NHS London

Pressure Surge Planning And Management Arrangements

2011/12

External Version

FINAL

Contents

Document History

Version	Author / Date	Comments
Draft 1	Richard McEwan 14.07.2011	Initial draft, updated from 2010/11 version, to include use of CMS for Community capacity reporting, use of Critcon and re-enforcement of LAS turnaround 1 hour breaches
Draft 2	Richard McEwan 22.07.2011	Incorporation of Cluster and internal feedback
External Final	Richard McEwan 31.08.2011	Incorporation of updated 'Critcon' levels
Document Filing S:\Performance\Performance Improvement\A&E & Winter Planning\Winter 2011 - 12\Pressure Surge Management 2011-12 Guidance External Final.doc		

Section One - Introduction and Context

1.0 Context in which Pressure Surge Planning takes places in 2011/12

The NHS has experienced two consecutively hard winters, with prolonged bouts of severe adverse weather conditions, last year coupled with increased seasonal influenza activity. The NHS response to these pressures in London has been acknowledged by the Department of Health (DH) to have been handled well. In updating this year's process and guidance, feedback from Cluster co-ordinated reviews has been used to inform the final outputs.

It is recognised that the recent structural changes in the NHS, particularly in relation to PCTs, may have created a degree of uncertainty or inconsistency in how or by whom services are delivered. For this reason, references in this document to 'PCTs' have been replaced with the use of the generic term 'Borough's'. If this is not appropriate in a particular local context, organisations are expected to interpret and apply this guidance with respect to the local arrangements in force at the time.

In 2011/12, against a backdrop of considerable change and uncertainty, NHS London and the Clusters must maintain a grip on the system. Planning needs to continue to be robust, whilst acknowledging the uncertainties created by the changing structures and responsibilities, and the future shape of the NHS landscape where known.

1.1 Process for assurance planning

Key to the success of local system management during times of increased pressure (not just winter), including the triggering of appropriate escalation plans, will be a robust planning process for pressure surges. This document and the Emergency Department (ED) Capacity Management and Closure Policy (ED Policy) v4 are designed to support London's NHS in preparing its pressure surge management plans for 2011/12.

1.2 Set out high level triggers which may indicate building pressure

The paper sets out the high level trigger points and escalation activities, which should be in place across all London Trusts. This is not an exhaustive list and there will be many more locally tailored to individual area needs. These relate to activities associated with keeping patients flowing through ED's, and preventing the need to request a redirection or closure of an ED. The triggers and escalation activities should be reflected in all local planning, and are not restricted to winter based increases in demand – they may occur at any time of year, and the NHS in London needs to be able to deal with this effectively.

1.3 High level pressure surge management arrangement for London in 2011/12

The paper includes direction on the high level management arrangements to be in place across London to ensure that a systematic approach is taken to pressure management. It is recognised that Clusters will want to supplement this with more detailed local arrangements. The guiding principle has been to maintain local management discretion to take escalation actions relevant to the local situation whilst ensuring that all possible escalation activities have been enacted before a redirection or closure is requested.

1.4 Objective of pressure surge (winter) planning:

- To identify potential risks to the delivery of (safe) health services during periods of increased seasonal pressure.
- To mitigate those risks (as far as practically possible) through the planning, documenting, monitoring and exercising of appropriate actions and escalation processes.

1.5 Risks:

There are two broad risks for the NHS posed by inadequate planning:

1. That the preventable deaths of patients occur.
2. That public confidence in our ability to deliver safe healthcare is undermined and the reputation of the NHS is damaged

There are a number of contributory risks, which if realised, could contribute to those listed at 1 and 2 above:

- The challenging financial situation (against a continuing rise in demand, expressed though increased calls to the LAS and A&E attendances) where there could be a constriction on the availability of additional resource this winter particularly to fund escalation capacity and extra staffing to cope with increases in demand.
- Increased acuity placing increased strain on critical care facilities, forces the adoption of triage systems to ration access to critical care facilities.
- Insufficient uptake of seasonal influenza vaccine amongst staff, undermines the ability to staff wards adequately, prolonging length of stay and clogging the admission and discharge pathways, adversely impacting on clinical outcomes and the ability to admit new cases.
- Stretched and tired staff fail to provide acceptable levels of care leading to an increase in complaints and the transmission of HCAIs.
- The delivery of care pathways jointly with social services is compromised through poor planning and inadequate staffing to move appropriate patients swiftly and seamlessly from the NHS to social care services. (As with the NHS, Social Services face tighter financial constraints, and NHS planning should not merely assume that historical levels of services will be maintained. There will need to be an assessment of social services capacity planning and its knock on effect on the NHS.)

Section Two - Pressure Surge Planning 2011/12

2.0 Assurance Approach (Timeline – Appendix C)

This year's assurance approach is designed to help the health system in London mitigate against the risks posed by increased winter related pressures. The assurance process for 2011/12 comprises the following components:

Process	Output	Who responsible	Timeline
Cluster undertakes assessment of risk(s), across the Cluster, based on previous performance, and local intelligence, to be agreed with NHS London in advance of the assurance process, which will guide the application of the evidential review requirements.	Cluster risk assessment	Cluster	End June – End July
NHS London produces planning letter and updated checklists including a defined list of areas from within the overall checklist, where evidential review will be required by the clusters (see appendix 1). This sets out the minimum expectations. In certain cases, based on risk, Clusters may wish to review more areas in detail.	Planning letter Updated checklist Updated management guidance	NHS London	Mid – late July
Local organisations review and update plans from last year, including any learning points from the reviews carried out in spring 2011/12	Updated plan documents and evidence for review	Local organisations (Trusts, Boroughs etc)	August – September (with further refresh continuing to end October)
Cluster / organisational meetings to review plans, involving where agreed, NHS London performance managers. It will be left for local decision how Clusters wish to involve emerging GP consortia in the process this year. (They should be involved in some way, as this will be important for the learning from 2013 onwards).	Cluster / local organisation review meetings Updated plans	Clusters Local organisations	September – early October
Exercises to be held (paired clusters preferable to enable joint cross boundary management of issues to be tested) to test readiness of winter plans.	Exercises Learning to feed further planning	Clusters / local organisations	September - mid October (if possible)
Cluster provides assurance to NHS London, regarding the areas of greatest risk, the mitigating actions, and the effect of mitigation they feel they can achieve – and thus what remaining level of risk exists. Cluster also provides Cluster level management plan for managing pressure surges	Overview document from the Cluster, detailing the main risks, the mitigating actions in place and the remaining level of risk A management document from each cluster, setting out their management and escalation arrangements, including on call details etc	Cluster Cluster	7 October 7 October
NHS London to review Cluster submission and discuss with Cluster if required	Feedback to Cluster Final submissions	NHS London / Cluster Cluster	20 October 28 October

Clusters provide final submissions to NHS London			
NHS London Performance Directorate produces submission to Delivery Group, outlining the outcome of the assurance process	Overview document outlining the highest risk areas and the remaining level of risk, once mitigating actions have been deployed	NHS London	Performance PLG 10 Nov Delivery Group 28 Nov

2.1 Checklists

An updated checklist in Excel format for 2011/12 has been produced and previously circulated. Please contact your cluster winter lead if you have not received this. The Checklist has three parts:

1) **Notes section**

2) **The Main Checklist** – this is for organisations to use to ensure that in their planning, they have covered all the relevant areas to ensure that their organisation is as well planned as possible to meet increased pressures over winter.

3) **The Evidential Checklist** – this is a subset of the main checklist which sets out the areas where organisations will be asked by their Cluster to submit evidence of planning, in order for the Cluster to be able to assure itself that the risks associated with winter pressures have been adequately planned for and mitigated as far as is practically possible. Clusters may decide to ask for further evidence, based on risk. Clusters will report to NHS London regarding the assurance they have received and the level of mitigation around these key areas, ahead of winter.

2.2 Exercises

As an integral part of pressure surge (winter) planning, Clusters are required to hold joint exercises as part of the assurance process, providing the opportunity to test joint working arrangements and the impact of out of area pressures on local plans. These should have taken place by the middle of October, to allow time for any learning to be used to update plans. NHS London will provide a basic scenario which can be locally tailored to test plans.

2.3 Seasonal Flu Planning and reporting

Boroughs and Trusts provided assurance to NHS London in May that sufficient stocks of seasonal influenza vaccine had been ordered to cover target populations. Trusts and Boroughs should ensure they have robust (local) monitoring and reporting arrangements in place, including into the on-line ImmForm system to ensure they are on target in terms of uptake, and take timely action if they are not. Local planning arrangements should also take into account that dependant upon circumstances, they may be required to report on additional information to the Department of health, via the SHA, if required to do so – e.g., vaccine stock levels, requirements for vaccine consumables etc.

Organisations should also have given due consideration to the DH seasonal flu plan as part of their own winter planning. The DH seasonal flu plan can be found at the following location:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127051

3.0 Triggers and Escalation Actions relating to Emergency Department (ED) Re-directions and Closures

The triggers and escalation activities are designed to maintain local management discretion to take escalation actions relevant to the local situation whilst ensuring that all possible escalation activities have been enacted before a re-direction or closure is requested.

The triggers set out at 3.2 are a combination of factors, suggested by different NHS organisations. Some are based on information collected and populated by acute trusts onto CMS. Data or information to support other triggers, including weather conditions or the number of calls to LAS will be linked to CMS pages by the Emergency Bed Service (EBS). Organisations will need to check this information regularly to ensure that they are aware of external factors which may affect them in the near future. The process by which this regular checking will happen should be clear in local pressure surge management plans.

3.1 Visibility and Management of Building Pressures

The level of pressure being experienced will be visible to the Cluster, both from CMS scores, and conversations with Trusts. Clusters will be able to determine if there is a need to trigger co-ordinated escalation actions and whether the actions taken are having an effect.

Unless there has been a sudden surge in activity which could not be anticipated, requiring the consideration of a re-direction if the unit is overwhelmed, the request for a re-direction or closure should not come as a surprise to the Cluster. It should become clear over a period of time that re-direction may need to be considered if all other actions are not having the required effect.

3.2 Trigger Points – individual organisation

All acute trusts should ensure that the following major trigger points are included in their plans, with actions prepared to mitigate against their impact.

3.2.1 Increased Demand

- Weather: – After a drop in temperature (to daytime maximum of four to five degrees and night time temperatures below freezing over a two to four day period) there is a known rise in attendances. This occurs three to five days later for cardiovascular conditions and 10 to 12 days later for respiratory illnesses. (See note 1)
- LAS activity – Overall call volume above 3000 calls per day and CAT A calls above 950 calls per day (if continues for 2 consecutive days, will indicate A&E departments coming under pressure.) (See note 1)
- Patient attendances or admissions through A&E reach higher than the daily expected norm under seasonal conditions (will be trust specific, baseline and tolerances will be expected to be specified in local pressure surge plans). Nationally an increase of up to 15% is recommended.
- Community / primary care services. Demand for these services reach higher than the expected norm under seasonal conditions – to be locally defined and monitored.

3.2.2 Decreased Supply

- Bed Capacity: (individual Trusts approaching or reach levels of bed availability outside of the planned for norms under seasonal conditions – baselines set in pressure surge plans and agreed by Clusters).
    - Critical Care beds (including PICU).
    - General beds (including paediatric).
- Discharges:
    - DTOCs reach five more (or locally agreed %) than the normally accepted level.
    - Overall predicted / confirmed discharge volumes are below the known threshold for daily discharges required to meet seasonal bed requirements.
- HCAIs – beds / ward closures due to D&V etc., and increasing community prevalence (See note 2).

3.2.3 Waiting times

- Performance against four hour operational standard falls below 95% for more than two - three days. (Or below agreed levels for new A&E Metrics as appropriate).
- Significant risk of patients waiting more than 12 hours in the department for admission.

3.2.4 Staffing

- Staff – actual or predicted staff sickness, absenteeism or vacancy levels reach a point at which provision of safe, effective care for patients is likely to be compromised. (Baseline to be specified by trusts in local plans. Not collected as part of CMS, will need to be monitored by internal trust processes).

Note 1 - Data not collected as part of the CMS tool, but EBS will ensure that weblinks to information such as severe weather alerts from the MET Office and NHSD Syndromic Bulletins are available and up to date via CMS.
Note 2 - numbers of beds (not wards) closed is collected on CMS

3.3 Trigger Points – Cluster and London level

These are included under Sections Six and Seven

3.4 Escalation Actions (see Appendix A)

In general increased pressure in ED's will be caused by either:

- Pressure building over time due to issues with patient flow out of the ED caused by capacity problems elsewhere in the Trust.
- Issues with resus capacity.*

*** Note:** There is a difference between units overwhelmed by too many patients requiring active resus for the size of the unit, as opposed to a unit having patients in beds who no longer require active resus, but cannot be moved on due to capacity issues elsewhere in the ED or Trust.

For the escalation actions listed at Appendix A to be most effective, they must be built into local planning and initiated as soon as possible, as pressure starts to build. They will not be effective in avoiding the need for re-direction, if they are only instigated once pressure has reached a level where re-direction is being considered to manage the pressure. This is due to the lead in time for their implementation.

The actions listed in the checklist at Appendix A are not intended as an exhaustive list, as there are numerous other actions, including increased staffing in minors, extended use of the discharge lounge etc., which can be implemented to help manage pressures in the longer term by improving patient flow and throughput.

They are not listed in an order of priority, and may need to be deployed in groups or singularly, dependant upon the level of pressure being experienced or the efficacy of previous actions taken and the rate at which the pressure is growing.

3.5 Redirection or Closure of an ED

Redirection of the LAS or closure to 'blue lights' should not be considered as a risk free way of managing pressure surges in an ED, as it may prolong a patient journey's leading to an increased risk of complications developing during the journey to an alternative ED.

Redirection or closure should normally only be contemplated when it is felt that the risk to patient safety at the unit outweighs the risk caused by extended journey times. The most effective way to prevent the need for redirection remains long term planning, although measures such as 'treat and transfer' should also be considered as short term ways in which to manage pressures, without the need to resort to a redirection.

Further details on redirections or closure (including Cluster responsibilities) can be found in the 'Emergency Department Capacity Management and Closure Policy (ED Policy) v4'.

Trusts should ensure that any redirections or closures are investigated at a senior (executive or nominated deputy) level, to ensure that the causes are established and actions taken to prevent a reoccurrence where possible. These reviews should be shared with the Cluster.

Section Three - Pressure Surge Management Arrangements

4.0 Overview

The following sections to set out the management arrangements for London in 2010/11 in relation to pressure surges associated with seasonal weather conditions on NHS services. This sets out the agreed roles and responsibilities for the Clusters and NHS London, (including the arrangements should it be necessary to move to pan London command and control of the NHS).

In local pressure surge plans, NHS organisations, including Clusters, will need to provide in hours and out of hours contact details. Trusts should note that Clusters should be the first point of contact for discussions regarding capacity related re-direction or closures of EDs – in accordance with the ED Policy. Capacity related requests should not be directed, either in hours, or out of hours, to NHS01. **Only if an ED closure is required, due to an infrastructure failure, should contact be made directly with NHS01.**

5.0 Capacity Management System (CMS)

During winter 2010/11, CMS provided a near real time view across the Capital of the relative pressures being faced by acute Trusts, across a range of indicators. Whilst not perfect in every respect, feedback reflected the usefulness of the system in managing pressure surges. For 2011/12, the Critical care functionality will be used by LAS EBS to help manage capacity and NHS London is mandating the use of the Community Capacity reporting function. **All Clusters not currently using this functionality are expected to have adopted this prior to the beginning of winter (November 2011).**

5.1 Update Schedules

It is extremely important for all Trusts to keep CMS up to date, including Foundation Trusts, so that a complete picture of pressures across the capital can be formed and jointly acted upon. **If trusts do not keep the information up to date, it will be assumed that they are not experiencing any pressures, and are in a position to offer mutual aid, including taking re-directed patients.**

Update schedules for CMS are as follows:

- ED Pressure – 2 hourly
- Bed status – 4 Hourly
- Critical Care – 3 x Daily by EBS
- Community Hospitals – Twice daily (or more frequently if locally agreed)

5.2 Critical care

At the present time **LAS EBS** will continue to contact Trusts three times a day to ascertain bed capacity, and will populate the data onto CMS. This will then be used by them, as now, to manage the critical care bed transfers across London. Trusts and NHS London will be able to view this information, although initially not make changes to the data locally. Further work will be undertaken to allow trusts to update data directly, although LAS EBS will continue to fulfil their current role of facilitating bed transfers between Trusts. Further information regarding this will be circulated separately in due course.

5.3 'Critcon' Reporting

EBS will collect the Critcon status directly from the critical care unit at their 3x daily ring round and post the score on the CMS system. Changes to Critcon status between EBS ring-rounds can be called in to EBS on 020 7407 7181.

5.4 Community Services

A 'community hospital' module on CMS has been developed for London to facilitate the sharing of live community bed capacity data (such as step down beds/intermediate care) and aid in Acute Trust discharge decisions.

This module is live in ONEL, NCL and due to roll out in NWL shortly. *All clusters are expected to have implemented this module ahead of November 2011*. Acute Trusts, Boroughs and NHS London will be able to view the capacity data which will need to be updated twice daily by the relevant community services.

5.5 SITREP Reporting

Acute trusts will continue to be required to complete the Department of Health daily winter Situation report (Sitrep) from November to end of February.

6.0 Roles and Responsibilities

This section sets out the roles and responsibilities to be undertaken throughout winter by the Clusters and NHS London.

6.1 Cluster

- To Lead the Cluster response to pressure surges (on behalf of the SHA), on a day to day basis (both in and out of hours).
- To keep in touch with the day to day situation across the Cluster and be aware of any developing issues.
- To ensure that a complete picture of the pressures across London is available through the timely updating of the CMS system. (Acute, Community and Critical Care)
- To be aware of the measures taken by trusts to address the pressure increases and ensure they are activated in a timely manner in order to ensure a swift countering of the pressures.
- To broker agreements across the Cluster (and with other Clusters if possible) to ensure that mutual aid is available if required to re-balance pressures (acute and community services). Where possible this should always be primarily through co-operative and collaborative working with all providers of NHS services recognising the overriding imperative to provide safe and timely care to NHS patients as a priority. The Cluster would be expected to arbitrate between local providers to ensure an appropriate outcome is reached, bearing in mind the above priority if this is not possible. If there is protracted failure to reach a conclusion favourable to patient care, NHS London may become involved in reaching a resolution.
- To liaise with LAS over pressure levels, including authorising re-directions from ED departments where necessary, under the ED Policy (both in and out of hours).
- To ensure Trusts investigate at a senior (executive or nominated deputy) level the reasons for redirections and learn the lessons to prevent reoccurrence.
- To ensure mechanisms for robust recording and monitoring of all 1 hour ambulance handover breaches are in place and properly utilised and liaise with NWL Cluster LAS Commissioning Team to help resolve any LAS issues where appropriate.
- To advise the SHA if there are actions which need to be taken, requiring SHA approval or brokerage, especially where these will affect trusts or organisations outside of London.
- During periods of central command and control, to ensure that the actions requested or endorsed by NHS London are carried out on the ground in a timely manner, and to escalate to NHS London any problems encountered in enacting those decisions.
- To keep NHS London informed through the provision of additional briefings which may be required in order for the SHA to manage the developing situation and to keep the DH informed.
- To ensure that all partner organisations are working effectively together to ensure that sufficient capacity is in place to deal with demand, including patient discharges.
- To overcome any barriers to this co-operation across the Cluster, and escalate to the SHA if this is not possible.
- To brief bordering Clusters on any issues which may impact their own management of pressure surges, including notification of ED re-directions or closures which will see LAS traffic re-directed to beyond the Clusters own border.

6.2 NHS London

- To be aware (Performance Managers) of the day to day picture of pressures across the NHS in London once the upper limits of amber and above on CMS are reached.
- To provide advice to the Clusters on the handling of escalating situations, if requested.

- To brief surrounding SHAs and liaise pro-actively with them if pressures in London are likely to impact outside the Capital.
- Ensure that appropriate communication routes are followed if pressures affecting Trusts outside of London are likely to impact on London Trusts and LAS. (To be included in updated ED Policy due for release in August 2011).
- To brief the DH on any issues likely to attract media attention through pressure surge conditions, participating in DH weekly winter conference calls.
- To enact command and control arrangements if pressure levels cross agreed thresholds, in order to ensure that actions across London are taken in a co-ordinated and timely manner, to ensure that patient safety remains uncompromised, including enactment of Critcon provisions (see section eight).
- To ensure that Emergency Preparedness team (via NHS01) within NHS London is kept abreast in a timely, manner of any developing situations, which it may need to take into account during a major incident.

6.3 Specific Actions to discharge roles and responsibilities:

6.3.1 Conference Calls

Conference calls between Clusters, LAS and NHS London will begin in September (exact timetable to be advised). This is to ensure that there is a commonly shared view of the progress of the assurance process initially, coupled with the seasonal influenza vaccination campaign.

Calls will initially be held weekly, becoming more frequent as winter pressures build, and will be held daily on week days during periods of sustained pressure. They can be de-escalated if pressures subside, and re-escalated if required.

Representation from the Cluster should be at Winter Lead level initially, escalating to Director of Performance or agreed deputy during periods of sustained pressure or if requested to attend by NHS London.

6.3.2 Monitoring Cluster and London Pressure Levels on CMS

The scores recorded on CMS, are by the changing nature of the situation on a day to day and even hour to hour basis, necessarily fluid and variable. CMS does not give a Cluster level or London level CMS score in the same way that it does for individual Trusts. Therefore the status of each Cluster and London as a whole, is open to a degree of interpretation. This is helpful in enabling the tailoring of local arrangements to fit the prevailing circumstances giving a greater degree of flexibility to the Clusters and NHS London, in deciding how to respond to rising pressures.

In general the status of the Cluster and London is judged by the prevailing RAG rating of its constituent Trusts and Clusters over a period of time. For example, if a Cluster had three Trusts, two on amber and one on red, the overall status would generally be thought of as amber. If one of the amber Trusts turned black and the other two remained unchanged, the Cluster would probably be considered overall as Red. There is no hard and fast rule which sets out what the Clusters status is, if it has its Trusts showing a mixture of RAG ratings. This is partly driven by the fact that it is acknowledged that CMS does have some quirks, and is not perfect and partly by the fact that the true pressure level for a Cluster will be a combination of CMS scores, and local confidence in the escalation actions being undertaken to manage those pressures.

The imposition of the command and control procedures, set out in section ten, would generally only be considered if the appropriate escalation status was reached and then remained relatively unchanged for a significant period of time.

This year, a fifth level of escalation has been added to the pressure surge management arrangements, to bring London's process into line with National proposals. This is not covered by CMS, but would be nationally designated, with the country moving to the implementation of a 'National Health Service', as occurred during the Swine Flu pandemic of 2009/10.

6.3.2 Cluster / London at Level 1 - Green

- Maintain normal day to day relationship with trusts, Boroughs and the SHA.

6.3.3 Cluster / London at Level 2 - Amber

- Ensure that contacts occur with acute Trusts and Boroughs on a daily basis to keep abreast of developments. These do not need to be additional calls etc, but can be ones which are likely to occur naturally during the course of working business relationships.
- Hold weekly conference call with Cluster organisations to ensure that a Cluster wide view of the pressures is understood, and share any concerns / actions relating to upcoming events.
- Trusts under pressure will, in consultation with the Cluster handle the consequences of pressure increases, according to their own internal escalation plans. If pressures continue to rise, the Cluster will need to provide co-ordination and direction on the availability and scope of mutual aid.
- To brief NHS London (senior performance managers) on an informal basis if required on upcoming situations.

6.3.4 Cluster / London at Levels 3 or 4- Red or Black

- Cluster to hold daily conference calls with relevant partner organisations, and provide system management and leadership.
- Keep NHS London (senior performance managers) informed of the picture across the Cluster, on a daily basis, providing a high level brief of actions being taken and the next steps as appropriate – e.g., the next intended set of escalation activities to be used, if the previous set have not rectified the situation, through the daily conference calls.
- To convene additional conference calls to discuss pressure increases as required, ensuring that all participants are aware of the arrangements in a timely manner.
- If two or more Clusters report level four (Black), or five or more Clusters report level three (Red), NHS London will take a view, following discussions with Cluster Chief Executives / Directors of Performance, and dependent upon the causes and likely duration, as to whether to invoke central command and control arrangements. If this step is taken, NHS London will co-ordinate multi Cluster or pan London actions, overseen by NHS Gold or the Director of Performance, until such a time as the pressure levels have returned to more acceptable levels, and control can be returned to Cluster level.
- If an ED closure is agreed, due to capacity constraints, this may act as a trigger for the enactment of command and control arrangements in that Cluster, under the direction of NHS London, irrespective of the pressure levels across the rest of London.

6.3.5 National Health Service - Level 5

National co-ordination of health services may be implemented when demand is such that only a nationally coordinated response is appropriate. This may be reached following escalation through the various stages above or imposed by the DH for such cases as the Swine Flu Pandemic. Separate arrangements will be communicated to the NHS Locally, in the event of a Level 5 scenario being reached.

7.0 Cluster Escalation levels and actions

This flow chart illustrates the relationship between the pressure levels reflected on CMS, and the accompanying high level Cluster and NHS London actions to be taken.

Level 1 – Green - trigger is 120 - 180 score on CMS -

Actions expected:

- Maintain business as usual
- Information sharing on any potential upcoming issues which may affect the Cluster
- Weekly Cluster calls with NHS London from September

Pressure increasing

Pressure decreasing / remaining stable

Level 2 – Amber - trigger is 181 - 220 score on CMS

Actions expected - As level 1 and in addition:

- Cluster to ensure daily contact with acute trusts via normal business routes.
- Cluster to hold at least weekly conference call to ensure weekends etc will not be an issue
- Sharing of information with adjoining Clusters that may be affected by rising pressures.
- Ensure that escalation actions are being taken in line with identified causes of pressures, and Cluster pressure surge plans.
- Scope out availability of mutual aid.
- LAS to assist through "smoothing" of patient conveyances if possible to less pressured organisations to help balance the load.

Pressure increasing

Pressure decreasing / remaining stable

Level 3 – Red - trigger is 221 - 250 score on CMS

Actions expected - As level 1 & 2 and in addition:

- Daily conference calls between Cluster and Boroughs / acute trusts (include MH, LA, LAS as required)
- Daily conference calls between Cluster and NHS London senior performance managers on pressures and response with high level brief.
- Invocation of mutual aid arrangements within Cluster.
- Co-ordination with neighbouring Clusters re their ability to provide mutual aid.
- **5 or more Clusters on Red – discussion between NHS London (Gold / DoP) and Clusters regarding potential likelihood of triggering command and control arrangements.**

Pressure increasing

Pressure decreasing / remaining stable

Level 4 – Black - trigger is 251+ score on CMS

Actions expected - As level 1, 2 & 3 and in addition:

- Full implementation of all escalation actions identified under pressure surge planning.
- Cluster direction if required to Boroughs and adjoining Trusts etc to increase capacity, through purchase of additional beds, cancellation of patient operations etc.
- **2 or more Clusters on black– discussion between NHS London (Gold / DoP) and Clusters regarding triggering of command and control arrangements.**

Pressure increasing

Pressure decreasing / remaining stable

Level 5 – National Health Service

Not part of CMS escalation – nationally imposed e.g., Flu Pandemic, instructions and actions will be issued by DH, cascaded via SHA's

8.0 Critical Care Condition ('CRITCON')

During both the Swine Flu Pandemic of 2009/10, and winter 2010/11, critical care facilities across London and the rest of the UK faced times of significant pressure. The Critical Care Condition (Critcon) definitions were agreed to ensure a common level of understanding regarding pressures and associated actions.

8.1 Critcon Reporting

CMS will again be used this year to monitor the critical care pressure levels, and NHS London will in conjunction with the clusters, and medical advice, ensure the implementation of the actions required at each Critcon level, should it become necessary.

Critcon scores will be collected by LAS EBS on their 3x daily ring rounds and entered into CMS.

9.0 LAS Handover and One hour (Black) breaches

During the winter, it is inevitable that ED's will experience heightened pressures, and the risk of one hour handover delays increases significantly. Trusts are expected as part of their planning process to ensure that these incidents are eliminated as far as possible.

9.1 Serious Incident Reporting

Where they do occur, trusts are expected to report them as Serious Incident's (SI's), and investigate their causes. Clusters are expected to ensure that both they and their Trusts have implemented robust monitoring arrangements, to ensure that one hour breach SI's are identified, reported, investigated and the lessons learnt implemented to reduce the likelihood of recurrence in the future. Considerable work has been undertaken on this in NWL Cluster, and all Clusters were asked in June to ensure the recommendations have been implemented.

9.2 Hospital Based Alert System (HAS)

Trusts are expected to maximise usage of the HAS to ensure accurate data collection on handover times, reducing disagreements between trusts and the LAS about the number of 1 hour breaches taking place, enabling resource to be focused on investigating those which did occur.

9.3 The following definitions and reporting processes have been agreed and are in effect across London:

- ***LAS arrival at Hospital:*** The time that the LAS vehicle parks at the Emergency Department off loading bay and 'Red at Hospital' button' pressed within the ambulance.
- ***Clinical Handover:*** The time at which essential clinical information about the patient has been passed from the attending LAS crew to a clinician within the Emergency Department to allow a decision about where ongoing treatment can safely be delivered.
- ***Patient Handover:*** The time when clinical handover has been completed and the patient has been physically transferred onto a hospital trolley bed, chair or waiting area, and the LAS equipment has been returned to crew enabling them to leave.
- ***LAS Green:*** The LAS Crew have notified their Emergency Operations Centre they are available for further deployment via 'Green Available' button press.
- ***Arrival to Patient Handover:*** The time from when the LAS vehicle arrives at Hospital to Patient Handover
- ***Patient Handover to Green:*** The time from when the patient handover has taken place to the ambulance being made available for further deployment

9.4 Reporting Responsibilities:

HOSPITAL TURNAROUND STAGE	DATA CAPTURE MECHANISM	RESPONSIBILITY	COMMENT
LAS arrival at Hospital	**'Red at Hospital' button press via the LAS MDT**	**LAS crew**	**The 'Red at Hospital' button press triggers time of LAS arrival on the Hospital Based Alert System (HAS) This time is available to the LAS Information Management Team (IM) and input into their reporting process**
Clinical Handover	**Written on to the Patient Report Form (PRF)**	**LAS crew / ED clinician**	**The Patient Record Form (PRF) is scanned by LAS and available to LAS IM and input into their reporting process**
Patient Handover	**'Patient Handover' button press on Hospital Based Alert System (HAS)**	**Acute Trust**	**By using the HAS, the patient handover stage of the patient journey can be accurately captured putting the acute trust in control of this reporting stage. This time is available to the LAS Information Management Team (IM) and input into their reporting process**
Handover to Green	**'Green Available' button press via the LAS MDT**	**LAS Crew**	**This time is available to LAS Information Management Team (IM) and input into their reporting process.**
Administrative Handover	**Patient Administration System (PAS)**	**Acute Trust**	**Patient information is taken from LAS PRF**

10.0 Command and Control Arrangements

It may be necessary dependant upon the circumstances for NHS London to impose command and control arrangements, where it is believed that this is required to resolve a situation. CMS scores will be one of the primary means of judging whether pressures have increased to such an extent, that individual clusters do not have sufficient capacity to cope requiring greater central co-ordination of resource.

In addition, there are other circumstances when it may be deemed necessary to impose command and control, including for example, when there is the potential that a Trust needs to close its ED and to new admissions, through infection outbreak or if critical care capacity reaches the predefined limits set out in the Critcon system – see section eight and Appendix B.

10.1 Objective of Command and Control

These arrangements have been specifically created for the management of pressure surges such as those attributable to adverse weather conditions or significant infection outbreaks which could cause the closure of a Trust to admissions. They are designed to enable pan Cluster or pan London co-ordination of NHS resources, to cope with a significant increase in pressure, through the use of mutual aid, in order to re-balance the urgent care load being placed on the NHS system, to maintain patient safety and access.

Note: Command and control arrangements, in response to pressure surges created by increased activity such as that experienced during either a heat-wave, or winter conditions, differ from those during a major incident, which will be governed by existing Major Incident Policies.

10.2 Cluster Input

Prior to enacting Command and Control, NHS London will endeavour to seek the opinions of Clusters, before a decision is made regarding their initiation. Alternatively, NHS London may consider their use, if they are requested to do so by the Clusters, or the Department of Health.

10.3 Duration

Command and control arrangements will be maintained for as long as it is felt necessary to resolve the situation, with the intention of handing back control to the Clusters as quickly as possible.

10.4 Role of NHS London Performance Directorate and NHS London Gold

At NHS London, the management of winter pressures is the responsibility of the Performance Directorate, supported as required by other teams and Directorates, including Emergency Preparedness and the Medical / Chief Nurse's Directorate. The imposition and management of command and control arrangements will be overseen either by the Director of Performance, or NHS London Gold.

10.5 Information to support decision making

This will be available through the CMS system, regular briefings from the Clusters and twice daily conference calls (see below for suggested attendance), chaired by NHS Gold or Director of Performance. The purpose of these calls will be to support collective decision making and information sharing.

10.6 Conference Call arrangements

Once Command and Control arrangements have been invoked, and following the initial conference call to discuss the situation and identify actions, regular conference calls will initially be scheduled daily at 10.00 and 14.00, but may be varied according to the developing situation. It is likely that calls will also take place over weekends. This will be confirmed at weekday conference calls. Call arrangements, including dial in number and participant codes, will be circulated by Clusters or NHS London (SM01, Performance Directorate Heads of Performance or support staff) to all attendees by email.

Attendee	Responsibility
NHS Gold / NHS London Director of Performance	Run the “incident” on behalf of the NHS in London
NHS SM01	To provide support to NHS Gold as required
NHS01	To be aware of capacity issues in the event of other emergency situations
Cluster Directors of Performance	To provide updates on Cluster actions, give local direction and leadership, oversee implementation of actions required by NHS London, and liaise with neighbouring Clusters regarding potential impacts or actions required
Trust / Borough representatives **(If only 1 or 2 Clusters are affected)**	To report on the current situation, measures taken and further measures planned. To action SHA requirements as appropriate.
Senior Performance Managers in NHS London	To liaise with Clusters outside of calls on progress, additional support required etc
NHS London HCAI Lead	If pressure HCAI linked
LAS Representative	To provide an overview of LAS issues and support to EDs etc.
NHS London Winter Lead	To provide support, advice and brief DH etc
Others by invitation	To provide ad hoc specific advice as required

10.7 Draft Agenda

1. Welcome and introductions.
2. Updates against an agreed range of criteria for each trust / Cluster.
3. LAS update.
4. Update against agreed actions from previous conference call.
5. Look ahead to situation over the next 12 hours and agreement of further actions.
6. Confirmation of next conference call and dial in details.

10.8 Circulation of notes:

- Notes of the meeting will be taken by the Winter Lead or an appropriate member of the Performance Directorate and circulated to all participants, cc’d to:
- NHS London Chief Executive’s Office.
- NHS London Communications.
- NHS London Director of Performance.
- Cluster Chief Executives.
- NHS01.
- NHS London Head of Emergency Preparedness.
- Bordering SHA’s when relevant.

10.9 Briefing of Department of Health / NHS London Chief Executive’s Office

Following the conference calls, briefings will be communicated to DH as appropriate to keep them informed of the progressing situation. This will be particularly necessary in the event of norovirus outbreaks or the need to close A&E departments due to capacity issues.

10.10 Briefing of surrounding Ambulance Services

The London Ambulance Service will liaise with their counterparts regarding re-directions / closures, on behalf of NHS London and the Clusters.

Appendix A Escalation Actions Checklist

The following actions require implementation as early as possible when ED pressure starts to build in order to minimise the need for redirection or closure.

Escalation Activity	Completed
Acute Trust – managing and reducing demand	
• There should be senior clinical leadership (i.e., consultant level) immediately available within the A&E department.	
• All patients to have initial assessment by registrar or consultant grade, to determine appropriateness of attendance or need for admission – re-direction wherever possible and not life threatening, all admissions to be reviewed and agreed by a consultant.	
• Maximisation of alternative care pathways, prior to arrival of patient at A&E, through telephone triage of all GP referrals for admission, led by consultants (e.g., acute physicians, not necessarily ED consultants – see above) to ensure that admission levels are kept to a minimum, including: ○ Advising on more appropriate care pathways (e.g., community based) for specific patients or conditions. ○ Enabling access to diagnostics not normally directly available to primary care. ○ Re-assurance to GPs about continuing to manage patients on “care of the dying” pathways at home, rather than admitting to hospital. ○ Brokering urgent outpatient appointments in other consultant clinics, to avoid unnecessary admissions to hospital etc.	
• GP patients (not calls) sent directly to a ward or Admissions Unit rather than via ED	
Acute Trust - Improving supply	
• All inpatients reviewed early in the morning for discharge by consultants before 10am.	
• “Case conferences” between consultants, medical directors and managerial staff to review all inpatients individually and agree appropriateness of continued stay.	
• Opening of all possible extra escalation capacity, private wards etc.	
• 7 day working to ensure continued flow of discharges, access to therapies and diagnostics etc. Tight performance management of ward TTO requests to pharmacy to reduce delays.	
• Maximisation of use of day case and laparoscopic procedures to maintain elective programme, but reduce requirement for beds.	
• Cancellation of all clinically non urgent electives (including private work) / transfer of work to private sector.	
• Consideration given to cancellation of some urgent electives / move of work to other NHS trusts / transfer of work to private Cluster.	
• Social Services on call managers have been notified of the situation and requested to expedite care packages. Social Services to be in contact several times a day.	
• Inclusion of Social services, Borough’s, LAS etc in A&E bed meetings to ensure actions required are understood by the whole system.	
Acute trust - Improving supply - Support Services	
• Pharmacies have been tasked to prioritise TTOs and ensure that medication is dispatched to wards immediately (or discharge lounge if appropriate).	
• Facilities and porters tasked to prioritise cleaning and transfers.	

• Scheduled maintenance has been reviewed, and if likely to impact on capacity or patient flow, rescheduled.	
• PTS providers are prioritising patient transfers (discharges) above other work.	
Primary / Community Care Actions	
• Maximise discharges from community facilities to increase capacity.	
• Purchase extra capacity in community to enable discharges from acute care / prevent patient admissions. Requires full discussion, clarity and agreement between Boroughs / Trusts prior to the surge to enable swift and responsive spot purchasing where appropriate, supported by locally agreed guidance.	
• Use of community resource (community nursing teams etc) to pull patients from the trusts, if appropriate, including use of intermediate care in-reach to ED and assessment units.	
• Placement of patients “without prejudice” by local Borough’s for those patients out of area where external Borough’s are not expediting repatriation.	
• Early domiciliary visits to assess urgent care needs	
• Provide extra GP resource / more hours to WICs, UCCs etc to deal with primary care presentations, enabling A&E to focus on acute presentations.	
• Provide support by contacting OOH and GPs to ensure that only the very sick are referred for admission, and that where possible, conditions are managed in other settings either at home or in community facilities, with Borough support. E.g., OOH providers to provide increased and more rapid visits to patients left at home by LAS crews.	
• Where an outbreak appears to be occurring ie: D&V in a nursing home use a small nurse/Dr team to visit & treat patients in situ, thus preventing admissions – work in liaison with acute trust if more specialised clinical experience required.	
• Liaise directly with GP practices where referrals increase inappropriately.	
Staffing	
• Cancellation of staff leave, training courses and re-direction of clinical staff from managerial duties to front line care.	
• Plan local accommodation for staff.	
• Consider supporting staff childcare when schools are closed	
• Staff to be redeployed from around the Trust to support the ED as necessary.	
LAS Escalation Actions	
• LAS to use pressure information on CMS etc to help manage vehicle flows away from Trusts under high sustained pressure where possible and consider use of ‘immediate re-direct’ to ease sudden peaks in pressure, before a situation develops which requires a ‘planned’ re-direction.	
• LAS, acute Trusts / Borough’s discuss and agree additional conditions / levels of acuity that can be dealt with via WICS / UCC, to provide more options for LAS crews to convey patients to, other than just A&E.	
Final escalation action:	
• Request to Cluster for re-direction or for closure of the ED.	

Appendix B Critical Care Conditions 'CRITCON'

SECONDARY CARE (including Acute, Specialist & Foundation Trusts etc)	
DEFINITION	**STATUS**
NORMAL - *'Business as usual'*	
• Normal, able to meet all critical care needs, without impact on other services. • Normal winter levels of non-clinical transfer and other 'overflow' activity.	**CRITCON 0**
LOW SURGE - *'Bad winter'*	
• Critical care capacity full. Some non-clinical transfers.	**CRITCON 1**
MEDIUM SURGE - *'Unprecedented'*	
• Critical care capacity full - overflow into quasi-critical care areas (theatre recovery, other acute care areas). High level of non-clinical transfers • Trusts beginning mutual aid and phased reduction of elective work to support critical care, by local decision. • When significant number of Trusts declare CritCon 2, SHA to consider co-ordinated action.	**CRITCON 2**
HIGH SURGE - *'Full stretch'*	
• Expansion into non-critical care areas, and/or use of adult facilities for paediatric critical care. Trust operating at or near maximum physical capacity • Elective surgery and medical procedures minimised to urgent/cancer and lifesaving only. Maximum mutual aid between Trusts, with SHA co-ordination. • The prime imperative in CRITCON 3 is to prevent any single Trust entering CRITCON 4.	**CRITCON 3**
TRIAGE - *'Last resort'*	
• Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation) • This level must only be defined by the SHA – must be reviewed every 12 hours • No Trust to begin triage *unless* all other Trusts and SHAs are at CritCon 3.	**CRITCON 4**
CRITCON 1,2 AND 3 SHOULD BE FURTHER CATEGORISED A OR B	
Adhering to BACCN / ICS staffing recommendations or unit norm	**A**
Staffing below BACCN / ICS staffing recommendations or unit norm	**B**

Appendix C - Useful Numbers

LAS Control Room:	020 7921 5197
LAS Gold Doctor:	Page via LAS control room

The following can be contacted via PageOne on 0844 822 2888 and the call sign below (Trusts will need to leave a name and contact details):

NHS London	NHS01

Cluster Directors on Call:

ELC Cluster:	ELC1
ONEL Cluster:	ONEL1
NWL Cluster:	NWLCP01
SEL Cluster:	SEL1
SWL Cluster:	SWL1
NCL Cluster:	NCL1

Appendix D

Pressure Surge Assurance 2011/12 Flowchart