Agenda Item: 12

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

REPORT TO THE TRUST BOARD OF DIRECTORS

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Denise Smith Chief Operating Officer	Decision	✓	High	Med	Low
	Discussion		✓		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Sarah Jones, Deputy Chief Operating Officer	Strategic				
	Operational	✓			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	Responsive				

Meeting Date: 7 April 2020

Report Title: Full Capacity Protocol

Purpose:

This paper sets out the revised Full Capacity Protocol for the Trust.

Summary:

The Full Capacity Protocol sets out the rules, policies and procedures for responding to periods of increased pressure on available services at the Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust, this reflects national best practice and guidance.

The Full Capacity Protocol outlines the Trust's approach to categorising the severity of operational pressures and the mitigating actions that should be taken at each level of pressure. Capacity Protocol.

Financial Implications / Efficiency Savings: None as a direct result of this report

Risk Assessment (cross-reference with Risk Register where appropriate):

Strategic / External	Operational / Organisational	Financial	Clinical	Legal / Regulatory	Reputation / Patient Experience
	✓				

Trust Board is asked to approve the Full Capacity Protocol

QUEEN ELIZABETH HOSPITAL KING'S LYNN ESCALATION AND FULL CAPACITY HANDBOOK

Primary Intranet Location	Version Number	Next Review Year	Next Review Month
	1.0	2021	January

Current Author	Corwen Hull
Author's Job Title	Head of Patient Flow
Department	Corporate
Approved by	Senior Leadership Team
Date	March 2020
Ratifying / Monitoring Committee	Senior Leadership Team
Ratified Date	March 2020
Owner	Denise Smith
Owner's Job Title	Chief Operating Officer

It is the responsibility of the staff member accessing this document to ensure that they are always reading the most up to date version - this will always be the version on the intranet

Related Policies and Procedures	Queen Elizabeth Hospital King's Lynn Capacity & Flow Handbook *See appendix for full list of linked documents and policies*

Stakeholders	1. All staff who have a role to play in Capacity and Flow management across the Trust, including (but not limited to): • Capacity & Flow Team • Executive Team • Divisional Senior Leadership Teams • All medical staff • All nursing staff • All AHP staff groups • Porters • Estates and facilities • Transport service providers • Integrated Discharge Team 2. Patient safety and clinical governance teams 3. Patients and their carers and families

Version	Date	Author	Author's Job Title	Changes
V1	31/01/2020	Corwen Hull	Head of Patient Flow	Initial development
V2				

Summary of the guidance

This document sets out the rules, policies and procedures for responding to periods of increased pressure on available services at the Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust. Much of this document draws on national best practice and guidance from NHSE and NHSI. It outlines the Trust's approach to categorising the severity of operational pressures, and the mitigating actions that should be taken at each level of pressure. The document includes both the Trust's standard escalation processes, as well as the organisation's Full Capacity Protocol.

Key words to assist the search engine

Capacity

Flow

Emergency Department

A & E

Site Team

Bed management

Escalation
Reporting
Urgent and Emergency Care
Full Capacity Protocol
Critical Incident
OPEL
Ambulance divert
Escalation ward
Electives cancellation

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1 Equality Impact Assessment

1. INTRODUCTION

Proactive management of patient flow is an imperative for all NHS hospitals. For those that provide acute care, such as the Queen Elizabeth Hospital, this means ensuring a safe, effective emergency service whilst maintaining elective activity using the resources available across the site.

All NHS hospitals will experience fluctuations in demand relative to available capacity, whether that be hour-by-hour, day-by-day or over more extended periods. Whilst smaller fluctuations can be managed as part of the day-to-day or 'business as usual' processes and procedures in the hospital, significant increases in demand call for a standardised, coordinated and consistent response from across the Trust. Through the unerring application of a set of rules, policies and procedures around escalation, QEHKL can make sure that high standards of patient experience and patient safety are maintained for all users of the hospital's service through such periods of high demand.

This document sets out the rules, policies and procedures for responding to periods of increased pressure on available services at the Queen Elizabeth Hospital NHS Foundation Trust. Much of this document draws on national best practice and guidance from NHSE and NHSI. It outlines the Trust's approach to categorising the severity of operational pressures (section 5), and the mitigating actions that should be taken at each level of pressure (section 0). The document includes both these standard escalation processes, as well as the organisation's Full Capacity Protocol (section 0). Detailed procedures for specific escalation actions are included in section 8, whilst useful templates and additional guidance are given in section 9. Finally, the escalation procedures for the Trust's Children's and Maternity services are included in full, for reference, in sections 10 and 11.

This document covers all operational areas within the Trust including Medicine, Surgery and Maternity (Women and Children). It should be read in conjunction with the *Queen Elizabeth Hospital King's Lynn Capacity and Flow Handbook* which describes the rules, policies and procedures for 'business as usual' management of capacity and patient flow at the Trust.

1.1 Superseded documents

In the development of this handbook, various existing Trust protocols and policies have been used as starting source material. In most cases, the content of these existing Trust documents has been updated to reflect current practice, and as such the old versions of the protocols and policies are superseded. The table below outlines the old documents which have been superseded, and the section of this handbook where this content can now be found:

Old Trust document, now superseded	Relevant section of this handbook
System Wide Emergency Flow Escalation Standards 2016 09	Section 5.2 and 0
Full Capacity Protocol including ambulance handover delays Dec19	Section 0 and 8.6 – 8.14
Standard Operational Policy - Leverington Escalation Short Stay Ward V7 2019 10	Section 8.1

2. PURPOSE and SCOPE

The purpose of this document is to provide clear and easy-to-follow guidance on the management of capacity and flow within QEH when services are under pressure. Such circumstances may arise due to:

- a prolonged or sudden increase in demand
- loss of capacity i.e., closure of ward areas as a result of an outbreak
- a high level of acutely unwell patients in the trust reducing normal discharge rates

It is intended to be a practical document, so that all relevant staff can understand and execute their role successfully and consistently, reducing unwarranted variation in escalation response across the Trust.

This document has been developed by drawing together and updating a number of pre-existing QEH policies and protocols, as well as integrating best practice examples from other Trusts, NHSE and NHSI. It therefore supersedes various old QEH policies and protocols, consolidating all the relevant information from these documents into a single, user-friendly guide.

Although not intended to be a fully comprehensive guide to every operational element of QEH, this document does provide enough depth and breadth on the fundamental elements of escalation at the Trust for staff to perform their duties.

In ensuring the rules, responsibilities and roles of escalation are well-understood and followed within QEH, this document also aims to achieve the following outcomes:

- The level of pressure on Trust services is measured in a clear, standardised way at all times and is appropriately communicated clearly to all relevant parties, both internally and externally
- The Trust acts proactively, rather than reactively, in response to periods of increased operational pressure, with a coordinated response enabled by defined responsibilities and clear, concise actions
- Increases in demand relative to available capacity are responded to rapidly, with the Trust returning to a normal operating level at the earliest opportunity
- When appropriate, non-essential activities are cancelled or postponed allowing resources to be redeployed to priority areas
- In response to periods of high pressure, patient flow through the emergency department is increased, freeing capacity and increasing the ability to offload ambulances

3. DEFINITIONS

Term	Definition
A&E	Accident and Emergency department
ACN	Associate Chief Nurse (sometimes referred to as divisional chief nurse or divisional head of nursing)
ADO	Associate Director of Operations (sometimes referred to as divisional general manager)
AEC	Ambulatory emergency care unit
AHP	Allied health professional
ALS	Advanced life support
AMD	Associate Medical Director
AZ	Assessment Zone
BAU	Business as usual
Bed meetings	See *Capacity and Flow meetings*
Bronze command	The Operational level of the Trust's command-and-control hierarchy for management of capacity and flow. Bronze command sits below both Silver and Gold commands. This role is fulfilled by the Clinical Site Manager. Note that this role is not the same as the "Divisional Bronze".
Business continuity incident	An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.
Capacity and Flow meetings	Regular meetings taking place in the Trust Ops Centre at fixed points throughout the day, used for coordinating patient flow within the hospital. These are sometimes referred to as 'bed meetings', 'site meetings' or 'ops meetings'.
CCG	Clinical Commissioning Group Where "The CCG" is referred to, this normally corresponds to West Norfolk Clinical Commissioning Group
CCOT	Critical care outreach team
CD	Clinical Director
CGA	Comprehensive Geriatric Assessment
COO	Chief Operating Officer
Critical incident	Any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe, requiring special measures and support from other agencies, to restore normal operating functions. This could include a severe surge in demand for emergency care within an NHS trust – where the adverse impact is mostly localised to the organisation.
DCC	Direct clinical care activities – the class of activities in a consultant job plan that involves direct clinical work
DCOO	Deputy Chief Operating Officer
DGH	District General Hospital
DGM	Divisional General Manager
Divisional Bronze	The nominated contact within each division who acts as one of the first lines of escalation for issues faced by front-line teams (mostly for

	issues that can be resolved internally within the division). The divisional bronze role is assigned during working hours only (08:00-17:00 Mon-Fri) from a roster of senior leaders in the division. Note, this is not to be confused with "Bronze command".
DLT	Divisional Leadership Team
DNM	Duty Nurse Manager
DTA	Decision to admit
DTOC	Delayed transfer of care
ED	Emergency Department
EDD	Expected date of discharge
EEAST or EEAS	East of England Ambulance Service NHS Trust
EMAST or EMAS	East Midlands Ambulance Service NHS Trust
FCP	Full Capacity Protocol
Gold command	The Strategic (and highest) level of the Trust's command-and-control hierarchy for the management of capacity and flow. This role is fulfilled by the Chief Operating Officer during working hours, or the 'Gold-on-call' outside of working hours.
HASU	Hyper-acute stroke unit
HCA	Healthcare assistant
IDT	Integrated discharge team
IPACS	Infection Prevention and Control Service
Major incident	Any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For example: multi-vehicle motorway crashes, infectious disease outbreak.
MAU	Medical admissions unit
NIC	Nurse-in-charge
NNUH or NNUHFT	Norfolk and Norwich University Hospitals NHS Foundation Trust
OOH	Out of (working) hours
OPEL	Operational Pressures Escalation Level – a national framework for categorising, recording and reporting operational pressures by parts of a healthcare system. Comprised of four levels from OPEL 1 (least acute) to OPEL 4 (most acute). Higher levels typically require responses from system partners.
Ops centre	Trust Operations Centre, the venue of the capacity and flow meetings
Ops meetings	See *Capacity and Flow meetings*
PAU	Paediatric Assessment Unit
PICU	Paediatric Intensive Care Unit
QEHKL or QEH	Queen Elizabeth Hospital NHS Foundation Trust, King's Lynn
RN	Registered nurse
SAU	Surgical assessment unit
SDEC	Same day emergency care
SERU	Surgical Extended Recovery Unit
Silver command	The Tactical level of the Trust's command-and-control hierarchy for management of capacity and flow. Silver command sits below Gold command, and above Bronze command. This role is fulfilled by the designated Silver-on-call – as determined by the relevant rota.
Site meetings	See *Capacity and Flow meetings*
SPA	Supporting professional activities – the class of activities in a

	consultant job plan comprising their non-clinical work (as opposed to "DCC" or "direct clinical care"). For example, SPA includes research, audit, teaching and continuing professional development.
SpR	Specialist Registrar
T&O	Trauma and orthopaedics
TCI	To come in
TTO/TTA	To take out/to take away – prescription for medications for patients to take with them on discharge from hospital
UEC	Urgent and emergency care
W&C	Women & Children's Division
WNCCG	West Norfolk Clinical Commissioning Group

4. RESPONSIBILITIES IN RELATION TO THIS DOCUMENT

This document is intended to be read, understood and followed by all staff members who are involved in the management of capacity and flow at the Trust. The specific responsibilities for certain roles and staff groups in relation to *this document* are outlined below. Note that the responsibilities, tasks and actions for certain roles *in relation to specific escalation levels and activities* are described elsewhere in this document.

Chief Operating Officer

- The Chief Operating Officer has ultimate responsibility for the formulation, maintenance and implementation of the Trust's Escalation and Full Capacity policies
- The COO should be familiar with the content of the entire document, and proactive in ensuring compliance with the standards and procedures contained within it
- Where appropriate, the COO should coordinate the review, update and re-issuing of parts of this document – this is likely to include delegating this task to those with expertise and knowledge in the relevant areas

Other members of the Trust Executive Team

- All other members of the Trust's Executive Team should be aware of this policy, and endorse its use
- Where appropriate, this will include ensuring staff members within their professional group or area of responsibility understand and are complying with the policy e.g. the Medical Director ensuring procedures are followed by all medical teams

Divisional Leadership Teams

- The Divisional triumvirates have a responsibility to ensure that the relevant parts of this document are being followed within their Division
- As such, the Divisional Leadership Teams should be familiar with the content of this policy, and endorse its use within the Division
- Where appropriate, this will include ensuring staff members within their professional group or area of responsibility understand and are complying with the policy e.g. the Divisional Medical Director ensuring procedures are followed by all medical teams

Gold, Silver and Bronze roles

- Any individual who performs the Gold, Silver or Bronze role as part of their regular duties should be familiar and comfortable with the detail of all sections of this document
- In performing their role, they should comply with the standards and procedures outlined in this document, and ensure that others are doing the same

Clinical Site Manager

- Any staff member who performs the Clinical Site Manager role should be familiar and comfortable with the detail of all sections of this document
- They should also contribute to the formulation, maintenance and implementation of the policy, ensuring awareness and compliance amongst relevant staff members (both within, and outside of the Capacity and Flow Team)

Bed Managers

- Bed Managers should be familiar and comfortable with the detail of the relevant sections of this document
- In fulfilling their role, Bed Managers should comply with the policies and procedures outlined within the document, and only deviate from them if this has been discussed and agreed with a senior member of the Capacity and Flow Team

Doctors, Nurses and Allied Health Professionals

- All staff involved in the direct provision of care to patients in the Trust should be aware of this document, and familiar with the sections that are relevant to their role
- All doctors, nurses and AHPs should comply with the relevant policies and procedures outlined in this document

The Trust Communications team

- The Trust Communications team should be familiar with the content and usage of this document, to enable them to support in the dissemination of key messages and associated engagement activities

All other staff

- Any other staff member whose role might impact on capacity and flow within the Trust (e.g. porters, ward clerks) should be aware of this document, and familiar with the sections that are relevant to their role
- Where relevant, all staff should comply with the policies and procedures outlined in this document

Agenda Item: 12

5. DEFINITION AND DIAGNOSIS OF ESCALATION LEVEL

Summary of the guidance

This section provides an overview of the Trust's approach to managing increases in demand (relative to available capacity) for General and Acute services, including a clarification of the meaning of 'escalation' within this context. It provides an overview of the Trust's escalation triggers (or 'OPEL triggers') and the approach to categorising the level of operational pressures within the Trust.

For guidance on the specific actions to be taken at each OPEL level, see Section 0.

5.1 Overview of escalation at QEHKL

In order to protect the safety of its patients and maintain a high quality of care, the Queen Elizabeth Hospital NHS Foundation Trust needs to be able to plan for and respond to changes in demand and available capacity, as well as various other types of incidents and emergencies.

This document considers the management of increases in demand for services ("surge management") as well as decreases in available capacity for services (e.g., following closure of beds for infection control reasons). The policies and procedures described here incorporate the setting of escalation statuses, the trigger points and the action plans for the whole Trust to be able to provide a safe emergency service whilst ensuring the maintenance of priority elective activity.

The monitoring of, and response to, increases in demand for General and Acute services at the Trust is managed centrally via the ***Operational Pressures Escalation Levels (OPEL) framework***. This includes expectations for the mitigating actions that must be taken at each level of escalation. More detail on the different OPEL statuses is provided in Section 5.2, and the mitigating actions are described in Section 0. In circumstances of extremely high demand or very limited capacity, the Trust may choose to activate its ***Full Capacity Protocol*** – which is included in Section 0.

In addition to these Trust-wide responses, individual services in the hospital may each operate their own local escalation procedures. The most prominent examples of these are for the Trust's Children's and Maternity services, who generally manage their demand and capacity independently of the rest of the hospital. More detail on this is included in sections 5.4 and 5.5 (with the full policies and procedures included in sections 10 and 11).

There are various types of incident that the Trust must also be able to manage, but which are **out of scope** of this handbook. Whilst these might call for a form of "escalation", they do not fall within the specific definition of escalation used here. Such out-of-scope topics includes the management of:

- Severe weather (e.g., snow, flooding etc)
- Staff absence (including industrial action)
- Supply chain failure
- IT and communications outages

- Fire or other damage to buildings and equipment

5.2 OPEL Triggers / Escalation levels

The Trust uses a Black/Red/Amber/Green escalation framework to categorise the degree of demand relative to the current available capacity. This is aligned to the National NHS Operational Pressures Escalation Levels (OPEL) Framework – a single national system designed to standardise the recording and reporting of operational pressures.

Table 1 on the following page gives an overview of the Trust's OPEL triggers. The overall escalation status is calculated automatically by a spreadsheet, based on the set of indicators triggered. For more detail on the logic used in this calculation, see the explanation and worked examples in Section 5.2.2).

Please note that the triggers for the **Trust's Full Capacity Protocol** are annotated alongside **Table 1** for reference; please see **Sections 5.3 and 0** for more information on this protocol.

Table 1 Trust OPEL Triggers (and relation to triggers of the Full Capacity Protocol). See Section 7.1 for more detail on the triggers of the Full Capacity Protocol.

QEHKL OPEL Framework

The overall status is calculated from the particular combination of indicators that are triggered; this calculation is carried out automatically by an Excel spreadsheet used in the Ops Centre.

Indicator	OPEL 1 (Green)	OPEL 2 (Amber)	OPEL 3 (Red)	OPEL 4 (Black)
Bed occupancy – General and Acute (excl. W&C)	< 92%	92% - 95%	95% - 98%	> 98%
No. of escalation beds open	0	1	2 - 6	> 6
No. of beds available on AMU	> 2	1 - 2	0	0 **AND** pts bedded in ED
Longest current ambulance handover wait	< 30 min	30 – 59 mins	60 – 119 mins	> = 120 mins
ED 4-hour performance	> = 90%	80% - 89.99%	70% - 79.99%	< 70%
No. of elective operations cancelled	0	1 - 5	> 5	Operations cancelled for cancer patients
ITU status	Available capacity **AND** Patients to step down	Available capacity **AND** No patients to step down	No capacity **AND** Patients to step down	No capacity **AND** No patients to step down
Longest current delay for patient repatriations to the QEH	0 patients waiting	Patients waiting 0 – 24 hours	Patients waiting 24 – 48 hrs	Patients waiting > 48 hrs
No. of bays closed (e.g., due to IPACS)	0	1 - 3	4 - 6	> = 7

Full Capacity Protocol Flags

(**Two or more flags** triggered for > 24 hours, or expected to trigger for next 24 hours, leads to activation of FCP response)

- > = 99%
- All escalation capacity open, and of these > = 90% occupied
- 0 **AND** > = 10 pts bedded in ED
- All non-urgent operations cancelled for 2 consecutive days
- Cancellation of clinically urgent and cancer elective operations
- > = 2 wards closed **OR** > = 40 beds closed

Registered nurse shifts unfilled – General & Acute (excl. W&C)	< = 4	5 – 6	7 - 8	> = 9

5.2.1 Responsibility for changing OPEL status and cascading news of the change

Depending on the level being escalated to, different individuals are responsible for initiating and authorising an ***increase*** in the Trust's OPEL status. This is outlined in the table below. When decreasing the Trust's escalation status, the responsibility sits with the **same role** (i.e., since the Silver command is responsible for initiating an escalation up to OPEL 3, therefore the Silver command must also authorise any de-escalation from OPEL 3 back to either OPEL 1 or 2).

	During working hours		Out of hours	
OPEL level being escalated up to	**Person responsible**	**Key individual to be informed**	**Person responsible**	**Key individual to be informed**
OPEL 2 (Amber)	Bronze command (clinical site manager)	Medicine Divisional Director (within 15 mins)	Bronze command (clinical site manager)	N/A
OPEL 3 (Red)	Silver command	COO (within 30 mins)	Silver command	Gold on call (by telephone)
OPEL 4 (Black)	Gold (COO), following approval from WNCCG	CEO (within 30 mins)	Gold (Gold on call), following approval from WNCCG	CEO (within 30 mins)

Following the change in OPEL status, news of the change in escalation level should be cascaded through the hospital via the Trust's command and control hierarchy (i.e., Gold → Silver → Bronze → Divisional Leadership Teams → Division). This should be facilitated by the regular activities of the Capacity and Flow team, as well as via communication in the Capacity and Flow meetings. More detail on this can be found in the *QEHKL Capacity and Flow Handbook* – including guidance on the Trust's processes for circulating the OPEL status both internally and externally following the Capacity and Flow meetings.

In addition, the Trust's OPEL status should be consistently reported and disseminated via a standard 'status report' issued after every Capacity and Flow meeting (7-days a week). Specific guidance on this is included in Section 9.2; for further information on the Trust's regular reporting of operational pressures, see the *QEHKL Capacity and Flow Handbook*.

5.2.2 Calculation of the Trust's OPEL level

An Excel spreadsheet is used by the Capacity and Flow team to calculate the Trust's escalation status. This automatic calculation method should always be used to determine the Trust's OPEL status, however – for completeness – an overview of the calculation logic this uses is included below (indicating how this relates to the decision to trigger the Full Capacity Protocol), along with several worked examples.

The OPEL status is calculated as follows:

1. For each of the 10 indicators, the user selects the appropriate category (level 1 – 4) reflecting the current value of that metric as measured in the hospital
2. Each category contributes a numerical score (e.g., a 1 if that metric is at level 1, a 3 if at level 3)
3. These scores are summed, the total determines the Trust's overall status as follows:

Total score	Overall Trust OPEL status:
10-13	OPEL 1
14-23	OPEL 2
24-33	OPEL 3
34+	OPEL 4

1. **Calculate and assign Trust OPEL status**
   OPEL level is calculated using the Trust's OPEL spreadsheet, based upon the combination of indicators triggered at that time.

+

2. **Review Full Capacity Protocol Flags**
   If two or more FCP flags have been triggered for > 24 hours, or are expected to trigger for the next 24 hours, then Gold command may choose to activate the FCP.

=

Trust Escalation Status and FCP response

E.g., "OPEL 2", "OPEL 3", "OPEL 3 ***+ FCP****", "OPEL 4" etc…*

Worked example 1

	OPEL 1	OPEL 2	OPEL 3	OPEL 4	OPEL score contribution	FCP Triggers
List of 10 OPEL indicators	✓				1	
	✓				1	
	✓				1	
				✓	4	⚑
		✓			2	
	✓				1	
	✓				1	
	✓				1	
		✓			2	
	✓				1	
				TOTAL:	15	

Trust OPEL status

Total score		Result
10 - 13		*OPEL 1*
14 - 23	✓	**OPEL 2**
24 - 33		*OPEL 3*
34 +		*OPEL 4*

FCP activation

No. of triggers		Result
0 - 1	✓	**No FCP**
2 +		*FCP*

Worked example 2

	OPEL 1	OPEL 2	OPEL 3	OPEL 4	OPEL score contribution	FCP Triggers
List of 10 OPEL indicators	✓				1	
		✓			2	
		✓			2	
				✓	4	⚑
			✓		3	
		✓			2	
				✓	4	⚑
		✓			2	
		✓			2	
			✓		3	
				TOTAL:	25	

Trust OPEL status

Total score		Result
10 - 13		*OPEL 1*
14 - 23		*OPEL 2*
24 - 33	✓	**OPEL 3**
34 +		*OPEL 4*

FCP activation

No. of triggers		Result
0 - 1		*No FCP*
2 +	✓	**FCP**

Worked example 3

	OPEL 1	OPEL 2	OPEL 3	OPEL 4	OPEL score contribution	FCP Triggers
List of 10 OPEL indicators				✓	4	
				✓	4	
				✓	4	
			✓		3	
				✓	4	
			✓		3	
				✓	4	⚑
				✓	4	
	✓				1	
			✓		3	
				TOTAL:	34	

Trust OPEL status

Total score		Result
10 - 13		*OPEL 1*
14 - 23		*OPEL 2*
24 - 33		*OPEL 3*
34 +	✓	**OPEL 4**

FCP activation

No. of triggers		Result
0 - 1	✓	**No FCP**
2 +		*FCP*

5.3 Definition of "Full Capacity Protocol"

The *Full Capacity Protocol* (FCP) describes the steps taken when the trust **declares a critical incident** due to lack of beds leading to overcrowding in the emergency department. The protocol should only be activated when the Trust is operating at full capacity and normal

restorative actions (described in the standard Trust escalation protocol) have been exhausted.

The Full Capacity Protocol describes a ***series of actions*** that the Trust may choose to take in response to the hospital reaching a certain level of operational pressure; it is distinct from the OPEL Levels, which describe a framework for ***categorising*** the degree of operational pressure (with corresponding actions at each level). FCP should not be thought of as a "fifth" OPEL level, but rather a response that can be triggered at any time, during any OPEL status (although it is clear that FCP is far more likely to be activated in OPEL 3 or OPEL 4, due to the close relationship between the OPEL indicators and the FCP triggers).

The FCP describes the necessary actions when the ED is overcrowded or there is a severe shortage in available beds across the Trust. The resulting actions are intended to restore patient flow and promote safety via three means:

1. Management and coordination of the response
2. Clinical support for assessment/care-giving within the ED
3. Reviewing all activity and redeploying resources to focus on discharge.

Escalation to the FCP will be an executive decision (Gold) based on careful consideration of multiple indicators and triggers. The specific triggers are described in **Section 7.1.**

5.4 Escalation within Children's Services

In most scenarios, the Trust's Children's services manage their capacity and activity independently from the rest of the hospital.

The service operates its own Black/Red/Amber/Green escalation framework, with local triggers and actions defining each successive level. Only at the level of Red or Black escalation does the service significantly interact with the escalation processes across the rest of the hospital.

It is crucial, however, that the key figures in the Trust command and control hierarchy (e.g., Golds / Silvers / Bronzes / clinical site manager) are familiar with the escalation procedures within Children's service, so that the rest of the hospital is able to coordinate

appropriate Trust-wide support when needed. For this reason, a copy of the **Children's services escalation protocol** has been included in full in this handbook, see **Section 10**.

5.5 Escalation within Maternity Services

The management of operational pressures within the Trust's Maternity services mostly takes place within the service itself, independently of the rest of the hospital.

However, it is important that individuals in the Trust command and control hierarchy (e.g., Golds / Silvers / Bronzes / Capacity and Flow team) are familiar with these processes, so that the rest of the hospital can coordinate appropriate Trust-wide support when needed.

For this reason, a copy of the **Paediatrics service escalation protocol** has been included in full in this handbook, see **Section 11.**

5.6 Specific incidents requiring an immediate response

There are various incidents or circumstances that may occur at the Trust which will require immediate notification of Bronze command (the clinical site manager), but that which will not warrant a change in the Trust's OPEL status. For guidance, this includes all the following events:

- Loss of facilities (e.g. power, water, heating)
- Loss of IT systems
- Immediate reduction in service (e.g. loss of MRI scanner)
- Roof leaks

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6. ACTION CARDS FOR EACH OPEL / ESCALATION LEVEL

Summary of the guidance

This section outlines the specific actions that should be undertaken by key individuals in the Trust at each OPEL level. The actions are grouped by OPEL escalation status – with one action card for each level. Within each action card, actions are broken down by role and area of the hospital.

For information on the triggers for each OPEL level, and the process of initiating a change in the Trust's escalation status, see Section 5.2.

6.1 OPEL 1 (Green) Action Card

	OPEL 1 (Green)			
Role	**ED & Front door**	**Inpatient wards**	**Discharge**	**Trust-wide**
Gold (COO / Gold on call)				• Normal working: providing strategic leadership to ensure continued running of Trust services
Silver (Silver on call)				• Normal working: providing tactical leadership • 2nd line of escalation, after Bronze
Bronze (Clinical Site Manager)	• Work with ED, AZ & AMU NICs to manage patient flow and ED 4hr performance	• Ensure accurate info maintained in Ops Centre • Work with external providers to manage repatriations	• Support effective use of discharge lounge	• Chair Capacity & Flow meetings • Ensure fully staffed Capacity and Flow team rota
Medicine Divisional Leadership Team	• Support teams to ensure Internal Professional Standards are being followed	• Ensure consultant attendance to board rounds	• Support effective use of discharge lounge	• Be aware of OPEL status and pressure points in service • Ensure mechanisms to cascade escalation status to teams
Surgery Divisional Leadership Team	• Support teams to ensure Internal Professional Standards are being followed	• Ensure consultant attendance to board rounds	• Support effective use of discharge lounge	• Be aware of OPEL status and pressure points in service • Ensure mechanisms to cascade escalation status to teams
Women and Children's Divisional Leadership Team				• Manage Paeds and Maternity pressures through local escalation processes • Be aware of Trust OPEL status
Clinical Support Services				• Be aware of OPEL status and pressure points in service • Ensure mechanisms to cascade escalation status to teams

Medicine Ward Teams		• Ensure attendance of Consultant at daily board rounds • All patients to have up to date EDDs	• Identify suitable golden patients and potential outliers	• Be aware of OPEL status • Ensure up-to-date info communicated to Ops Centre
Surgery Ward Teams		• Ensure attendance of Consultant at daily board rounds • All patients to have up to date EDDs	• Identify suitable golden patients and potential outliers	• Be aware of OPEL status • Ensure up-to-date info communicated to Ops Centre

6.2 OPEL 2 (Amber) Action Card

	OPEL 2 (Amber)			
	ALL ACTIONS AT OPEL 1, PLUS THE FOLLOWING:			
Role	**ED & Front door**	**Inpatient wards**	**Discharge**	**Trust-wide**
Gold (COO / Gold on call)				*(Normal working)*
Silver (Silver on call)				*(Normal working)*
Bronze (Clinical Site Manager)		• Contact other hospitals to repatriate patients	• Expedite patients for transfer to available community beds • Contact Patient Transfer manager to request discharges become a priority	• Submit OPEL status to WNCCG
Medicine Divisional Leadership Team	• Ensure clinicians are using all methods for admission avoidance (e.g., SDEC)	• Support with resolving delays		• Cascade OPEL status to division • Develop plans for the next morning • Identify known constraints (e.g., staffing, IPACS)
Surgery Divisional Leadership Team		• Review pts waiting for on-going investigation, could this be done as an outpatient? • Review elective TCIs to prioritise pts for standby in event of Trust OPEL 3 or 4		• Cascade OPEL status to division • Develop plans for the next morning • Identify known constraints (e.g., staffing, IPACS)
Women and Children's Divisional Leadership Team				• Cascade OPEL status to division
Clinical Support Services				• Cascade OPEL status to division
Medicine Ward Teams		• Report any identified issues to Bronze (e.g., IPACS, staffing) • Develop plan for next morning	• Ensure TTOs for predicted and confirmed discharges are received in pharmacy by 1400	
Surgery Ward Teams		• Report any identified issues to Bronze (e.g., IPACS, staffing) • Develop plan for	• Ensure TTOs for predicted and confirmed discharges are received in	

		next morning	pharmacy by 1400	

6.3 OPEL 3 (Red) Action Card

	OPEL 3 (Red)			
	ALL ACTIONS AT OPEL 1 and OPEL 2, PLUS THE FOLLOWING:			
Role	**ED & Front door**	**Inpatient wards**	**Discharge**	**Trust-wide**
Gold (COO / Gold on call)		• Consider outlying patients • Consider use of additional capacity	• Alert Social Care with CCG to expedite care packages	• Issue comms externally • Consider activation of FCP, if appropriate
Silver (Silver on call)		• Consider use of additional capacity		• Communicate triggers for escalation • Contact EEAST and EMAST (with Gold)
Bronze (Clinical Site Manager)	• Work with EEAST and EMAST to manage ambulance flow through ED	• Discuss potential requirement for escalation capacity with Silver	• Agree with senior teams which pts can be discharged to community beds	• Submit OPEL status to WNCCG
Medicine Divisional Leadership Team	• Support ED to review resourcing • Consider prioritising ED pts requiring medical input • Request further senior review of patients in acute medicine areas	• Support with resolving delays • Support teams to identify pts suitable for outlying / escalation areas • Consider creating 'Transfer teams' for rapid movement of pts to ward beds • Review elective activity	• Ensure plans in place for all discharges – commission use of taxis if appropriate • ACN to ensure all appropriate discharges moved to discharge lounge	• With COO sign-off: cancel non-clinical sessions and/or SPA • One member of DLT to attend Capacity & Flow meetings • Review redeploying any clinical staff currently in non-clinical roles • Consider registrar-delivered clinics
Surgery Divisional Leadership Team		• Support with resolving delays • Support teams to identify pts for outlying / escalation areas • Consider creating 'Transfer teams' for rapid movement of pts to ward beds • Review elective activity	• Ensure plans in place for all discharges – commission use of taxis if appropriate • ACN to ensure all appropriate discharges moved to discharge lounge	• With COO sign-off: cancel non-clinical sessions and/or SPA • One member of DLT to attend Capacity & Flow meetings • Review redeploying any clinical staff currently in non-clinical roles • Consider registrar-delivered clinics
Women and Children's Divisional Leadership Team		• Paeds services to review 16-yr-olds and their suitability to be cared for in adult		• With COO sign-off: cancel non-clinical sessions and/or SPA • One member of

		wards		DLT to attend Capacity & Flow meetings
Clinical Support Services	• Prioritisation of inpatients and ED patients	• Consider relocating Therapy / Pharmacy staff to ED / TTOs / extra diagnostics • Consider cancellation of OPD activity and/or non-urgent activities		• With COO sign-off: cancel non-clinical sessions and/or SPA • One member of DLT to attend Capacity & Flow meetings
Medicine Ward Teams		• Clinicians to prioritise unwell pts, followed by golden pts and discharges, at start of ward round	• Drs to prescribe TTOs as time of decision to discharge	
Surgery Ward Teams		• Clinicians to prioritise unwell pts, followed by golden pts and discharges, at start of ward round	• Drs to prescribe TTOs as time of decision to discharge	

6.4 OPEL 4 (Black) Action Card

	OPEL 4 (Black)			
	ALL ACTIONS AT OPEL 1, OPEL 2 and OPEL 3, PLUS THE FOLLOWING:			
Role	**ED & Front door**	**Inpatient wards**	**Discharge**	**Trust-wide**
Gold (COO / Gold on call)		• Authorise opening of escalation area as appropriate • Ensure elective admissions have been reviewed and cancel / reschedule where possible		• ***Chair Capacity and Flow meetings*** • Contact EEAS and EMAS Gold, request soft divert • Develop appropriate comms with comms team for community
Silver (Silver on call)				• Support Bronze to coordinate escalation actions
Bronze (Clinical Site Manager)	*(Support divisions with escalation actions)*	*(Support divisions with escalation actions)*	*(Support divisions with escalation actions)*	• Send out external black alert messages to GPs, social services, community matrons, care homes
Medicine Divisional Leadership Team	• Ensure screening of all ED admissions by a consultant • Consider additional medical support for admission avoidance • Consider post-taking of pts within ED	• Ensure escalation capacity open, with agreed criteria and appropriate staffing • Coordinate further senior review of pts	• Support immediate transfer of pts to discharge lounge	• Cancel SPA and non-clinical activity as appropriate to allow extra review of pts
Surgery Divisional Leadership Team		• Review routine electives, cancel as appropriate • Ensure escalation capacity open, with agreed criteria and appropriate staffing • Coordinate further senior review of pts	• Support immediate transfer of pts to discharge lounge	• Cancel SPA and non-clinical activity as appropriate to allow extra review of pts
Women and Children's Divisional Leadership Team		• Review routine electives, cancel as appropriate		• Cascade OPEL status to division • Review SPA and non-clinical activity as appropriate

				• Support other divisions as appropriate
Clinical Support Services	• SpRs and consultants to liaise with ED to provide support	• Prioritise inpatient radiology vetting and reporting	• Social care work to be prioritised and non-essential work deferred • Coordinate extended hours of social work if necessary	• Consider cancellation of therapy OPD to support wards • Cancel SPA and non-clinical activity as appropriate
Medicine Ward Teams	• SpRs and consultants to liaise with ED to provide support			
Surgery Ward Teams	• SpRs and consultants to liaise with ED to provide support	• Be prepared to inform patients if their surgery has been cancelled		

6.5 Implications for Capacity and Flow meetings

The mandatory attendance at the Capacity and Flow meetings will depend on the time of the meeting and escalation level of the Trust. The table below provides a guide to the expected attendance at each meeting.

Role	08:00	11:00	14:00	17:00
COO/Gold-on-call	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 1 and above
Silver-on-call	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above
Bronze command (Clinical Site Manager)	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above
Medicine Bed Manager	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above
Surgery Bed Manager	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above	OPEL 1 and above
ED nurse in charge	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
AZ/AMU nurse in charge	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
SAU nurse in charge	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Matron – medicine	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Matron – surgery	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Matron – women and children	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Clinical support services representative	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Porters representative	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Domestic & estates representative	OPEL 1 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Discharge Team representative	OPEL 1 and above			
Head of Nursing – Medicine	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Head of Nursing – Surgery	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Divisional Director – Medicine	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Divisional Director – Surgery	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Divisional General Manager – Medicine	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above
Divisional General Manager – Surgery	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above	OPEL 3 and above

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7. FULL CAPACITY PROTOCOL

Summary of the guidance

This section outlines the triggers that may warrant the Trust to activate the "Full Capacity Protocol" – a critical incident called in response to overcrowding in the ED, or a severe shortage of available beds across the Trust.

It also includes the steps to be taken to activate and coordinate a Full Capacity Protocol response, as well as the steps for standing down and debriefing.

7.1 Triggers of full capacity protocol

The full capacity protocol may only be enacted when normal restorative actions have been exhausted.

Two or more of the triggers below must apply for the plan to be activated. For an overview detail on how these triggers relate to the definition of the Trust's OPEL levels, see **Table 1** on page 20:

#	Trigger area	Trigger description
1	**Bed occupancy**	> 99%
2	**Escalation capacity**	All escalation capacity open and, of these, > = 90% occupied
3	**Beds available in AMU / Patients bedded in ED**	0 beds available in AMU ***AND*** > = 10 patients bedded in ED
4	**Non-clinically urgent elective activity**	All non-urgent operations cancelled for 2 consecutive days
5	**Clinically urgent and cancer elective activity**	Cancellation of clinically urgent and cancer elective operations
6	**Bed / ward closures**	> = 2 wards closed OR > = 40 beds closed

The FCP will usually be activated **during normal working hours** (8.30am to 5.00pm Monday to Friday) whilst a broad range of staff are on duty to respond and implement the actions. The earlier in the day the protocol is activated the more effective the response is likely to be.

In the event of an unpredictable rise in pressure during the **out-of-hours period** the FCP can still be activated, but certain actions may be limited due to the availability of relevant staff groups. In such circumstances, the clinical site manager and Director on call will need to clearly define and assign the actions needed, calling in additional support if required.

7.2 Cascade of activation of Full Capacity Protocol

The Clinical Site Manager should inform the Communications Team once the FCP has been activated. The Communications team will coordinate a message to be cascaded throughout the Trust through Broadcast e-mail and via text (by the Switchboard team). Out of Hours this will be via the Page One alert system.

Assess	• Clinical site team assess the situation • Capacity levels placing patient safety at risk - Critical Incident triggers met • Activate this plan to support service/divisional response
Cascade	• Contact Communication informed on ext 3762 or 01553 613762 • message issued to FCP group
External	• Silver to inform WNCCG on 07623 514085 • CCG to establish daily system teleconference to ensure appropriate system response

Template messages for the broadcast email and text are included in the following sections.

7.2.1 Broadcast email template for FCP activation – to be sent by the Communications team

Appropriate details should be inserted into the sections in square brackets.

FULL CAPACITY PROTOCOL ACTIVATED

We have activated the Trust's Full Capacity Protocol at ***[INSERT TIME OF ACTIVATION]*** today as our hospital is experiencing severe pressure on its capacity.

It is critical that we act to improve the situation to reduce delays for patients and maintain patient safety. Please refer to the Full Capacity Protocol action cards for your role or area and support with the actions indicated.

These actions should include:

- ***[LIST 2-3 KEY ACTIONS FOR COMPLETION]***

This status is being kept under hourly review and we will move to an internal incident if the situation does not significantly improve by ***[INSERT SUITABLE TIME IN ~2-3 HOURS***].

7.2.2 Text message template for FCP activation – to be sent by the Switchboard team

Appropriate details should be inserted into the sections in square brackets.

The Full Capacity Protocol has been activated at ***[INSERT TIME OF ACTIVATION]***, please refer to the FCP action cards for your role. This status is being reviewed hourly, if the situation has not improved by ***[INSERT SUITABLE TIME IN ~2-3 HOURS***] we will move to an internal incident. An incident meeting will be held at ***[TIME]*** in ***[VENUE]***

7.2.3 Informing Specialties

Clinical teams are instructed to cascade the current situation to junior doctors. This should also be reiterated at all handovers.

When available, rota coordinators can cascade a message via email to all junior doctors that the FCP has been activated. The Capacity and Flow team should be aware that this has its limitations and should not be used as the only method of informing junior doctors.

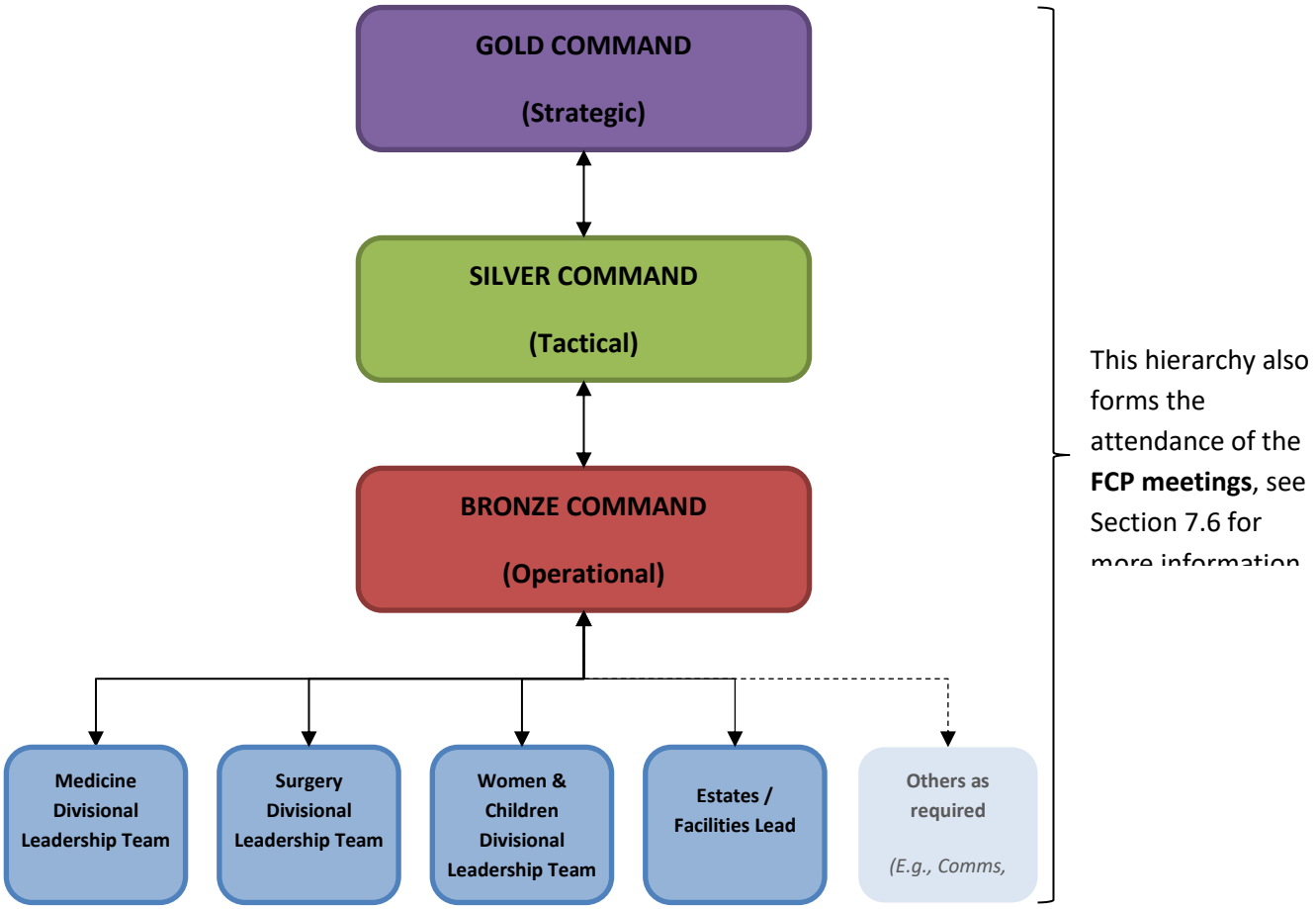
7.3 Command and control mechanism

During times of severe pressure and when responding to significant incidents and emergencies, NHS organisations need a structure which provides:

- clear leadership
- accountable decision making; and
- accurate, up to date and far-reaching communication.

This structured approach to leadership under pressure is commonly known as '*command and control*'. The table and diagram below describe the hierarchical structure through which this operates when the Trust's Full Capacity Protocol is active. It defines both the lines of authority and reporting structure to be used.

Command	Roles	Responsibility
Strategic (Gold Command)	Chief Operating Officer or Gold on call	• Enacting this protocol and undertaking the actions listed in Section 7.4. • Responsible for liaising with partners to develop the strategy and policies for the incident. • Consider the incident in its wider context to establish longer term and wider effects. • Delegate tactical decisions to Silver, so they are not directly managing the tactical or operational detail.
Tactical (Silver Command)	Silver on call	• Direct management of the Trust's response ensuring that all Bronze cells are undertaking the action as prescribed. • They will oversee and support, but not be directly involved in the operational response. • Provide tactical commands to Bronze.
Operational (Bronze Command)	Clinical Site Manager	• Deliver the actions identified in this protocol. • Management of the specific tasks in their action card. • Act on tactical commands from Silver.
Other leads: e.g., DLT, Estates, Comms	Senior individuals within the relevant division / department	Coordinate delivery of the actions described in this protocol and as laid out in the action cards (Section 7.5), alongside Bronze.



7.4 Overview of full capacity protocol actions

Once the Full Capacity Protocol has been enacted, the following actions, in no particular order, must be taken in addition to usual operating procedures.

7.4.1 Daily Senior Review

Whilst the FCP is activated, every patient in the hospital will receive a daily review from a consultant. See Section 8.7 for more information.

Who (Responsible Officer): *Clinical Directors*
Where: *All wards*
When (Timeframe): *4 hours (by 1300 on the first morning of activation)*

7.4.2 Consultant Admissions Only

On call Consultants in all clinical specialities must be available to attend the Emergency Department to review patients prior to admission with appropriate junior review. See Section 8.8 for more information.

Who (Responsible Officer): *On call consultants*
Where: *Emergency Department*
When (Timeframe): *All times*

7.4.3 Review of Clinical Activity

Once the FCP is activated, Divisional and Clinical Directors must review all outpatient and elective activity and make the necessary cancelations to allow clinicians to be redeployed to focus on discharge.

A 'Surgical Decision Group' will be established to undertake a Trust-wide review of elective cancellations, see Section 8.9 for information.

Who (Responsible Officer): *Divisional and Clinical Directors*
Where: *Admissions*
When (Timeframe): *4 hours*

7.4.4 Cancellation of Consultant SPA time

Upon activation of the FCP, consultant SPA time will be reviewed, and consultant time will be focussed on discharge. This will be coordinated by Divisional General Managers.

Who (Responsible Officer): *Divisional General Managers*
Where: *Wards / ED / Clinics*
When (Timeframe): *As required*

7.4.5 Cancellation of Non-Clinical Activity

Whilst the FCP is activated, the following non-clinical activity will be reviewed. Staff time should be reprioritised to focus effort that will support discharge and patient flow.

- Clinical and operational staff will be exempt from attending **non-essential meetings**
- Where possible, **non-mandatory training** for clinical staff should be postponed or cancelled

For more detail on this process, see Section 8.11.

Who (Responsible Officer): *Divisional Leadership Teams (and Silver for final decisions)*
Where: *Wards / ED / Clinics*
When (Timeframe): *As required*

7.4.6 Arranging additional patient transport

Additional transport will need to be made available during the working day and out of hours. The clinical site team should arrange this with all available Transport providers. See Section 8.6 for more information on this process.

Who (Responsible Officer): *Clinical site team*
Where: *Operations centre*
When (Timeframe): *As required*

7.5 Full capacity protocol action cards

7.5.1 Gold Command

Gold Command COO or Gold on Call		**Full Capacity Protocol**
Tasks		Complete
1	The Medical Director will ensure that all clinicians are communicated to and asked to lower the threshold for discharge	
2	Review and cancel all SPA activity to allow time to be focused on supporting discharge. Only in exceptional circumstances can SPA time continue, this must be authorised by a Divisional Medical Director.	
3	Ensure that there is an appropriate chair for the surgical decision group to review and prioritise urgent elective activity.	
4	Risk assess longer term impacts of FCP (i.e., consideration of workforce rota, impacts on other patient groups)	
5	Support for capacity decisions in close conjunction with Silver.	
6	Maintain oversight of the media and communications strategy.	
7	Be available to liaise with Silver and review progress and effectiveness of response. Consider any additional actions that may need to be taken.	
8	Ensure that NHSE, NHSI, EEAST, EMAST and CCG are informed	

7.5.2 Silver command

Silver Command Silver On-Call		Full Capacity Protocol
Tasks		Complete
1	Inform Communications that a critical incident has been declared and the full capacity protocol has been activated	
2	Inform the CCG that a critical incident has been declared.	
3	Liaise with neighbouring trusts and agree ambulance diverts where possible. Inform the CCG and EEAST Ops Cell once agreed.	
4	Liaise with clinicians and agree the level of escalation to divert tertiary networks. Inform the CCG and EEAST Ops Cell once agreed.	
5	Provide representation at the daily system teleconferences and place pressure on the system to heighten their response and support the trust to return to a safe operating level	
6	Cancel all training and meetings that require operational or clinical staff attendance. Only mandatory training should continue.	
7	Establish a daily surgical decision group and prioritise urgent elective activity. Inform Gold and divisional leadership teams so that appropriate representation can be organised.	
8	Authorise the continued cancellation of elective activity. Ensure that the resource freed up is appropriately distributed to support the ED and discharges.	
9	Receive a daily update on Confirmed Discharges (patient by patient) from each division	
10	Through Executive Directors, cascade messages to identify clinical & non-clinical staff in non-clinical roles with the view to redeploying them to support discharge.	
11	Review the criteria for Virtual Ward and liaise with system partners to establish bridging arrangements	
12	Ensure increased transport availability throughout the day. Clinical site team to report on outstanding transport requests at 15:00 every day so that appropriate action can be taken to ensure all patients are moved.	
13	Chair weekend incident meeting	

7.5.3 Bronze command

Bronze Command Clinical Site Manager		**Full Capacity Protocol**
Tasks		Complete
1	Coordinate patient movements and site safety	
2	Monitor any rising safety concerns as a result of activating the FCP and undertaking its actions	
3	Liaise with divisional leadership teams to ensure that reverse boarding is being operated. Coordinate support to areas if required	
4	Coordinate any additional nursing resource that is made available	
5	Include the contact details of additional weekend cover are included in the weekend plan	

7.5.4 Medicine Divisional Leadership Team

Medicine Divisional Leadership Team		Full Capacity Protocol
Tasks		Complete
1	Provide Silver with DLT contact details	
2	Ensure all specialities informed and the message is cascaded to junior doctors	
3	Ensure all patients have had a daily review by a consultant. Patients should be prioritised in terms of • Acuity/clinical urgency • Potential for discharge • All other patients	
4	Cascade requirement operational and clinical staff to prioritise discharge and flow over attending meetings and training, with the exception of mandatory training. Where the chair feels that the attendance is essential this should be escalated to Silver for a final decision.	
5	AMDs and CDs to review medical cover arrangements and source additional out of hours cover including weekends	
6	AMDs and CDs to review all elective and outpatient activity and where appropriate cancel clinics and surgery to free up resource to support discharge	
7	AMDs and CDs to ensure that senior clinical decisions makers from all specialities are available to attend and review patients in the Emergency Department within 60 minutes of being called.	
8	Medical teams to consider early discharge of patients who require additional investigations that could be provided as an outpatient appointment	
9	Review all Confirmed Discharges for the day and the next day and provide an update to Silver patient by patient.	
10	Ensure additional weekend resources are available prioritise Confirmed Discharges and prepare patients for discharge	
11	Identify patients appropriate for discharge lounge (see discharge lounge criteria, Trust Capacity and Flow Handbook)	
12	Provide contact details of additional weekend cover to the Ops Centre so it can be included in the weekend plan	

7.5.5 Surgery Divisional Leadership Team

Surgery Divisional Leadership Team		Full Capacity Protocol
Tasks		Complete
1	Provide Silver with DLT contact details	
2	Ensure all specialities informed and the message is cascaded to junior doctors	
3	Ensure all patients have had a daily review by a consultant. Patients should be prioritised in terms of • Acuity/clinical urgency • Potential for discharge • All other patients	
4	Cascade requirement operational and clinical staff to prioritise discharge and flow over attending meetings and training, with the exception of mandatory training. Where the chair feels that the attendance is essential this should be escalated to Silver for a final decision.	
5	AMDs and CDs to review medical cover arrangements and source additional out of hours cover including weekends	
6	AMDs and CDs to review all elective and outpatient activity and where appropriate cancel clinics and surgery to free up resource to support discharge	
7	AMDs and CDs to ensure that senior clinical decisions makers from all specialities are available to attend and review patients in the Emergency Department within 60 minutes of being called.	
8	Medical teams to consider early discharge of patients who require additional investigations that could be provided as an outpatient appointment	
9	Review all Confirmed Discharges for the day and the next day and provide an update to Silver patient by patient.	
10	Ensure additional weekend resources are available prioritise Confirmed Discharges and prepare patients for discharge	
11	Ensure that any consultants who are no longer undertaking elective surgery target early discharges	
12	Identify patients appropriate for discharge lounge (see discharge lounge criteria, Trust Capacity and Flow Handbook).	
13	Provide contact details of additional weekend cover to the Ops Centre so it can be included in the weekend plan	

7.5.6 Women and Children's Divisional Leadership Team

Women & Children's Divisional Leadership Team		Full Capacity Protocol
Tasks		Complete
1	Provide Silver with DLT contact details	
2	Ensure all specialities informed and the message is cascaded to junior doctors	
3	Ensure all patients have had a daily review by a consultant. Patients should be prioritised in terms of • Acuity/clinical urgency • Potential for discharge • All other patients	
4	Cascade requirement operational and clinical staff to prioritise discharge and flow over attending meetings and training, with the exception of mandatory training. Where the chair feels that the attendance is essential this should be escalated to Silver for a final decision.	
5	AMDs and CDs to review medical cover arrangements and source additional out of hours cover including weekends	
6	AMDs and CDs to review all elective and outpatient activity and where appropriate cancel clinics and surgery to free up resource to support discharge	
7	AMDs and CDs to ensure that senior clinical decisions makers from all specialities are available to attend and review patients in the Emergency Department within 60 minutes of being called.	
8	Medical teams to consider early discharge of patients who require additional investigations that could be provided as an outpatient appointment	
9	Review all Confirmed Discharges for the day and the next day and provide an update to Silver patient by patient.	
10	Ensure additional weekend resources are available prioritise Confirmed Discharges and prepare patients for discharge	
11	Provide contact details of additional weekend cover to the Ops Centre so it can be included in the weekend plan	

7.5.7 ED

ED		Full Capacity Protocol
Tasks		Complete
1	Ensure senior review at front door to triage and redirect patients when necessary.	
2	Ensure that there is appropriate junior doctor/SpR to support speciality consultants attending the ED	
3	Make arrangements to have all areas operational throughout the night. Identify staffing requirements early and fill any gaps	
4	Identify patients appropriate for discharge lounge (see discharge lounge criteria, Trust Capacity and Flow Handbook).	

7.5.8 Estates / Facilities

Estates / Facilities		Full Capacity Protocol
Tasks		Complete
1	Undertake a thorough stock take of beds/trolleys awaiting cleaning or repair and liaise with mechanical engineering to ensure that these are brought back into operational use as a soon as possible	
2	Review portering capacity and identify any additional resources that could be brought in	
3	Liaise with the communications lead to agree appropriate recorded message for the switchboard	
4	Review any planned maintenance for clinical areas and expedite any activity which will release bed space	
5	Make appropriate service adjustments which will support divisions	

7.5.9 Communications

Communications		Full Capacity Protocol
Tasks		Complete
1	Agree communication strategy with Silver and Gold, this should include: • Frequency of internal and external communications • Channels of communication to be used • Key themes within the messaging	
2	Issue timely internal communications using all appropriate channels to ensure	
3	Activate messages on channels not routinely i.e., screensavers or FCP poster	
4	Be available to respond to requests from Gold or Silver	

7.6 Full capacity protocol meetings

The FCP command and control hierarchy will meet shortly after the FCP has been activated at a time identified by Gold. The meetings will be **chaired by Gold**. Gold will identify the frequency and timing of meetings, but this must not conflict with any of the Ops Centre Capacity and Flow meetings.

Attendance is as follows:

- Gold command
- Silver command
- Bronze command (clinical site manager)
- Representation from each divisional leadership team (DLT)
- Estates and facilities lead
- Any other attendees as required (may include: IPACS, communications lead)

7.6.1 FCP Meeting Agenda

Agenda point		Lead
1	**Register** • Confirmation FCP has been activated: which triggers were met and what risk this posed • Confirmation that all attendees are present	**Gold**
2	**Current Bed State**	**Bronze**
3	**Emergency Dept**	**Medicine DLT**
4	**Staffing**	**Bleepholder**
5	**Target/Actions** • Outline what is the target for stand down and forecast for when this should be achieved • Identification of the actions and review effectiveness	**Silver**
6	**Divisional Updates**	**All**
7	**Communications** • Confirm the key messages internal and external	**Gold**
8	**Escalation to Gold**	**Gold**
9	**Next Meeting** • Confirmation of frequency, times and locations	**Gold**

7.7 Stand down of Full Capacity Protocol

The stand down criteria should be conveyed at the first incident meeting. Criteria for stand down are as follows, ***two or more*** of the following criteria must apply:

- There is a positive number of now beds across the trust
- The elective programme can safely restart within the pool of available (now and later) beds
- Staffing levels across wards, the ED and critical care are safe
- Stand down does not increase the risk of incident re-escalating

Stand down of the FCP must be authorised by **Gold command**. Following this authorisation, Bronze command (Clinical Site Manager) should inform the Communications Team.

The Communications team will coordinate a message to be cascaded throughout the Trust through Broadcast e-mail and via text (by the Switchboard team). Out of Hours this will be via the Page One alert system.

Template messages for the broadcast email and text are included in the following sections.

7.7.1 Broadcast email template for FCP stand-down – to be sent by the Communications team

Appropriate details should be inserted into the sections in square brackets.

DE-ESCALATION FROM FULL CAPACITY PROTOCOL

As of ***[INSERT TIME OF ACTIVATION]*** today we have de-activated the Trust's Full Capacity Protocol, following ***[INSERT CRITERIA MET FOR STAND DOWN]***.

Please be aware that the Trust remains in ***[INSERT OPEL STATUS]*** status. Please refer to the relevant OPEL action card for your area for the actions to be taken to maintain the safety of our patients.

Many thanks to everyone within the Trust for your hard work and support during this protocol. Your

7.7.2 Text message template for FCP stand-down – to be sent by the Switchboard team

Appropriate details should be inserted into the sections in square brackets.

The Trust's Full Capacity Protocol has been de-activated as of ***[INSERT TIME OF ACTIVATION]*** today. Please be aware that the Trust remains in ***[INSERT OPEL STATUS]*** status. Please refer to the relevant OPEL action card for your area for the actions to be taken to maintain the safety of our patients.

7.8 Debrief

A debrief will take place as soon as possible and will be conducted by the Chief Operating Officer to ascertain:

- What events lead to the activation
- The effectiveness of the actions
- the consequence on other patient groups
- the improvements required to the FCP

8. GUIDANCE ON SPECIFIC ESCALATION ACTIVITIES

Summary of the guidance

This section provides more detail on how to carry out some of the activities which are required as part of escalation procedures at the Trust. It is intended to be a reference point for staff, to understand the steps they must routinely follow in completing these tasks.

8.1 Standard operating procedure for escalation ward areas

8.1.1 Introduction

An Escalation Ward aims to provide a clinically appropriate and safe environment to care for patients, for a temporary period, when there are extraordinary capacity pressures within the emergency areas within the Trust. It aims to ensure that patient pathways are managed safely and efficiency whilst the ongoing elective work remains un-compromised.

8.1.2 Responsibilities

8.1.2.1 Gold command (COO or Gold on call)

The Trust's Gold command is responsible for authorising the opening or closing of the escalation ward area, as described in Section 8.1.3.

8.1.2.2 Divisional Leadership team

The Divisional leadership team is responsible for the management of the escalation ward for the period that it is open, through its existing governance structures. The Divisional Associate Chief Nurse (ACN) will oversee all nursing requirements, assisted by a divisional matron.

8.1.3 Authorisation for opening or closing an escalation area

The authority to open or close an escalation ward is as follows:

- **During working hours:** Chief Operating Officer (COO)
- **Out of working hours:** Silver command following escalation and agreement with Gold command and final approval from the Director of Nursing, Medical Director and COO.

Consideration should be given to holding patients in A&E, if beds are likely to become available within 12 hours; this is considered a safer option then opening temporary additional beds. If this is agreed as an appropriate option, patients must be transferred onto a hospital bed and provided with an appropriate care package including comfort rounds. A Datix form must be completed and submitted for audit purposes. This should also be included on the EDIS System.

8.1.4 Criteria for patients suitable for an escalation area

All criteria must be agreed prior to opening, with sign-off required from the Divisional Leadership team, alongside the relevant procedures for admission, discharge and transfer out of the ward. Example criteria and procedures are provided below for reference in Sections 8.1.4.1 – 8.1.7.

When the ward is opened as an escalation area, the On-call Physician/Surgeon in consultation with the site practitioners will retain overall responsibility for identifying appropriate patients to admit/transfer to the ward, supported by Bronze command or Silver command (OOH).

8.1.4.1 Example admission criteria (from Leverington Escalation Ward)

For reference, an example of criteria for admission to an escalation ward (then located on Leverington Ward, operating as a short stay unit) is included below:

Requirements before transfer to the escalation ward:

- The patient has been reviewed by the Acute Medicine team, and has been identified as requiring specialty input for a maximum of 5 days
- All nursing assessments / documentation must be completed prior to transfer

Exclusion criteria:

- Any patient admission who has experienced symptoms of infective/unexplained diarrhoea or vomiting within the last 72 hours
- Patients without an EDD
- Patients for whom resuscitation status is not known or is not clearly documented
- Patients who are critically ill or whose medical condition is labile and may deteriorate rapidly
- Patients with a history of falls
- Patients with delirium
- Patients with dementia
- End of Life patients
- Acute Stroke patients who require intensive rehabilitation
- Patients requiring hourly observations
- Patients who are physically aggressive or who are showing challenging behaviour, posing a risk to other patients or staff
- Patients with an EWS > 6
- Bariatric patients weighting 100kg or more
- Patients with learning difficulties
- Patients requiring transfer within the time period 23:00-6:00 (Except from assessment areas MAU/SAU)

Where alignment with these exclusion criteria is not feasible, a risk assessment should be made by the matron/senior nurse and a Datix completed.

8.1.5 Example procedure for admission to the escalation ward

On arrival to the escalation ward, the ward clerk (or receiving nurse when they are not present) will admit the patient onto the ward electronically via PAS and allocate the patient to the corresponding bed space on the whiteboard. They will also ensure the expected discharge date (EDD) is recorded on PAS and the whiteboard.

The nursing assessment/admission must include:

- Introductions and orientation of patient to the ward.
- Standard observations including EWS.
- Completion of the relevant sections of the admission documentation.

The junior doctor must:

- Review the clerking notes and complete any outstanding investigations/tests which need to be undertaken (ensuring they introduce themselves formally to the patient and fully explain the reason they have been admitted to the ward, allowing them the opportunity to raise questions).
- Ensure completion of CGA for patients aged > 75 years.
- Initiate the discharge documentation (TTOs).
- Ensure all investigations and treatment plans are actioned, including those requested by the referrer.
- Clearly document a management plan and communicate this to the named nurse.
- Commence discharge at the start of the patients journey in order to ensure this does not hold up the patients discharge

The consultant review must include:

- A clear management plan, documenting what is required to facilitate criteria led discharge.

8.1.6 Example procedure for discharging from the escalation ward

All patients will leave the ward within 7 days either to go back to their place of residence or to be transferred to a base ward for on-going medical needs. To ensure safe, timely discharge the following points apply:

- The patient should be informed of their EDD and be advised they will need their own transport home, so that they can make arrangements for their discharge
- Hospital transport should only be provided as an exception. The ward clerk (nurse in charge when they are not there) should arrange this as per protocol
- The TTOs must be finalised by the junior doctor at the time of decision to discharge and then sent directly to pharmacy to be dispensed (pharmacist / medicines reconciliation technician / ward clerk to arrange)
- All sitting patients should go to the discharge lounge if they are not leaving straight away
- The ward clerk / nurse in charge should discharge the patient electronically via Patient Centre as soon as the patient has left the ward and declare the bed to the CSM/bed manager immediately

8.1.7 Example procedure for transfer out of the escalation ward

Where a patient's condition changes clinically and they are no longer appropriate for treatment within the escalation ward, they will be transferred to the appropriate base ward which clinically suits their needs:

- The nurse in charge must inform the Clinical Site Manager as soon as possible of the patient's deterioration
- The Clinical Site Manager will identify and allocate an appropriate specialty bed

Patients should not be transferred from the ward without the following:

- Clearly documented management plan recorded in the medical notes (junior doctor). Completion of transfer sticker
- Updated documented EDD (MDT review – named nurse to record).
- Full explanation to the patient and family as to why they are moving and where to (named nurse).
- Verbal handover to the receiving teams (junior doctor and named nurse).
- PODS

Failure to transfer patients should be taken to operations at the Trust Capacity and Flow meetings.

8.1.8 Staffing of the escalation area

8.1.8.1 Medical Staff

There is no additional Medical cover for the escalation ward. It is the responsibility of the **specialty teams identified on the outlier list** to provide appropriate medical/surgical cover (this should also be clearly documented in the medical notes). Out of hours issues with medical cover should be discussed with the on-call Consultant and Silver Command.

8.1.8.2 Nursing Staff

There is no additional permanent resource for the provision of nursing staff for the ward. During periods of escalation **nurses will be identified from within the escalating specialty where possible**. Staffing levels will be reviewed by the Associate Chief Nurse/Deputy/Silver Command to ensure safety of patients. Attention should be given to ensure nursing staff are competent to administer intravenous medications and blood transfusions. Safe staffing should be 2RN/2NA per shift

When safe staffing levels cannot be delivered from within ward staffing reallocation, specialist nurses should be considered part of the rota (for their own division). This should be used to allow some ward cover so that ward staff can be released to Escalation and/or bank nurses to be placed on ward areas to release staff to this facility. Availability of specialist nurses will be dependent on their

workload and will only be within normal working hours during proposed months of escalation. This also must consider any pre-booked annual leave and should not result in the cancellation of any outpatient clinics.

8.1.9 Authorisation form for opening an escalation ward area

Location of escalation area				
Trust Escalation status at time of opening	OPEL 1 **Green** ☐	OPEL 2 **Amber** ☐	OPEL 3 **Red** ☐	OPEL 4 **Black** ☐
Incident form completed by	Date/time: _____			

Escalation ward opening – checklist for key actions and points of contact:

Action	Time & date	Notes on information given/ requests made/ Issues	Who by
Estates and facilities bleep informed			
Catering informed			
Security informed			
Pharmacy informed			
Each relevant divisional bleep holder informed (depending on specialty use)			
"Escalation Area Equipment Checklist" completed			
Emergency equipment, bedside oxygen and suction checked & functioning			
All essential IT equipment available and functioning			
Email re opening to all on call teams, divisional directors, site team and divisional ACN network			

Confirmation of authorisation of opening of escalation ward	
Name of authoriser (Gold command)	
Signature of authoriser	
Date and time of opening	

8.1.10 Opening an Escalation Area Equipment Checklist

Items with an * are essential, the area must not be opened until they are present

Items	Acquired/checked Y/N	Staff member signature	Notes/ issues/ action taken
KITCHEN			
Jugs*			
Cups*			
Cup Holders			
Cutlery*			
Hot drinks dispenser trolley*			
Basic food supplies – cereal, bread, milk etc*			
Water heater*			
Fire blanket*			
EMERGENCY EQUIPMENT			
Cardiac arrest trolley – complete with Defibrillator*			
Wall oxygen and suction equipped, checked and working*			
Portable suction in working order*			
Portable oxygen in working order*			
Fire extinguishers*			
CLINICAL SUPPLIES			
Oxygen tubing and connectors – various sizes*			
Oxygen masks – variety*			
Suctioning catheters and tubing*			
Drip stands*			
IV giving sets*			
Commonly used medications* (refer to medication checklist)			
Drug Trolley with keys*			
Pod locker keys			
CD cupboard keys and CD record book*			
Syringes – variety of sizes*			
Insulin Syringes*			
IV prep equipment* (e.g., bungs)			
Sterile trolleys for IV prep			
Sterile trolleys for dressings			
PA trolley including phlebotomy equipment			
Dressing packs			

Items	Acquired/checked Y/N	Staff member signature	Notes/ issues/ action taken
OFFICE NEEDS			
Access to a handover sheet template*			
Computers and printers in working order*			
Printer paper*			
Basic stationery* (refer to "*Commonly used documentation*" section below)			
Telephones*			
INFECTION CONTROL			
Cutan foam hand sanitizer and holders*			
Soap for dispensers*			
Hand towels*			
PPE supplies*			
SLUICE			
Commodes*			
Bed pans*			
Commode/bed pan liners*			
Urine bottles*			
Catheter bags and relevant equipment*			
Equipment for personal hygiene* (e.g. wipes, toothpaste etc)			
Toilet tissue*			
Linen*			
Linen skips*			
Waste bags*			
Continence pads*			
Disposable slings for hoist in xlge and lge*			
Disposable slide sheets*			

Items	Acquired/checked Y/N	Staff member signature	Notes/ issues/ action taken
OTHER EQUIPMENT			
Use of a hoist and appropriate slings*			
Sliding sheets			
PAT slide*			
Bladder scanner			
ECG			
Point of care testing equipment including scanners and label printers**			
Glucometer*			
Sharps bins*			
Dynamap*			
Thermometers*			
Pulse oximeters (if not on Dynamap)			
Sphygmomanometers			
Nebuliser			
COMMONLY USED DOCUMENTATION			
Death certificate book			
PALS 'What happens next' leaflet			
Anticoagulation books			
Ward register			
Printer paper			
OCS paper			

Please complete the checklist.
All emergency equipment must be checked to be in working order.

Enough documents and folders must be provided to ensure that patients' records can be stored in a safe and confidential way.

Signature of operational matron / senior sister / ACN to confirm that ward is prepared and safe to be opened

Signature ……

Print name……

Date and time ……

8.1.11 Authorisation form for closing an escalation ward area

Location of escalation area				
Trust Escalation status at time of closure	OPEL 1 **Green** ☐	OPEL 2 **Amber** ☐	OPEL 3 **Red** ☐	OPEL 4 **Black** ☐

Escalation ward closure – checklist for key actions and points of contact:

Action	Time & date	Notes on information given/ requests made/ Issues	Who by
Estates and facilities informed		Request that ward is locked down after closing	
Contact centre informed		Inform that ward is closed	
Catering informed			
Domestic team informed		Request ward & side-rooms cleaning; bed space checklist by all beds	
Nurse bank contacted		Ensure requests are cancelled	
Security informed		Inform them ward is closed	
Pharmacy informed			
Documentation and patient sensitive info secured; EPIC updated; computers secured			
Email re closure to all on call teams, divisional directors, site team and divisional ACN network			
Controlled drugs reconciled and signed			
Ward keys returned to matron and book signed			
"Escalation Area Closure Equipment Checklist" completed			

Confirmation of authorisation of closure of escalation ward	
Name of authoriser (Gold command)	
Signature of authoriser	
Date and time of closure	

8.1.12 Closing an Escalation Area Equipment Checklist

Items	Implemented Y/N	Staff member signature	Notes/ issues/ action taken
KITCHEN			
All jugs, cutlery trolley and hot drinks dispenser will remain in the kitchen.			
Basic food supplies – cereal, bread, milk etc (Housekeeping will remove perishable food)			
EMERGENCY EQUIPMENT			
Cardiac arrest trolley – complete with Defib (must be checked when ward closes)			
Portable suction in working order			
Wall oxygen and suction in working order & restocked			
Portable oxygen in working order (ensure cylinders are full and ready for use prior to closing)			
CLINICAL SUPPLIES			
Inform procurement ward is closed 4305 (in hours) Procurement will top up as usually on Mondays			
Drug trolleys (store in prep room)			
Ward keys (return to operations centre sign in book)			
CD record book and CD drugs (ensure checked before closing)			
Ward storeroom keys (lock in CD cupboard)			
OFFICE NEEDS			
Paper documentation – commonly used paperwork and charts (top up before closing)			
SLUICE			
Blood bags and sharps bins (contact 2696 - waste team to collect)			

Items	Implemented Y/N	Staff member signature	Notes/ issues/ action taken
OTHER EQUIPMENT			
Drip stands (store in bathroom)			
Point of care equipment			
Bladder scanner			
ECG			
Glucometer			
Dynamaps (store and charge in equipment room)			
Thermometers (store in equipment cupboard at nurses' station)			
Pulse oximeters (store in equipment cupboard at nurses' station)			
Nebuliser (store in equipment cupboard under nurses' station)			
Scales (store and charge in equipment room)			

Please ensure that the list is completed. All emergency equipment must be cleaned.

The ward must be left in a tidy state, ready for cleaning.

Signature of operational matron / senior sister / ACN to confirm that ward is prepared for closing.

Signature ……

Print name……

Date and time ……

8.1.13Trust policies

All Trust policies and procedures will apply to the operation of the escalation ward. All Nursing and multidisciplinary internal / external audits will commence and continue for the duration that the ward is open. These will be presented with the Nursing metrics and quality reports for the Executive Board.

8.1.14Monitoring

The ward will have clear Key Performance Indicators (KPIs) for which the Nurse in Charge will be accountable for the delivery of including;

- Bank/agency usage
- Sickness and HR issues
- Bank/agency usage
- Training uptake (e.g. IG compliance)
- Appraisal rates
- Complaints and learning
- Nursing indicators
- Standards and performance
- Budget management
- Risk registers and preparedness

8.2 Opening of additional beds

This is a copy of the Trust's SOP for the opening of additional beds. It is included in full here, however the most up-to-date version will always be found on the intranet, or from the Trust's Urgent and Emergency Care leadership.

Brief Description

This document outlines the standard operating procedure for the opening of escalation beds.
Depending on operational demands these escalation beds can be flexed up to 33 beds.

The opening of escalation beds and/or expansion of the bed base can only be undertaken following detailed planning around both nursing and medical staff to support. This plan should cover the immediate 24hrs post opening and then reviewed at the formal staffing huddles throughout the working day. If the ward needs to be considered at weekends discussions are to take place between silver and gold on call plus senior nursing team.

The escalation beds will be managed by the Medicine Consultant team. All patients must be transferred with a consultant approved treatment plan and EDD.

Due to the pressures placed on the organisation these consultants may be locums, they will undertake daily Consultant review. Any consultant to consultant referral activity must be identified early and a decision made as to whether the patient is required to stay for that specific consultant review or seen in OPD. Consultant to consultant referral will be made via a direct phone call.

Admission will be the responsibility of the nurse in charge of the escalation beds (substantive member of QEH staff) in conjunction with the silver on-call or site manager OOH and at weekends. The Clinical Site Manager must be kept informed of all planned patient moves between ward areas. PAS should be updated at the earliest opportunity. No moves onto the ward can occur post 22.00.

1. INTRODUCTION

1.1 This operational policy describes the pathway of care for patients requiring in-patient care when all base ward beds are full. The use of this area should be discussed at each bed meeting and the clinical advantages of using escalation beds articulated and risk assessed. However, it is important that the patient journey is given careful consideration and if there is a likelihood that if closed, the ward may well open the following day due to lack of flow and operational demands this must be factored into the decision process.

2. PURPOSE

2.1 The purpose of this policy is to outline the standards of care for patients treated within this area and to provide clear operational guidance to ensure the above are achieved.

2.2 The escalation beds aims to provide a clinically appropriate and safe environment to care for patients, who have been identified as requiring admission but due to capacity there are no base ward beds available, in line with the Criteria for Admission on page 5 of this Standard Operating Procedure.

If patients deteriorate during their stay there is a clear process and mechanism to recover the patient back to an acute medical ward. However teams need to be mindful of number of moves a patient has already experienced.

3. DEFINITIONS

3.1 Escalation beds are temporary inpatient beds used at times of extreme pressure were demand significantly exceeds capacity and patient safety may be compromised.

4. RESPONSIBILITY

4.1 **Appropriate patient base**

4.2 The patient group should be patients who have been reviewed and post-take and have a treatment plan in place.

4.3 **Operational responsibility**

4.4 When the ward is open it will be managed within the existing governance structures of the Medical Division, reporting to the Divisional Board. The Head of Nursing for the Division of Medicine will oversee all nursing requirements assisted by a medical matron.

5. Criteria for Admission

Criteria	
Essential If this patient is to outlie, these criteria **MUST** be met for **ALL** patients, regardless of speciality	The patient has a confirmed diagnosis and/or a treatment and discharge plan is in place. (*NB this is not a mandatory field for AZ).
	The patient is clinically stable and has not experienced any deterioration in their condition in the previous 24 hours. The NEWS score is within expected limits for patient.
	The patient's resuscitation status is known/clearly documented.
	The patient has not experienced any symptoms of diarrhoea or vomiting within the last 72 hours.
	The patient is not suffering from acute delirium or exhibiting significant behavioural issues.
	The patient does not pose a risk to other patients, staff or themselves e.g. severe dementia.
	The patient does not have a grade ¾ pressure ulcer and/or complex wound.
	The patient has not previously been outlied (for non-clinical reasons) during this episode of care/current admission.
	The patient is not expected to die or on end of life pathway
	The patient has no known learning disabilities that should preclude them from being outlied.
	No bariatric patients.
	No acute stroke patients.
Desirable Patients who meet ALL of the above essential criteria but SOME of the desirable criteria may be suitable to outlie where this has been agreed.	The Patient is pain free or on a stable analgesia regime
	The predicted date of discharge will normally be within 72 hours
	The patient has completed their acute phase of their admission and no longer requires active treatment

Additional Emergency Assessment Unit (AZ) Criteria	
1	The patient has been reviewed on a post take ward round by a medical consultant or their deputy and allocated a specialty.
2	The patient has had a full medical clerking completed as well as nursing admission and a treatment and investigation plan is documented in the notes.
3	The patient has a consistently recorded NEWS score below 3 on two consecutive occasions.
4	The patient has had medications and intravenous fluids prescribed.
5	The patient does not require vital signs monitoring more frequently than 4 hourly
6	The patient does not require specialist interventions or treatments requiring close observation.

All decisions must be supported by clinical professional judgement during the assessment of patients against this criteria.

6. Transfer from Escalation Beds

6.1 **Where a patient's condition changes clinically and they are no longer appropriate for treatment within Leverington ward, they will be transferred to the appropriate base ward which clinically suits their needs.**

6.2 **The Nurse in Charge must inform the Clinical Site Manager as soon as practically possible that a patient's condition has deteriorated. An appropriate specialty bed will be identified and allocated by the Clinical Site Manager.**

6.3 **Patients must not be transferred from the ward without completion of SBAR transfer documentation (Appendix 1), supported by a verbal handover.**

6.4 **Any concerns regarding care and management of patients on the escalation area, must be escalated appropriately in line with Divisional and Trust procedures.**

7. WARD STAFFING LEVELS

7.1 **Medical Staff All patients will have a named consultant responsible for their care. Weekend Consultant cover will be provided by the on-call physician as required.**

7.2 **Nursing Staff Staffing levels will be assessed and agreed by the Senior Nursing Team and flexed according to patient numbers, acuity and dependencies. There will be a minimum of 2 Registered Nurses per shift, one of which will be a substantive member of QEH staff. Other AHP and support staff will be allocated as appropriate from existing teams and included in the opening checklist. (Appendix 2).**

8. TRUST POLICIES

8.1 **All Trust policies and procedures will apply to the operation of this unit. All Nursing and multidisciplinary internal / external audits will commence and continue for the duration that the Ward is open. These will be presented with the Nursing metrics and quality reports for the Executive Board.**

9. Appendix 1 - Trust SBAR Telephone Referral Tool

NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

SBAR

Adult Patient Transfer Handover Sheet

Addressograph

Situation

Hospital Admission Date:_____

Discharge Ward/Hosp:_____

Date & Time Transfer agreed:_____ Receiving Ward/Hospital:_____

Consultant Transferred from:_____ Consultant Transferred to:_____

Transfer Authorised by PRINT:_____ SIGN:_____ DATE:_____

DNA CPR: Yes☐ No☐ **NOT DISCUSSED:** ☐ **Documentation Complete:** Yes☐ No☐

NOK informed: Yes☐ No☐ If "Yes", Who:

Background

INFECTION STATUS

Swab/Samples sent: Yes☐ No☐

Date:_____

IPAC's aware: Yes☐ No☐

Other potentially infectious diseases: Yes☐ No☐

If "yes":_____

Isolation Required: Yes☐ No☐

Discussed with Receiving Ward: Yes☐ No☐

Allergies: Yes☐ No☐

If "yes":_____

BACKGROUND

Presenting Condition:

Verbal handover or relevant medical history:

Outline of treatment and nursing care so far:

Family/Carer Involvement Yes☐ No☐

Diabetic Ipswich Test Touch Yes☐ No☐

Enhanced care level Yes☐ No☐

Cognitive Impairment Yes☐ No☐

MCA/DOLS in place Yes☐ No☐

Risk of Falls Yes☐ No☐

Waterlow Score Yes☐ No☐

Pressure Ulcer Yes☐ No☐

Urinary Catheter Yes☐ No☐

Cannula Yes☐ No☐

Blue Ribbon Patient (Silver aware) Yes☐ No☐

Dietary Requirements:_____ MUST Score Yes☐ No☐

Assessment

Transfer Risk Flowchart Category: _____

Escort Required: Yes☐ No☐ Registered ☐ Unregistered ☐

Suction Required: Yes☐ No☐

Oxygen Required: Yes☐ No☐

% or Flowrate:_____ **(2 Full Cylinders for transfer)**

Oxygen Cylinder Valve: ON/OFF Switch Yes☐

Obs taken in hour before transfer: Yes☐ No☐

Most recent NEWS2 Score:_____ **Time:**_____

Frequency of Obs: 1hr☐ 2hr☐ 4hr☐ 6hr☐ Other:___

Neurological Observations Required: Yes☐ No☐

Summarise all current nursing needs:

Immediate concerns:

Insulin requirements:_____ N/A☐

Latest BM:_____ Time:_____ N/A☐

CD/Fridge Medication: Yes☐ No☐ Patient Clerked: Yes☐ No☐

Property: Yes☐ No☐ Senior Review: Yes☐ No☐

Valuables: Yes☐ No☐ Mental Health Triage: Yes☐ No☐

Recommendations

Bloods to review: Yes☐ No☐

_____

Outstanding tests, care needs, referrals: Yes☐ No☐

_____

Drug Chart checked: Yes☐ No☐

Continuous IV infusion: Yes☐ No☐

Clear plan in hospital notes: Yes☐ No☐

If "yes" discussed with patient/carer: Yes☐ No☐

Date:_____ Time:_____

Confirm Patient Centre Transferred: Yes☐ No☐

Planned Discharge Date:_____

Receiving ward aware of equipment required: Yes☐ No☐

Oxygen ☐ Bed Space☐

Mattress: Invacare☐ Nimbus 3☐ Equivalent☐_____

IV Pump☐ Syringe Driver☐ Epidural☐ PCA☐ **IV Fluids:** Yes☐ No☐

Other Specialist Equipment (eg., bariatric, tracheostomy etc):

Outstanding preparation for discharge:

Has all the patient's own medication been collected & ready for transfer: Yes☐ No☐ If "no", give details:_____

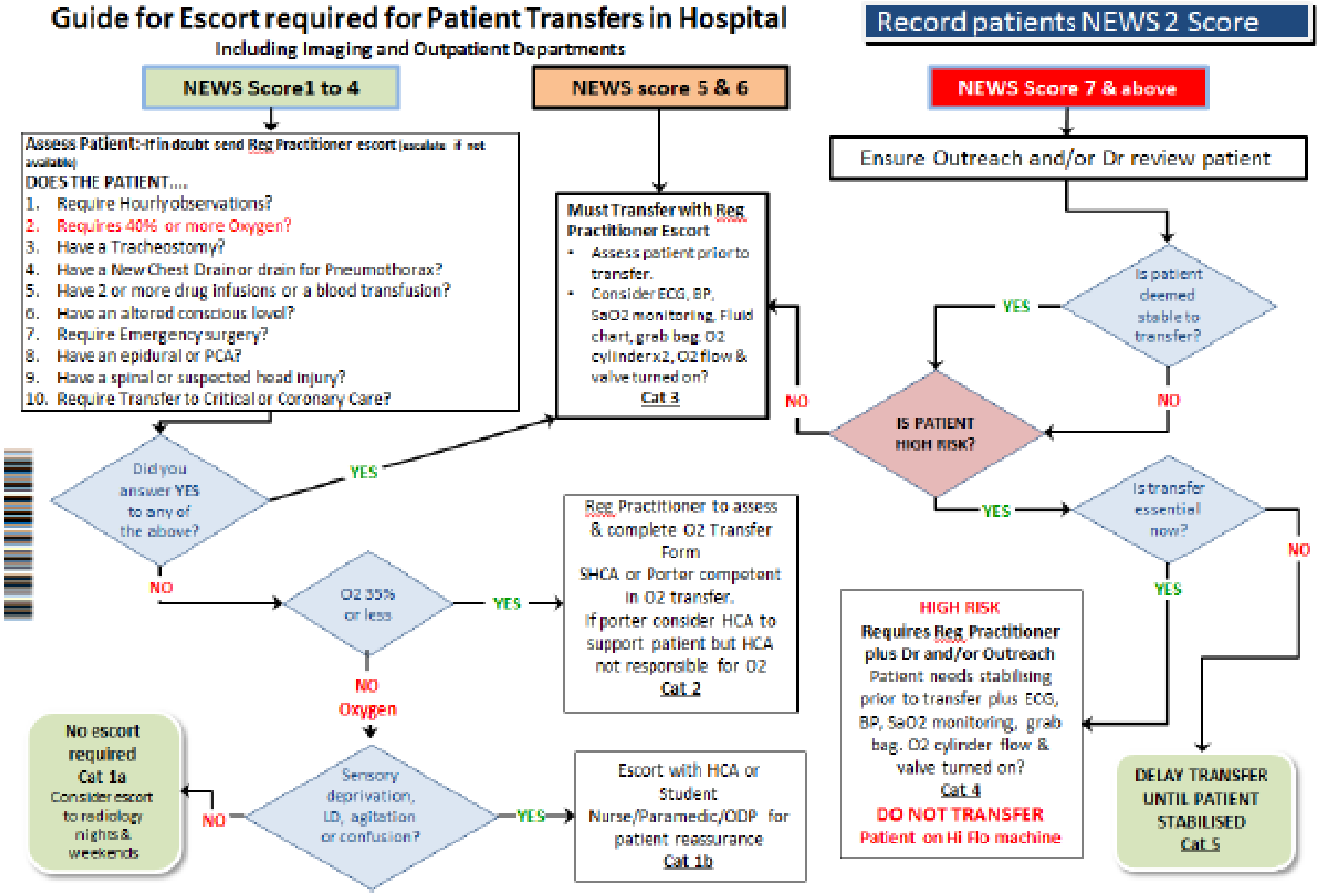
Outgoing Ward Nurse: PRINT:_____ Sign:_____

Incoming Ward Nurse: PRINT:_____ Sign:_____

Face to Face☐ Telephone☐ Initial:_____ Date:_____ Time:_____

Guide for Escort required for Patient Transfers in Hospital

Including Imaging and Outpatient Departments



10. Appendix 2 - Trust Escalation beds opening checklist

The site team have key location information and door security codes

Trust escalation status at time of opening: ……

Authorised by ……..……

Date opened ……

Connect updated with status (date & who by?) ……..……

Incident form completed (date & who by?) ……

Trust contingency area - Points of contact / Key actions:

PERSON/ AREA TO CONTACT	TIME/ DATE OF CONTACT	NOTES ON INFORMATION GIVEN/ REQUESTS MADE/ ISSUES	WHO BY
Estates and facilities			
Catering / Domestic			
Security			
Pharmacy			
Switchboard			
Point of Care Lead			
Complete the opening extra beds form			
Porters to collect escalation cases			
Escalation Drug trolley to be collected from Pharmacy by Registered Nurse			
Review and notify co-located speciality clinical team – In hours			
Bleep holder Contact all divisional bleep holders		• Medical – Ext 1290 • Surgical – Ext 1227 • Women & Children - 1232	

Emergency equipment, bedside oxygen and suction checked & functioning including Resus trolley			
All essential IT equipment available and in working order on ward			

11. Appendix 3 - Trust escalation bed area check list - Equipment:

Note: items with a * are essential and the area must not be opened until they are present.

ITEMS	ACQUIRED/CHECKED Y/N	SIGNATURE OF STAFF MEMBER	NOTES/ ISSUES/ ACTION TAKEN
KITCHEN			
Jugs*			
Cups*			
Teapot			
Cutlery*			
Hot drinks dispenser trolley*			
Basic food supplies – cereal, bread, milk etc*			
Water heater*			
Fire blanket*			
EMERGENCY EQUIPMENT			
Cardiac arrest trolley – complete with Defibrillator*			
Wall oxygen and suction equipped, checked and working*			
Portable suction in working order*			
Portable oxygen in working order*			
Fire extinguishers*			
CLINICAL SUPPLIES			
Oxygen tubing and connectors – various sizes*			
Oxygen masks – variety*			
Suctioning catheters and tubing*			
Drip stands*			
IV giving sets*			

ITEMS	ACQUIRED/CHECKED Y/N	SIGNATURE OF STAFF MEMBER	NOTES/ ISSUES/ ACTION TAKEN
Commonly used medications* (refer to medication checklist)			
Drug Trolley with keys*			
Pod locker keys			
CD cupboard keys and CD record book*			
Syringes – variety of sizes*			
Insulin Syringes*			
IV prep equipment* (i.e. bungs etc)			
Sterile trolleys for IV prep			
Sterile trolley for dressings			
Trolley including phlebotomy equipment			
Dressing packs			
OFFICE NEEDS			
Access to a handover sheet template*			
Notes Trolley			
Computers and printers in working order*			
Printer paper*			
Basic stationery* ie Death Certificate, Self-discharge books. PALS "What happens next?" leaflets - refer to commonly used documentation list			
Telephones*			
INFECTION CONTROL			
Cutan foam Hand Sanitizer and holders*			
Soap for dispensers*			
Hand towels*			
PPE supplies*			
SLUICE			
Commodes*			
Bed pans*			
Commode/bed pan liners*			

ITEMS	ACQUIRED/CHECKED Y/N	SIGNATURE OF STAFF MEMBER	NOTES/ ISSUES/ ACTION TAKEN
Urine bottles*			
Catheter bags and relevant equipment*			
Equipment for personal hygiene* (e.g. wipes, toothpaste etc)			
Toilet tissue*			
Linen*			
Linen skips*			
Waste bags*			
Continence pads*			
Disposable slide sheets*			
OTHER EQUIPMENT			
Use of a hoist and appropriate slings*			
PAT slide*			
Lockers			
Tables			
Chair			
ECG			
Point of care testing equipment including scanners and label printers*			
Glucometer*			
Sharps bins*			
Dynamap*			
Thermometers*			
Pulse oximeters (if not on Dynamap)			
Nebuliser			

Please complete the checklist. All emergency equipment must be checked to be in working order. Sufficient documents and folders must be provided to ensure that patients' records can be stored in a safe and confidential way.

Signature of Clinical Site Manager or Clinical Silver On-Call to confirm that ward is prepared and safe to be opened

Signature ……

Print name ……

Date and time ……

12. Appendix 4 - Trust escalation area checklist – commonly used documentation that needs to be available

Documentation	Acquired/ checked Y/N	Signature of staff member	Notes/ issues/ action taken
Death certificate book			
'What happens next' leaflet			
Anticoagulation books			
Ward register			
Printer paper			
OCS paper			

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NHS Foundation Trust

13. Appendix 5 - Trust escalation area closing checklist

Trust status at time of closure: ……..

Authorised by ……

Date closed……Time:……..

Trust contingency area – Points of contact:

PERSON/AREA TO CONTACT	TIME/DATE OF CONTACT	NOTES ON INFORMATION GIVEN/ REQUESTS MADE
Estates and facilities		Request that ward is locked down after closing
Ops centre		Inform that ward is closed
Catering		
Domestic team		Inform that ward is closing, and request clean for the ward. Place bed space checklist by all beds. Ensure side rooms have the appropriate level clean.
Nurse bank		Ensure requests cancelled
Security		Inform them ward is closed
Pharmacy		
Emergency equipment, bedside oxygen and suction checked & functioning		

DRAFT - NOT FOR CIRCULATION

All documentation and patient sensitive information secured EPIC updated Computers closed down and secured		
Switchboard		
Point of Care Lead		
Notes Trolley to be returned		
Escalation cages to be repacked and returned		
Locker, table and chair to be cleaned and returned		
Escalation Drug trolley to be returned to Pharmacy by Registered Nurse		
Review and notify co-located speciality clinical team – In hours		
Bleep holder Contact all divisional bleep holders		• Medical – Ext 1290 • Surgical – Ext 1227 • Women & Children - 1232
Emergency equipment, bedside oxygen and suction checked & functioning including Resus trolley		
All essential IT equipment to be secured.		
Email communication to update re: ward closure sent to all on-call teams, divisional directors, site team and divisional lead nurse network		
CDs reconciled and signed		
Ward keys handed to operational matron and book signed		

Trust escalation area closure check list - Equipment

ITEMS	IMPLEMENTED Y/N	SIGNATURE OF STAFF MEMBER
KITCHEN		
All jugs, cutlery trolley and hot drinks dispenser will remain in the kitchen.		
Basic food supplies – cereal, bread, milk etc (Housekeeping will remove perishable food)		
EMERGENCY EQUIPMENT		
Cardiac arrest trolley – complete with Defib (must be checked when ward closes)		
Portable suction in working order		
Wall oxygen and suction in working order & restocked		
Portable oxygen in working order (ensure cylinders are full and ready for use prior to closing)		
CLINICAL SUPPLIES		
Inform procurement ward is closed 4305 (in hours) Procurement will top up as usually on Mondays		
Drug trolleys (store in prep room)		
Ward keys (return to operations centre sign in book)		
CD record book CD drugs (ensure checked before closing)		
Ward storeroom keys (lock in CD cupboard)		
ITEMS	**IMPLEMENTED Y/N**	**SIGNATURE OF STAFF MEMBER**
OFFICE NEEDS		
Paper documentation – commonly used paperwork and charts (top up before closing)		
SLUICE		
Blood bags and sharps bins (contact 2696 waste team to collect)		
OTHER EQUIPMENT		
Drip stands (store in bathroom)		
Point of care equipment		
Bladder scanner		
ECG		
Glucometer		
Dynamaps (store and charge in equipment room)		

Thermometers (store in equipment cupboard at nurses station)		
Pulse oximeters (store in equipment cupboard at nurses station)		
Nebuliser (store in equipment cupboard under nurses station)		
Scales (store and charge in equipment room)		
Please ensure that the list is completed. All emergency equipment must be cleaned. The ward must be left in a tidy state, ready for cleaning.		
Signature of operational matron or senior sister/ SCN to confirm that ward is prepared for closing. Signature…… Print name…… Date and time……		

8.3 Opening of winter ward

[Currently being drafted – to be provided by Deputy Chief Nurse]

8.4 Ambulance handover SOP, including escalation of delays

This is a copy of the Trust's SOP for the coordination of ambulance handovers, including management of delays. It is included in full here, however the most up-to-date version will always be found on the intranet, or from the Trust's Urgent and Emergency Care leadership.

8.4.1 INTRODUCTION

The purpose of this Standard Operating Procedure (SOP) is to provide details of the process for ambulance offload within the Emergency Department (ED). The current space limitations mean that the department fails to provide adequate privacy for those patients undergoing initial assessment when arriving by ambulance. Where there is no space for patients to be offloaded, there is a risk that patients do not receive timely medical or nursing assessments. In order to mitigate some of the risks associated with this practice and maintain the privacy and dignity of patients, this SOP has been developed with clear instruction for escalation when the ED is at full capacity.

The assessment of patients on the back of ambulances has always been a contentious issue but the position of NHS England on clinical responsibility was clarified in a letter in November 2017 stating that:

> *"The patient is the responsibility of the ED from the moment that the ambulance arrives outside the Emergency Department, regardless of the exact location of the patient."*

8.4.2 PURPOSE AND SCOPE

This SOP is designed to ensure that safe, timely and effective handovers take place between ambulance crews and ED, thereby ensuring efficient use of resources both within the hospital and the wider community.

The aim is to reduce the delays experienced by the ambulance service and will improve the patient's experience, along with standardising the process for escalating delays.

Pre-alerts requiring resus will be afforded priority offload as per the department's normal procedures.

8.4.3 RESPONSIBILITIES

8.4.3.1 Chief Executive Officer (CEO)

The CEO is responsible for ensuring compliance with National access standards.

8.4.3.2 Gold Command

Gold Command is responsible for providing operational expertise to support the delivery of this SOP, enacting plans to support flow from ED once ambulance offload delays reach 55 minutes and for sharing details of the plan with the relevant ambulance service operations cell, as well as escalating to the CCG Director On Call and the NHSE/I Director.

8.4.3.3 Medicine Divisional Leadership Team (DLT)

The General Manager, Head of Nursing and the Divisional Director for the Division of Medicine or deputies are responsible for ensuring compliance with this policy.

8.4.3.4 Silver Command

Silver Command is responsible for contacting the relevant ambulance service operations cell with a plan for offload for delays over 30 minutes and in instances where there is no plan, is responsible for escalating to Gold Command.

8.4.3.5 Head of Nursing for Medicine

The Head of Nursing for Medicine or deputy is responsible for the safe staffing of cohorted patients in hours.

8.4.3.6 Clinical Site Manager (CSM) (Bronze Command)

The CSM, who is the Trust designated Bronze Command, is responsible for identifying beds for patients in ED in order to create flow. Where no plan can be identified which results in an ambulance handover delay of 15 minutes, the CSM is responsible for escalating to Silver Command for support.

8.4.3.7 ED Consultant

The ED Consultant is clinically responsible for all patients listed on the Emergency Department Information System (EDIS), jointly with the relevant Specialty consultant for those patients who have been referred for specialist care.

8.4.3.8 Specialty Consultant

Specialty consultants will be responsible for cohorted patients who have been clerked by the relevant team and will share responsibility for patients still within the ED who are awaiting specialty review.

8.4.3.9 ED Nurse in Charge / ED Co-ordinator

The Nurse in Charge is responsible for managing flow within the ED and escalating to the CSM at 15 minutes if there is no plan to offload.

8.4.3.10 Allocated Ambulance Handover Healthcare professional

The Ambulance Handover Healthcare Professional is responsible for taking a timely clinical handover. Please see Section 8.4.12.

8.4.3.11 Ambulance Crews

The crews are responsible for ensuring a timely handover (clinically and administratively) and offload to the ED Handover Healthcare professional, and for the timely input of the PIN following handover on the EEAST/EMAS inbound screen.

8.4.3.12 Divisional Bronze

The Divisional Bronze representatives for the day are responsible for supporting to resolve any blockages impacting flow identified by the Site Team and Ward staff. Therefore assisting to create capacity on the wards to decompress the Emergency Department.

8.4.4 ROUTINE PROCESS FOR AMBULANCE HANDOVER

The ambulance handover navigator is situated near the ambulance entrance to the department. They are responsible for the coordination of crews through the department. Patients will be offloaded into the ambulance handover area (previously Obs Bay and CDU)

which has capacity for six patients on hospital trolleys, directly into Resus if this is clinically required, directly to a major cubicle space if they require isolation (i.e. potentially infectious or neutropenic patients), into the "Fit to Sit" bay (M10), or the main department waiting room. M9 will be kept as the assessment and treatment room for patients within the "Fit to Sit" area so that privacy and dignity can be maintained.

In the ambulance handover area, crews will be greeted and allocated to a bay for initial assessment. Once offloaded, the crew will enter their pin at the staff base reception area and exit the area via the doors toward the main department (not back through to entrance corridor). There is a one-way system in operation through the offload area. Crews can collect linen on the way past the main department store before leaving the department. The nursing team will undertake initial assessments and investigations as appropriate for patients.

The department has a designated red bay creating "drop and go" capacity which can be used to release an ambulance crew to respond to a Category 1 call in the community if all other vehicles are in use. The red bay is located next to "Fit to Sit" (M10).

To ensure that flow through the ambulance offload area is maintained, patients should be moved from the ambulance handover area to the main department within 40 minutes of arrival.

If the capacity required for ambulance offload exceeds six patients, internal cohorting should be commenced.

8.4.5 COHORT OF PATIENTS IN THE AMBULANCE HANDOVER ESCALATION AREA

A maximum of four patients can be cohorted within the ED ambulance entrance corridor and will be under the care of a suitably qualified healthcare professional. This is known as the ambulance handover escalation area.

Patients that have been pre-alerted requiring resus will take priority as per normal processes; in the event that resus is full, the most clinically stable patient will be moved out of resus and transferred to the next available cubicle. In this event the ED Co-ordinator will escalate to the CSM the urgent need of capacity.

It is expected that those patients allocated to the ambulance handover escalation area will be transferred from an ambulance trolley to a hospital trolley whilst maintaining the patient's privacy and dignity. These patients will then be allocated cubicles in time order as they become available unless an urgent clinical need is established. The use of resus should be avoided unless there is a clinical need.

It should be established on arrival whether a patient is awaiting a major or a minor cubicle and any patients that are 'fit to sit' should be allocated to the waiting room or "Fit to Sit" area and handed over.

Interventions in the ambulance handover escalation area should be kept to a minimum, and consent should always be obtained. The use of screens is essential to ensure patient privacy.

Acceptable interventions would be:

- Taking blood and inserting a cannula
- Administering IV or oral drugs
- Performing an ECG (careful consideration should be given as to whether this can wait for a free cubicle)
- A brief history and superficial examination can be performed but the patient should not be undressed.
- Ordering x-rays or CT scans

All interventions done should be documented on EDIS.

M9 can be used for performing brief interventions but will need to be vacated once necessary interventions are complete to ensure all cohorted patients receive interventions in a timely manner.

A log of associated actions and rationale will be recorded by the Shift Coordinator as part of their Daily Log.

Ambulance handovers that are over one hour and rationale for why, will be recorded by the Shift Coordinator as this may be required to be reported to the CCG (NHS England, 2017)

8.4.6 REQUIREMENT FOR COHORT OF >4 PATIENTS

In the instance where all cohort capacity in the ambulance handover and escalation area is in use and there are no immediate plans for transfer of patients awaiting beds, enacting Full Capacity Protocol should be considered in discussion with Gold On Call.

When additional cohorting in-hours (08:00-17:30) is required, options are to be discussed with Clinical Lead for the Emergency department and Clinical Site Manager / Silver Command.

8.4.6.1 Additional Cohorting Out of Hours

The decision to create additional cohort capacity out of hours is an exceptional action to manage ambulance handover delays.

The trigger for implementing this is a delay to offload of 45 minutes with no clear plan to be able handover by 60 minutes.

Site Manager & ED Nurse in Charge agree the trigger has been met and Silver Command is informed of decision to commence cohorting as above. Gold Command should be informed but not required to agree activation.

EEAST support will be a two-person crew to manage up to three patients. The EEAST crew must consist of at least one paramedic. A walkie-talkie radio should always be held by the cohort crew to ensure patient safety

8.4.6.2 Where to place additional cohort capacity out of hours

Out of hours cohorting may take place in the Fracture Clinic (plaster room). This is usually available from 17:30 Monday – Friday and all weekend.

Additional cohorting capacity of up to three trolley spaces will be made available in the Fracture Clinic. There is limited space for beds therefore, if patients are on inpatient beds the capacity will be limited to two spaces in order to manage care safely and maintain dignity for the patients.

As a Trust we **DO NOT** support corridor care under any circumstances.

8.4.6.3 Criteria for additional cohort capacity

The ED Nurse in Charge will identify patients that are clerked and awaiting transfer to an inpatient area. If there are no appropriate clerked patients un-clerked patients may be identified, in this instance identified patients **MUST** have Senior clinical authority to be cohorted and this needs to be documented in the notes. ED Nurse in Charge will identify patients with stable physiological observations of the same sex and clear management and treatment plans.

If there are no suitable patients awaiting inpatient beds the Nurse in Charge & EPIC (or Senior Decision Maker overnight) will agree three patients from any of the following:

- The ambulance handover area
- Patients under the care of ED that are expected to go home currently occupying a trolley
- Delayed Ambulances waiting to handover

Senior decision makers in ED must assist in clinically safe decisions for patients that are cohorted.

8.4.6.4 Exclusion criteria

Exclusion criteria for cohorting patients will be:

- Patients with known dementia or acute confusion
- Acute mental health presentation, (no risk assessment in fracture clinic for mental health patients)
- Concerns of IPC (Infection control)
- NEWS2 > 4
- Ongoing unstable chest pain or abnormal ECG

- Patients requiring on-going cardiac monitoring
- Under 16s

8.4.6.5 Deterioration of patients in the Cohort area

If the clinical observations of a patient deteriorate leading to an increase in the NEWS2 score by 2 points or more, this should be escalated to the Nurse in Charge or the handover Healthcare Professional. There should be agreement on next actions which will be based on the clinical condition of the patient.

Following escalation of a deteriorating patient to the nurse in charge following should take place:

Prompt discussion with senior nursing team and agreement as to the safest place to continue to care for the patient.

In the event of sudden and significant reduction in GCS (more than 3 points) the patient should be moved to the resus area immediately. (This may displace other resus patients, internal escalation of this need will also include the rapid transfer the next patient who is scheduled to transfer to the ward (even if bed not ready yet) out of the department. This will be supported and actioned by the site team.

8.4.7 PROCESS FOR MANAGING PATIENTS DELAYED ON THE AMBULANCE DUE TO NO COHORTING CAPACITY AVAILABLE

When there are delays in the transfer of care from the pre-hospital team to the Emergency Department (ED) it is paramount that patient safety is maintained and where new concerns are escalated to the department that this escalation is acted upon promptly. This section outlines the expectations of both the Ambulance service and the Emergency Department when this situation arises.

When this section is activated the ED Nurse in charge should inform the EEAST Leading Operational Manager in addition to normal internal escalation.

On arrival to the Emergency department the Ambulance crew should initially liaise with the suitably trained Handover Healthcare professional to provided details of the patient and complete the normal handover sheet.

If it is not possible to transfer the patient to a cubicle within the department, the handover area or cohort the patient, the patient should remain on the ambulance under the supervision of the Ambulance crew for the purpose of comfort, safety and dignity.

All patients who are held on the Ambulance will have an initial set of observation completed by a suitably qualified Healthcare Professional that will be recorded on Emergency Department Information System (EDIS). Patients will have regular clinical observations recorded by the crew on the Electronic Patient Care Record (ePCR).

It is expected that clinical observations will consist of:

- Heart rate
- Respiratory rate
- Oxygen Saturations
- Blood Pressure
- Temperature (can be recorded hourly)
- Glasgow coma score.
- Blood Monitoring (BM) (if recording >20 should prompt immediate escalation)
- NEWS2

Observations should be recorded at 30-minute intervals. Unless advised otherwise by the ED Healthcare Professional taking patient details on arrival.

  - Rationale for this is that if a patient requires Ambulance transfer into hospital and is too unwell to sit in the waiting room it is essential that regular clinical observations are completed until full medical assessment can be completed.

Recording of observations should continue on the ePCR. However, if the Crew is using a paper PCR, the ongoing observations should be recorded on a Trust TPR chart. The CAD number should be recorded on the front of the TPR chart and the name of the crew member completing the observations should be written on the chart. The TPR chart must be handed over to the QEH staff (with top copy of PCR) when the patient is transferred to the department. It is recommended that EEAST staff make reference to recording observations on trust paperwork in their EEAST / EMAS paperwork.

Patients should be escalated to the handover Healthcare Professional when:

- Patients scoring NEWS2 >4
- If the clinical observations of a patient deteriorate leading to an increase in the NEWS2 score by 2 points

Following escalation of a deteriorating patient to the nurse in charge the Ambulance service can expect the following:

- Prompt discussion with senior nursing team and agreement as to the safest place to continue to care for the patient.
- In the event of sudden and significant reduction in GCS (more than 3 points) the patient should be moved to the resus area immediately. (This may displace other resus patients; Internal escalation of this need will also include the rapid transfer the next patient who is scheduled to transfer to the ward (even if bed not ready yet) out of the department. This will be supported and actioned by the site team.

If bringing the patient into the department is not possible due to capacity, a senior doctor (senior decision maker) will strive to review all patients on the vehicles if the delay is over 60 minutes. Where this is not possible due to the acuity and demand of the department, a review of escalated deteriorating patients will be prioritised, and appropriate action taken.

Some patients may require treatment in the vehicle e.g. sepsis. This should be facilitated by the appropriately trained healthcare team but the responsibility for monitoring will remain with the ambulance service until the patient is transferred into the department.

Whilst managing patients in the Ambulance, the Crew are expected to continue care which will include administration of medication in line with JRCALC guidelines. Where medication doses administered are approaching the maximum dose allowable under these guidelines, this should be escalated to the ED Nurse in Charge or handover Healthcare Professional.

Some patients, such as a suspected stroke, will potentially benefit from early assessment in the vehicle by the specialist team. The decision to do this assessment rests with the specialist teams and should be respected. If urgent CT is required, then the ambulance service may be asked to support the transfer to radiology in the absence of any ED trolley

capacity. If a patient moves directly to CT on the ambulance trolley the ED will strive to ensure there is capacity to accommodate the patient on return from CT to release the Ambulance crew.

See **Section 8.4.12** for EEAST and QEH expectations for delivering patient care during offload delays in exceptional circumstances.

8.4.8 PATIENTS WITH SPECIAL REQUIREMENTS

Patients that are potentially infectious (e.g. symptoms of D&V, meningitis, shingles etc.) will require a side room. There is no pre-alert for this patient group unless requiring resus for other symptoms. If a side room is required, patients will be assessed against the Trust D&V toolkit in the ambulance.

Side room capacity will be identified as a priority to offload patients. Side rooms available in ED are: A2, M5, M6, M7, M8.

8.4.9 ADDITIONAL ACTIONS TO BE DONE IN LINE WITH THIS POLICY

- Trust-wide / system-wide actions should be implemented in parallel to ensure exceptional cohorting is stepped down as soon as possible, ideally within two hours.
- Senior decision makers in acute assessment areas to ensure clear plans in place for patients who can be stepped down to wards to create capacity to receive from ED.
- Acute Medicine receiving bleep holders to explore all reasonable alternatives to admission when taking GP calls.
- Managing patients in ambulances for periods of longer than one hour are considered a significant risk to patient safety and all escalation efforts and senior decision making (clinical & non-clinical) are required to support exceptional actions to ensure patients are handed over to the emergency department team.
- A datix should be completed by the ED nurse in charge whenever emergency cohorting is implemented.

8.4.10CONTACT NUMBERS

ED Coordinator Extension – 2552

CSM Bleep – 1231

Silver On Call (out of hours) – available via switchboard

Gold on Call (out of hours) – available via switchboard

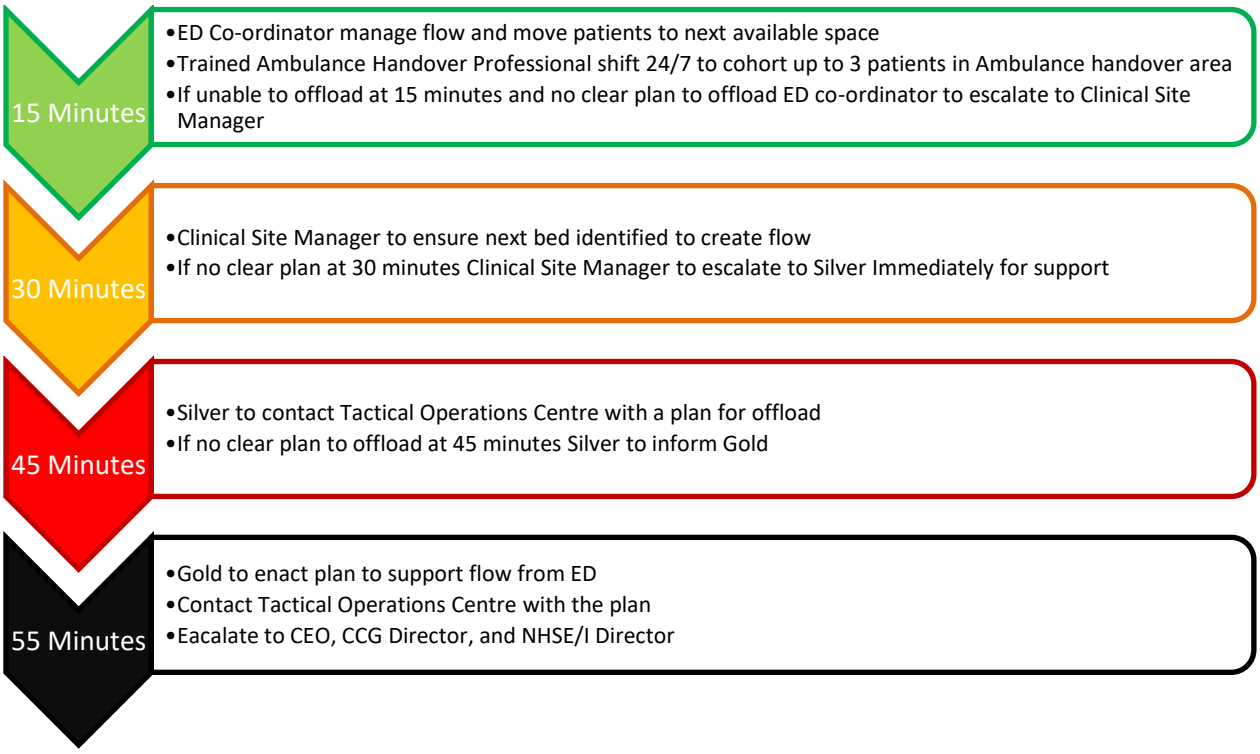
First Consultant On Call (out of hours) – available via switchboard

CCG Director – available via switchboard

NHSE Director – available via switchboard

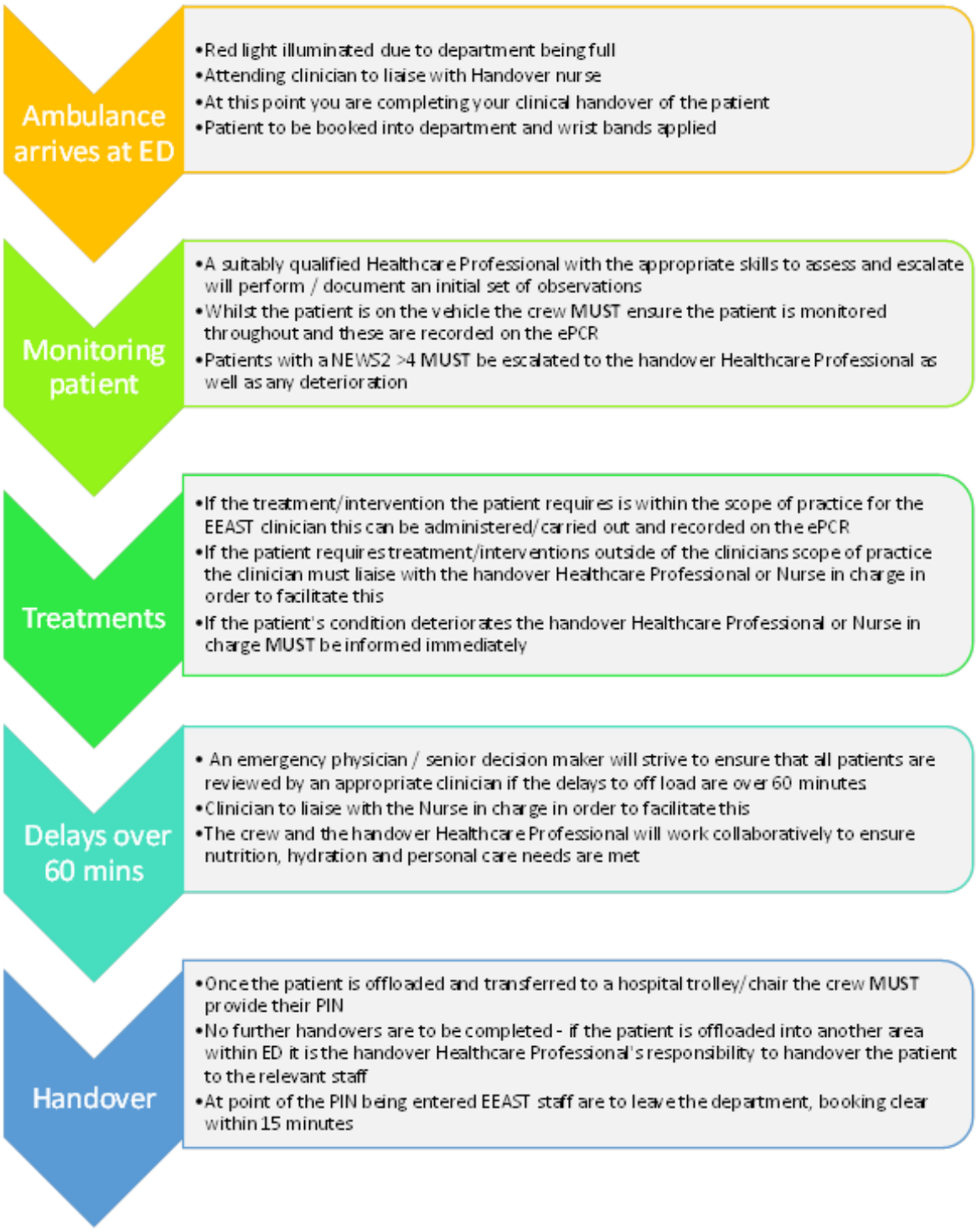
Winter Director – available via switchboard

8.4.11 AMBULANCE HANDOVER ESCALATION FLOW CHART



8.4.12 EEAST AND QEH EXPECTATIONS FOR DELIVERING PATIENT CARE DURING OFFLOAD DELAYS IN EXCEPTIONAL CIRCUMSTANCES

N.b., this excludes pre-alerted patients.



8.5 Ambulance diverts

8.6 Arranging additional patient transport (under FCP)

Whilst the Full Capacity Protocol is in operation, additional transport will need to be made available during the working day and out-of-hours.

This is the responsibility of the Capacity and Flow team, who should coordinate this with all available Transport providers.

8.7 Daily senior review (under FCP)

Whilst the FCP is activated every patient in the hospital will receive a daily review from a consultant, including weekends and bank holidays where there is 7/7 cover. Patients will be prioritised for review in terms of acuity/clinical urgency and potential for discharge.

Clinical directors should ensure that appropriate provisions are in place to ensure that specialties have sufficient staffing to ensure these daily senior reviews take place. In the even that a consultant is unavailable, clinical directors may choose to allow these reviews to be undertaken by a registrar.

Activities that should be considered include the early discharge of patients who do not need a hospital bed but who need further investigations or assessment that could be undertaken via an alternative mechanism, including early outpatient review (even if clinics are over-booked as a result) and fast tracking of diagnostics, transfer to the Virtual ward.

Patients meeting clearly specified and documented criteria may be suitable for senior-nurse led discharge without subsequent medical review.

8.8 Consultant admissions only (under FCP)

All on call Consultants in all clinical specialities must be available to attend the Emergency Department to review patients prior to admission with appropriate junior review.

8.9 Review of clinical activity (cancelling outpatients and electives)

This will be agreed between the DLT

8.10 Cancellation of consultant SPA time

This will be agreed between the DLT

8.11 Cancellation of non-clinical activity (including meetings and training)

At times of extremely high operational pressure, the Trust may choose to exempt groups of clinical and operational staff from attending non-essential meetings and non-mandatory training. Staff time should be reprioritised to focus effort that will support discharge and patient flow. This action should take place as part of the Trust's Full Capacity Protocol.

Divisional bronze cells will take the lead in cascading this throughout their divisions.

For the period that this exemption is in operation, the following actions should be taken:

- **Non-essential meetings:** clinical and operational staff will be exempt from attending non-essential meetings. Where the chair feels that attendance is essential this must be escalated to Silver for a final decision.
- **Training:** aside from mandatory training, all training for clinical staff should be reviewed. Where possible, training should be postponed or cancelled. Consideration should be made about subsequent operational impacts of cancelling the training and pay progression. Training should be rescheduled to take place at the earliest opportunity.

8.12 Specialty in-reach into ED / Acute Floor

It is expected that there would be a heightened response to request for speciality review during the full capacity protocol period. Referrals will be on a Consultant to Consultant basis and not via the green card system .A timely response for patients in ED is required from al surgical and medical specialities

8.13 Integrated discharge team response

The role of the integrated discharge team during Full Capacity Protocol will be to support additional discharges and liaise with partner organisations to facilitate discharge. Close liaison with the site team will be imperative

8.14 Admissions from outpatients

All teams referring patients from an outpatient clinic will need to consider if admission at that time is a clinical priority or if the patient could be safely manged through an alternative route e.g. TIU. All referrals must be manged via the Clinical Site Manager.

9. USEFUL TEMPLATES FOR MANAGING ESCALATION

Summary of the guidance

This section contains various templates which are regularly used in the management and reporting of escalation at the Trust.

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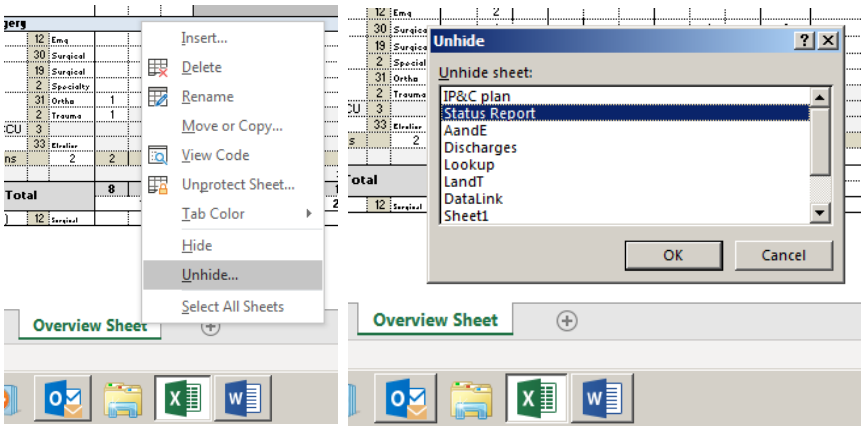
9.1 Templates for reporting OPEL status externally

Need to insert the most up to date report in this section – informatics to provide

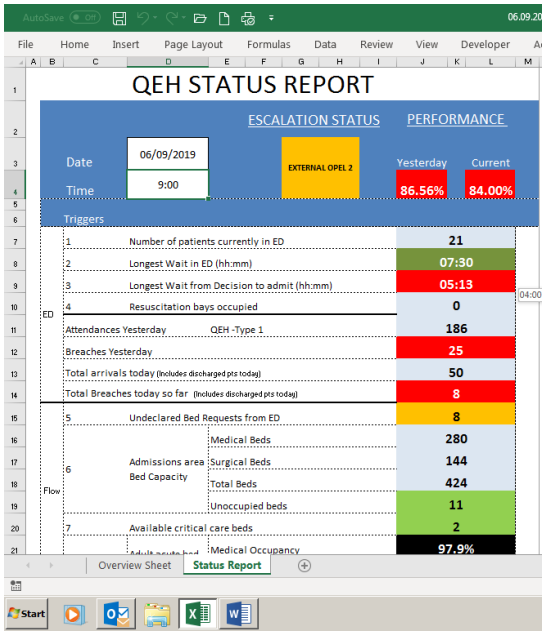
9.2 Generating the Trust OPEL Status Report

As described above, Trust Status Updates (the "QEH Status Report") must be created daily and emailed, following Capacity and Flow meetings or evening handover). During normal weekdays, between the hours of 8am and 4pm, the Operations Clerks will issue the report. However, outside of these times, and at evenings, weekends and Bank Holidays, the Capacity and Flow team is responsible for creating and emailing the report. The steps below describe how to complete this task:

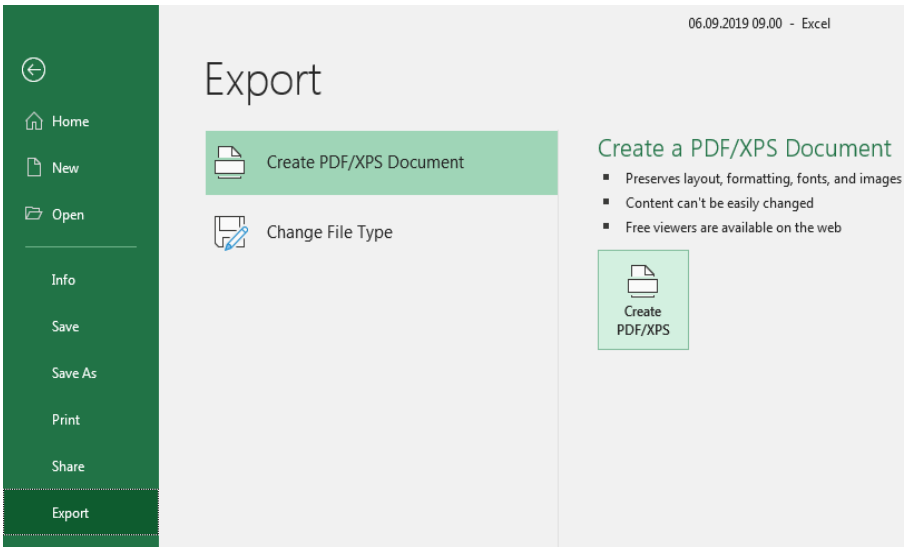
1. The Status Report is on a hidden tab – so right click on the tab at the bottom (Overview Sheet), click 'unhide' and then select the one named 'Status Report' from the list.



2. With the exception of the number of beds closed due to Flu or D&V (these cells are highlighted in yellow on the Overview Sheet tab, and should also be updated please when bays/beds are closed and re-opened) the Status Report data automatically updates, so once it's unhidden; we just need to make it into a PDF ready to email.



3. There is a folder in the file location where the Capacity and Flow Meetings are saved named 'CEO Reports' – this is where we need to save the PDF to. There is a folder for each month to save them into.



4. The file must then be emailed to the Distribution List - Trust Status Report - as agreed by the Chief Operating Officer, which includes all executives and non-Executives.

5. Remember to right click on the status report and hide the tab once you've done.

10. QEHKL CHILDREN'S SERVICES ESCALATION PROCEDURE

Summary of the guidance

This section sets out the escalation procedure for care of Children and Young People requiring inpatient admission at The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust (QEHKL). This procedure operates mostly independently of the rest of the hospital but will require input from across the Trust when pressure is most acute.

It is therefore crucial that individuals in the Trust command and control hierarchy (e.g., Golds / Silvers / Bronzes / Capacity and Flow team) are familiar with these procedures, so that the rest of the hospital can coordinate appropriate Trust-wide support when needed.

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10.1 Scope

This section sets out the escalation procedure for care of Children and Young People requiring inpatient admission at The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust (QEHKL).

10.2 Purpose

- To standardise the procedure for managing capacity in order to maintain patient flow whilst also ensuring patient safety and quality of care.
- To provide a structure to efficiently manage bed capacity.
- To outline key responsibilities of staff involved.
- To provide trigger points for implementation of actions.
- To be used as a guide by junior staff out of hours.

10.3 Responsibilities

10.3.1 W&C Manager of the Day

This is the senior clinical nurse, who is available 08:00-16:00 Mon-Fri to assist with staffing and capacity issues as well as other managerial decisions and to troubleshoot across the Unit.

10.3.2 3977 Senior Paediatric Nurse Bleep Holder

The 3977-bleep holder is a senior paediatric nurse, who is responsible for Trust wide paediatric capacity and staffing, as well as troubleshooting across the Unit and dealing with managerial issues out of hours. They are also the single point of contact for specific paediatric advice.

10.3.3 Medical and Nursing Teams (All Grades)

Any patient placement issues should be escalated to the nurse-in-charge, who will escalate to the W&C manager of the day or senior paediatric nurse bleep holder. Patient flow should be expedited, and any barriers identified and dealt with early or escalated

appropriately. All patients will have an EDD within 24 hours of admission, and discharge planning will commence on admission.

10.3.4Special Circumstances

The transfer of patients from the ED to other hospitals should only be considered as a last resort and after full discussion with the consultant on call/ consultant of the week.

All seriously ill children should be seen in the ED at QEH. The decision to transfer a child to another hospital must be made by a paediatric consultant. If a child needs to be transferred to another hospital, transport needs of the patient should be discussed with the consultant and the paediatric bleep holder, and appropriate transport booked.

Patients requiring repatriation back to QEH will be discussed with the consultant on call/consultant of the week and the nurse-in-charge.

Decisions regarding the closure of PAU/Rudham/NICU:

- **In working hours (Mon – Fri 08.00 – 17.00):** the Matron/Lead Nurse for Paediatrics, the divisional bleep holder, ACN, Consultant Paediatrician and an Executive director must be involved in the decision to close. Once made the site practitioner, CDS co-ordinator, Waterlily staff and Consultant Obstetrician will be informed.
- **Out of Hours ((Mon – Fri 17.00 – 08.00; Saturday, Sundays and Bank Holidays):** the NICU co-ordinator must inform the site practitioner that a closure is required, who will then contact Silver on call who are responsible for communicating with the Gold on call. The decision must be made in conjunction with Gold on call. Once made the CDS co-ordinator, Waterlily staff and Consultant Obstetrician will be informed.

10.4 Children's Services Escalation Status: Green

Children's Services Escalation Status: GREEN
TRIGGERS: • Sufficient beds to meet elective and emergency demand • Confirmed and predicted discharges expected • ED patients expected to achieve four-hour target • Sufficient capacity and flow through PAU to manage demand • Acuity matches the commissioned bed capacity • Staffing meets RCN guidance

Responsibility	Action
Nurse-in-charge jointly with W&C Manager of the Day	• Co-ordinate elective/emergency admissions • Maintain an overview of bed status • Report bed state to Ops Centre • Identify possible discharges and support discharge planning • Liaise with retrieval services regarding patients awaiting intensive care beds • Liaise with transport services regarding patients awaiting transfer to other hospitals • Liaise with ED, PAU, Day Surgery Unit regarding potential emergency admissions • Liaise with QEH maternity services to identify any potential admissions • Ensure bed capacity will meet elective and emergency demand • Regularly update the matron
Senior Paediatric Nurse bleep holder	• Maintain an overview of the department bed status and capacity required for paediatrics • Provide support and advice to NIC of wards concerning any clinical or staffing issues • Provide support and guidance as required
Consultant of the Week/ Consultant on call	• Provide clinical support and visibility for escalation of acuity or capacity concerns raised by nurse in charge or bleep holders • Be aware of department and hospital status
Operational Team	• Be aware of department and hospital status

10.5 Children's Services Escalation Status: Amber

Children's Services Escalation Status: AMBER
TRIGGERS: • Number of patients due for admission (emergency and elective) is greater than the number of available beds/cubicles • Confirmed and predicted discharges expected • There are patients in ED/PAU requiring admission • Sufficient capacity and flow through PAU to manage demand • The number of patients requiring HDU or ITU support exceeds commissioned bed capacity • Staffing meets RCN guidance

Responsibility	Action *(All actions at previous escalation status levels undertaken)*
Nurse-in-charge jointly with W&C Manager of the Day	• Liaise with paediatric medical and surgical teams to inform of current bed situation and request prompt ward rounds and discharges • Consider diverting elective inpatient surgery to DSU and explore the use of recovery for extended stays as an interim measure • Review flow of patients through PAU and ED • Review admissions to CDS and Castleacre, highlighting potential admissions to NICU • Identify additional staffing needs and put shifts out to bank as required to support changing capacity and acuity • Inform matron and ACN of status
Senior Paediatric Nurse bleep holder	• Discuss all elective admissions with the operational team • Liaise with surgeons in order for children to be prioritised and discuss patient pathway options such as day case stay or inpatient stay
Paediatric registrars, general and sub-specialties/all specialty teams	• Ensure prompt ward rounds to identify and expedite confirmed and predicted discharges • Prompt completion of discharge letters and TTOs to expedite discharge
Consultant of the Week/ Consultant on call	• Provide support and advice to registrars • Support ED/PAU with senior decision making and safety netting for possible admission avoidance • Be available to undertake additional ward rounds as capacity dictates
Operational Team	• Provide support and guidance to CBU4 manager of the day • Review all elective admissions, highlighting long waiters/ clinically urgent patients. Discuss with relevant management

	teams • Be aware of department and hospital status

10.6 Children's Services Escalation Status: Red

Children's Services Escalation Status: RED
TRIGGERS: • There are insufficient inpatient beds available to meet demand • All appropriate beds are open • Elective patients at risk of being cancelled • There are patients in ED and PAU that require admission • ED have more than one patient approaching four-hour target • PAU demand exceeds capacity and flow through PAU is being impacted • The number of patients requiring HDU or ITU support exceeds commissioned bed capacity • Staffing does not meet RCN guidance

Responsibility	Action *(All actions at previous escalation status levels undertaken)*
Nurse-in-charge jointly with W&C Manager of the Day, Matron and ACN	• Contact other hospitals to arrange cover in the region • Review long waiters and elective list to identify potential cancellations and discuss with relevant teams • Ensure that paediatric medical registrars/ consultant are aware prior to handovers in order that they are able to identify discharges/ transfers to other hospitals and to ensure appropriate admissions and use of cubicles • Review of staffing levels to support increased capacity and acuity. Including the identification of paediatric competent staff and other children's trained nurses across the Trust • Re-distribution of staff to areas of increased demand to maintain safety • Liaise with Operations Centre to agree patient cancellations if needed, and inform of need to potentially transfer emergency patients out of the Trust • Consider using NICU as an inpatient area for babies suitable for care within NICU • Liaise with the midwifery matrons and Director of midwifery and discuss the impact of NICU admissions and potential NICU closure • Identify any 15 and 16 year olds that could be placed as a paediatric outlier within an adult ward • Regularly update current bed state to identify any anticipated discharges or potential transfers • Identify delays to discharges and escalate to matron/ACN for support • Consider diverting PAU patients to ED
Senior Paediatric	• Liaise with Operations Centre to agree patient cancellations, and

Nurse bleep holder jointly with Matron and ACN/Silver on call	inform of need to potentially transfer emergency patients out of the Trust • To be a support mechanism for advice and assistance for the management of paediatric patients within the Trust
Paediatric registrars, general and sub-specialties/all specialty teams	• Day team need to identify and process all suitable patients for discharge liaising with paediatric consultant of the week • All relevant surgical teams to identify and process suitable patients for discharge when requested to by ward nurses • Identify patients suitable for an internal/external transfer to increase internal capacity
Consultant of the Week/Consultant on call	• Support registrars in decision making regarding discharges/ transfers • Liaise and refer to retrieval services regarding patients awaiting intensive or HDU care • Consider preparation and decision-making regarding PAU/NICU/Rudham closure
Operational Team	• Lead responsibility and decision-making regarding capacity constraints • Review escalation options within the organisation, considering requirements for air, oxygen and suction points, infection control, safety and security
Other	• Consider extraordinary capacity meeting • Ensure procurement review undertaken and additional supplies organised as required • Escalate to the Chief Operating Officer (in hours) and Silver and Gold on call out of hours via site practitioners • Prepare communications for global distribution regarding paediatric capacity and escalation process including communication to be given to patients and their families on admission

10.7 Children's Services Escalation Status: Black

Children's Services Escalation Status: BLACK
TRIGGERS: • There are insufficient beds available to meet demand • All available beds are open • There are no predicted discharges • Elective patients have been cancelled • Patients in ED/ PAU awaiting admission and several expected ED breaches • PAU demand severely exceeds capacity and there is no available space to maintain flow • The number of patients requiring HDU or ITU support exceeds commissioned bed capacity • Staffing falls significantly below RCN guidance and patient safety is at risk of being compromised

Responsibility	Action *(All actions at previous escalation status levels undertaken)*
Nurse-in-charge jointly with W&C Manager of the Day	• Review and prioritise admissions for the next 24 and 48 hours and implement the cancellation plan for elective work • Ensure emergency medical and surgical consultant-led ward rounds • Inform all on-call teams of black status • Inform Ops Centre and Senior Paediatric nurse bleep holder of black status • Ensure regional bed cover as for children suitable for transfer • Follow NICU escalation plan considering closure to the network and delivery suite
Senior Paediatric Nurse bleep holder	• Working jointly with W&C Manager of the Day, Associate Chief Nurse, Consultant of the Week and Operational Team to implement a contingency action plan using escalation options identified at red status • Open contingency areas if able to staff with appropriately trained paediatric nurses • Ensure paediatric resus trolley available in contingency area • Continue to monitor the situation and keep all relevant personnel informed • Keep patients and their families up to date, supporting and managing families who raise concerns
Paediatric registrars, general and sub-specialties/all	• Continue to ensure patients are reviewed and discharged/ transferred in a timely manner • Consider other pathways of care to prevent admissions • If a patient requires admission and no bed is available discuss

specialty teams	with Consultant on Call/Consultant of the Week for plan • If following all actions there are no beds available, patient will need to remain in ED until a suitable bed becomes available
Consultant of the Week/ Consultant on call	• To be the main point of contact and decision-making regarding patient placement • Implement PAU/NICU/Rudham closure as required
Operational Team	• Implement contingency action plan
Other	• Undertake extraordinary capacity meetings 2-4 hourly • Ensure external communication of capacity highlights service demands • Discuss diversion of ambulances and load levelling • Follow major incident and full capacity protocol • Ensure contingency action plan is circulated for full visibility

10.8 Monitoring compliance with and the effectiveness of this document

1. Any four-hour target ED breaches will be investigated.
2. Information will be collated to review capacity, demand and any delayed discharges.
3. Ward usage will be reviewed.
4. Collate data pertaining to any out of hospital transfers which will be reviewed by the Women's and Children's management team.

10.9 Associated documents

1. **Paediatric Assessment Unit Operational Policy**
   http://qehkl-inet/documentation/documents/Clinical-Guidlines/Women-and-Children/Paediatrics/Procedures%20Processes%20and%20Operational%20Policies/Paediatric%20Assessment%20Unit%20Operational%20Policy%202014.pdf

2. **Admission and Discharge of Children on Rudham Ward**
   http://qehkl-inet/documentation/documents/Clinical-Guidlines/Women-and-Children/Paediatrics/Paediatric%20Nursing%20Policies/Admission%20and%20Discharge%20of%20Children%20on%20Rudham%20Ward.pdf

3. **Admission Process to NICU**

http://qehkl-inet/documentation/documents/Clinical-Guidlines/Women-and-Children/N%20Neonatal/Neonatal%20Unit/Admission%20process%20to%20NICU%202016.pdf

4. **Closure of Unit (NICU) communication with the Network**
   http://qehkl-inet/documentation/documents/Clinical-Guidlines/Women-and-Children/N%20Neonatal/Neonatal%20Unit/Closure%20of%20Unit%20communication%20with%20the%20network%20Nov09.doc

11. QEHKL MATERNITY SERVICES ESCALATION PROCEDURES

Summary of the guidance

This section sets out the key escalation procedures for the hospital's Maternity services. In the main, these procedures operate independently of the rest of the hospital. However, it is important that individuals in the Trust command and control hierarchy (e.g., Golds / Silvers / Bronzes / Capacity and Flow team) are familiar with them, so that the rest of the hospital can coordinate appropriate Trust-wide support when needed.

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11.1 Escalation Process for Central Delivery Suite Closures

In place for QEHKL and NNUHFT from 1 July 2015

- Appropriate internal escalation and approval to close delivery suite takes place within QEHKL, following agreed escalation policy.
- QEHKL Director On Call, or nominated deputy, contacts neighbouring Acute Trust(s) to discuss capacity and potential divert.
- Any divert(s) should be agreed by the Acute Directors on call. This agreement must include the proposed length of time for the divert and a time for review. Peripheral Diverts or Deflects should only require authorisation by the CCG Director On-Call where Ambulance and Acute Trust Directors On-Call cannot reach agreement locally. When escalation to CCG is required the Site Manager or Director On Call are to contact:
    - ***In hours*** *(Monday to Friday 08.30 to 17.00hrs) West Norfolk Urgent Care & System Flow Manager:* 01553 666911 / 07826 921382
    - ***Out of hours*** *(Monday to Friday 17.00hrs to 08.30hrs and weekends/bank holidays): CCG Director On Call via pager no:* 07699 762794
- QEHFT then contacts EEAST (01245 444515/16) to agree temporary divert(s), including time period and agreed time for review.
- QEHKL to confirm closure and divert arrangements in writing to EEAST using the email address: operations@eastamb.nhs.uk and copy in WNCCG: nikki.bartrum@nhs.net
- QEHKL must confirm to EEAST, neighbouring Trusts & WNCCG Urgent Care & System Flow Manager when unit reopens so divert can be lifted

12. LIST OF USEFUL CONTACTS FOR ESCALATION

Summary of the guidance

This section lists out the contact details for various individuals and roles who are key in supporting the management of capacity and flow and key escalation processes across the Trust.

12.1 Internal QEHKL contacts

Clinical Site Manager Bleep 1231

12.2 Ambulance Trust

EMAS Regional Manager 0115 8845463
EEAST Regional Tactical 01245 444515 Option 1
EEAST Local tactical cell 01603 271404/6

12.3 Clinical Commissioning Groups

WNCCG Duty Director 07623 514085
Useful local WNCCG email contact westnorfolkccg.unplannedcare@nhs.net

12.4 Mental Health Trust

Mental Health Bed Management 01603 421439

12.5 NHS England

NHSE reporting email england.er-uecoperations@nhs.net

13. LINKED DOCUMENTS AND POLICIES

Summary of the guidance

This document is *not* intended to be a fully comprehensive guide to every element of operations within the Trust. As such, throughout the various sections other Trust policies and procedures are referenced, but the content has not been duplicated in this handbook. This section therefore provides a link to some of the most relevant policies and guides, which can be found on the Trust intranet.

This document is *not* intended to be a fully comprehensive guide to every element of operations within the Trust. As such, throughout the various sections other Trust policies and procedures are referenced, but the content has not been duplicated in this handbook. The table below therefore provides a link to some of the most relevant policies and guides, which can be found on the Trust intranet.

Please note that the documents referenced below were up to date at the time of writing, though may have been superseded (and the links updated).

Resource/Policy/Document	Trust Intranet link
Admission and discharge policy and procedures	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Discharge/Admission%20and%20discharge/Admission%20and%20Discharge%20Policy%20and%20Procedures%20v6%202020%2011.pdf
Ambulance handover SOP, including delays	*[No Intranet link at present]*
Critical Care Complex operational policy	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Operational/Operational%20Policy%20for%20the%20Critical%20Care%20Complex%20V5%202021%2003.pdf
Discharge checklist	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Discharge/Direction%20of%20choice/QEH%20Discharge%20Checklist%20V2.4%20180919.pdf
Direction of choice policies ***Link to page with multiple policies***	http://qehkl-inet/documentation/?subdir=./documents/Policies-and-Procedures/Discharge/Direction of choice
Fire policy	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Risk-and-Governance/Fire-Safety/Fire%20Policy%20V8%202020%2011.pdf
Incident reporting and investigations policy and procedures	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Risk-and-Governance/Clinical%20Governance/Incident%20Reporting%20and%20Investigation%20Policy%20V4.1%202020%2005.pdf
Infection prevention and control policies ***Link to page with multiple policies***	http://qehkl-inet/documentation/?subdir=./documents/Policies-and-Procedures/Infection-Control
Medical Electives standard operative procedure	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Operational/SOP%20Medical%20Electives%20v1%202019%2008.pdf
Medical staffing policies ***Link to page with multiple policies***	http://qehkl-inet/documentation/?subdir=./documents/Policies-and-Procedures/Human-Resources/Medical Staff Policies and Procedures/Medical Staffing Policies
Nursing and midwifery policies ***Link to page with multiple policies***	http://qehkl-inet/documentation/?subdir=./documents/Policies-and-Procedures/Nursing-and-Midwifery
Overseas visitors policy	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Patient%20Experience/Overseas%20Visitors%20Policy%20%20v7%202020%2002.pdf
Roster management policy	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Operational/Roster%20Management%20Policy%202019%2009.pdf
Staffing escalation for nursing inpatient and access areas	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Operational/Staffing%20Escalation%20for%20Nursing%20Inpatient%20Areas%20v1%202019%2011.pdf
Surgical extended recovery unit standard operating procedure	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Operational/SOP%20Surgical%20Extended%20Recovery%20Unit%202019%2012.pdf
Transfer of patients	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Operational/Transfer%20of%20Patients%20v6%202020%2006.pdf
VIP policy	http://qehkl-inet/documentation/documents/Policies-and-Procedures/Trust-Wide-Policies-and-Procedures/VIP%20Policy%20v2%202022%2007.pdf

14. TRAINING

In order to maximise compliance with this document, training will be required for all staff groups to whom it applies. The amount of training will vary depending on staff group, and at the very least each group should be aware of the document's existence and content, so that it can be used for reference.

Specific training activities are outlined below. Details of how the guidance is to be disseminated are outlined in Section 16:

Staff Group	Training activity or mode of dissemination
Trust Executive Team	• Circulation to Team in electronic format • Discussion at Trust Executive meeting (e.g. CELM) • One-to-one discussion with Chief Operating Officer or Head of Patient Flow if required
Divisional Leadership Team	• Circulation to Team in electronic format • Discussion at Divisional Team meeting • One-to-one discussion with Chief Operating Officer or Head of Patient Flow if required
Clinical Site and Bed Managers	• Circulation to Team in electronic format • Discussion at Capacity and Flow Team meeting • Training sessions as part of educational programme for Capacity and Flow Team • Core element of induction process and presentations for Capacity and Flow Team
Medical Teams	• Circulation to all medical staff in electronic format • Introduction to the document at Trust Consultant's meeting • Introduction to the document in Trust induction for junior doctors
Nursing Teams	• Circulation to all nursing staff in electronic format • Introduction to the document at Divisional and Departmental nursing meetings • Introduction to the document in Trust induction for new joiners
Allied Health Professionals	• Circulation to all AHP staff in electronic format • Introduction to the document at Divisional, Departmental and professional group meetings • Introduction to the document in Trust induction for new joiners
All other staff	• Access to documentation on Trust intranet • Introduction to the document in relevant staff group meetings

15. REFERENCES

Resource/Policy/Document	Website/Link
Achieving Better Access to 24 7 Urgent and Emergency Mental Health Care	https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf
Addressing Ambulance Handover Delays Letter from NHSE&I	https://www.england.nhs.uk/wp-content/uploads/2017/11/ambulance-handover-letter.pdf
An Improvement Resource for Urgent and Emergency Care (National Quality Board)	https://improvement.nhs.uk/documents/1908/Safe_Staffing_urgent_and_emergency_care.pdf
An Innovation to Improve Safety in Emergency Care (The Health Foundation)	https://www.health.org.uk/sites/health/files/Bristol%20final%20report_website%20version_0.pdf
Developing People - Improving Care -National Framework for improvement and leadership development (NHS Improvement)	https://improvement.nhs.uk/documents/542/Developing_People-Improving_Care-010216.pdf
ECIST - 6As of Managing Emergency Admissions	https://improvement.nhs.uk/documents/630/6As-managing-emergency-admissions-RIG.pdf
ECIST - Expected Date of Discharge and Clinical Criteria for Discharge	https://improvement.nhs.uk/documents/629/expected-date-of-discharge-and-clinical-criteria-RIG.pdf
ECIST - Internal Professional Standards	https://improvement.nhs.uk/documents/578/internal-professional-standards-RIG.pdf
ECIST - Maximising AEC Services	https://improvement.nhs.uk/documents/583/maximising-aec-services-RIG.pdf
ECIST - Red and Green Bed Days	https://improvement.nhs.uk/documents/610/red-and-green-bed-days-RIG.pdf
ECIST - Reviewing Stranded Patients in Hospital	https://improvement.nhs.uk/documents/631/reviewing-stranded-patients-in-hospital-RIG.pdf
ECIST - SAFER Patient Flow Bundle	https://improvement.nhs.uk/documents/633/the-safer-patient-flow-bundle.pdf
Emergency Preparedness, Resilience and Response framework	https://www.england.nhs.uk/ourwork/eprr/
Emergency and Acute Medical Care in over 16s - Service Delivery and Organisation	https://www.nice.org.uk/guidance/ng94
Fit2Sit Campaign – NHS Improvement	https://improvement.nhs.uk/resources/are-your-patients-fit-sit/
Future Hospital - Caring for Medical Patients	https://www.rcplondon.ac.uk/projects/outputs/future-hospital-commission
Guide to Reducing Long Hospital Stays	https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/
NHS Long Term Plan	https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
OPEL Framework	https://www.england.nhs.uk/wp-content/uploads/2019/02/operational-pressures-escalation-levels-framework-v2.pdf
Patient Flow Guidance – NHS Improvement	https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/
Primary Care and Emergency Departments	https://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Primary_Care_and_Emergency_Departments/Primary_Care_and_Emergency_Departments_RELEASE.pdf
Same Day Emergency Care (SDEC) guidance – NHS Improvement	https://improvement.nhs.uk/resources/same-day-emergency-care/
Securing the Future Workforce for Emergency Departments in England	https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf
Seven Day Services Clinical Standards	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
Sharing Best Practice for ED	https://www.cqc.org.uk/sites/default/files/20171124_sharing_best_practice_emergency_departments.pdf
Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time	https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

16. DISSEMINATION OF THE DOCUMENT

The form below outlines how this document will be disseminated. This should be done in addition to the training activities outlined in Section 14 above.

Title of document:	Queen Elizabeth Hospital King's Lynn Escalation and Full Capacity Handbook		
Date finalised:	31st January 2020	**Dissemination lead:**	Corwen Hull Head of Patient Flow
Previous document already being used?	No, though see section outlining documents this handbook supersedes		
If yes, in what format and where?	Various documents superseded by this one were available on the Trust Intranet		
Proposed action to retrieve out of date copies of the document:	IT to remove documents that this one supersedes, supported by clinical governance		
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Format (i.e. paper or electronic)**	**Comments: Paper, daily plan, operations centre folder. Intranet**
Trust Executive Team	Electronic copy circulated in advance of Executive Meeting at which it is introduced and discussed	Electronic	
Divisional Leadership Team	Electronic copy circulated by Chief Operating Officer	Electronic	
Capacity and Flow Team	Electronic copy circulated by Head of Patient Flow; all team members provided with printed version	Electronic & paper	Paper version in ring binder to be available in the Operations Centre
Medical Teams	Electronic copy circulated by Medical Director	Electronic	
Nursing Teams	Electronic copy circulated by Director of Nursing	Electronic	
Allied Health Professionals	Electronic copy circulated by Chief Operating Officer	Electronic	
All other staff			

16.1 Dissemination Record

(To be used once document is approved)

Date put on register / library of procedural documents:		**Date due to be reviewed:**	

Disseminated to: (either directly or via meetings, etc.)	**Format (i.e. paper or**	**Date Disseminated:**	**No. of Copies**	**Contact Details / Comments:**

	electronic)		Sent:	

17. EQUALITY IMPACT STATEMENT

An assessment has been carried out on the Queen Elizabeth Hospital King's Lynn Capacity and Flow Handbook, and there is nothing identified that affects one group more or less favourably than another. Please see Appendix 1 for the full assessment.

18. ARRANGEMENTS FOR MONITORING COMPLIANCE

Key elements	Process for Monitoring	By Whom	Responsible Governance Committee /dept	Frequency of monitoring
Monitoring of relevant **capacity and flow outcome metrics**, for example: • All ED performance indicators e.g. ED 4 hour performance, DTA times, WTBS • Bed occupancy • Average length of stay • Discharge numbers and % before midday	All relevant capacity and flow metrics are regularly reviewed in various forums in the Trust. Failure to meet these consistently might represent a failure of the processes described in this document, or compliance with them, necessitating review of this document and the processes it describes	Chief Operating Officer and Executive Team Divisional Leadership Teams Capacity and Flow Team	Chief Operating Officer and Executive Team have the ultimate responsibility, and will use CELM, Board Meetings and Divisional Performance Reviews to monitor performance	Daily review of metrics as part of regular work Weekly or monthly review in CELM, Board meetings and Divisional meetings
Monitoring of impact on **quality and safety of patient care**	The impact on quality will be highlighted through CQC reports, and internal CQC-style audits. In addition, indicators will include the Safety Thermometer, the number of safety incidents reported (DATIX) and complaints from patients and staff	Chief Operating Officer and Executive Team Divisional Leadership Teams Capacity and Flow Team Ward Team – medical, nursing and other MDT	Chief Operating Officer and Executive Team have the ultimate responsibility, and will use CELM, Board Meetings and Divisional Performance Reviews to review any potential impact this document (and compliance with it) is having on quality and safety of care	Daily of quality and safety as part of regular work Weekly or monthly review in CELM, Board meetings and Divisional meetings
Monitoring of **compliance with the processes described**, for example: • Undertaking role and responsibility as described • Using the action cards as	Regular observation of the performance and behaviours of individuals key to Escalation, and assessment of their performance in existing appraisals	Line Managers of those with a specific role to play in the management of Escalation / Capacity & Flow e.g. Head of	Performance monitored and discussed as part of existing appraisal system	Frequency of existing appraisals In the case of poor performance or

described		Patient Flow		observed lack of compliance, intervention will be ad hoc, and not within the appraisal calendar

APPENDICES

Appendix 1

EQUALITY IMPACT ASSESSMENT

STAGE 1 - SCREENING

Name & Job Title of Assessor: Corwen Hull – Head of Patient Flow	**Date of Initial Screening:** 31st January 2020 **Date of Review:** 31st January 2020
Policy or Function to be assessed: QEHKL Escalation and Full Capacity Handbook	

		Yes/No	Comments
1.	**Does the policy, function, service or project affect one group more or less favourably than another on the basis of:**		
	• Race & Ethnic background	No	
	• Gender including transgender	No	
	• Disability:- This will include consideration in terms of impact to persons with learning disabilities, autism or on individuals who may have a cognitive impairment or lack capacity to make decisions about their care	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
2.	**Does the public have a perception/concern regarding the potential for discrimination?**	No	

If the answer to any of the questions above is yes, please complete a full Stage 2 Equality Impact Assessment.

Signature of Assessor:_____ **Date:**

Signature of Line Manager:_____ **Date:**

STAGE 2 – EQUALITY IMPACT ASSESSMENT

If you have indicated that there is a negative impact on any group in part one please complete the following, is that impact:

		Yes/No	Comments
1.	**Legal/Lawful under current equality legislation?**	N/A	
2.	**Can the negative impact be avoided?**	N/A	
3.	**Are there alternatives to achieving the policy/guidance without the impact?**	N/A	
4.	**Have you consulted with relevant stakeholders of potentially affected groups?**	N/A	
5.	**Is action required to address the issues?**	N/A	

It is essential that this Assessment is discussed by your management team and remains readily available for inspection. A copy including completed action plan, if appropriate, should also be forwarded to the Equality & Diversity Lead, c/o Human Resources Department.