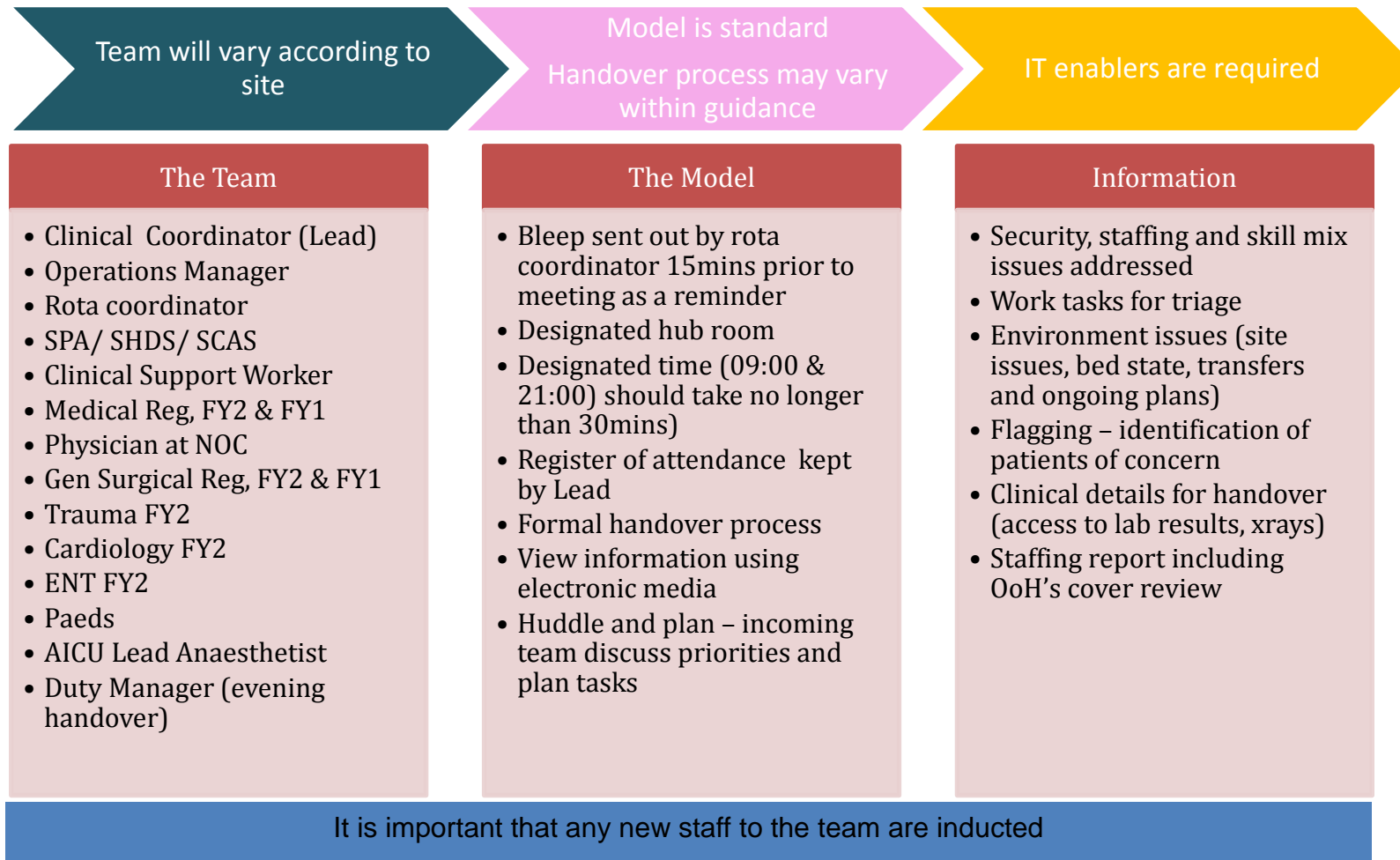
References

15. "Safe handover: safe patients" British Medical Association
"Acute care toolkit 1: Handover" Royal College of Physicians

Document History

Date of revision	Version number	Reason for review or update
02/07/2014	1	Original document

Appendix 1: A template for verbal and written handover between multidisciplinary teams which will vary according to site.



Appendix 2 Royal College of Physicians Template for Out of Hours Handover

Out of hours handover (please complete in block capitals)

Handover details

Handed over by _____ Handed over to _____

Day(s) covered by this handover (please tick) Mon Tue Weds Thu Fri Sat Sun

Patient surname, fore name date of birth, NHS hospital no	Responsible consultant, patient current location	Diagnosis/problem list/ differential diagnosis (include any risks or warnings)	Reason for handover	Outstanding issues (tasks to be done)	Aims and limitations of treatment (eg resus/ITU/ventilation/ not operative/palliative/ surgery – yes/no)
					Weekend discharge yes/no
					Weekend discharge yes/no
					Weekend discharge yes/no
					Weekend discharge yes/no
					Weekend discharge yes/no