Croydon Health Services NHS
NHS Trust

Croydon Health Services Winter Plan Summary 2017/18

1. INTRODUCTION

The purpose of this plan is to provide an overview of the Trusts programmes of work to ensure operational resilience and to maintain safe, effective services throughout the winter period of 2017/18.

Each year the Trust faces additional pressure at specific points of the year and in particular the winter months. Croydon Health Services NHS Trust plays a key role in ensuring effective winter planning, operational resilience and capacity planning is in place for all services across the health economy. Working in collaboration with commissioners and partners, this report sets out the parameters in order to meet the needs of our patients in a timely and effective manner. The Trust will continue to improve the quality of the care that it offers to the local population through learning from best practice and by continually reviewing its services on a regular basis.

In 2017/18 the Trust continues with its strategy to respond to the challenges we face and to create services that are clinically and financially sustainable, to meet the changing and growing needs of the local population and reduce health inequality in Croydon. The key challenges going ahead are:

- The continuation of the Emergency Department (ED) rebuild and associated moves and the constraints experienced in the physical environment, both in ED and bed escalation capacity
- Reliance on agency staff due to vacancies across the professional groups
- To work within the Trust's deficit financial control total
- Continued population growth with seasonal pressures and the expectation of continued high quality services

The purpose of this plan is to articulate the Trust's actions to maintain effective access to all services and in particular strengthen emergency preparedness for surges in activity, changes in estate or environment (infection control issues) which can impact on the core business of Croydon Health Services (CHS).

We are committed to continuing to provide cost efficient, safe and quality services, good patient experience, achieving both performance and Improvement trajectories for ED 4 hour performance, Referral to Treatment (RTT), Cancer and Diagnostics sustainably. With this in mind our winter planning will build on lessons learnt from 2016/17 and incorporate:

- Embedding the escalation processes and internal professional standards across ED and departments across the Trust
- Continuing the work within our Assessment Units to prevent admissions and continue to drive down length of stay (LOS)
- Increasing access and availability of Ambulatory services
- Improving our Discharge processes
- Reducing our bed base
- Elective Capacity and Demand Management
- Information Technology Stabilisation
- Revised workforce planning, recruitment and retention

The key pressures posed by winter include:

- a tendency for a more complex / dependant case mix leading to an increase in length of stay and a subsequent reduction in capacity
- reductions in timely discharge of patients due to increased demand from the hospital Trust and primary care for capacity in community / social care
- increased demand for acute services due to higher levels of infection and/or ill-health within the community
- significant peaks of bed closures due to sustained infection (e.g. Norovirus) outbreaks
- increase in medical outliers, cancelled operations and ambulance handover delays
- pressure on adult and paediatric critical capacity across the network
- unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus)
- adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work.

Croydon has seen significant challenges over the last two years fuelled by an increase in demand for services and a decrease in patient flow. More specifically the trust has seen:

- An increase in admissions from outside of the borough
- Increased admissions from Croydon as a result of a combination of increased acuity / complexity of patients presenting at A&E and increase in decisions to admit
- Increasing difficulties in discharging the more complex patients from hospital to suitable long-term care (home care and/or nursing or residential home placements) caused by:
    - increased complexity of long-term needs for some patients
    - Increased numbers of older people with mental health needs and/or challenging behaviours that are not always well served by current models of care
    - Increased number of adults with a mental health need requiring transfer into a mental health unit waiting for placement to be available
    - Increased number of Delayed Transfers of Care

The overarching purpose of this Winter Plan then is to provide a collective overview of those new and existing initiatives that will ensure Croydon Health Services NHS Trust experiences operational resilience throughout the winter period (1st November 2017 to 31 March 2018). Historical data, learning from past winter periods and knowledge of the Trust's current position has been used in the development of these arrangements.

The Winter Plan is written to compliment and add to the whole systems winter plan for Croydon and to build on 'business as usual'.

2. AT A GLANCE WHAT IS DIFFERENT?

2.1 Key initiatives from the Croydon A&E Delivery Board

The focus on continuous improvement of patient pathways and services (across both acute and community) and embedding the ethos of integrated services for adults and children will continue through the winter months.

Through the (AEDB), the key actions that have been defined to deliver the optimisation of patient flow, a clinically safe and sustainable service and delivery of the 4 hour performance are:

- Re-designation of Urgent Care Centre (UCC) to Urgent Treatment Centre (UTC)
- Direct booking from 111 to GP Hubs
- Direct booking from 111 to GP surgeries in hours
- Identification of frequent callers/attenders and development of care plans
- Comprehensive streaming model to alternative treatment pathways (e.g. UTC, GP Hubs, Pharmacy and RAMU)
- 7 day ambulatory care to South West London (SWL) model
- Mental Health Care – Core 24 services in place
- Implement the national 8 High Impact Changes for Discharge
- Implementation of the Out of Hospital Business care to support admission avoidance and early supported discharge
- Review, recruitment, retention and re-training of staff across UTC/ED
- Processes and Flow: Review roles and responsibilities, Emergency care pathways, bed capacity and usage

2.2 Key initiatives within the Trust

These include:

- Improved governance and monitoring of Emergency performance
- Changes in medical model within ED and across the assessment units/wards to avoid overcrowding in ED maintain safe handover from London Ambulance Service (LAS) and ensure the right placing of patients, thus reducing length of stay (LOS).
- Developments in technology to support clinical practice and patient flow
- Implementation of the new Urgent Care model through the Croydon Urgent Care Alliance.
- Revisions to processes and workforce to support patient flow.

These key actions also reflect the Trust's strategic priorities and concentrate on:

- Improving patient experience and maintaining safety
- Continuing to deliver high quality care
- Making the best use of our resources

Allowing for the Trust to:

- Maintain resilience throughout peak periods of activity and changes in environment
- Manage and improve patient flow through changes in clinical models; streaming of patients to the 'right place, at the right time'; improve discharge processes and management and ensure senior decisions makers at the 'front door' of the hospital
- Ensure alignment with arrangements with the local health economy
- Reflects work undertaken across the hospital and community based services and by partners to implement robust, effective and timely preparation for additional pressures.
- The outcome through this process is to provide uninterrupted provision of high quality, timely care

The plan then underpins the continuity of safe, resilient, high quality, integrated services and provides effective response for managing winter pressures.

This will be achieved by:

- Ensuring the directorates and service level action plans are in place for seasonal variation
- Ensuring risks are identified, monitored and appropriately managed
- Monitoring of agreed key performance indicators (KPI's) and measures for management of patient flow in and out of hospital are undertaken.
- Ensuring clinical operating standards are monitored and maintained throughout the pressure period to ensure clinical and patient safety
- Support and monitor our governance arrangements for strategic, tactical and operational level oversight, throughout peak periods
- Emergency Planning and preparedness is maintained as a priority within the Trust to support periods of severe weather, holiday periods and significant events

2.3 Winter Listening into Action (LiA)

In October 2017, the Trust held a 'Winter' LiA Big Conversation, attended by over 80 clinical and operational staff from both the acute and community. From this a number of suggestions have now been incorporated into the Trust's winter plan. These include:

- Management of workforce and annual leave planning, especially across holiday periods
- Improve communications across the organisation of 'how it is'
- Forward planning
- Agreed triggers for wards, departments and escalation processes

A follow up 'Winter' LiA is being held on the 7th December to feedback to staff and to communicate and test out new arrangements.

3. ACTIVITY AND PERFORMANCE

In 2017/18 the NHS nationally and locally have experienced significant and sustained demand resulting in considerable operational pressure resulting in a poor experience for some patients and the Trust underperforming against the 95% 4 hour Accident and Emergency standard, as well as ambulance handover delays and cancelled operations.

Historically at CHS and nationally, the period running from October through to the end of the financial year brings surges in activity, a number of these surges are predictable (Christmas, New Year and Public Holidays) but other surges that are less so (Norovirus, Influenza). In order to manage both planned and unplanned surges, the Trust requires the development and deployment of robust plans in order to manage these significant changes in demand.

Notoriously with surges in activity impact on performance and CHS are committed to delivering over 90% through September to the end of February and 95% in the month of March 2018. Performance is monitored in REATLIME and on a daily basis operationally but the required initiatives within the organisation to sustainably deliver against these targets are managed internally through the Emergency recovery Board (EDB) and through the Emergency Care Clinical Leadership Group (ECCLG) and externally via the Croydon A&E Delivery Board.

The activity levels have changed for the Trust in this financial year with the UCC and GP Hubs now being included as part of the overall performance. In essence this has enabled the trust to 'extend' the "Front Door" as an acute Trust but also as a Community Provider. Harnessing this is key to the Trust to ensure the successful management of performance, to improve flow of patients through the organisation and home to their normal place of dwelling.

In recent weeks, the Trust have seen a significant improvement in performance, consistently achieving greater than 90% despite the continued reduction in our bed base as preparation for our surge periods in the winter. The organisation must maintain this position in order to safely and sustainably manage demand through this period and deliver against the targets that have been set.

What the organisation has experienced recently is:

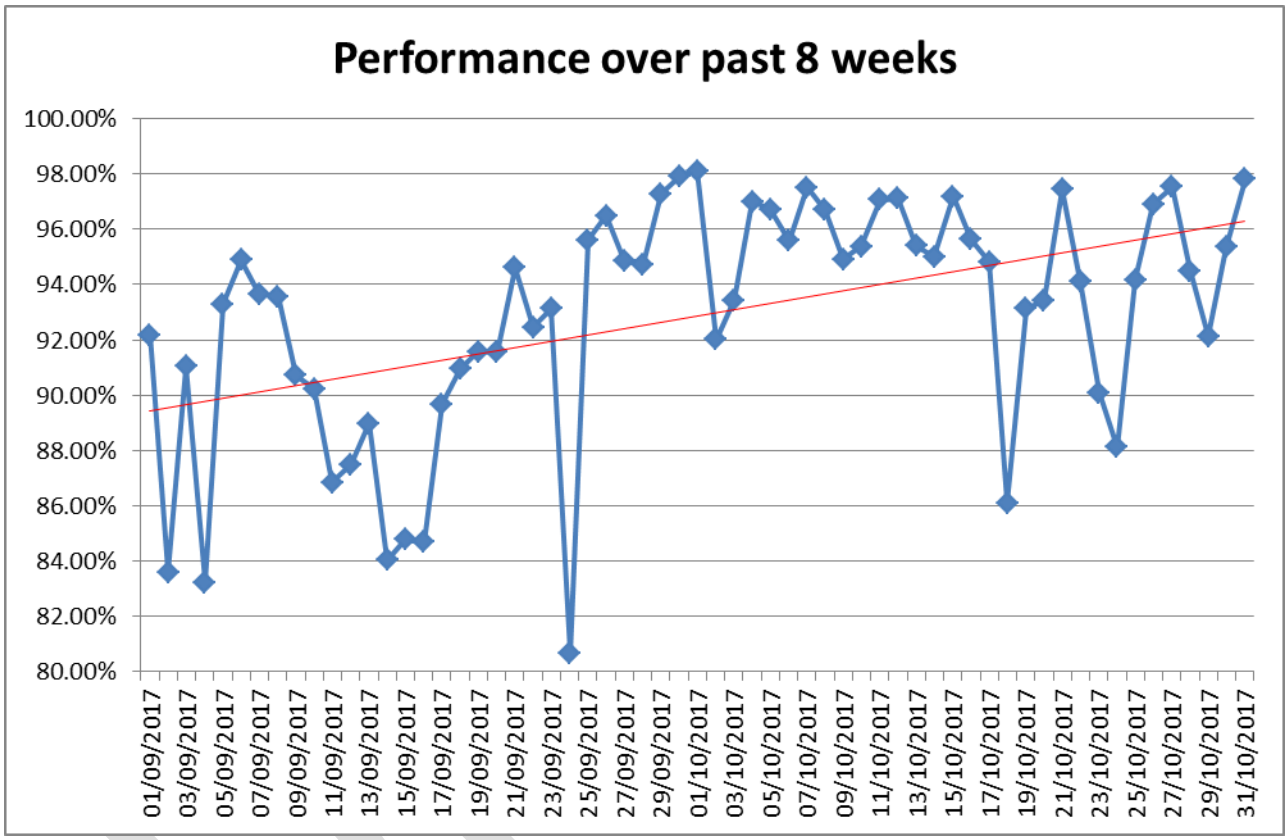
- Attendances to Emergency Care continue to rise
- The organisation continues to reduce the number of admissions on a daily basis
- Length of stay continues to decline
- The Discharge Profile of the organisation to create capacity is still too late in the day
- DTOCs (Delayed Transfers of Care) are increasing (but also nationally)
- Our conversion rate remains above the national average
- We have, until recently, seen a reduction in the use of models of care that we have implemented (e.g. RAMU, SAU and Rapid Response)
- Right Person, Right Bed and the placing of patients appropriately

With this in mind, the winter period will remain to be a challenge for the organisation, but a challenge that is being prepared for. The 2017/18 Winter Operational Resilience plan for the Trust will be released in the next week to be operationalised and the drive to deliver effective models of care that have been developed internally remain to be the priority for the Trust.

Over the summer the Trust has developed an Emergency Recovery Plan, which forms part of the Croydon Emergency Plan. This has been developed and monitored through the monthly Croydon A&E Delivery Board (AEDB). In September the Trust reorganised the internal governance of monitoring emergency performance to ensure that visibility of the plan and issues is seen from all levels and supports the NHSI requirements of demonstrating

delivery of the Emergency NHSI Undertakings . For the organisation and staff (clinical and non-clinical) this governance structure entails a greater focus on following process and actions that has been designed to optimise flow, defines roles and accountability and identifies and mitigates risks within the system. The last eight weeks of improved performance by the Trust have demonstrated how effective this can be.

Graph 1: 4 hour performance (Sept '17 to 15th Oct 2017)



Graph 1 demonstrates the impact on performance when focus is given to flow through ED and the redirection of clinical care to the most appropriate environment. In order for the Trust to continue to achieve the current performance, this is key and the visualisation and communication of flow from attendance through to discharge is paramount.

4. CAPACITY PLANNING and ESCALATION

With process being a priority for the organisation, planning to support the delivery of flow, especially during surge periods is key. To that end the Trust has modelled the required bed capacity, month by month through to the end of the financial year. The bed requirements are monitored through the 'Forward planning' group, chaired by the Director of Operations. This also takes into account staffing, discharge profiles and will ensure communication across the organisation of what is expected and any issues.

The bed capacity requirements are demonstrated in the table below:

Table 1: Winter Bed Capacity 17/18

Month	Oct	Nov	Dec	Jan	Feb	Mar
Number of beds required	420	416	455	482	447	465
Number of beds available (incl. escalation)	459	459	459	459	459	459

If no other changes were to be implemented, then the Trust would require the additional 27 bed capacity. This winter the Trust and health economy is looking to utilise resources differently and by working collaboratively with external partners, especially through the Croydon Alliance. In the first instance the Trust will endeavour to redirect patients to the most relevant resource, if the acute trust is not the appropriate setting. Hospital avoidance measures and alternative settings to the emergency Department include:

4.1 Front door streaming:

The clinical streaming model to General Practitioners (GPs), GP hubs, the Urgent Care Centre and to other alternatives such as pharmacies and other self-help initiatives is in place.
Clinical streaming has been part of the urgent care model since November 2015. This covers both adults and paediatrics. Streaming is in place to UCC and both medical and surgical assessment areas, including ambulatory care.

Since the beginning of October, there has been direct booking to GP hubs. Further redirection to Rapid Response and Pharmacy is coming online in this quarter. To compliment this, NHS 111 will also be able to book appointments direct into GP practices in core hours.

4.2 Alternative pathways

Work is underway with London Ambulance Service (LAS) to utilise alternative pathways through the increased use of patients directed admission straight to Rapid Assessment Medical Unit (RAMU), Community Rapid Response and the roaming GP – this is being monitored through the Croydon AEDB.

4.3 Implementation of the Out Of Hospital model through the joint working of the Croydon Alliance, which includes the key establishment of the 'Life' model, Discharge to Assess, Care Home initiative and the Integrated Community networks. This model has commenced in October and will roll out over the winter period. The implementation and success of these initiatives is monitored through the Out of Hospital Delivery Board and the Croydon AEDB.

4.4 Optimising internal Trust pathways

Through the introduction of the national initiative 'SAFER', the Trust has developed a collaborative way of ensuring patients are placed in the most appropriate place for their needs.

Initially at the beginning of the year a 'SAFER' week was run across the whole Trust through which SORT was developed as the preferred methodology. This meets all the principles of SAFER.

This methodology is used by the clinical teams on a daily basis to assess the following:

- **S**ick patients
- **O**ut today or tomorrow?
- **R**est of the patients
- **T**o come in

SORT is in place across all adult wards. There is a strong emphasis on setting estimated discharge dates (EDDs), Golden patients before 10.00am and discharge before 1pm. Multidisciplinary Board and Ward Rounds are in place and all use SORT as an aide memoire.

Two years ago the Trust commenced review of all patients over 28 days, down to over 7 days. Now, over the past 6 months **every patient** is reviewed by the MDT group once a week. This determines the delayed transfers of care (DTOCs) and medically fit for discharge (MFFD).

Additional work will also be in place as follows:

- Criteria led discharge in being developed for roll out in November
- The Trust is reviewing the policy for monitored patients
- The Trust is trialling 'Patienteer' which monitors appropriateness of processes/ tests ordered. This is being rolled out for 10 hypothesis in November and a 'live' initiative in ED

4.5 Right person, right bed

The Trust has instigated a programme of work to improve the patient journey to provide an improved patient experience ensuring patients who arrive at Croydon University Hospital remain only while necessary, understand and plan their discharge and when our patient has received an intervention that supports their journey through to discharge, all that is planned or requested happens on the day it is requested. This programme consists of a number of work streams which are medically, nurse and operations led creating a collaborative, professionally diverse team to support:

a. Patient Flow

The review and improvement of our Hospital at night, Site Practitioners and discharge services optimising our opportunity to reduce LOS and improve the patient journey; revised workforce alignment and supervision structure which is consistent with the current nursing structures within the Trust providing equity to those within these services and to improve patient flow and care. A new Head of Operations has been appointed to lead the work in patient flow and managerially responsible for the site team and complex discharge. This role will link with the initiatives and teams in the new Out of Hospital model implementation.

The Trust has 'tested' out a number of initiatives that have had significant benefit in improving patient experience, patient flow and emergency performance. In particular the introduction of:

- An acute physician working in and alongside ED. This has supported 'streaming patients to the right beds and utilising alternative pathways, such as ambulatory, rapid response, more effectively

- Specific dedicated medical/nursing cover for escalation areas and MDT reviews have had the greatest impact. The trust is currently working through how these can be sustainable throughout winter.

b. Inpatient Review

The review and submission of Internal Professional Standards for inpatient reviews on all wards (Surgical and Medical) supporting a consistent and standardised approach to inpatient management. Implementation of a standardized Estimated Date of Discharge (EDD) process and Ward/Board rounds which will continue the roll out of the Perfect Ward process which was piloted on 2 wards in 2015-16 and as part of SORT.

c. Discharge /Transfer Process

The review and clarification of the roles and responsibilities has been carried out of all those who interact with a patient as they begin their journey within Croydon University Hospital, enabling discharge planning to begin on admission. Review and submission of Discharge policy and supporting documentation enabling a consistent and standardised approach to Discharge which aligns clinically and complies with all mandatory requirements of our partner organisations who enable supported discharges. Therefore, this provides assurance for our Delayed Transfer of Discharge process, with consistent and accurate data to support the Health and Social Care system to identify any unmet need within the system. Monitoring of 'stranded' patients is also in place. In addition, as part of the Out of Hospital model implementation, Discharge to Assess has commenced and will be rolled out across the Trust for completion by January 2018.

4.6 Escalation Process (Emergency Department)

For the Winter period of 2017/18, the Trust are adopting a new escalation process "The Bristol Shine Toolkit" which will go LIVE on Monday 6th November. The toolkit is an Emergency Department (ED) Safety Checklist developed in order to standardise and improve the delivery of basic care in EDs, to improve resilience in EDs during periods of crowding, to improve the safety and clinical outcomes for patients accessing the emergency care system, and to improve ED performance against Best Practice Tariffs.

4.6.1 What is the ED Safety Checklist?

An ED Safety Checklist is a time based framework of tasks that is completed for every patient, other than those with minor complaints. The ED Safety Checklist can be completed by any member of clinical staff in any area. It is prescriptive and contains all basic elements of care. Best Practice Tariffs and early triggers to specific care pathways such as sepsis are included.

4.6.2 What is the problem we are trying to address?

Crowding has a profound impact on the ED's ability to deliver safe care. Delays in recognition and treatment of severe illness are common, with associated poor outcomes. This is particularly problematic for patients suffering from stroke, heart attack and sepsis. A scarcity of staff in the ED workforce has resulted in a reliance on agency and non ED-trained staff. Human factors - as staff become overwhelmed by the tasks they need to complete in a timely fashion and with constant interruption.

4.6.3 What is the evidence base for the intervention?

At University Hospitals Bristol NHS Foundation Trust (UH Bristol) the mean proportions in Key performance Indicators (KPI) taken before and after the introduction of the ED Safety Checklist improved in 5%-25% in most cases.

The tool will be used by ED to assess trigger points in crowding and clinical care to be communicated to the Site and Operational teams.
Quality improvements we hope to achieve:

- Improved baseline clinical care
- Less clinical incidents
- More efficient handover
- More efficient documentation
- Improved performance against best practice tariff
- Decrease avoidable harm by recognising deterioration
- Enhanced safety region-wide
- Improved communication
- Improved team morale
- Improved patient and staff feedback

The ED Safety Checklist is structured into two parts:

Part 1 - Provision of basic safe clinical care

A time-based framework for vital sign measurement and calculation of the National Early Warning Score (NEWS), pain scoring, administration of drugs and front-loading investigations.

Part 2 - Value added tasks

Include referrals to drug and alcohol services, liaison psychiatry and occupational therapy. Commencement of pathways that demonstrably improve outcomes (e.g. fractured neck of femur, stroke and diabetic ketoacidosis).

Diagram 1: ED Safety Checklist

Emergency Department Safety Checklist

Patient Label here...

Date_____ Time Booked in_____

	Action	Time	Initials	Comments
1st hour completion time :	Assessment/Triage			
	Vital signs measured + NEWS recorded			
	Chest Pain:			
	ECG recorded (within 10 minutes)			
	*ECG reviewed by Dr (within 30 minutes - **time** on ECG)*			
	Undressed and gown			
	Wristband			
	Pain score assessed			
	Analgesia administered (if appropriate)			
	Infection control screening			
	Sepsis suspected (Temp < 36° or > 38°C, HR > 90 or RR > 20)			
	Investigations initiated (as appropriate):			
	IV access + care plan			
	Blood tests			
	Imaging (Stroke, # NOF within 1 hour)			
	Specific Pathway Triggered (see box 1)			
	PFC informs CST - specialty bed required			
	Pathway commenced (e.g. Stroke, DKA, NOF, GI bleed, Sepsis)			
2nd hour completion time :	Vital signs measured + NEWS recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Next of kin aware			
	Patient has dementia (*This is me* commenced)			
	Refreshments offered (if not NBM)			
	Pressure Area Care:			
	Assessment undertaken			
	Care plan commenced (as appropriate)			
	Patient good to go:			
	Patient ready for transfer			
	Specialty bed confirmed			
3rd hour completion time :	Vital signs measured + NEWS recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Refreshments offered (if not NBM)			
	Review by senior doctor			
	Regular medication administered (if appropriate)			
4th hour completion time :	Vital signs measured + NEWS Recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Refreshments offered (if not NBM)			
	Regular medication administered (if appropriate)			
Referrals & Pathway/Speciality Triggers if required	Adult safeguarding referral			**Box 1 - Specialty Bed Trigger:**
	Child cause for concern referral			
	Mental health matrix completed			Stroke/TIA □ Stroke Unit (B504)
	Mental Health referral			Upper GI Bleed □ Ward 11 (B404) or MAU (A300)
	Domestic or sexual violence Yes / No			DKA □ MAU (A300) or ITU/HDU
	IDSVA referral			NIV □ Respiratory (A522) or MAU (A300)
	Paddington Alcohol Test Yes / No			Chest Drain □ MAU (A300), Respiratory (A522) or BH/700
	Referral to Alcohol Clinical Nurse Specialist			# NOF □ T&O (A609)
	Referral to Drug Clinical Nurse Specialist			Tracheostomy □ Ward 700, A522 or ITU/HDU/CICU)

Authors: Jason Lugg & Hayley Thomas (November 2014)

4.7 Escalation Process

The current Trust escalation policy is being reviewed following the winter LiA in October and will be completed for the 1st December. This is being based on the triggers identified across a number of areas into one policy. To support this a revised policy for monitored beds has been designed (appendix 1) .

4.8 Additional Escalation Capacity

In the event of requiring additional capacity, plans and provisions for both adult and paediatric beds has been made. The escalation for using additional bed capacity is currently being revised and to be signed off in November Executive Management Board and clinical cabinet. This will include triggers for opening and closing escalation capacity. This will cover both adult and paediatrics.

Adult Escalation

In order to be able to manage the increased demand in admissions and the beds required to do so, the Trust have define additional (escalation) capacity for this period and the triggers required to unlock this capacity, thus giving the Trust access to an additional 54 beds if required. The use of escalation beds will be opened by defined triggers and signed off by the Director of Nursing and the Medical Director to ensure patient safety.

Paediatric Escalation Capacity

Additional paediatric inpatient capacity has been identified for a defined cohort of children. As with adults, this escalation capacity will be opened as defined by a set of specific triggers and signed off by the Director of Nursing and Medical Director. The escalation area will be managed by the Paediatric Matron, and the patients will be managed by the Paediatricians.

5 RESOURCE, WORKFORCE AND MANAGEMENT OF FLOW

The Trust has focused on a number of initiatives pertaining to the management of flow within the organisation from admission through to discharge.

In conjunction with these initiatives, the Trust is looking to align its workforce requirements to the pressures in both ED and at ward level in order to mitigate our expected “pinch points” and manage capacity more effectively over the winter period.

Workforce analysis requirements therefore have been completed to support the continued ED decant period and additional requirements for Winter Resilience. The Emergency Care Intensive Support Team (ECIP) have carried out a workforce analysis alongside the ED Consultants and the Trust will complete a ‘heat map’ of the ED activity and nursing workforce.

It has also been agreed that to ensure continuity that NHSP bank staff can be booked in advance on ‘lines’ for agreed areas.

In addition to the above for Winter 2017/18 with regard to the workforce analysis, the Trust are committed to the review of annual leave over the pressure periods in order to ensure ourselves that leave has not been over committed thus preventing service areas being understaffed unnecessarily. The Trust have also committed to clarifying what meetings are essential to attend over this period to prevent staff being pulled from clinical duties and adding additional pressure to the service areas.

In times of surge, alternative workforce options are being explored, following suggestions from the ‘Winter LiA’ to support the ward areas and departments. This will be added to the revised surge escalation plan.

6 STRANDED PATIENTS

It is nationally recognised and supported by ECIP (Emergency Care Improvement Programme) led by NHSI that “stranded patients” have a direct impact on flow within any acute hospital environment. During the course of the winter months, the number of stranded patients in acute hospital beds will increase due the acuity of illness and additional pressure on capacity externally.

CHS currently hold a weekly meeting to discuss all patients and this will continue throughout the winter period with representation from the wards, site team, discharge co-ordinators, social services and therapies. The purpose of this meeting is to discuss and ensure discharge arrangements are put in place as soon as possible.

In addition, CHS will hold separate meetings to discuss those patients on a CHC pathway with the CHC team, those patients who have no recourse to public funding and those who have a length of stay over 100days.

Any concerns regarding discharge delay that cannot be resolved locally will be escalated to the Director of Operations who escalates accordingly and supports the system to resolve the situation.

7 ASSESSMENT UNITS

CHS have established assessment areas through the Edgecombe Unit (RAMU, Ambulatory Care and ACE), a Surgical assessment unit (SAU) and a Gynaecological Assessment Unit (GAU), which are all fundamental to effective flow through and out of the organisation.

The key benefits of this model streamline patients to the right place for assessment; reduce length of stay and avoid hospital admission by redirecting patients to community support services. Further development of the ambulatory care pathways will reduce the admission of patients further and increase the access to immediate medical intervention via a GP for those in our community

Additional work is being done in partnership with the CCG to review the model for the 'front end' of the hospital, but also to enable access to these services to expedite and support discharges. Our ambulatory care service through the implementation of fast-track pathways, pulls suitable patients at the point of triage and signposts them to Ambulatory care, thus bypassing the Emergency Department. The Trust will also be continuing the placing of Acute Physicians in ED, to support flow and pull patients through the system, as well as provide another strand, to avoiding hospital admissions and placing patients in alternative care settings. Surgical Consultants are currently trialling an alternative model in providing 'senior surgical decision makers' at the 'front door'.

For the winter period, CHS are driving the utilisation of these pathways from the moment our patients are greeted by the Clinical Streamer at the front door and significant work is underway via our clinical and non clinical staff to drive these pathways and rejuvenate this flow through the organisation.

The assessment units will enhance the patient experience through a defined pathway, focusing specifically on their healthcare needs in order to provide optimal care. Short stay patient flow will therefore be realigned by managing cohorts of patients in one location. This will in turn reduce average length of stay on the short stay wards and avoid ED breaches.

The reduction in LOS will support the reduction in our bed base therefore contributing to the associated capacity planning in previous sections.

8 INFORMATION TECHNOLOGY

For Winter 2017/18, IT is currently in the process of implementing new software via IMPRAVATA to give additional stability to CERNER mPage technology (Whiteboards/ Worklists/ Maternity and Theatres). This will allow for prolonged and sustained utilisation of these systems to further support visualisation of patient flow across the hospital. There is currently a rollout programme in place within IT to deliver this to all ward areas.
All desktop PCs and laptops continue to be upgraded to Windows 7 or Windows 10 this year (replacing the obsolete windows XP), and remote access systems will be implemented to allow a more flexible approach to working.

The '835' system has now been fully implemented to the Trust giving greater access to REALTIME data for the organisation and accessibility to data queries need to run our services. The Trust is in the process of developing a specific Patient Tracking List for ED in order to monitor flow through the department more effectively. This coupled with the PATIENTEER clinical system will allow for enhanced clinical and operational management of flow at the front end.

The Trust has implemented 'Tap & Go' into ED and will commence over the coming months electronic prescribing and depart processes.

In relation to Community, there has been an increased focus on improving IT support, and work will commence shortly on delivery of EMISWeb to replace EPEX. This will support improved business processes such as mobile working, and, eventually, information sharing with acute and primary care services across Croydon

9. TRUST RESILLIENCE AND MITIGATION IN ADVERSE SITUATIONS

9.1 Infection Control

It is widely acknowledged that outbreaks of infections may result in the closure of a number of ward areas throughout the winter period, the Trust will build on the success of previous winters by the close monitoring and tight infection control measures to minimise the closures and disruption.

In the event of the development of an infection control outbreak daily meetings will be led by the Infection Control Team to ensure that there is appropriate management of the outbreak. These meetings will be attended by a member of the respective site team in order that the impact on ward/bed closures can be discussed and an action plan for managing inpatient capacity can be agreed.

Infection control policies relating to the outbreak of infections are documented in the Trust Infection Control Manual and are available on the Trust Intranet.

As part of the winter planning, alternative capacity and provision has been identified and will only be activated by the Director of Nursing, Medical Director and Chief Operating Officer.

9.2 Influenza

The Trust is currently carrying out a flu vaccination programme to achieve 75% of staff by the end of December.

10. Adverse Weather

The Trust has an Adverse Weather Plan which will be implemented in the event of adverse weather during the winter period. The Trust receives regular weather updates from the Met Office which will be circulated to all key staff and used to ensure robust plans are in place to maintain business continuity.

The Adult Community Nursing Team and Children's Hospital at Home Team have robust Business Continuity Plans (BCP) in order to triage and maintain community care for all vulnerable adults and children on their case loads. There are plans in place to have the availability of 4X4 vehicles if required to ensure that the difficult parts of the borough can be reached and staff have suitable winter clothing to ensure that essential visits are made on foot where required. The use of 4X4s is also available in order to maintain business continuity.

11. Single Sex Accommodation

The Trust remains committed to ensure that all patients are nursed in single sex accommodation, and is building on the successes of winter 13/14 to mitigate any challenges associated with meeting this standard over the winter period.

An escalation process has been agreed for delays in transferring patients from critical care to a suitable inpatient ward.

Any requirement to mix male and female patients in any ward area will be escalated to the Deputy Chief Executive/Chief Operating Officer (in hours) and the Director on call (out of hours).

12. RISK MANAGEMENT

Measures are being taken to identify and manage risks associated with key elements of the plan and to ensure mitigation strategies are robust. These will be reviewed as part of the report to the Trust's monthly Executive Management Board.

Eight keys areas have been identified as being vital to ensuring all services and planning arrangements are well coordinated. These are:

- Handover of patient care from London Ambulance Service (LAS)
- Operational readiness (bed management, capacity, staffing, escalation and de-escalation areas and forward planning for events such as downtime of IT systems – CRS Millennium)
- Out of Hours arrangements
- NHS/Social Services joint arrangements and work with Croydon Council to prevent/avoid admissions and speed discharge
- Links between LAS, Croydon CCG and Trust
- Preventative measures, including flu vaccinations, infection control measures
- Development of improved pathways supported by both the Paediatric and Gynaecological Assessment Units
- Communication with all stakeholders developing a collaborative approach to support our community

Preparations for this winter included identification and development of mitigation measures to ensure all services are well coordinated, responsive and resilient.

Risk	Mitigation Actions
Lack of bed and workforce capacity to cope with increased demand	- Proactive management of patient length of stay - Reduced tolerance of patients delays due to diagnostic, specialty review, intervention - Review of current and potential escalation capacity - Implementation of Discharge to Assess in October 2017 - Implementation of 'in reach' to AMU by Cardiology, Gastro and Diabetes by October 2017 - Review of specific job plans to support increased workload - Recruitment to middle grade vacancies in ED - Implement ECIP recommendations

Risk	Mitigation Actions

Patients remaining in hospital who no longer require acute care	- Weekly escalation of individual cases by Discharge Co-ordinator to system leads - Restructure of Complex discharge team at CHS - Provision of in-reach from community service teams, escalated by Discharge Co-ordinator

Risk	Mitigation Actions
Emergency Department attendances exceed plan	- Implement revised Croydon Health Services Escalation policy - Escalation to CCG - Increasing capacity for admission alternatives through Ambulatory Care, Rapid Access Clinics, Hot Clinics and or assessment units. - Escalation to the system via AEDB membership - Fully implement AEDG actions for streaming to alternatives in primary care and community.

Risk	Mitigation Actions
Loss of Elective capacity	- Increase day case capacity - Exploration of assistance from local NHS and independent sector providers

Risk	Mitigation Actions
Loss of capacity for prolonged periods due to adverse weather, staff absence, infectious outbreak	- Implement Croydon Health Services Escalation Policy - Implement local business continuity arrangements - Activate enhanced Infection Control actions and measures - Implement communications strategy

Risk	Mitigation Actions
Lack of uptake	- Proactive management of data and responsive increase in

for seasonal flu vaccination	communication with support from senior leadership

13. TRUST COMMAND AND CONTROL ARRANGEMENTS

The Executive lead for operational resilience and capacity planning at the Trust is the Deputy Chief Executive**/**Chief Operating Officer.

The operational lead for operational resilience is the Director of Operations

The 'in hours' co-ordination and response for managing emergency pressures is led by the Director of Operations and Head of Clinical Operations. The 'out of hours' response will be led by the Clinical Site Practitioner Team with support from the General Manager on call. The General Manager on call will escalate any issues to the Director on call.

To support this process, the Trust has completed a further review of the roles and responsibilities of the General Managers on Call, and Director on Call during the out of hour's period.

14. COMMUNICATION

CHS are committed to ensuring staff are kept updated with how the Trust is performing, capacity issues that the organisation faces, initiatives that have been implemented and the current state of play. Such communication is led by the Communication department linking closely with the Operational and Clinical teams to update our staff via the website, LiA events and ALL USER emails.

On more local level it is paramount that the MDT keep wards updated as to where patients are on their journey, tasks that are outstanding, issues that need to be addressed and actions that have been agreed and by whom.

The first port of call for this is during the daily Board Rounds, utilising the Nursing Whiteboard to drive the operational monitoring of flow and Consultant Led Ward rounds. Key communication must be disseminated at bed meetings, to ward managers and consultant teams in order to understand the "Current State of Play" and any outstanding actions. At these points of communication, if issues are raised, these must be escalated at the appropriate point, to the appropriate person as defined in the Triggers and Escalation points defined in Section 4.

Our recent Winter LiA event picked up on a number of key themes to ensure the Trust work towards being ready for winter but the key theme being Communication across the board as imperative to effective delivery. As of the 1st November, a 'How are we doing today', daily update will be emailed to all users from the Deputy Chief executive/Chief Operating Officer.

15. MONITORING AND REPORTING ARRANGEMENTS

- **External**

For this Winter as part of an NHSI initiative, an automated daily SITREP will be generated for submission to the Department of Health and Trust Development Authority by 11:00 hours. This will be automatically prepared within informatics and approved by either the Director of Operations or the Associate Director of Operations for Integrated Adults Directorate .

The Trust Deputy Chief Executive/Chief Operating Officer (or nominated deputy) will participate in sector wide conference calls on behalf of CHS two weekly or more frequently as required.

For the Winter of 2017/18 there will also be a National Winter Room (Skipton House for London) in order to avoid an abundance of daily phone calls. The Winter Room will go LIVE on the 6th November 2017.

- **Internal**

A SITREP report is circulated by the Clinical Site Practitioner sharing the day's previous position. The SITREP provides an update on the position in A&E, available and upcoming inpatient bed capacity, infection control, critical care CRITCON level, Nurse staffing levels and repatriations and identifies any immediate operational issues and the mitigations, and contingency plans required, as well as the SPEWS and CMS status.

In addition, the Trust has access to the Operational Control Centre (OCC), a mobile application that provides REALTIME key information of the state of ED and our ward areas with agreed thresholds in place and RAG status. OCC will be developed over the coming weeks with 835 in order to provide richer detail, increase and enhance the level of key data that is being passed onto our staff.

16. WORKING AND EXTERNAL PARTNERSHIPS

NHS South West London has a sector wide escalation plan that will be operationalised during the winter period.

The Director of Operations will be responsible for identifying the internal escalation level as per the SPEWS policy and ensuring all actions in the plan are implemented and that escalation occurs as per policy to the Deputy Chief Executive/Chief Operating Officer (in hours) or the Director on call (out of hours) who will determine the need for a sector wide conference call.

APPENDIX 1

Monitored Bed Policy- DRAFT 1

This brief policy is to enable the site practitioners to ensure that the right patients are placed in the right place.
Monitored beds are limited in the trust. These beds are mainly on CCU and in the monitored sections C & D in AMU.

Telemetry is also available on AMU and Duppas wards.

The request for monitored beds normally come from the admitting medical team or on call teams.

Clinical situations:

There are various clinical situations where patients will be required to be monitored. These are detailed below:

1. Patients with ACS
2. Patients with unstable cardiac rhythms
3. Patients on NIV
4. Patients who are haemo-dynamically unstable due to organ failure – eg sepsis
5. Patients requiring monitoring due to medical intervention – ie amiodarone infusion, phosphate infusion.

Patients with ACS and unstable cardiac rhythms should primarily be admitted to CCU.

All other patients should be on the monitored sections in AMU.

De-escalating patients

Ward rounds:

- On duty AMU consultants will highlight patients who can be de-escalated during the twice daily ward rounds.
- On duty CCU consultants will highlight patients who can be de-escalated during the daily ward rounds.

If no beds available,
Medical SpR to call on call consultants (medical for patients < 80, Elderly care for patients > 80) to discuss need for monitored bed and also to discuss any suitable patients for de-escalation.

KKOct2017