ADULT PATIENT FLOW AND ESCALATION POLICY

POLICY

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For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
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Summary of Changes from Previous Version	v3.0 • Revised escalation triggers • Alignment of escalation triggers to OPEL Framework • Revised action cards • Updated narrative from Divisions • Reference to associated links • Added escalation for ED and IDAT v3.1 • 2 x forms: *Patient Outlier Information Tool* and *Gynaecological patients on maternity ward decision tool* now associated with this policy as outlier information included in this policy when reviewed at v3.0. Patient Outlier Policy superseded.		
Supersedes	• Adult Patient Flow and Escalation Policy, v2.0, Issued November 2018 to February 2021 (ext[3]) • Patient Outlier Policy v2.1 Issued 30th May 2018 to RV date May 2021 • Opening of additional bed capacity to meet demand including the bed escalation plan SOP, v1.0, Issued 27th October 2017 to Review Date May 2021 (ext[2])		
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Sponsor (Position)	Chief Operating Officer		
Author (Position & Name)	Head of Operations - Dale Travis		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Capacity and Flow		

Position of Person able to provide Further Guidance/Information	Chief Operating Officer
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Patient Outlier Information tool Gynaecological patients on maternity ward decision tool	Jan 2020 May 2018
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1.0 INTRODUCTION

Emergency Department (ED) attendances and non-elective patient admissions to the Trust, which can be unpredictable in nature, pose a challenge to the Trust on a daily basis. ***The proactive response to surge in non-elective activity is fundamental to ensure patient safety.***

This policy details the procedures for ensuring safe and effective utilisation of non-elective patient pathways and in-patient beds to ensure those, who require admission, are admitted on the right pathway

2.0 POLICY STATEMENT

- Patient safety and experience is our first priority. This policy is intended to support clinical decision making not to replace it.
- Aim for emergency patients requiring an admission are transferred to a bed within four hours of attending ED, following necessary investigations, unless there is a valid clinical reason to remain in ED.
- Same Day Emergency Care will provide an alternative care pathway for some conditions
- Elective admissions will not be cancelled due to lack of bed availability unless in accordance with this escalation policy.
- All patients from assessment areas will be pulled into the correct specialty beds as soon as possible. When this process no longer complements emergency flow, as a last resort, additional capacity and outlying capacity will be used to maintain flow throughout the hospital.
- Discharge lounge to be maximised to create early bed movement
- **Any pandemic escalation will supersede the bed/ surge capacity plans contained within this document**

The above objectives rely on the following assumptions:

- Divisional Leadership Teams will manage their own non-elective and elective demand through the daily Bronze rota and weekend planning process.
- Wards will ensure they are aware of the expected non-elective and elective demand and have daily plans to manage this.
- The movement of patients will comply with the Trust Infection Control Policies.
- It is the responsibility of all SFH staff engaged in acute, adult care to ensure the actions detailed in this plan are undertaken and supported.
- Divisions will have operational action plans in place to support this policy and the Trust during the stages of escalation.

- These procedures relate to acute and adult capacity only. Paediatric and Maternity capacity will be managed by the Women's and Children's Divisional Management Team – see:
    - Maternity Escalation and Suspension of Acute Maternity Services Policy
    - Ward 25 Capacity Management and Escalation SOP
- The processes included in this document will be managed through the Flow meetings in collaboration with all Divisions
- Ward MDT will maintain Nerve Centre and accurately record MSFT to enable prompt issuing of TTOs and transport booking.
- Ward MDT will use the Discharge Decision Tool to review their patients

3.0 DEFINITIONS / ABBREVIATIONS

AECU	Ambulatory emergency care unit
AHP	Allied health professional
BAU	Business as usual
BOC	Bronze on call
BRAG	Black, red, amber, green
CCG	Clinical Commissioning Group
COO	Chief Operating Officer
D2A	Discharge To Assess
DCOO	Deputy Chief Operating Officer
DGM	Divisional General Manager
DLT	Divisional Leadership Teams
DNM	Duty Nurse Manager
DTA	Decision to admit
DTOC	Delayed transfer of care
EAU	Emergency Assessment Unit
ED	Emergency Department
EDAS	Early Supported Discharge Service
EDD	Expected date of discharge
EMAS	East Midlands Ambulance Service
FCP	Full Capacity Policy
IDAT	Integrated Discharge and Assessment Team
HOO	Head of Operations
LDNM	Lead Duty Nurse Manager
MSFT	Medically safe for transfer
NEMS	GP out of hours provider
OPEL	Operational Pressures Escalation Levels
PC24	Primary Care 24
PMSFT	Predicted Medically safe for transfer
SAFER	Patient flow bundle incorporating 5 elements of best practice
SAU	Surgical assessment unit
SDEC	Same Day Emergency Care
SOC	Silver on call
T2A	Transfer To Assess
TCI	To come in

4.0 DEFINITIONS / ABBREVIATIONS

Responsibility

The management of all bed capacity is the responsibility of the Chief Operating Officer and this responsibility is disseminated through a Silver/Gold on call structure, which is in place at all times in the Trust.

Expectations of each role are outlined in the action cards at Appendix D.

The management of patient flow, during working hours, remains the responsibility of the Head of Operations (HOO) Duty Nurse Manager (DNM) and the Divisional Leadership Teams (DLT). (See Appendix A – Capacity and Flow Meetings SOP)

The DNM is accountable for the management of flow 'Out of Hours' and has designated authority to work in conjunction with the Silver and Gold on call as required. The day to day process and roles and responsibilities of these individuals are outlined below:

Roles

DNMs	Acts as Site Manager co-ordinating effective flow across each hospital site. Reports back to Silver/Capacity and Lead Duty Nurse if actions are not completed or are insufficient to meet demand.
Silver on Call	Senior Managers' within the Trust provide the 'Silver on Call 'role, ***24 hours a day, 7 days a week.*** The role of the 'Silver on Call' is to provide Senior Leadership to help deliver the timely flow of patients through the Trust, supporting the decision making process and troubleshooting as required. During an incident, 'Silver on Call' has overall responsibility for co-ordination of the Senior Managers, Nurses and AHP's within the Trust. Matrons rota will cover the Monday-Friday day silver 17.00-20.00 pm
Head of Operations *in conjunction with the Lead Duty Nurse Manager*	Acts in the capacity as Silver 9-5 Monday- Friday and is supported by the Lead Duty Nurse Manager Manages the Capacity and Flow team to ensure the timely flow of patients through the Trust. Holds the Divisional teams to account in delivering their plans as outlined in this policy. Assess whether the divisional plans are sufficient to ensure flow or if escalation is required.
Gold on Call	The primary role of 'Gold on Call' is to give strategic direction to the 'Silver on Call'. ***The Chief Operating Officer or the Deputy Chief Operating Officer is 'Gold on Call' Monday to Friday, 0800-1700***. ' Out of Hours' is the 'Executive Gold on Call'

5.0 APPROVAL

The policy has been consulted on by the Divisional Leadership Teams, Medical Managers LNC, Capacity and Flow Team, Discharge Team and Chief Operating Officer Operational Group.

6.0 DOCUMENT REQUIREMENTS

6.1 Normal working

All Trust staff are required to actively contribute to the timely and safe discharge of patients from hospital. All patients should have a consultant approved care plan containing a **predicted medically safe for transfer (MSFT)** date set within 14 hours of a patient's admission to help co-ordinate and plan for discharge in a timely manner. The patient's discharge planning is a key element of the best practice SAFER Patient Flow Bundle (NHSI) and should commence upon the admission of the patient.

MSFT should be set by a consultant with the MDT, and represent a professional judgement of when a patient is anticipated to achieve his/her clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence). The Discharge Review Tool can assist this process. TTOs and discharge planning can commence at this stage.

Once a patient has achieved his/her clinical and functional goals the consultant and MDT can confirm a patient is medically safe for transfer (MSFT)

Patient progress towards MSFT should be assessed every day at a board or ward round led by a senior clinical decision maker (normally the consultant). Patients should be routinely involved and aware of the progress they are making. Patients (and/or their next of kin) should be able to answer these questions:

1. What is wrong with me or what are you trying to exclude?
2. What have we agreed will be done and when to 'sort me out'?
3. What do I need to achieve to get me home?
4. Assuming my recovery is 'ideal' and there is no unnecessary waiting, when should I expect to go home?

All members of ward / departmental teams should be able to discuss and explain the PMSFT/EDD.

Ward and board rounds play a crucial part in reviewing and planning a patient's care. They are an opportunity to inform and involve patients, and for joint learning for healthcare staff. The multidisciplinary team – doctors, nurses, pharmacists, therapists and allied health professionals – should provide dedicated time to participate in ward and board rounds, with clarity about individual roles and responsibilities during and after ward rounds. Board Rounds, if undertaken daily in the early morning, enable teams rapidly to assess the progress of every patient in every bed and address any delays to treatment or discharge. A second afternoon board round is best practice to review progress.

Medical staff must ensure that ward and board rounds are complete in a timely manner on a daily basis and patients MSFT identified. These should follow the core recommendations

and principles for best practice for conducting medical ward rounds as set out in guidance produced jointly by the Royal College of Physicians and the Royal College of Nursing (Modern Ward Rounds – good practice for multidisciplinary inpatient review, 2021).

In addition the national decision tool to support patients who should remain in hospital or be discharged on an alternative pathway should be used. (See Appendix G for SFH Discharge Review Tool).

Potential and definite discharges should be declared on Nerve Centre / E-Beds when known. Ward staff should make appropriate use of the Discharge Lounge to ensure that beds are released to accept acute admissions.

Normal working includes:

- Completed morning 'Board Rounds'
- Completing Board rounds before 12:00 using SHOP *(Sick, Home, Others, Plan)*
- Setting a patient's clinically agreed PMSFT /EDD within 14 hours of admission
- Commence discharge planning upon the patient's admission
- Completion of TTO requests to Pharmacy and recording on Nerve Centre at least the day before the patient's discharge
- Document when a patient is MSFT on Nerve Centre
- Ensure the patient is assessed and made ready for transport in a timely manner
- Ensure transport is booked as soon as possible, the day before discharge or earlier whenever possible
- Identifying discharges the day before discharge and proactively move 'Golden Patients' from the wards to the discharge lounge at 8am on day of discharge
- Proactively identifying patients for Newark and MCH wards (supported by IDAT through DTA)
- Proactively review all of the patients with a LoS of over 7 days on a daily basis
- Check any patient with an EWS of 4 and less against the national recommendation for "reason to reside" and locally adapted **Discharge Decision/ Review Tool** (see Appendix G)

6.2 Admission

Avoidance of admission is essential to managing capacity and flow. Elective admissions will be managed by divisions in line with clinical urgency and access standards. For non – elective attendances the aim is to explore all clinical pathways to avoid an unnecessary admission. To ensure patients are entered into the correct pathways

- ED streaming will remain in operation to effectively place patients in a correct setting e.g. PC24, AECU or other SDEC processes such as hot clinics
- The ED Consultant has the right to decide on the most appropriate specialty for an admitted patient – refer to the trust's Internal Professional Standards SOP.
- An Acute Frailty service is in place to review the frail elderly
- Specialities should attend ED within 30 minutes of referral. Where this does not happen then the ED Consultant can decide on the most appropriate specialty to admit to
- Transfers from assessment areas will be undertaken within 45 minutes with bed availability and booking done through Nerve centre

6.3 Discharge

Timely planned discharge is essential to managing capacity and flow. The Integrated Discharge Team (IDAT) will continue to lead on all complex discharges through the Discharge to Assess process (D2A). Simple discharges will remain the responsibility of the ward areas. To ensure effective discharge planning it is essential that ward teams

- Communicate the discharge date and any expectations to the next of kin or responsible member of the family
- Prepare all discharge documents ReSpECT, TTOs, transport booking BEFORE the date of discharge
- Ensure the patient has got warm clothes to go home in
- Ensures all patients are considered for the Discharge Lounge before 10 am
- Ensure patients leave with all the necessary belongings

IDAT will undertake twice daily locality calls with partners to maintain oversight of discharges and available community capacity

- Discharge Policy
- Criteria Led Discharge SOP
- Patient assessment for suitability of taxi transport home SOP
- Discharge Lounge (KMH) Operational Policy (including criteria at section 6.5)
- Hospital Discharge Service: Policy and Operating Model (HSC 2020)

6.4 Escalation

Non elective capacity and demand inequity, which may be caused by means of a surge of emergency admissions or a failure to deliver sufficient discharges, undermines the Trust's ability to deliver to its operational standards and to care safely for individual patients in the correct environment.

Assumptions are made that the Trust does not close for emergency admissions and will not be able to divert acute workload to another acute provider unless authorised by the Chief Operating Officer or Head of Operations in hours and the 'Gold On Call' out of hours. This should only happen in accordance with escalation status and subsequent action cards.

The objectives of escalation are:

- To ensure the safe and clinically appropriate placement of patients requiring an acute inpatient bed at all times, in line with infection control and mixed sex policies.
- To minimise any potential risk to patients in terms of waiting times and cancellations.
- To ensure patient flow into and out of ED is maintained to reduce the risks associated with overcrowding.
- To reduce overcrowding in ED thereby allowing safe assessment of patients.
- Turn ambulances around safely.
- **Keep patients safe**

Patients should only be placed in clinical accommodation that is appropriately staffed and equipped to manage their presenting condition and this must be supported with an appropriate Medical and Nursing infrastructure.

It is also the responsibility for all the Divisional Leadership Team to manage their clinical activity within their own bed base and to establish, implement and manage their own Divisional plans for each level of escalation.

It is important that the Trust is able to assure its healthcare partners that all internal measures have been taken before escalating to the highest escalation status.

6.4.1 Escalation triggers

SFH uses a Black, Red, Amber and Green (BRAG) escalation framework; this is aligned to the NHS Operational Pressures Escalation Levels Framework (OPEL), see Appendix B.

The Trust escalation framework is included at Appendix C.

During normal working the Trust will function on OPEL 1 (GREEN), indicating that there are no significant issues expected within the next 24 hours. It is when the Trust enters OPEL 2 (AMBER) that this policy comes into effect. At this point the Site Management Team/DNM,

On Call Teams and Divisional Leadership Teams will need to employ actions, supported by this policy that will help to regain control over the Trust's flow and capacity.

6.5 Escalation actions

Expected responses to each escalation from key areas are detailed in the action cards at Appendix D.

6.6 Outlying patients

Outlying is considered an exception to normal processes. It is not a business-as-usual activity. It is recognised as a symptom of a system under stress. As a result outlying patients has inherent risk, recognised by the Trust Board, which has to be balanced against the risk of an overcrowded Emergency Department.

Escalated discharge processes in line with the escalated action cards should deliver adequate patient flow, such that outlying is seen as an exceptional response to high levels of admissions. Every ward and medical team is expected to be able to demonstrate actions in place to facilitate prompt discharge of patients early in the working day, every weekday (early morning Board rounds, early TTOs, good use of discharge lounge etc.).

Outlying, when it happens, should incur the lowest possible risk to any patient affected; and should be as equitable as is possible in terms of additional workload across the spread of medical and nursing teams.

At times when OPEL 3 or OPEL 4 alert is declared, wards are to identify at least 2-5 patients who could be safely out lied into another specialty ward.

The outlying of patients in such circumstances should be robustly assessed, including completion of the Trust's Patient Outlier Information Tool / Gynaecological patients on

maternity ward decision tool for each patient being outlied, to ensure patient safety and experience is not compromised. Any decisions taken to out lie patients must be taken in line with Appendices F – Medical Outlier Allocations).

A number of specialty beds are ring fenced and should not be used for outlying capacity unless at full capacity.

NB in light of current pandemic risks the Pandemic Incident Control Team may step outside of the outlying and bed allocation stipulated in this policy.

6.7 Opening and closing additional capacity

The decision to open additional capacity must not be undertaken lightly and will only be agreed by the Chief Executive Officer or the Chief Operating Officer following escalation from 'Gold on Call' – see Appendix E. A Quality Impact Assessment (QIA) must be completed for any additional bed capacity and should be completed by a senior nurse (HoN or Matron).

Consideration will be given to opening additional capacity if the Trust is at escalation level OPEL 3 (RED) or OPEL 4 (BLACK) and will be considered in light of any additional risks e.g. COVID-19

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

When a decision is made to open beds or escalation areas a plan must also be in place for closing the beds or escalation area. All decisions to open or close additional capacity will only be agreed by the Chief Executive Officer or the Chief Operating Officer.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc.) and by who)**
Compliance with Action Cards	Chief Operating Officer	Observation	Ad hoc – quarterly as a minimum	Divisional Performance Review Operational Managers Meeting Clinical Chairs meeting
Compliance with Capacity and Flow Meeting SoP	Head of Operations	Observation	Ad hoc – quarterly as a minimum	Divisional Leadership Teams Operational Managers Meeting

8.0 TRAINING AND IMPLEMENTATION

Training and implementation will be undertaken as follows:

- Dissemination and cascade to all corporate and Divisional Leadership Teams via the Chief Operating Officer
- All new staff participating in the Duty Nurse Manager, Silver and Gold on call rota will be trained in this policy by the Head of Operations
- The policy will be available on the Trust intranet under the Silver / Gold Resource page section

This policy is a working document and should be readily available as a reference guide to all staff, particularly those working in admission and inpatient areas. Multidisciplinary team members involved in ward and board rounds may find it useful to have this policy and relevant action cards on view in areas where they undertake board rounds.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix H
- This document has not been subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Good practice guide: Focus on improving patient flow (NHSI July 2017)
- Rapid Improvement Guide to: The SAFER Patient Flow Bundle (NHSI 2018)
- Emergency and Acute Medical Care (NICE NG094, March 2018 & RCP 2017)
- Hospital Discharge Service: Policy and Operating Model (HSC 2020)
- Royal College of Physicians and the Royal College of Nursing (Modern Ward Rounds – good practice for multidisciplinary inpatient review, 2021).

Related SFH Documents:

- Medical Outlier Allocation
- Major Incident Plan
- Women's and Children's Escalation Policies
- Emergency Department Escalation Policy
- Infection Prevention and Control Policy
- Full Capacity Policy
- Patient Outlier Policy
- Integrated Discharge SOP
- Discharge Review Tool
- Clinical Site Management SOP
- Bronze SOP
- Flow and Capacity SOP
- Discharge Lounge Policy
- Transportation of patients by Taxi SOP

11.0 KEYWORDS

Bed Management, Gold, Silver, Bronze, On-call, Capacity and Flow, Outlier, Outlying, Outlay, outlied, Black Alert, Red, Amber, Escalate, Ward Pairings, discharge review tool, decision, additional, to meet demand, including, plan, for

12.0 APPENDICES

Appendix A	Capacity and Flow Meetings SOP
Appendix B	National OPEL Framework
Appendix C	Trust Escalation Triggers
Appendix D	Opel Action Cards
Appendix E	Additional Capacity
Appendix F	Medical Outlier Process
Appendix G	SFH Discharge Review Tool
Appendix H	Equality Impact Assessment

APPENDIX A CAPACITY & FLOW MEETINGS STANDARD OPERATING PROCEDURE

This SOP is a guide to the expectations and information to be discussed in each Capacity & Flow meeting. The Divisional Bronze representatives will be expected to review and discuss their relevant division against the e-beds information maintaining accuracy and confirming any actions taken.

It does not exclude the raising of other issues and attendees should feel able to raise any issues that they are concerned about or need help with. The overall objective of these meetings is to ensure patients get safe access to the care that they need. In terms of meeting attendance it should be read in conjunction with the Trusts escalation policy.

Etiquette – all Divisions to attend, start on time, no use of phones, action oriented, no specific patient discussions unless repatriations or safety issue. Infection prevention routines to be adhered to for COVID-19.

Capacity and flow meetings Standard Operating Procedure.

08:00:

- Welcome
- Update by COO/HOO or Lead nurse of previous 24 hours attendance and performance.
- Identify Opel Status
- Handover from the night DNM including any escalations to divisions
- Capacity Status Trust wide

DNM/ UEC	ED bed waits Ambulance handover times Speciality bed waits and long waits Number of swab waits PDD's Staffing escalations
Medicine	PDD's TCI's Closed beds Staffing escalations
IDAT	MFFD Expected supported discharges Escalations
Surgery	PDD's TCI Cancellations Critcon status Closed Beds Staffing escalations
W&C	PDD's TCI Staffing escalations
D&O	Escalations

Transport	Pre booked Made ready Escalations/concerns

Confirm actions to be taken based on pressure points and Opel Status.

11:00 and 14:00

DNM/UEC	ED status: Number of patients in each area, WTBS times, Bed waits Ambulance turnaround EAU status: Capacity Beds booked out Speciality beds and long wait beds required Number of swabs and results waiting Staffing escalations
Medicine	Capacity TTO's Transport (Identify outliers if appropriate) Staffing escalations
Surgery	Capacity TTO's Transport ITU internal moves Staffing escalations
W&C	Capacity Staffing escalations
D&O	Escalations
Transport	Booked on Made ready Delays Number of Stretchers
Infection control	Escalations and care home update
Repatriations	DNM to update

17:00

DNM/UEC	ED status: Number of patients in each area, WTBS times, Bed waits Ambulance turnaround EAU status: Capacity and predictive capacity Beds booked out Speciality beds and long wait beds required Number of swabs and results waiting Staffing escalations
Medicine	Capacity TTO's Transport (Ensure outliers are being transferred if appropriate) Staffing escalations Golden patients TCI for following day
IDAT	Update MFFD numbers
Surgery	Capacity TTO's Transport Ensure ITU internal moves happened Staffing escalations Golden patients TCI following day
W&C	Capacity Staffing escalations Following day TCI
Transport	Remaining number booked on To be made ready escalations

20:00

Handover from DNM and silver to silver including Capacity, ED status, Escalations and Staffing.

APPENDIX B NATIONAL OPEL FRAMEWORK

	NATIONAL DESCRIPTOR	SUGGESTED TRIGGERS
GREEN (OPEL 1)	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.	• Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. No staffing issues identified • No technological difficulties impacting on patient care • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. Pressure on maintaining ED 4 hour target • Infection control issues monitored and deemed within normal parameters
AMBER (OPEL 2)	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.	• Anticipated pressure in facilitating ambulance handovers within 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services • Lack of beds across the Trust • ED patients with DTAs and no action plan • Capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)
RED (OPEL 3)	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms	• Actions at OPEL 2 failed to deliver capacity • Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Hospitals within 48 hour timeframe • Awaiting equipment causing delays for a number of other patients • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that can't be rectified within 2 hours
BLACK (OPEL 4)	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.	• Actions at OPEL 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Infectious illness, Norovirus, Severe weather, and other pressures in Acute Trusts (including A&E handover breaches) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that can't be rectified within 4 hours

APPENDIX C TRUST ESCALATION TRIGGERS - Total score denotes OPEL escalation status

	OPEL 1 – score 1 for each		OPEL 2 – score 2 for each		OPEL 3 – score 3 for each		OPEL 4 – score 4 for each	
Patients / Performance in ED	Resus <2		Resus 2 -5		Resus >5		Resus >7	
	Majors <25		Majors 25 - 30		Majors 30-35		Majors 35+	
	ED >95%		ED 90% - 95%		ED <90% >80%		ED <80%	
	Time in department <4 hours		<4 hours		4 - 7 hours		8 - 12 hours	
Waiting to be seen	0-1 hours		1-2 hours		2-3 hours		4+ hours	
Electives cancelled	0		0		1		>1 Urgent/Cancer	
ICCU step downs	<2		2 to 4		>4		No Flow out	
Admissions Area Capacity	Medicine - 8		4 - 6		<2		Nil	
	Surgery - 5		4		2		Nil	
Outliers	0		0		5		>5	
Beds Closed	<2		3-5		6-16		>16	
MSFT	<10		11-21		22-35		>35	
TOTAL SCORES								
RANGE	**0-18**		**19 - 28**		**29 - 35**		**35+**	

APPENDIX D OPEL ACTION CARDS

Green Opel 1 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
GREEN (OPEL 1) Urgent and Emergency Care Division	**Divisional Bronze to ensure:** • Work with clinical teams escalating and responding to any delays • Attend all capacity and flow meetings providing up to date information on flow positions and update of actions from previous meetings	No action identified	• Ensure that there is senior medical decision maker at the daily Board Round and that all clinical teams are working towards expected date of discharge (EDD). • Escalation of patients on EAU >18 hours • Work with clinical teams escalating and responding to any delays
GREEN (OPEL 1) Medicine Division	**Divisional Bronze to ensure:** • All specialties to utilise the ambulatory pathways through AECU or specialty ambulatory clinics • Patients for IV therapy to be considered for OPAT • Procedures to be undertaken as day case • FIT team at front door		• Available beds should not be empty above 45 mins • The daily hub will escalate any delayed discharges for senior manager input • Stranded patients meeting led by HoN/ Deputy HoN • All patients to be discussed at Board round with EDD • Escalation of patients waiting >1 day for anything outside the ward
GREEN (OPEL 1) Surgery Division	**Divisional Bronze to ensure:** • Attend all Capacity and Flow Meetings, providing up to date information on flow positions and update of actions from previous meeting	• Collate list of TCI's for the remainder of the day and following day	• Ensure a daily Board Round is undertaken with the MDT – all patients should be discussed along with EDD's. • Any known next day discharges should have TTO's written and transport booked the day before • Continually promote a culture to promote the discharge process from time of admission. Escalation of patients waiting >1 day for anything outside the ward

Green Opel 1 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
	(CAU/GAU/Ambulatory/Clinics/PUDS)	**(Ward 25/14)**	
GREEN (OPEL 1) Women's and Children's Division	**Divisional Bronze to ensure:** • Ensure senior decision makers are present in the admission units • Use PUDS line to provide advice and guidance to GP's and other medical professionals Ensure ambulatory and assessment pathways are followed	• Manage the patient expectation by promoting the discharge process from the time of admission • All planned and accepted unplanned admissions have an allocated bed that is included in the bed state tally	• Senior Decision Boards rounds daily at designated times to include EDD, ETDs, Golden patients and Nurse led discharges
GREEN (OPEL 1) Diagnostics and Outpatients	**Divisional Bronze to ensure:** Responsive to ED and admissions area referrals for therapy and diagnostics	• No action identified	• Endeavour to complete diagnostic referrals within 24 hours • Timely Therapy and Pharmacy support for assessment and discharge
GREEN (OPEL 1) Head of Operations	**NORMAL WORKING INCLUDING:** • Ensure fully staffed rota in place for the capacity and flow team to ensure DNM on site 24/7. • Ensure there is a fully staffed rota in place to enable the collation of capacity and flow information to support decision making • Oversee work with the Divisional Bronzes to ensure that accurate and up to date information is maintained in the capacity and flow room, for example regarding admissions / discharges / patient transport / waiting lists / repatriations / external capacity Oversee effective use of the discharge lounge		
GREEN (OPEL 1) Duty Nurse Manager	**NORMAL WORKING** • Refer to Clinical Site Management SOP and Bronze SOP		
GREEN (OPEL 1) GOLD	***Maintain oversight of Trust operational status and set any strategic objectives*** **NORMAL WORKING**		
GREEN (OPEL 1) SILVER	***Maintain oversight of Trust demand, capacity, pressure points and escalation status*** ***Set any tactical actions*** **NORMAL WORKING, INCLUDING:** Attend the 08:00 am and 17:00 pm Capacity and Flow Meetings.		

Amber Opel 2 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
AMBER (OPEL 2) Urgent and Emergency Care Division	**Divisional Bronze to:** • Ensure that clinicians are using all possible methods for admission avoidance e.g. referring to AECU etc • Ensure that senior streaming takes place • Nurse in charge in AECU to visit ED to proactively pull/identify patients for AECU pathways.	No action identified	• Work with clinical teams escalating and responding to any delays • Nurse in Charge in AECU to visit EAU to identify patients for AECU pathways • Ensure specialty reviews have taken place promptly
AMBER (OPEL 2) Medicine Division	**Divisional Bronze to ensure:** As above plus • Specialty Doctors to deliver Consultant reviews on EAU am	As above plus • Move to out lie up to 5 patients into identified capacity for specialities where bed capacity will not meet expected demands for the next 24 hrs	As above plus • Golden patients to be prepared and made ready for early next day discharge • Partner agencies to identify capacity and support
AMBER (OPEL 2) Surgery Division	**Divisional Bronze to ensure:** As above plus: • Communicating information on 'Alert Status' and 'Actions' to staff and services within the Division	As above plus: • No further action identified	As above plus: • Escalate issues to Specialty and Divisional Teams to mitigate blockages to discharge • Ensure all patients reviewed by Senior Decision Maker within 12 hours
AMBER (OPEL 2) Women's and Children's Division	**(CAU/GAU/Ambulatory/Clinics/PUDS)**	**(Ward 25/14)**	
	Divisional Bronze to ensure: As above plus: • Streamline all appropriate patients to assessment units or ambulatory pathways prior to decision to admit • Ensure all admissions are reviewed by a senior decision maker	As above plus: • Bed state to be reviewed hourly and recorded on the bed state board • Identify beds which will be available until afternoon and can be used medically in interim.	As above plus: • Senior ad hoc board round to identify and aid early discharges e.g. senior review, discharge planning, commencing TTO, etc.

<table>
<tr><th></th><th>Actions focussed on reducing admissions</th><th>Actions focussed on expanding the bed base</th><th>Actions focussed on safely discharging more patients</th></tr>
<tr><td>AMBER (OPEL 2) Diagnostic and Outpatients Division</td><td>Divisional Bronze to ensure:
As above plus:
• Communicating alert status to staff and services
• Responding to patient delays impacting on decision to admit eg therapy, pathology and radiology</td><td>• No action identified</td><td>As above plus:
• Responding to patient delays impacting on discharge, eg dietetic review, therapy and pharmacy assessment, radiology, speech and language therapy</td></tr>
<tr><td>AMBER (OPEL 2) Head Of Operations</td><td colspan="3">AS ABOVE PLUS:
• Be present at the Capacity and Flow meeting.
• Assess where pressure point exists (e.g. plenty of beds but long waiting times in ED) and escalate to relevant Divisional Bronze and/or Silver as appropriate
• Escalate to Divisional Bronze any problems related to divisional patient flow which cannot be resolved within the capacity and flow team
• Ensure that IDAT are providing information to be used to manage patient flow out to the peripheral capacity and any access issues for community/transfer to assess beds are fed through to the commissioning teams
• Ensure that the Capacity and Flow Team are maintaining accurate overview of Trust capacity and patient discharge / transfers
• Ensure there is accurate and up to date information regarding the number of patients going through the discharge lounge and understand any constraints.
• Ensure submission of OPEL status to the CCG.
• Join system call as necessary.
Ensure all MFFD have a plan</td></tr>
<tr><td>AMBER (OPEL 2) Duty Nurse Manager</td><td colspan="3">• Discuss with NIC in ED to identify flow issues and what further resource can be brought in to improve the situation.
• Via Divisional Bronze, actively encourage utilisation of the discharge lounge during its opening hours.
• Identify any known constraints e.g. staffing, infection control and numbers of planned electives.
Assess where pressure point exists (e.g. plenty of beds but long waiting times in ED) and escalate to relevant Divisional Bronze.</td></tr>
<tr><td>AMBER (OPEL 2) GOLD</td><td colspan="3">Maintain oversight of Trust operational status and set any strategic objectives
NORMAL WORKING</td></tr>
<tr><td>AMBER (OPEL 2) SILVER</td><td colspan="3">Maintain oversight of Trust demand, capacity, pressure points and escalation status
Set any tactical actions
• Attend the 08:00 am and 17:00 pm Capacity and Flow Meetings.
Out of hours – see Capacity and Flow Matron actions.</td></tr>
</table>

Red Opel 3 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
RED (OPEL 3) Urgent and Emergency Care Division	**Divisional Bronze supported by Divisional Leadership Team to:** • Consider prioritisation of patients requiring medical input. Holding a breach within ED for patients who may be able to be discharged later the same day to prioritise a patient requiring an extended period of acute medical input. • Ensure all admissions are screened by a Consultant before admission (working with Acute Medicine and all specialities as necessary). • Articulate clearly what help is needed from within and external to the Division e.g. specialities to come and see appropriate patients i.e. orthopaedic team to see hip injuries, ICU, theatre nurses can assist in resus and for transfers etc. • Establish whether PC24 can support streaming at the front door.	No action identified	• A further senior review of patients will be requested. Along with the nurse in charge revisit the Board Round to ensure that all plans each Consultant has put in place have been enacted and that patient discharge has been prioritised. • Any blocks to patient discharge are to be escalated immediately to UEC Bronze/Capacity and Flow Team. • Identify patients that could be out-lied within the hospital or to community setting e.g. transfer to assess or integrated care team. • Matrons to support clinical areas as required/needed e.g. assist in driving discharge plans for patients at ward level. • EAU to fill in only the important/bare minimum section of the nursing admission documentation if the bed is available within the next few hours e.g. bed is assigned allowing the patient to leave ASAP freeing up the bed on EAU. • Work with Matron, NiC and Consultant in charge on EAU to review plans for patients- identify if patients could be nursed on a general medical ward rather than specialty specific • Patients on FLAP (formerly EGO) pathway to move to SAU
RED (OPEL 3) Medicine Division	**Divisional General Manager to ensure:** As above plus • DGM, HoN and Clinical Chair to attend Capacity and Flow meeting in hours	As above plus • Move a further 10 patients to out lie into surgical capacity • Identify surger capacity and make plans to safely staff (HoN- nursing, DGM/Clinical Chair- medical staff	As above plus • Patients to be moved to Discharge area with or without TTOs • Consider TTOs to send separately • Consider calling back staff on training to provide additional support to ward discharges • IDAT to review all morning discharge plans and escalate any inertia to senior manager

Red Opel 3 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
RED (OPEL 3) Surgery Division	**Divisional General Manager to ensure:** As above plus: • ST3+ oversight of all admissions in ED	As above plus: • Obtain list of patients to be 'Out lied' from Specialty Wards • Identify staffing for any ward stock not used and consider opening additional beds overnight/weekends • Increase clinical staff on shop floor to provide support – this may require review of clinical staff not currently based in clinical areas (i.e. management staff, staff in training etc.) that could be redeployed to provide support. • Collate list of Trauma patients with clear swabs for moving to Ward 21	As above plus: • Ensure all patients reviewed by Senior Decision maker within 8 hours • Ensure plans in place for all patients who are being discharged are completed within 2 hours (commissioning use of taxis, as appropriate to support increased discharges if ambulance service and third party providers cannot provide sufficient capacity) • Divisional Nurses to ensure all patients for discharge are moved to the discharge lounge where the patient meets the discharge lounge criteria

Red Opel 3 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
	(CAU/GAU/Ambulatory/Clinics/PUDS)	**(Ward 25/14)**	
RED (OPEL 3) Women's and Children's Division	**Divisional General Manager to ensure:** As above plus: • Review the option of extending the opening hours of GAU/CAU to maximise reducing admissions	As above plus: • On call Consultants to assist with ward reviews and new admissions • Neighbouring hospitals with potential beds identified by Nurse in Charge, Ward Sister or Paediatric Matron (daytime) or DNM (night time). • Nurse in Charge ensures ED Coordinator is advised of the bed state • Review of planned activity for next day to be led by NiC and Divisional Bronze • Outliers (gynae only) identified	As above plus: • Nurse in Charge to inform Consultants to review possible patients for discharge
RED (OPEL 3) Diagnostics and Outpatients Division	**Divisional General Manager to ensure:** As above plus: • Priority to be given to ED and admissions areas for diagnostic appointments and other service clinical reviews, eg pharmacy and therapy	• No action identified	As above plus: • Priority to be given to inpatient areas for assessment and diagnostics. • Pharmacy to prioritise urgent activities to provide additional support for discharge eg TTOs

RED (OPEL 3) Head Of Operations	**AS ABOVE PLUS:** • Chair the Capacity and Flow meeting, • Ensure 'Discharge Team' contact Social Services, Call For Care and Community Intermediate Care Team to proactively remove patients out of the Hospital, MCH and Newark • During the management of extreme capacity pressure assume the point of contact for capacity for Division during normal working hours to enable the Duty Nurse Manager to support clinicians in the discharge of patients and freeing of capacity. • Work with Senior East Midlands Ambulance Service (EMAS) representative to ensure that Ambulance flow is managed through ED. • Work with senior team in agreement and enactment of the contingency plans. • Ensure effective handover of contingency plans to the out of hour's team. • Ensure all patients EWS<4 have been assessed with Discharge Tool Escalate to D2A hub to expedite all patients waiting for discharge
RED (OPEL 3) Duty Nurse Manager	**AS ABOVE PLUS:** • Via Divisional Bronze, ensure all clinical teams are aware of escalation and taking actions in line with their action cards. • Ensure that PC24 are aware of the level of escalation and understand capacity and capability to provide additional support. • Contact Hospital Transport to discuss the prioritisation of inpatient discharges and ensure they follow their own escalation process in the event of capacity pressures. • Ensure Silver on call/Capacity and Flow Matron is kept informed of the plans/progress. Discuss with Capacity and Flow Matron (Silver on Call OOH) the potential requirement of escalation capacity and understand the state of readiness of this capacity (in line with SOP).
RED (OPEL 3) GOLD	***Maintain oversight of Trust operational status and set any strategic objectives*** **AS ABOVE PLUS:** • Confirm and challenge Divisional plans if requested by Head of Operations (Silver on Call OOH). • Consider rescheduling of elective admissions where appropriate. • Consider utilisation of additional capacity. • Consider outlying patients. • Review any planned maintenance work where work is likely to impact on capacity or patient flow. • Issue communications internally and externally, ensuring clinical leaders are aware and cascade to teams. Alert Social Care in conjunction with the CCG to expedite care packages.
RED (OPEL 3) SILVER	***Maintain oversight of Trust demand, capacity, pressure points and escalation status*** ***Set any tactical actions*** **AS ABOVE PLUS:** • Attend the 08:00 am and 17:00 Capacity and Flow Meetings. Out of hours – see Capacity and Flow Matron actions.

Black Opel 4 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
BLACK (OPEL 4) Urgent and Emergency Care Division	**Divisional Leadership Team to:** • Attend capacity and flow meetings • Increase shop floor medical capacity to avoid admissions, support patient flow and safety – this may involve standing down SPA activity* or non-essential training, bank/agency, additional hours, time shifting etc. • Post-taking of patients to occur within ED	• Consider opening up 3 beds on Discharge Lounge to extend SSU to 43 beds	• Undertake beds peer review process on EAU/SSU.
BLACK (OPEL 4) Medicine Division	**Divisional General Manager to:** As above plus • Consider cancelling electives via clinical prioritisation • Consider alternative recovery areas for day case procedures e.g. WTC, Cath lab • Specialty Doctors to review EAU am and pm – this may require prioritisation of duties • Consider the need for specialist clinics to free capacity eg rapid access chest pain, echo • Ward managers and HoS to attend the 8am flow meeting and any others deemed necessary to take actions	As above plus • Out lie 10+ patients into surgical capacity	As above plus • Consider specialty actions to release bedded capacity eg cath lab list expansion and clinic cancellation to accommodate • Spot purchase care packages to discharge those patients who are waiting • Support senior doctor supportive ward rounds for patients on EAU, ward 36 and medical wards • Transfer all patients, on the balance of risk (ED) to discharge lounge – following individual risk assessment • Free up junior doctor(s) to focus on TTO in each area **MEDICINE SPECIALTY** **Black Actions for Geriatrics:** When hospital reaches Black Alert (Opel 4) a 'WhatsApp' message is sent to all consultants in Geriatrics to inform them of the need to carry out 'black actions', by the Head of Service or deputy Morning actions *(these should be business as usual in the specialty)* • Senior doctor to attend 9am Board Round (should include one or both of the ward consultants) • Patients suitable to be outlied must be highlighted and Flow Team informed (at least 2 per ward) • All actions to facilitate discharge must have an 'owner'

Black Opel 4 Action Card			

			• Any TTOs that need writing (or actions required to progress a same day discharge) must be prioritised and completed after the Board Round
			• Escalate any actions/issues to Flow Room as necessary
			• All patients to be reviewed by senior doctor (consultant – or SpR if consultant unable to)
			
			Afternoon actions *(these are escalation black actions beyond business as usual, to maximise discharges and base ward capacity for new patients)*
			• Consultant or SpR from the ward must carry out a Board Round of all patients to ensure:
			  ○ Actions to facilitate discharges have happened
			  ○ There are no patients who have become MFFD since the morning Board Round
			• Patients suitable to be outlied must be highlighted and Flow Team informed (at least 2 per ward)
			• Actions/issues escalated to Flow Room as necessary
			• Patients for discharge the following day have all actions completed
			• All patients suitable for the Discharge Lounge have been highlighted
			• All new transfers to the ward since the morning are reviewed (? Potential discharges)
			• Ward to contact HoS if senior doctor does not attend Board Round.
			Black actions for Stroke:
			• Hot week consultants will review patients in ED with difficult presentations at ED team request.
			• In certain circumstances for patients refusing admission they will review and discharge direct from ED
			
			• TIA clinic already runs daily- appropriate patients will be seen in the clinic as additions or brought to ward for review as needed if clinic is full

Black Opel 4 Action Card			
			• If TIA clinic _and_ stroke bed areas full then specialty consultant or registrar to consider review/triage in ED with discharge from ED + appropriate investigation safety-netting
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
BLACK (OPEL 4) Surgery Division	**Divisional General Manager to ensure:** As above plus: • Ensure all patients have Consultant oversight prior to admission • Review elective admissions with consideration of cancellation • A member of the DMT to attend the Capacity and Flow Meeting (in hours) • Contact all Medical Teams and Clinicians to review patients	As above plus: • Collate list of Trauma patients with clear swabs for moving to Ward 21 • Consider opening DCU to 18 beds (Minimum staffing of 3 x RN) • Consider opening Ward 21 to 24 beds (Minimum staffing of 3 x RN)	As above plus: • Management presence on each ward to support timely resolution of escalations • Consultant review of all patients in Acute bed base within 4 hours if not already reviewed that day

Black Opel 4 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
	(CAU/GAU/Ambulatory/Clinics/PUDS)	**(Ward 25/14)**	
BLACK (OPEL 4) Women's and Children's Division	**Divisional General Manager to ensure:** As above plus: • ED Resus for seriously ill children • Review in ED if unlikely to need admission or if level of illness unclear • Redirect GP referrals to alternative hospital with permission from that hospital	As above plus: • On-call consultant agrees in liaison with Nurse in Charge that the ward is full. • Consultant to inform ED that full, anticipated duration and who allocated senior supporting doctor will be. • Registrar or consultant make referrals to neighbouring hospital clinical team as clinically indicated • Nurse in Charge to Consultants that ward is full and not able to accept new patients and request patient review where necessary • Nurse in Charge complete Escalation form within Escalation folder. Update book 2 hourly • Nurse in Charge record any resulting incidents in Datix • Re-open at the earliest opportunity	As above plus: • Review at KMH and decision made to refer on to alternative hospital • Arrange ambulatory appointment • Give telephone advice

Black Opel 4 Action Card			
	Actions focussed on reducing admissions	**Actions focussed on expanding the bed base**	**Actions focussed on safely discharging more patients**
BLACK (OPEL 4) Diagnostics and Outpatients Division	**Divisional General Manager to ensure:** <u>As above plus:</u> • Clinical Chair, DGM or Divisional Lead Nurse to attend Capacity and Flow meetings • Cancel any training to free up staff in clinical areas • Divisional medical staff to liaise closely with ED to provide support • At the request of Gold, to cancel non-urgent OP activity to free up clinical staff to support patient flow and safety	• Support in patient expansion with therapy support	<u>As above plus:</u> • Divisional medical staff to prioritise vetting of requests, reporting and clinical advice to ward areas. • Provision of additional or extended services if required
BLACK (OPEL 4) Head of Operations	**AS ABOVE PLUS:** • Chair the Capacity and Flow meeting • Ensure tracking of long wait patients and their safety, care and comfort. • Maintain contact with EMAS to effectively manage the pressures. • Maintain a complete and accurate evaluation of patient admission, discharge and transfers • Maintain overview of patient discharge/transfer of patients to inform if de-escalation can occur. • Obtain an action plan from all Divisions via DGMs/Clinical Chairs to create capacity. Obtain support from partner colleagues to place all MFFD		
BLACK (OPEL 4) Duty Nurse Manager	**AS ABOVE PLUS:** Maintain a complete and accurate evaluation of patient admission, discharge and transfers, to be readily available upon request		

BLACK (OPEL 4) GOLD	***Maintain oversight of Trust operational status and set any strategic objectives*** **AS ABOVE PLUS:** • Chair Capacity and Flow Meetings. • Ensure elective admissions have been reviewed and, where possible / appropriate, rescheduled or cancelled • Liaison with EMAS to request divert • Support Divisional Teams *(walk areas in crisis)* Contact Chief Nurse and Medical Director to discuss Trust pressure and agree their action to maintain patient safety.
BLACK (OPEL 4) SILVER	***Maintain oversight of Trust demand, capacity, pressure points and escalation status*** ***Set any tactical actions*** **AS ABOVE PLUS:** • Attend the 08:00 am and 17:00 Capacity and Flow Meetings. Out of hours – see Capacity and Flow Matron actions.

APPENDIX E ADDITIONAL CAPACITY

Updated July 2020				
Division	**Ward**	**Core**	**Escalation**	**Total**
UEC	EAU	40	0	40
	Wd 36 (SSU)	40	0	40
		80	**0**	**80**

W&C	Wd 14	13	10	23
	Wd 25	30	0	30
		43	**10**	**53**

Surgery	Wd 31	24	0	24
	W32	24	0	24
	W11	24	0	24
	Wd 12	24	0	24
	W21	16	8	24
	DCU	16	2	18
		128	**10**	**138**

Medicine	wd 22 Gastroenterology	24	0	24
	wd 23 Cardiology	23	0	23
	wd 24 Cardio, Haem	24	0	24
	wd 33 (Oakham)	24	0	24
	wd 34 Diabetes	24	0	24
	wd 41 Sub acute rehab	24	0	24
	wd 42 Respiratory	24	0	24
	wd 43 Respiratory	24	0	24
	wd 44 Respiratory	24	0	24
	wd 51 HCOE	24	0	24
	wd 52 HCOE (Woodland Ward)	24	0	24
	KSRU Stroke	29	0	29
		292	**0**	**292**

Newark	Sconce	24	8	32
MCH	Oakham	0	0	0
MCH	Lindhurst	12	0	12
MCH	Chatsworth	0	0	
		36	**8**	**44**

		579	**28**	**607**

NB Ashmere contract 26 beds
Lindhurst is currently closed
Chatsworth is currently closed

APPENDIX F MEDICAL OUTLIER ALLOCATIONS

Division of Medicine outlier allocations 2020-21

	Ward 21	Ward 31 & 32	Ward 41
September and October 2020	orthopaedics	geographical cover	closed
		geographical cover (no resp)	respiratory
November & December 2020	orthopaedics	locum (diabetes)	respiratory
January & February	locum (HCOP)	locum (diabetes)	respiratory
September and October 2020	orthopaedics	geographical cover	closed
		geographical cover (no resp)	respiratory

Geographical allocation on 31/32
Ward 41 closed

Ward 31
Resp 18 beds 31 Cubs 7-12 and A, B, C bays
Gastro 6 beds 31 Cubs 1-6

Ward 32
Diabetes 6 beds 32 Cubs 1-6
Stroke 6 beds 32 Cubs 7-12
HCOP 12 beds 32 A, B C bays

Ward 41 open

Ward 31
Gastro 9 beds – cubs 1-9
Diabetes 3 beds cubs 10-12
Stroke 4 beds – A bay
HCOP 8 beds – B & C bays

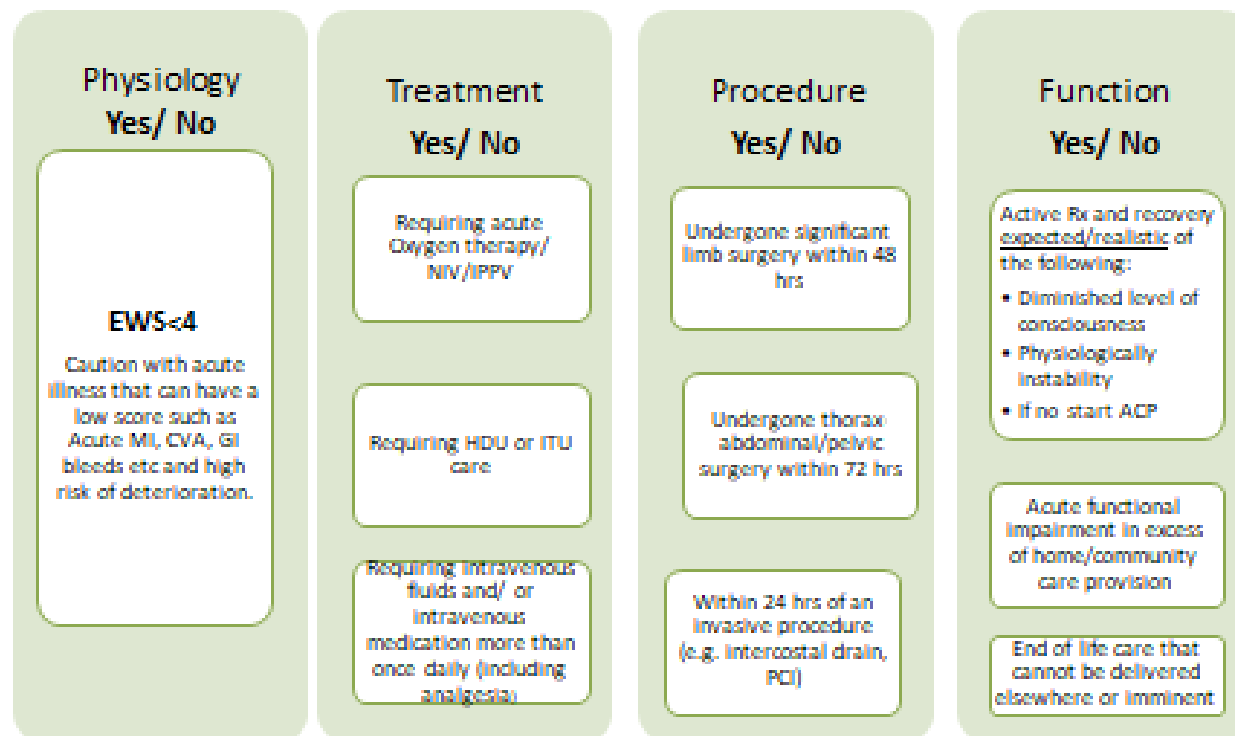
Ward 32
Diabetes 6 beds 32 Cubs 1-6
Stroke 6 beds 32 Cubs 7-12
HCOP 12 beds 32 A, B C bays

Mark Roberts
Clinical Chair
24 Sept 2020

Appendix G – Discharge Review Tool

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Discharge Review Tool



- Every patient on every ward should be reviewed on a twice daily board round led by a senior decision maker to ask the above. *What treatment or care is your patient receiving that they can only receive in a hospital?*
- If the answer to each question is 'NO', active consideration for discharge to a less acute setting must be made.
- Consider stepping down treatment when improving in a timely manner.

APPENDIX H EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed:	Adult Patient Flow and Escalation Policy		
New or existing service/policy/procedure:	Existing		
Date of Assessment:	May 2020		
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity	Non identified	None identified	None identified
Gender	None identified	None identified	None identified
Age	None identified	None identified	None identified
Religion	None identified	None identified	None identified
Disability	None identified	None identified	None identified
Sexuality	None identified	None identified	None identified
Pregnancy and Maternity	None identified	None identified	None identified
Gender Reassignment	None identified	None identified	None identified
Marriage and Civil Partnership	None identified	None identified	None identified
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None identified	None identified	None identified

What consultation with protected characteristic groups including patient groups have you carried out? • **Governors**
What data or information did you use in support of this EqIA? • **WRES**
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • **No**
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: Low Level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment: Dale Travis
Signature: D Travis
Date: December 2020