EPUT Capacity, Flow and Escalation Protocol

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OPERATIONAL POLICY SUMMARY

This protocol serves to support the delivery of a consistent approach across services in EPUT.
Optimising flow throughout the system and ensuring consistent gatekeeping for admission means admitting the right patients, to the right beds, at the right time and for the right duration.
This Policy is informed by national guidance and details the whole system response to an escalation in operational pressures.

The Trust monitors the implementation of and compliance with this operational policy in the following ways;

Services	**Applicable**	**Comments**
Trustwide	**x**	

The Director responsible for monitoring and reviewing this policy is The Executive Director of Mental Health

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CAPACITY, FLOW & ESCALATION

1. INTRODUCTION

1.1 To develop whole system approach to manage the flow, demand and capacity; focusing on patient choice, variations in admission and discharge processes, reducing length of stay and routine data collection to monitor outcomes.

'The term flow describes the progressive movement of products, information and people through a sequence of processes. In simple terms, flow is about uninterrupted movement, like driving steadily along the motorway without interruptions, or being stuck in a traffic jam.

In healthcare, flow is the movement of patients, information or equipment between departments, staff groups or organisations as part of a patient's care pathway.

Improving patient flow is one way of improving health services. Evidence suggests that enhancing patient flow also increases patient safety and is essential to ensuring that patients receive the right care, in the right place, at the right time, all of the time (reliability). However, it is important that patient flow does not improve at the expense of safety or system reliability.'

(Patient Flow, NHS Institute for Innovation and Improvement, 2013)

1.2 **Aims**

This policy serves to support the delivery of a consistent approach and method across all services in EPUT. Optimising flow throughout the system and ensuring consistent gatekeeping for admission means admitting the right patients, to the right beds, at the right time and for the right duration.

The system is complex and multi-factorial. It relies on procedural, structural and behavioural responses from many teams and professionals. A Flow and Capacity working group has been developed that includes Stakeholders views/support and includes patient and carer experience. Priorities of this group are to:

- Analyse the acute care pathway and make proposals to support sustainable management of inpatient beds in the future
- Consider and implement a "live" bed management system to control inpatient capacity across the Trust
- Routine data collection to monitor outcomes – effective, responsive, safe, care, well-led

The above priorities contribute to the following:

- Patients to be treated in the least restrictive environment which is consistent with their clinical and safety needs
- Inpatient admissions and pressure on beds should be reduced
- Equity of access to an alternative to admission for patients and families must be ensured
- Reduce need for sleeping out to other wards
- Reduce use of private beds
- Increase admission avoidance
- Reduce length of stay (LOS), promote safe early discharge.
- To improve communication with patient, carers, GPs and other health and social care services in relation to interventions and care planning and exit from services
- Improved patient and carers experience
- For EPUT to have real time data detailing current capacity, flow and bottlenecks

1.3 **Five Year Forward View**

The Five Year forward view for Mental Health has made the case for transforming mental health care in England. The associated implementation document lays out a blueprint for delivery over the coming years 2020/2021. The common theme within this plan is building capacity within community based services to reduce demand and release capacity from the acute sector and inpatient beds. Whilst in parallel moving the commissioning model for inpatient beds towards more "placed based" approach so that pathways are better aligned. The underlying principles are that delivery models are transformed to support resilient and sustainable services.

1.4 **'Old Problems, New solutions: Improving acute psychiatric care for adults in England' (Feb 2016)** made 12 recommendations including the following:

1) A new waiting time pledge is included in the NHS Constitution from October 2017 of a maximum four hour wait for admission to an acute psychiatric ward for adults **or** acceptance for home-based treatment following assessment.

2) The practice of sending acutely ill patients long distance for non-specialist treatment is phased out nationally by October 2017.

3) Commissioners, providers and clinical networks in each area together undertake a service capacity assessment and improvement programme to ensure that they have an appropriate number of beds as sufficient resources in their Crisis Resolution and home Treatment teams to meet the need for rapid access to high quality care by October 2017.

NHS England and NHS Improvement will hold both commissioners and providers to account for achieving these targets.

Therefore, Patient Flow is a priority to all health providers and integral to the whole system, the following three aspects of flow will provide the model to this policy and EPUT practice

- **Create flow: provide services to meet demand**
- **Flow: reduce variation and improve reliability**
- **Increase responsiveness to problems in patient flow**

2. CREATE FLOW: provide services to meet demand

Flow & Capacity needs to remain 'live' with changing cultures and demographics continuously reviewed. The Flow & Capacity Lead and Senior Service Managers will process map and analyse the system, with support from informatics on a regular basis.

Process Mapping should underpin all service redesign, demand, capacity, activity and queue management, patient flow modelling and service planning.

Once the process map is complete, the next stage is analysing it by considering the following:

- Where are the delays, queues and waiting built into the process?
- Where are the bottlenecks?
- What are the longest delays?

2.1 **Patient Journey:** the efficiency of the whole patient journey is more important than the individual team's efficiencies. Coordinating and understanding is key to supporting patient flow.

Following initial process mapping and analysis the following areas are key:

2.2 **AMHP HUB:**

Referral for a Mental Health Act (MHA) assessment will in all but exceptional circumstances be made following interventions from one of the community teams. MHA assessments should be planned and collaboratively undertaken with service users care team. All least restrictive alternatives must be explored. Planning for assessments should include identification of an appropriate inpatient bed. The AMHP hub will operate to ensure that these standards are complied with, enabling the efficient and effective use of the AMHP services and high quality patient experience.

2.3 **Home Treatment Model- Development of 'Home First' model of acute care.**

- All referrals for admission will have an acute service Gate keeping assessment completed (Band 6 Clinician) to ensure consistency.
- Use of language is important – gatekeeping for home treatment must always come before consideration of gatekeeping for admission.
- Home treatment criteria to include intervention as an alternative to admission.

- Home Treatment Team to attend clinical meetings and ward reviews on a regular basis.
- All Home Treatment Teams to ensure **all** inpatients prominently displayed
- All informal patients to be assessed by the Home Treatment team within 72 hours of admission and plan to facilitate discharge implemented.
- Home Treatment teams will support leave plans from wards, thereby promoting earliest safe discharge.

2.4 FUNCTIONAL MODEL (Inpatient):

- All referrals are admitted for an assessment period and reviewed within a maximum of 72hours by Consultant Psychiatrist in Ward Review (x3 ward reviews per week – functional model).
- All admissions are purposeful with agreed goals for admission.
- Daily Safer Staffing and Bed Management Situation Reports completed and communicated in line with operational Pressures Escalation Level (OPEL) structure.
- Roles of Bed Management and Discharge Coordination defined.
- Establish centralised Bed Management team.
- Discharge Coordinators to be established and Job descriptions aligned: Emphasis of the role is to ensure smooth transfer of care from acute admission wards into community services at the earliest opportunity. To support clinical manager/matrons in moving forward patients experiencing delayed transfer of care.
- Develop a whole system approach to flow and capacity. Regular monthly meeting to be established with participation and sign up from Inpatient and Community Operational and Clinical managers, Consultant and Clinical leads, Inpatient Discharge Coordinators and Home First Discharge lead. To ensure compliance from different service elements, ensuring an effective, safe, responsive, caring, well-led service.
- Whole system sign-up to a Weekly Extraordinary SitRep to be embedded. Weekly inpatient and community call to escalate actual and potential delays in transfer of care. Membership to include senior representation and participation from each community and inpatient team, discharge coordinators and social work consultants. Emphasis of the call is to identify barriers to discharge and agree joined up actions to address and resolve.
- Joined up High Intensity Users group to be established in each locality. Membership to included inpatient and community clinical Managers and consultants. Forum established as a forum to review the plan of intervention for all frequent and high intensity users of mental health services in the locality. To ensure comprehensive and joined up care plans are in place across service lines and pathways. To act as a consultation forum for clinicians managing very high risk patients. To identify patterns and themes which may inform strategic service development and delivery.

2.5 COMMUNITY TEAMS

Philosophy and Purpose

The overarching philosophy within the community services is that of a person centred recovery model enabling service users to receive care as close to home as is practicable and of a nature and type which accords with their individualised outcome based care plans. Within this model the role and importance of carers, family members and informal networks is equally acknowledged and where practicable supported to maintain their caring role. It is fully acknowledged that this support element is crucial in supporting “out of hospital” care for those who use our services.

Hospital admission should therefore only be considered when the assessment and/or treatment needs of an individual cannot be delivered within this community context for reasons of complexity and or risk or can only be delivered subject to compulsion under a section of the Mental Health Act.

All admissions must therefore be planned and purposeful, with all members of the MDT team having a shared clarity as to purpose and proposed outcome. This plan should also wherever practicable include proposed intervention type and projected length of stay.

Home Treatment – Home First

All admissions will be “gate kept” this process will involve assessment and formulation of a treatment and support plan. This formulation will be either community or inpatient based in accordance with the principles as outlined above. The assessment will be accepted by the receiving team in accordance with the Trusted assessor model and where the assessment indicates an inpatient admission will be used as the working care/treatment plan for the initial stages of the admission

Where the service user is known to the community team referrals will only be accepted following an up to date review by that team which has been undertaken shortly before referral and that the review relates to the current episode of concern.

All admissions will be supported by a comprehensive assessment which will be inclusive of social circumstances. Any accommodation and employment needs will be identified enabling any such needs to be addressed from the point of admission and prevent avoidable delays in discharge.

All those admitted to an inpatient unit will have a care co-ordinator allocated within 24 hours of admission.

All those who are admitted to the adult wards should have a projected discharge date (EDD) which the home treatment team will monitor and support.

The home treatment team will engage with the inpatient services including the bed management team on a daily basis. The frequency of interaction will be determined by the demands and needs of the patient group in that moment but will be not less

than twice a day.

The home treatment team will actively identify with the inpatient Multi-Disciplinary Teams including Discharge Coordinators (MDT) those service users ready for supported discharge and facilitate such over a 7 day period.

The efficient and effective operation of the home treatment service is dependent on flow through its own pathway. The Zoning Model will be the operating model to support this, only those service users who are within the (Red Zone) or those recently moved to amber will be seen within the HTT service. The home treatment service will also utilise service user led outcome based care plans to support step-down.

It is recognised to facilitate this flow; capacity necessarily has to be created within the community pathways. The community pathways will also adopt flow and capacity processes and procedures and will utilise the following tools; The Zoning model and a case load capacity monitoring dashboard, both these tools will support managers managing service demand these tools will not be used exclusively and the increased use of service user led outcome based care plans will additionally support discharge and step-down.

Multi Agency Working

Creating flow and capacity is dependent upon multi-agency working – the longer term teams have employment advisors within them to support service users to both retain and find employment a significant factor for sustained recovery. Formal liaison with Housing, Police, Ambulance and Local Authority services facilitates both multi-agency planning to enable service users to remain in their own home and to facilitate early discharge. Whilst essential to flow it is recognised that effectiveness is consequent upon the formulation of good collaborative partnerships and the priorities and demands of these services. Regular interface meetings will be held to facilitate these relationships.

Sustainability

Training at the point of implementation and regular updates is essential to maintaining “grip” in attaining successful outcomes. The policy will therefore be supported by a training package aimed at both internal staff and system partners. The purpose of the training will be to inform re objectives and outcomes for positive patient outcomes and guidance as to process.

3. FLOW: reduce variation and improve reliability

In order to achieve timely decision making with the necessary information available the following principles are to be embedded:

3.1 **Team Approach** – Pooling similar work and sharing staff resources can positively impact upon variation in waiting times, capacity and resources. Proactive management of staff rosters, team organisation and caseload management are all central to a whole team approach.

3.2 **7 day Service** – Delivering a responsive, 7 day Service which improves the flow of people through the acute mental health services and across the interface between health and social care.

3.3 **IT infrastructure and Systems to Monitor Patient Flow**–Use of electronic patient flow systems (Red2Green, see Appendix 2). Providing real time data enable teams to identify and manage barriers and potential difficulties i.e. Access & Assessment Tracker, Dashboards

3.4 **Gatekeeping** – Consistent face to face Gatekeeping by experienced clinicians who are able to collaboratively explore an intensive home treatment intervention as an alternative to inpatient admission. This robust Gatekeeping supports the trusted assessor ensuring purposeful admission over the 24 hour period. There is recognition that with increased successful gatekeeping and admission avoidance resources need to be able to meet demand. Good gatekeeping will increase demand on Home Treatment Teams.

3.5 **Discharge Planning**

- **Discharge Planning** is to be discussed with service users from the point of admission and an appropriate strategy to support safe discharge identified within 72 hours of admission. This will be carried out as part of a structured review of care needs and in line with the Care Program Approach (2008). The review will consider the package of care required, the presenting risks, and the identification of an appropriate clinical strategy to support a planned discharge. The SAFER patient flow bundle should be applied to support timely discharge.

- **Timely Discharge/Transfer from Acute Inpatient Wards.** Once a patient is medically fit for discharge it is not suitable that they remain in hospital. Prolonged and unnecessary inpatient admission can negatively impact upon health outcomes. Patients do not have the right to remain in hospital longer than required. If a patients preferred care placement or package is not available once the patient is medically fit for discharge an available alternative which is appropriate to their health and social care needs will be offered on an interim basis. The patient will be discharged to the interim placement whilst they await the availability of their preferred choice (see Appendix 5 for Choice Letters).

- **Multi - Disciplinary / Multi - Agency Discharge Planning** (inc. voluntary sector): Joined up planning will promote effective discharge and positive outcomes for the Patient. Where appropriate joint assessments with for example Essex County Council or New Haven are to be facilitated. Where patient need indicates, presentation to external panels such as continuing healthcare panel or joint referral panel is to be completed.

- **Complex High Risk Cases –** The High Intensity Users group whose membership includes inpatient and community clinical managers and consultants has been established as a forum to review the plan of intervention for frequent and high intensity users of mental health services in each locality. The focus of this group is to ensure comprehensive and joined up care plans are in place

across service lines and pathways. To act as a consultation forum for clinicians managing very high risk patients, particularly around transfer of care from hospital. To identify patterns and themes that may inform strategic service development and delivery.

- **Delayed Transfers of Care / Length of Stay (LOS)** - Whole system sign-up to a Weekly Extraordinary SitRep to be embedded. Weekly inpatient and community call to escalate actual and potential delays in transfer of care. Membership to include senior representation and participation from each community and inpatient team, discharge coordinators, social work consultants, health and social care commissioning teams. Emphasis of the call is to identify barriers to discharge and agree joined up actions to address and resolve. Action Log to be completed and individuals to be accountable for ensuring actions identified completed.

- Social work consultants will offer support and advise to teams where patients are awaiting Adult social care intervention. Validation of the social care Delayed Transfers of Care completed. (See Appendix 12)

- All Operational and Clinical Managers to support Ward Managers and Discharge Coordinators with resolving delays in:

    - Completion of Mental Health Nursing Needs Assessments
    - Completion of Continuing HealthCare documentation – DST checklist and tool
    - Preparation of reports and presentations to S.117, SDS/CPB and CHC panels
    - Ensuring Care Act compliance
    - Ensuring compliance with Mental Health Act and Mental Capacity Act requirements.
    - Safeguarding
    - Complex cases involving multi agencies/services
    - Choice and accommodation issues for patients and carers

4. Increase responsiveness to problems in patient flow

Right patients, to the right beds, at the right time and for the right duration.

4.1 BED MANAGEMENT & BED ESCALATION (adult & older adult functional wards)

This policy incorporates the SAFER Mental Health Patient Flow Bundle, which is a combined set of simple principles for mental health inpatient wards to improve patient flow and prevent unnecessary delays for patients (see Appendix 1). The Patient Flow Bundle draws together five principles which when delivered together, support the smooth management of a patients care and timely discharge. This enables teams to ensure discharge planning is happening in parallel to the

treatment/care plan. The Red and Green Bed Days (NHSI, 2016) management system (see Appendix 2) is also used to enhance the patient experience and reduce internal and external delays as part of the SAFER patient flow bundle.

An important principle of the patient flow bundle is the Daily Trust-wide SITREP (see Appendix 3) that supports bed management and identifies the 'live' demand on the whole system:

- how many MHA assessments are happening across the trust, including Health Based Place of Safety (HBPoS)
- how many crisis assessments are happening in A&E/EAU departments
- Home Treatment/Gatekeeping Activity

All information indicated on template (Appendix 3) is collated from across the Trust for the SITREP calls. Calls are chaired by the Operational Service Managers (or delegate) and participants include Clinical Manager/Matrons, Ward Managers, & Clinical Manager/Matron Home Treatment, Discharge Coordinators and Bed Management Team.

The Daily SITREP calls identify:

- Capacity Problems / Bottlenecks
- Predicts bed capacity
- Provides out of hours contingency plans
- Highlights delayed transfers of care
- Consistent gatekeeping with clear reason for admission
- Records admissions to private sector, supporting care co-ordination and discharge planning
- Facilitating recall to trust beds at earliest opportunity
- Proactive instead of reactive actions

At the end of the SITREP consideration is given to the trigger points as identified in the Operational Pressures Escalation Level (OPEL, Appendix 4) and OPEL Status recorded by the Chair. OPEL Status is communicated with the whole system. It is escalated to Directors within EPUT and shared locally with the 7 Clinical Commissioning groups and 5 Acute Trusts.

OPEL (Operational Pressures Escalation Levels Framework, Oct 2016) is an overarching framework/single national system that brings consistency to local escalation alert levels that improves management of system–wide escalation and encourages wider cooperation.

Each level of escalation has identified actions to be implemented with the focus on providing flow and a safe whole system status. See below.

Please note that specialist wards adhere to NHS England bed management strategy supported by NHS England placement leads.

4.2 Roles and Responsibilities for Patient Flow

The following outlines the main roles and responsibilities for patient flow within EPUT:

- Chief Executive, Director of Mental Health and Director of Nursing have overall responsibility for patient flow within the Trust
- The Operational and Clinical Management Team for Community and Inpatient Directorate are responsible for the day to day management of patient flow
- The Ward Manager is to support patient flow, focussing on future requirements such as planning for tomorrow's discharges and to escalate any barriers regarding flow and discharge. To highlight delayed discharges and support Matrons with patient flow
- Discharge Coordinators and Matrons/Clinical Managers have responsibility for proactively actioning issues identified within their areas of responsibility and for providing support and advice to the ward teams to support them in the management of effective discharge
- Home Treatment Teams have the responsibility for the face to face gate keeping of all possible admissions on a daily basis. This role also includes identifying alternative treatment and care to inpatient admission. Proactively providing Home Treatment and seeking to promote earliest safe discharge
- Discharge Coordinators are responsible for identifying patients whose discharges are delayed or require input to support timely discharges and support ward managers to enable safe and effective patient discharges
- Matron/Ward Manager/Bleep holder is responsible for ensuring that accurate, timely information about capacity is communicated with the bed management team and that the SITREP template and Portal is kept up to date and their staff are aware of and working to this policy
- Named Nurses/Care Co-ordinators for each patient are responsible for proactive management of individual arrangements and for escalating issues as appropriate. Ensuring links are maintained between ward and community care to expedite and support timely discharge.
- Clinical Director is responsible for ensuring their lead Consultants and teams are aware of and adhere to this policy. At Operational Pressures Escalation Level (OPEL) level 3 alert the Clinical Director is responsible for obtaining full briefings on Trust Capacity and for identifying any areas for intervention or where extra resource is required.
- Ward Consultant and Medical Teams are responsible for timely review of patients and for ensuring the patient records are updated regularly with expected discharge date (EDD) and clear medical discharge/management plans recorded

Bed Management 24/7

- The Bed Management teams operate 9am – 5pm Monday to Friday.
- The teams will be present on all Situation Report (SitRep) Calls and lead on collating information regarding patient assessment and admission from clinical teams and AMHP Hub
- Ward teams are to inform bed Management teams of all patient discharge and leave to facilitate smooth flow of patients.

- The bed team will adhere to national guidance and facilitate admissions for those patients who have a GP in the EPUT Locality. They will lead on Communication and Liaison with neighbouring Trusts and CCG's with reference to out of area patients. Escalation to Senior Managers, Contracts Dept. and Commissioning Teams may be required.
- Once Senior authorisation agreed, the Bed Management team are responsible for collating the accurate information regarding all patients for whom an out of area admission is sought. Bed Management team will also ensure IPPA documentation for funding requests are up to date.
- A daily handover of all bed demand and capacity will be emailed to Operational and Clinical manager/Matrons; Ward managers and Discharge Coordinators. On Call Managers will also receive handover at the end of each day (Appendix 10)
- Clinical Managers and Ward Managers are to share this information with the identified Bleep holder/Site coordinator in their locality.
- Bed Management passes to the Locality Bleep holder/ Site Coordinator from 5pm until 9am. Good written handover from site coordinator to bed management team to be forwarded each morning (Appendix 11)
- Following guidance for On-Call Managers included in daily handover:

Guidance for On-Call

***Should overnight mental health crisis admission be required the bed occupancy/availability detail (above) will indicate location of available EPUT Beds.**

***Bleep Holder/Site officer in each locality to liaise and identify suitable bed internally for admission. Night bed Management handover to detail admission and be forwarded to epunft.northbedmanagement@nhs.net – Opel 1/2**

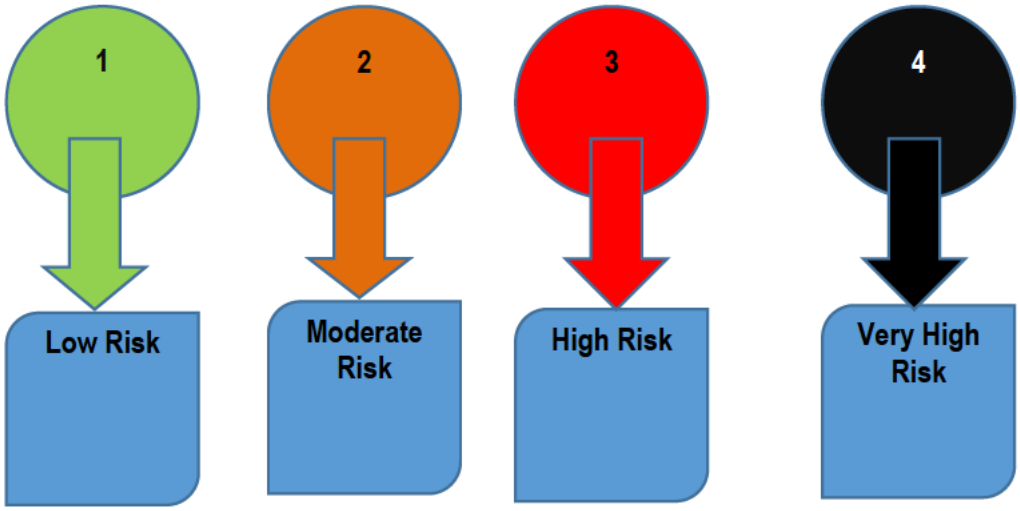
***Should no suitable bed be identified Site officer/Bleep holder to liaise with locality On Call Manager to explore options for use of leave beds/functional bed stock – Opel 3**

*** Use of private out of area beds for admission to be authorised by Senior On Call Manager and notification to be forwarded to epunft.northbedmanagement@nhs.net with copy to Associate Director I/S Opel ¾**

4.3 **Escalation Alert Levels**

The following alert levels will be used to help communicate the escalation status and guide people to the correct actions. This is based on the Operational Pressures Escalation Level (OPEL) number scale that reflects the level of risk to patient safety and the extent to which patient experience may be compromised

Escalation Alert Levels



Patient Safety and Experience: Escalation of the EPUT Alert level is informed by the following:

- **Flow & Capacity – Admissions and discharges.**
- **Activity - Ward activity and observation levels.**
- **Staffing levels - Adequate safe staffing, training compliance.**

TRIGGERS FOR ALERT LEVELS

4.4 Must trigger 1 or more of the below points to trigger alert level

- Bed occupancy at 90% or less with beds available in all areas – specialist units, Older Adult/dementia, Adult & PICU
- There is capacity for the expected emergency and elective demand
- Staffing is sufficient

→ **Alert level OPEL 1**

- Bed occupancy 90 to 99 %
- Insufficient discharges to create capacity for the expected crisis
- Lower levels of staff available but sufficient to maintain services
- Infection control status
- No beds available in the following areas but patients have been identified who could transfer out of the ward or make capacity

→ **Alert level OPEL 2**

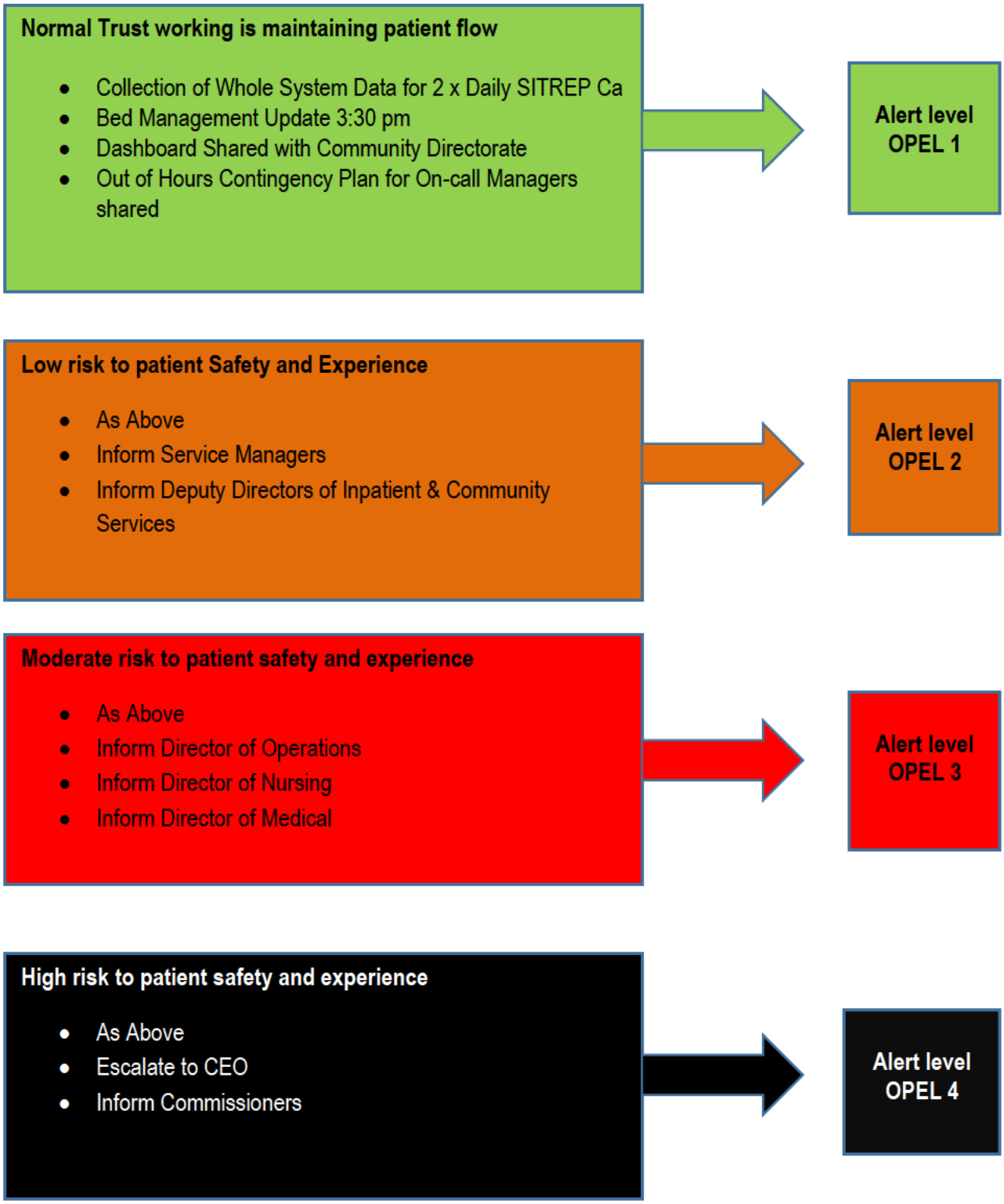
- Actions at Alert level 2 have failed to deliver capacity
- Insufficient discharges to create capacity for the expected crisis activity.
- Significant unexpected reduced staffing numbers. There is no available with expectation of risk share beds

→ **Alert level OPEL 3**

- Actions at Alert level 3 have failed to deliver capacity
- The number of discharges is insufficient to create capacity for the expected emergency and elective activity despite escalation beds being utilised
- We are looking at other NHS and private providers

→ **Alert level OPEL 4**

4.5 COMMUNICATION RESPONSIBILITIES



4.6 ACTIONS

Bed Manager/Bleep Holder – As Alert 1. Liaise with other Trust Bed Managers/Private Providers, Community & HTTs.
Named Nurses – As Alert 1, ensure any issues are escalated appropriately
Ward Manager/Leader – Responsible for communicating situations and actions required with your teams. Ensure all patients are considered for early discharge and actions required to promote flow are clearly communicated and actioned.
Matron/Clinical Managers – As Alert 1. Escalate to Operational Service Managers. Liaise with other Clinical Managers. Supporting staff in their response
Medical Teams – As Alert 1
Home Treatment - As Alert 1. Escalate to HT Service Manager

→ **Alert level OPEL 2**

Bed Manager/Bleep Holder – As Alert 1 & 2. Support Consultants/Ward Managers in identifying patients suitable for leave/HTT.
Named Nurses – As Alert 1, ensure any issues are escalated appropriately
Ward Manager/Leader – Responsible for communicating situations and actions required with your teams.
Matron/Clinical Managers – As Alert 1 & 2. Communicate information on alert status and actions to staff, Community peers, Service Managers and Directors.
Medical Teams – As Alert 1 & 2
Home Treatment - As Alert 1 & 2

→ **Alert level OPEL 3**

Bed Manager/Bleep Holder – As Alert 1,2 &3. Continually review capacity and work closely with senior management and medical team.
Named Nurses – As Alert 1, ensure any issues are escalated appropriately
Ward Manager/Leader – Responsible for communicating situations and actions required with your teams.
Matron/Clinical Managers – As Alert 1, 2, 3.
Medical Teams – As Alert 1, 2. Consultants join bed management meeting at 4pm to discuss **out of hours contingency plan.**
Home Treatment - As Alert 1, 2 & 3

→ **Alert level OPEL 4**

4.7 Red to Green Week

How does Red to Green Week work?

Red to Green Week will take place during peak times.

It is a week when all staff will focus on achieving the best operational performance and providing the best standard of care for our patients. In order to know how we are doing at any point in the week, we will measure our performance regularly each day.

The standards of good practice we will work to during Red to Green Week, are the same standards that we work to now, but with additional focus on the national **SAFER** bundle initiative and greater intensive support from system colleagues and leadership teams across the Trust. We will focus on making sure that we identify and fix issues as they occur across the week. (See Appendix 1)

Ward Information packs will be distributed prior to an intensive week.