NHS
Croydon Health Services
NHS Trust

Croydon Health Services

Winter Operational Plan

2024-25

Version 1.0

DRAFT

Document Control

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Location of Policy	Trust Intranet

Review and Updates

Version	Date	Summary of Changes
1.0	7th October 2024	New paper

Contents

1 Introduction and Strategic Context

1.1 Purpose

The Croydon Health Services (CHS) Trust-wide Winter Plan sets out the organisations arrangements for the winter period 2024/25. The plan sits as part of the wider South West London system plan.

To effectively manage the increased pressures during the winter period, health and social care organisations must have a comprehensive winter plan. This plan has four main areas to ensure optimal patient care and resource management:

Patient Flow and Capacity Management	**Optimising Bed Availability**: Ensuring there are sufficient beds to meet the increased demand by implementing efficient discharge processes and avoiding unnecessary admissions.
	Enhanced Discharge Planning: Coordinating with social care to facilitate timely discharges, including the use of discharge lounge and rapid response teams.
	Utilising Alternative Care Settings: Leveraging community services, step-down facilities, and hospital at home to reduce the burden on acute services.
Staffing and Workforce Planning	**Adequate Staffing Levels**: Planning effectively to ensure safe staffing levels across all areas.
	Staff Training and Support: Where required, providing additional training and support for managing winter-specific issues and ensuring staff well-being to maintain morale and reduce burnout.
	Contingency Plans for Staff Absences: Preparing for potential staff shortages due to illness.
Infection, Prevision and Control	**Vaccination Programs**: Promoting flu and Covid-19 vaccinations among staff and patients to reduce the spread of infections.
	Enhanced Hygiene Measures: Implementing strict hygiene protocols, including hand hygiene, use of personal protective equipment (PPE), and frequent cleaning of high-touch areas.
	Infection Surveillance and Response: Monitoring infection rates and having rapid response teams ready to manage outbreaks of infectious diseases like norovirus or flu.
Communication and Coordination	**Clear Communication Channels**: Ensuring effective communication within the organisation and with external partners, including social care and community services.
	Public Awareness Campaigns: Educating the public on when and how to seek medical care, promoting the use of primary care and virtual consultations.
	Regular Situation Reporting: Maintaining frequent updates on the status of patient flow, capacity, and any emerging issues to allow for timely interventions and adjustments to the plan.

By focusing on these four areas, we are better able to manage the increased demands and challenges associated with the winter period, ensuring patient safety and maintaining the quality of care.

1.2 Aim

The aim of the CHS Winter Operational Plan is to describe the Winter Operating Model which will enable the organisation to effectively manage additional demand and other challenges associated with winter whilst continuing to deliver excellent patient care and maintaining business as usual between 1 November 2024 and 31 March 2025.

1.3 Objectives

The CHS objectives of the CHS Winter Operational Plan are to:

Maintain Patient Safety and Quality of Care	Ensuring continuity of care by providing uninterrupted services and maintaining high standards of care despite increased patient volumes. Reducing the incidence and spread of winter-related illnesses such as flu, COVID-19 and Norovirus through effective prevention and control measures.
Optimising Patient Flow and Resource Utilisation	Maximise the utilisation of available beds, staff and equipment to accommodate increased demands. Streamlining admission, treatment, and discharge processes to improve patient throughput and reduce wait times.
Enhancing Staff Preparedness and Well-Being	Ensuring sufficient staff across patient areas to maintain morale and productivity Provide any necessary support and training for specific winter demands.
Strengthening Infection Prevention and Control	Prevention of outbreaks through the implementation of measures to prevent and manage infectious diseases, protecting both patients and staff. Promotion of vaccines to mitigate the impact of illnesses.
Effective Communication and Coordination	Ensure seamless communication within the hospital and with external partners. Educate the public on how to access care appropriately, helping to reduce unnecessary hospital visits.
Contingency Planning and Flexibility	Contingency plans in place for unexpected situations such as extreme weather, major outbreaks, or other emergencies. Being able to quickly adapt strategies based on real-time data and emerging challenges to maintain service continuity.

In addition, the CHS seeks to achieve the objectives of the NHS 2024/25 Operational Plan Objectives related to urgent and emergency care:

- Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
- Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25

The NHS has published ten priority high impact interventions for 2024/25:

Same Day Emergency Care: strengthening SDEC services to provide care for a minimum of 12 hours per day, 7 days a week.	**Intermediate care demand and capacity:** planning and commissioning the required amount and type of intermediate care needed to ensure timely discharge from acute settings.
Frailty: boost services to detect more cases that could benefit from specific frailty advice and ensuring referrals to avoid admission.	**Virtual wards**: increasing utilisation of virtual ward capacity to provide care for more people in their homes.
Inpatient flow and length of stay (acute): making sure patients with specific conditions stay in hospital for the shortest period necessary and are discharged on time.	**Urgent Community Response**: appropriately assessed all patients who would benefit from urgent community care to avoid unnecessary transfer to hospital.
Community bed productivity and flow: discharging patients from community care as soon as they are medically ready.	**Single point of access**: creating a consistent and coordinated system for health and care professionals to access when referring patients for UEC care.
Care Transfer Hubs: ensuring all care transfer hubs are operating effectively and in a standard manner as they connect with community partners to speed up discharge of patients.	**Acute Respiratory Infection Hubs**: provide same day urgent assessment for people experiencing respiratory conditions such as covid, flu, and RSV.

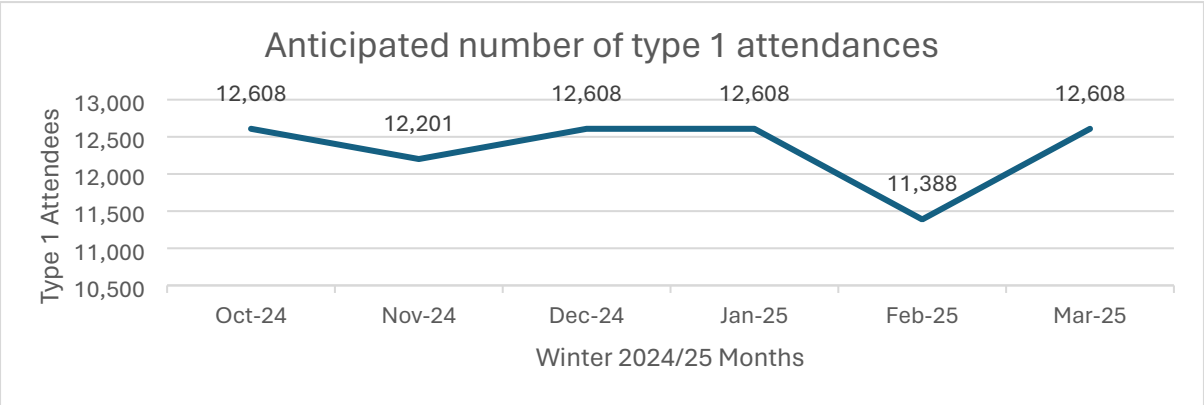
1.4 Scope

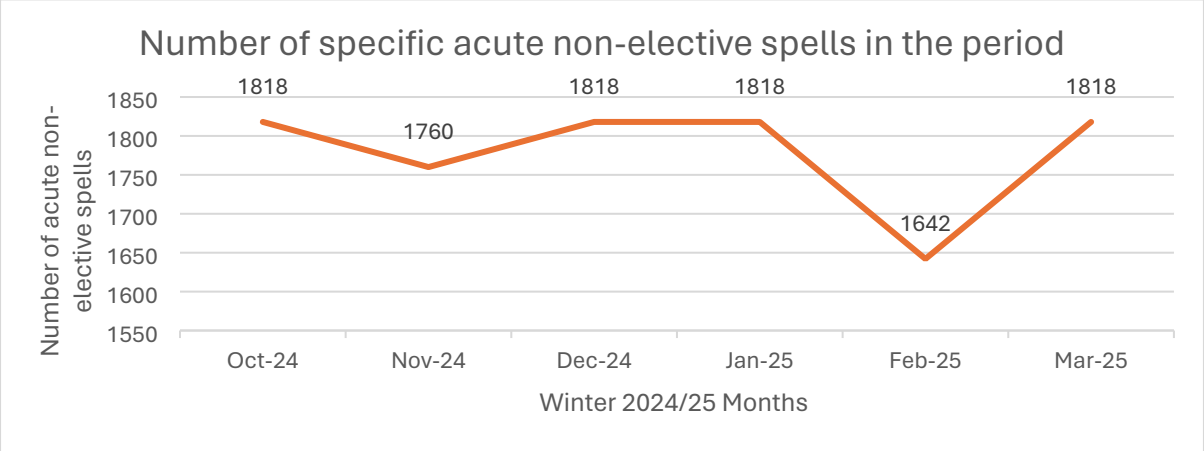
The focus of this plan is to detail the arrangements for the mitigation and management of consequences associated with winter pressures. Therefore, detailing what will be done differently during the winter months to mitigate those pressures and manage issues.

The Winter Plan will operate alongside existing and separate arrangements for managing day to-day capacity pressures such as Operational Escalation Policy and Full Capacity Protocol. For incidents and emergencies, the Trust's existing Emergency Preparedness, Resilience and Response arrangements will be utilised under the leadership of the Trust's Gold Commander.

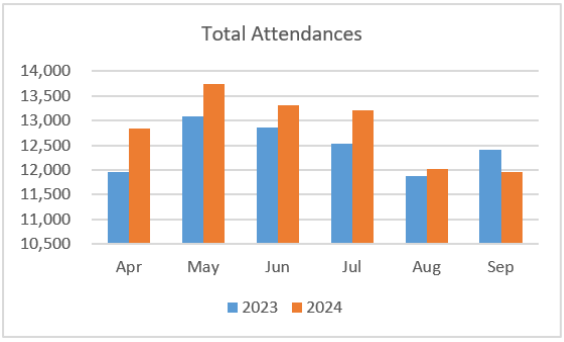
1.5 Winter 2024: Trends and Modelling

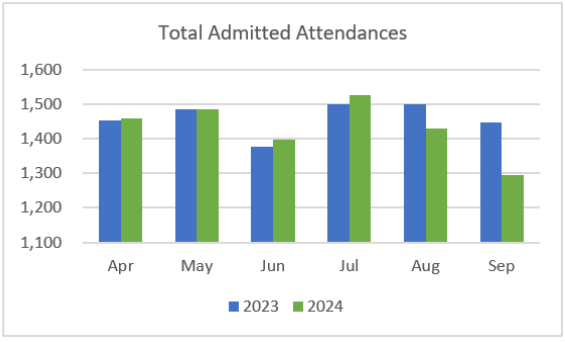
Winter modelling has been completed by the Business Intelligence for winter 2024/25.





	Total Attendances				Total Non-admitted				Total Admitted attendances				Admit %	
Month	**2023**	**2024**	**Var**	**%**	**2023**	**2024**	**Var**	**%**	**2023**	**2024**	**Var**	**%**	**2023**	**2024**
Apr	11,950	12,842	892	7%	10,498	11,382	884	8%	1,452	1,460	8	1%	12%	11%
May	13,086	13,751	665	5%	11,601	12,266	665	6%	1,485	1,485	-	0%	11%	11%
Jun	12,866	13,316	450	3%	11,490	11,918	428	4%	1,376	1,398	22	2%	11%	10%
Jul	12,524	13,209	685	5%	11,023	11,683	660	6%	1,501	1,526	25	2%	12%	12%
Aug	11,884	12,028	144	1%	10,383	10,597	214	2%	1,501	1,431	- 70	-5%	13%	12%
Sep	12,412	11,953	- 459	-4%	10,964	10,657	- 307	-3%	1,448	1,296	- 152	-10%	12%	11%





2 Winter Readiness and Management – System Level

2.1 Winter Planning in South West London

South West London's (SWL) Winter Plan for 2024/25 outlines several key initiatives aimed at preparing the healthcare system for increased seasonal pressures. The plan adopts a whole-system approach, coordinating efforts across various healthcare services, including urgent and emergency care, primary care, mental health services, and community care, to ensure capacity and resilience throughout the winter months. Areas of focus include:

- **Reducing Length of Stay (LoS):** A central priority for SWL is to reduce overall hospital length of stay by 1.5 days. This target will be achieved by improving patient flow within hospitals, enhancing discharge processes, and integrating community and social care services. Senior working groups have been established to drive this initiative, with the goal of better managing bed availability and improving patient outcomes.
- **Same Day Emergency Care (SDEC):** SWL continues to expand SDEC services to reduce hospital admissions and treat patients in a timely manner. By maximising direct admissions from emergency services such as the London Ambulance Service (LAS) without prior clinician referral, SWL aims to improve efficiency. The region is also focusing on enhancing the use of SDEC for more complex patients, such as those needing infusions, despite challenges around bed capacity and diagnostic support.
- **Virtual Wards and Hospital at Home:** Virtual wards provide an alternative to hospital stays, allowing patients to receive care at home with remote monitoring and face-to-face support. By March 2025, SWL aims to offer 425 virtual ward beds, with services particularly focused on high-acuity conditions like heart failure and frailty. These services are closely coordinated with other admission avoidance programs and are seen as critical in managing demand during winter.
- **Frailty Pathways:** Frailty care is a priority due to the increasing number of elderly and complex patients in SWL. The plan focuses on proactive care, early identification, and better management of frailty to prevent hospital admissions. The frailty pathways include working with community assets like social prescribers and voluntary sector groups to support patients in their own homes, thereby reducing ED pressures.
- **Reablement and Intermediate Care:** Reablement services are being expanded across the region to facilitate faster discharge from hospitals and reduce the likelihood of readmission. Specific boroughs, like Kingston and Richmond, are investing in additional intermediate care and rehabilitation services to improve patient flow.
- **Urgent Community Response (UCR):** SWL's UCR services, operating across all boroughs, are designed to provide rapid response care in the community, often within two hours of referral. This service helps prevent hospital admissions by addressing urgent issues like falls, frailty, and palliative care needs. Winter funding is being used to extend UCR services to ensure they are available 7 days a week, with efforts underway to streamline referral pathways from 111 and ambulance services.
- **Primary Care Capacity:** To manage winter demand, SWL is increasing primary care capacity by extending operating hours in GP practices and primary care networks. This will include additional surge capacity during critical periods like late December. The

plan also emphasises the promotion of "Pharmacy First" services to relieve pressure on emergency departments.

- **Mental Health Services:** Addressing mental health needs is a key component of the winter plan, with services like the "Press 2 for Mental Health" option on 111 being promoted. SWL is also trialing new mental health triage services at emergency departments and expanding hostel bed availability to prevent unnecessary admissions
- **Covid-19 and Flu Vaccinations:** SWL is bolstering vaccination efforts to protect vulnerable populations and reduce hospital admissions. This includes the rollout of Covid-19 boosters, flu vaccines, and the introduction of the Respiratory Syncytial Virus (RSV) vaccine for high-risk groups like the elderly and pregnant women.
- **System Coordination and Workforce Management:** The SWL System Coordination Centre (SCC) provides 24/7 oversight of system pressures, helping to manage patient flow and address barriers in real-time. Workforce planning is a critical part of the winter strategy, with a focus on proactive recruitment, flexible shift patterns, and mental health support for staff to maintain resilience during high-demand periods.

3 Winter Readiness and Management – Croydon Health Services Acute Site

Planning for Winter 2024/25 commenced July 2024 with a review of previous winter plans, South West London planning and NHS England operational planning guidance. The organisation reflected on approach taken in previous years to operational demand, and lessons learned to inform the plan for winter 2024/25.

Lessons learned included:

- Planning and use of escalation areas across the hospital to support patient flow whilst maintaining quality of care.
- Engagement and use of community services to support timely discharge and admission avoidance.

3.1 Managing Capacity and Demand

Effective management of capacity and demand during the Winter period is crucial for maintaining patient flow across the hospital. Over the summer months, efforts have been made to enhance patient flow meetings, support improvements in the Emergency Department, and improve responses to increased operational pressures. Escalation beds have been identified and will be utilised and de-escalated in accordance with the Patient Flow and Escalation Policy – and in line with OPEL scoring. The Boarding Policy will only be implemented as outlined in the same policy. Safety in ED will be maintained through the use and adherence to the Full Capacity Protocol for ED.

Regular Multi-Agency Discharge Events (MADE) are scheduled in November and December to support discharge of complex patients. In addition, the Trust is holding a ‘Perfect Week’ whereby the organisation focuses on providing additional support to wards and resolving discharges on patient journeys.

3.1.1 Day to Day Capacity Management and Escalation

3.1.1.1 Daily Patient Flow Meetings

Patient Flow Meetings will continue to be held in person, in the Major Incident Control Room at 09:00, 12:00, 15:00. A nominated representative will attend from each Directorate, as per the OPEL score requirements, to provide a situational report for their areas. A plan will then be formed, and actions agreed to support patient and manage operational pressures.

To ensure operational support is provided out of hours, a handover meeting is held at 17:00 (site team to on call teams). At 22:00 hours a safety call is held which includes oncall teams, mental health, ED and Site.

3.1.1.2 Clinical Site Practitioners

The Clinical Site Practitioners operate a 24-hour, seven-day service, providing essential support to the management of patient flow and coordination of clinical site operations. The team are based from the Major Incident Control Room and include Clinical Site Practitioners, who offer senior nursing support and are the first point of escalation during incidents or emergencies.

Throughout the Winter, the Clinical Site Practitioners will continue their normal operations, leading the Site's Operational Management. During a Level 4 Incident Management protocol is activated, the team will continue to maintain flow and capacity site-wide and will support the command-and-control structure implemented in OPEL 4. The team will remain responsive to daily operational demands, adapting their approach based on OPEL escalation levels, and executing actions as outlined in the Patient Flow and Escalation Policy.

3.1.2 Patient Flow, Escalation, and Full Capacity Protocol

The hospital will manage operational pressures in accordance with OPEL triggers and corresponding actions. In periods of extremis, and if required, the Full Capacity Protocol will be enacted. Escalation beds have been identified for Winter 2024/25 and these will be used in accordance with appropriate approvals as per the Patient Flow and Escalation Policy.

Croydon Health Services acute site has 530 beds.

Paediatric Inpatients (inc. Critical Care)	18
Adult Critical Care	15
Adult G&A core beds	437
Adult G&A escalation beds	34
Total	**530**

3.1.2.1 Internal Operational Pressure Escalation Level Framework

Indicator	**1 Point**	**3 points**	**5 points**	**8 points**
Empty Trolleys in ED Majors	more than 6	6 or less	2 or less	0
Empty Trolleys in Resus	more than 2	2	1	0
Number of patients in ED	less than 20	20 to 30	30 to 50	more than 50
Number of patients in Paeds ED	less than 10	10 to 20	20 to 30	more than 30

Number of Patients in UTC	less than 10	10 to 20	20 to 30	more than 30
Number of DTAs in ED with no bed allocated	less than 5	5 to 10	10 to 15	more than 15
Bed requests in SDEC/ESC/EPU/Other	0	2 or less	3 to 5	more than 5
Number of 4 hour breaches	less than 15	15 to 30	35 to 50	more than 50
Number of 12 hour breaches	0	1	2	more than 2
Number of patients currently in ED for longer than 8 hours	0	1	2	more than 2
Number of Ambulance RED or BLACK Breaches	0	1 to 4	5 to 10	more than 10
Number of ambulances waiting to Offload	0	1 to 2	3 to 5	more than 5
Bed Status	0 or positive balance	minus 10 to minus 15	minus 16 to minus 25	more than minus 25
Number of Beds closed due to Infection Control	0	1 to 6	7 to 12	more than 12
Number of empty ITU/HDU Beds	4 or more	2 to 3	1	0
Number of patients in flexible escalation areas	0	1	2 to 3	more than 3
Number of patients in Recovery with DTA	0	1 to 2	2 to 3	more than 4
Staffing - ED medical	Green (0 down)	Green (1 to 2 down)	Amber (3 to 4)	Red (more than 4)
Staffing - ED Nursing	Green (0 down)	Green (1 to 2 down)	Amber (3 to 4)	Red (more than 4)
Staffing - Critical care medical	Green (0 down)	Green (1 to 2 down)	Amber (3 to 4)	Red (more than 4)
Staffing - Critical Care Nursing	Green (0 down)	Green (1 to 2 down)	Amber (3 to 4)	Red (more than 4)
Number of wards at RED nursing staffing in Trust	Green (0 down)	Green (1 to 2 down)	Amber (3 to 4)	Red (more than 4)
Number of medical gaps on wards	Green (0 down)	Green (1 to 2 down)	Amber (3 to 4)	Red (more than 4)
Number of electives cancelled on the day	0	1 to 5	6 to 10	more than 10

OPEL 1	**OPEL 2**	**OPEL 3**	**OPEL 4**
less than 47	47 to 75	76 to 117	more than 118

3.1.2.2 Escalation Beds

The following areas are identified as escalation areas, should they be required, during winter. The beds will be opened with approval from the Managing Director Acute Care, Chief Nursing Officer and Medical Director in hours, gold command out of hours. The opening and closing of

ward areas will be done using relevant policies and procedures and managed in accordance with specific area Standard Operating Procedures.

Escalation Position	Area Name	Number of beds	Patient Type / Restrictions	Additional Information
1st	HDU CCU	8 beds	Stable female cardiology patients *(if not filled with cardiology patients over 80 years of age ICORs patient, under 80 IAC patient)*	Admission in and out of hours must have been discussed with cardiology on call
2nd	EDU	12 beds (08:00 – 20:00) 14 beds (20:00 – 08:00)	Preferred next day discharges *(over 80 years of age ICORs patient, under 80 IAC patient)*	Opening area overnight will potentially impact flow due to impact on use as a discharge lounge.
3rd	Kenley 2	12	As per criteria	To be used in extremis. IAC triumvirate with Managing Director – Acute Services to determine due to operational pressures.

3.1.2.3 Community Escalation Support

Being an integrated trust affords the opportunity to effectively manage out of hospital care, to ensure capacity is available to both support discharge and avoid admission.

When discussing the discharge destination of a patient, all the community services should be taken into consideration as they can oversee safe discharges.

The table below outlines the services available:

Service	Contact	Referral Criteria.
Virtual Ward	Ext 6445 OOH 07768376832	Includes patients with Acute infection, Respiratory conditions including nebuliser weaning, Heart failure/ fluid overload, change or addition to medication for monitoring. The team are happy to discuss referrals for suitability.
Rapid Response	Ext 6445 OOH 07768376832	As detailed in Virtual ward but also the team will take on supported hospital discharge.
District Nursing	Via SPOA or OOH 07768376832	Management of a long term conditions Post-operative / traumatic / chronic wound management Continuing care assessment End of life care Specialist nursing equipment for patients with nursing needs Diagnostic tests/screening Ear irrigation IV therapy/management

		Patient education/health promotion, e.g. teaching self-administration of Insulin Medicines management, e.g. patient compliance; Injectable medication Nutritional monitoring/management e.g. malnutrition, Gastrostomy Continence management e.g. urethral/supra pubic catheter, bowel management
Intermediate Care Beds	Via the D2A, ensuring the reablement section is completed.	Patients with rehab goals that will enable them to reach their full potential.
Croydon Respiratory Team (CRT)	ch-tr.crt@nhs.net	Respiratory patients including those on Long Term Oxygen therapy.

3.2.2 Paediatric Escalation

As with adult beds, during winter, there is often additional pressure on paediatric capacity. This is often, but not exclusively, because of an increase in childhood respiratory viruses throughout this period.

As a result, the trust needs to ensure that a surge plan is in place to support paediatrics during this time.

Surge: for the purposes of this document a surge is defined as either:

1. Full paediatric inpatient bed occupancy (all 16 beds) and children requiring admission being held in Paediatric Emergency department or short stay unit with no bed availability anticipated same day
2. More than 4 paediatric patients requiring acute respiratory support (ie CPAP or Opti flow) and the paediatric critical care unit being full with no additional capacity for admissions

Bed capacity: Rainbow Children's Unit (RCU) is a 18 bed inpatient unit. 2 beds are reserved for Paediatric Oncology leaving 16 beds used for all other paediatric inpatient activity for children and young people aged 0-15 years.

In response to a surge in demand, it is anticipated the paediatric bed capacity can be increased from 16 beds up to 33 beds, if necessary. A summary of the steps to achieve this is outlined below:

- Cohort all children with bronchiolitis in green bay if same virus identified as cause of disease
- Convert adolescent beds to beds or cots available to all age groups
- Open 7 beds on the short stay unit.
- Open a further 10 beds on the RCU day unit and cancelling elective activity.

Rainbow Children's Unit Staffing: To open additional capacity, the required staffing numbers and skill mix need to be in place. Neonatal nurses are being trained/inducted for RCU to support in times of surge. The full actions for staffing are outlined below:

Number of Beds	Day Nursing Establishment		Night Nursing Establishment	
16 (+2 Oncology)	6RN	1HCA	6RN	1HCA
26	8RN	1HCA	8RN	1HCA
33	9RN	2HCA	9RN	2HCA

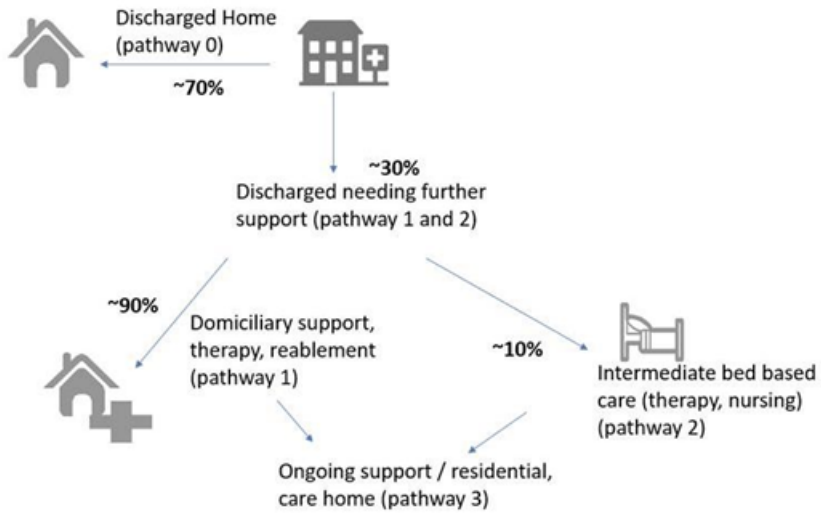
Should an increase in Paediatric Nurse availability be required to achieve the above the following staff redeployment measures may be considered (in order of priority):

1. Ward paediatric staffing ratios should switch to the ratios shown above.
2. Subject to availability / neonatal activity levels, a neonatal nurse should be released to work in RCU.
3. Subject to availability and Paediatric Emergency department activity levels, a Paediatric Nurse should be released from the Emergency Department to work on the RCU.
4. Where available, consider the redeployment of paediatric trained adult nurses from other specialties.
5. Paediatric Practice Development Nurses (PDN) and Paediatric Matrons should be redeployed to work clinically on the ward.
6. Other specialist paediatric nurses should be redeployed to act down as RN on the RCU.
7. Other paediatric doctors may be redeployed to work on RCU to support the RN on the RCU.
8. Non-emergency clinical activities such as outpatient clinics to enable the release of Paediatric consultants to support the RCU.

At all times, there must be a supervising paediatric nurse to oversee the care given if adult trained RNs and HCAs are caring for these children.

3.2.3 Discharge Planning

To maintain patient flow across the hospital daily discharge planning will be maintained. The below diagram provides an illustration of discharge pathways for patients.



Discharge planning will be managed by the multidisciplinary team at the ward level on an ongoing basis, with daily board rounds to discuss necessary next steps, criteria to reside, and

relevant discharge pathways. For more complex cases, the Integrated Discharge Team will provide additional support.

The Trust benefits from access to the following services to assist with safe and timely discharges:

- Blitz cleans
- Furniture moves / Environmental set-ups
- Pest Control

Patients classified as "stranded" (with a length of stay over 14 days) or "super stranded" (over 21 days) will receive an additional review during weekly long length of stay reviews. These reviews will follow a multidisciplinary team (MDT) approach, led by senior staff, to support ward-based teams in facilitating patient discharge.

Appendix C provides criteria for eligibility for patient transport.

3.3 Infection Prevention and Control

Patients with IPC requirements are managed via the side room priority algorithm that is utilised by the Clinical Site practitioners, which ensures patient safety remains the highest priority.

The Trusts must always adhere to a strict IPC regime for admissions to reduce the risk of any nosocomial transmission.

With regards to a requirement for an IPC scaled admission need the detail phases are noted below. The escalation of phases will be overseen by the Director of Unplanned Care in hours and the Strategic on call out of hours. All planning for escalation of capacity ideally should be in place prior to the 17:00 bed meeting including plans for overnight.

3.3.1 IPC scaled admissions

IPC triggers	Phase 0	Phase 1	Phase 2	Phase 3
Number of positive patients	0-16	16-56	56-84	84+
IPC suspected admissions	Side rooms	Side Rooms	Side Rooms Cohorted Bays	Side rooms Cohorted Bays
IPC ward	Side rooms	Q2 P2	Q2 P2 W3	Q2 P2 W3
Location and number of NIV beds for IPC admissions	Side rooms	Q2	Q2	Q2
Location of NIV beds Non IPC admissions	AMU	AMU	AMU	AMU
Medical Admissions No IPC affected	AMU & ACE	AMU, ACE	AMU, ACE	AMU, ACE

Surgical Admissions non IPC affected	F1, P1 & Q3	F1, P1 & Q3	F1, P1 & Q3	F1, P1 & Q3
Elective Admissions	Q1	Q1	Q1	-

3.3.2 Ward Detail for IPC Cohorted Admissions

First identified ward – Queens 2. This is a 28 bed, mixed sex general medical ward. The oxygen flow is up to 500 l/min. The ward will have the capacity to manage up to 6 patients on Non Invasive Ventilation (NIV). If this number is exceeded, the ward manager and matron will review the workforce and increase the number of trained staff in line with acuity.

Second identified ward – Purley 2. This is a 28 bed, mixed sex general medical ward. The oxygen flow is up to 250 l/min. The ward manager and matron will review the workforce and increase the number of trained staff in line with acuity. The patients managed on Purley 2 will not be those that are requiring NIV.

Third identified ward – Wandle 3. This is a 28-bed mixed sex general medical / care of the elderly ward. The oxygen flow is up to 250 l/min. The ward manager and matron will review the workforce and increase the number of trained staff in line with acuity. The patients managed on Wandle 3 will be those that are of a low acuity, requiring general nursing care.

3.3.2.1 Patient who are contacts of a Covid positive patient

If a patient in a bay is identified as positive, this patient should be moved to a side room, or positive bay at the earliest opportunity. Any patient that has shared a bay with the index case in the previous 48 hours is considered to have been exposed. Contacts should be isolated with similarly exposed patients or moved into side rooms. Contacts should be isolated for 5 days. If any of the contacts need to be transferred to another ward for clinical reasons, they should go into side-rooms or be isolated with similarly exposed patients.

3.3.2.2 Covid Discharges or transfers

If a Covid positive patient needs to be transferred to another hospital or be repatriated to CUH dates of positive swab will need to be communicated to ensure correct placement of the patient. Nursing or residential homes may ask for a Lateral flow test on the day of discharge for information, but this should not affect the discharge occurring.

3.4 Mental Health

Twice daily surge calls, chaired by SWL SCC in conjunction with our mental health providers south London and Maudsley (SLAM). Escalation to exec level for any patient with a length of stay of 24 hours in ED. SLAM have a psych liaison team based on site 24/7 accessed via ext. 4499.

3.5 Mortuary

The mortuary is assured sufficient capacity is in place. The below capacity is in place for Winter 2024/25:

Area	Capacity
BAU capacity – Fridge general	80
BAU capacity – Fridge bariatric	8
BAU capacity – Freezer general	38
BAU capacity – Freezer bariatric	10
Surge capacity – Fridge general	22
Surge capacity – Freezer general	12
Surge capacity unit 1+ unit 2	100

3.6 Pharmacy

Throughout the winter period the pharmacy will continue to run a full service. Any additional 24 bed capacity will require:

1 x Band 7 Pharmacist
1 x Band 4 Technician

3.7 Estates and Facilities

The current ISS contract has an 11% resilience contingency built in should this be required to meet demand during periods of peak demand. This will support during the winter period. Estates and Facilities are aware of all escalation areas identified for the winter period and can support as required with reasonable notice.

Cleaning services: will continue to be managed as per contract agreements with ISS. All wards are cleaned in accordance with FR2 standards. High priority areas will be cleaned to FR1.

Portering: will be a reactive service for ward areas. ED will transition to logging requests via tablets. Supervision will be provided within ED 24 hours a day.

Transport: HATs will continue to provide patient transport, including CICs patients. Any additional transport required will be requested via HATs should this be required.

Catering: Areas that do not pantry facilities will be catered to centrally and food provided via a trolley service.

3.8 Diagnostics

Diagnostics will continue to provide a seven-day service and are well position for winter 2024/25. No concerns have been raised regarding staffing and a decreased dependency on agency allows for improved planning.

There continues to be a risk regarding the sites GE CT machine, replacement will not occur until 2025/26 and this represents a risk should the machine break down. EMBE have a fund as part of the mitigation in the event of downtime which would pay for a CT mobile to be brought on site.

There are similar risks due to aged equipment (OPG, Purleys XRay machine, most ultrasound machines) as per the services risk register.

Ad hoc demand will also risk the continuity and timeliness of the service, this will be managed through winter by close discussion with the management teams of diagnostics and areas such as outpatients and theatres. The outputs from 6-4-2 planning meetings are to be shared across services to allow for full visibility of planned activity.

4 Winter Readiness and Management – Directorate Level Management

As part of the Trust's preparations and resilience for Winter 2024/25 during Summer/ Autumn all Directorates were invited to identify any additional support required to facilitate patient flow throughout winter. Previous actions taken to manage winter operational pressures were also considered and evaluated to support planning for 2024/25.

4.1 Integrated Adult Care Directorate

The IAC directorate will strengthen existing pathways and criteria to safely improve patient flow throughout winter. Areas of operational improvement will include introducing criteria to admit within the Emergency Department and optimising use of SDEC areas.

EDU open overnight
Opening of old HDU 1 x RN and 1 x HCA + 1 x Resident Dr
Acute Medics - Day 1 Reg @ Weekend : 9-5 (locum Sat & Sun) October-March
Additional Registrar overnight – senior decision making
Opening of Kenley 2 in periods of extremis
ED – Volunteer support for eating and drinking
ED - Nurse for UTC Long day Monday-Sunday

4.2 Integrated Surgery, Cancer and Clinical Support Directorate

The ISCCS directorate are focused on optimising the use of their SDEC area and managing their own flow of patients throughout winter whilst refurbishment work is ongoing on Queens 1. To support flow out of the hospital close collaborative working is taking place to optimise post-surgical recovery at home wherever possible.

Full use of ASH as an SDEC area (estate works required)
Increased access to IR for PICC lines through additional activity / enhanced hours (Saturdays)
Retention of Purley 1 beds to support flow for surgical patients

4.3 Integrated Women's, Children's and Sexual Health Directorate

The IWCSH Directorate is bolstering clinical provision to match periods of increased demand. Where significant escalation is required within paediatrics, this will be done through the network.

Paediatrics - One additional Registrar – 16:00 - midnight, 7 days a week
Gynaecology - One additional Registrar 17:00-22:00, 7 days a week

4.4 Integrated Community Older People Rehabilitation and Specialist Services Directorate

The ICORS directorate is enhancing frailty SDEC services, this area will not be used as escalation, and will be supported to maintain early flow. LAS direct access will commence from November, this initiative will allow patients avoid ED and taken directly to the most suitable place for their care.

Direct LAS access to frailty SDEC
Extension of portering between frailty SDEC and EDU (extend to start at 8:30 - 9:30am)
Frailty recruiting to support weekend provision (frailty SDEC)
Increased frailty SDEC space to 6 spaces
Increased package of care provision (volume and acuity)
Virtual ward occupancy up to 130

4.5 Therapies

Additional therapy requirements have been identified to support timely discharge.

1 x Occupational Therapist
1 x Physical Therapist

5 Workforce and Wellbeing

5.1 Staff Influenza and COVID-19 Vaccination Campaign

The staff influenza and COVID-19 booster vaccination campaign will start at the beginning of October 2024 and continue throughout winter until end of February 2025.

The purpose of the 2022/23 Influenza Campaign is to protect patients and staff by:

- Ensuring that 100% of frontline staff have flexible access to the flu vaccine.
- Achieving 100% uptake of the Influenza vaccine among frontline staff.

Objectives of the campaign include:

- Reduced number of staff sickness related to Influenza; this will reduce the need for bank / agency shifts to cover sickness.

The operational delivery plan:

- CUH based vaccination clinic – walk in or book an appointment at Shirley House (OH)
- Community "on-request" visits
- Jabathon – dates and rolling schedule to be confirmed

The vaccination team is also running an "evergreen" offer for staff to ensure their MMR and whooping cough vaccinations are up to date.

The key measure is the number of staff who have been vaccinated. The communications team work with the vaccination team to deliver an annual flu/covid vaccination campaign during the winter period to ensure staff are protected.

6 Patient and Staff Communications

The overarching approach to communication with patients is led by South West London, the Croydon Health Services communications team provide local messaging in line with this direction. The CHS Communication team will also utilise the NHS Winter Tool Kit which provides direction and guidance for communication throughout winter.

For staff, the toolkit acknowledges ongoing operational stress but encourages continued focus on delivering high-quality care. Staff are urged to get their winter vaccinations to protect themselves and patients. Mental health support services, like the SHOUT text helpline, are also promoted.

The public message is to use the appropriate NHS service for their needs, such as NHS 111 online or local pharmacies. Vaccination is encouraged to help protect against serious winter illnesses, and efforts to promote good health practices, like staying warm and washing hands, are emphasized through campaigns like "Stay Well This Winter."

In addition, high impact interventions like increasing the use of virtual wards, urgent community response services, and ensuring effective discharge planning are promoted to alleviate pressure on emergency services and hospital beds. The toolkit includes guidance on leveraging digital tools and resources, as well as communication strategies for engaging both patients and healthcare staff.

Overall, the communications toolkit is designed to support the NHS in managing winter challenges by reinforcing clear messaging, promoting critical interventions, and ensuring both staff and patients are well-prepared.

7 Governance and Management

The Managing Director – Acute Services will hold weekly meetings with multi-disciplinary teams from directorates across the hospital with the following aims:

1. **Accountability for Winter Schemes and Patient Flow:**
    - Ensure that Directorate leadership teams (triumvirates) are responsible for delivering planned winter initiatives and managing patient flow effectively to reduce congestion and improve care.
2. **Timely Solutions to Emerging Challenges:**
    - Quickly identify and implement solutions for unforeseen or unresolved challenges during the winter period to minimise disruption to hospital operations and patient care.
3. **Risk Management:**
    - Continuously review risks and issues related to winter pressures, ensuring that all potential risks are recorded and that strategies are in place to mitigate them.
4. **Strategic Overview of Winter Operations:**
    - Provide a high-level strategic perspective on winter operations, coordinating efforts both within the hospital and with external partners (e.g., community care, local authorities) to ensure a seamless response.
5. **Constructive Challenge and Escalation:**
    - Offer constructive feedback and support to teams, escalating any obstacles or delays in delivery to senior management, ensuring that barriers to success are addressed quickly.
6. **Integration with Other Programmes:**
    - Ensure that the winter workstream is aligned with other hospital programmes, identifying interdependencies and making sure that collaborative efforts are well-coordinated for smooth execution.

Appendix A: Additional Reserve Winter Initiatives

Several contingency initiatives for addressing extreme operational pressures have been identified. The initiatives have not yet been approved and will be considered throughout the winter period should additional measures be required to maintain patient safety.

In cases of sustained OPEL 4, these additional initiatives will be brought up for discussion. OPEL 4 reflects critical levels of pressure, such as bed shortages, high patient demand, or staff constraints. These options will be discussed during the weekly winter meetings, chaired by the Managing Director of Acute Services. The rest of the executive team will then be involved in decision-making. Any decisions about implementing these out-of-scope initiatives will require executive team approval, including the allocation of any additional funding necessary to support them.

This approach ensures that contingency plans are in place to respond to extreme situations, while maintaining a structured decision-making and funding process.

1	Placement of a Registrar into SDEC at weekends to increase volume of patients seen in SDEC.
2	Opening of SDEC overnight at weekends for ambulatory patients from ED.
3	In-reach by gastro, cardiology, respiratory into ED
4	Designation of a flow team (nursing, medical and operational) to support daily flow of patients with a length of stay of less that 14 days
5	Move from desktop reviews to ward based reviews of 14 – 20 day length of stay patients as part of long length of stay safari rounds
6	Consideration of additional escalation areas such as Cath Lab
7	Introduction of escalation policy for virtual ward (including stretching of admission criteria where appropriate)
8	Purchasing of hotel beds for patients
9	Increased blitz clean capacity

Appendix B: Non-Emergency Patient Transport (NEPT) Eligibility Assessment

A patient can only be assessed for NEPT if they have no alternative means of transport to get to and from hospital. If the patient still requires transport, the below assessment needs to be completed to ensure they are eligible:

Medical Assessment

If the answer to any of the below is YES, then the patient is eligible for transport:

Does the patient require oxygen and are unable to self-administer this during transit
Does the patient need specialised equipment during the journey
Does the patient need to be closely monitored during the journey
Does the patient need to be transferred to another hospital
Does the patient have a medical condition, have undergone major surgery (such as transplant) and/or the potential side effects of treatment are likely to require assistance or monitoring during their journey
Does the patient have a medical condition or disability that could compromise their dignity or cause public concern on public transport or in a licensed taxi or private hire vehicle, and do not have access to appropriate private transport
Does the patient have a communicable disease with which travel on public transport or in a taxi is not advised, and do not have access to appropriate private transport
Has the patient been clinically determined as at risk from using public transport due to being immunocompromised and are unable to make their own way with relatives/friends and/or escorts/carers whether by public transport or taxi
Does the patient have dementia or another mental health condition that means they are unable to make their own way with relatives/friends and/or escorts/carers whether by private transport, public transport or a taxi
Does the patient have a confused state of mind, learning/communication difficulties, hearing loss and/or impaired sight of a severity that they are unable to make their own way with relatives/friends and/or escorts/carers whether by private transport, public transport or a taxi
Is the patient at risk to themselves or others if they travel independently
Is the patient travelling to or returning from in-centre haemodialysis

Escorts

Is the answer to any of the below is yes, then the patient is eligible to have an escort travel with them:

The patient is under 16 years of age and are required to travel with an escort or carer
The patient needs an escort or carer's particular skills and/or support
The patient cannot be left alone, or their condition means that they need the support of an escort
The patient is under the care of the patient who is eligible for NEPTs, cannot be left alone, does not require the support of the NEPTS ambulance care assistant when travelling, and no alternative care is available at that time