PATIENT FLOW AND ESCALATION POLICY

POLICY

Reference	CPG-TW-PF&EP		
Approving Body	Trust Management Team		
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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	• Title change from Adult Patient Flow and Escalation Policy (including Full Capacity Protocol)
	• Appendices removed for:
	  ○ Capacity and Flow Meetings SOP
	  ○ National OPEL Framework
	  ○ NEWS 2 Decision Tool
	  ○ Capacity Issues in ED
	  ○ 'One-Over' SOP
	  ○ Comparative Risk Assessment
	• Updated action cards (Appendix B)
	• Updated relevant procedures and policies		

Supersedes GSU to complete	Version 5.0, CPG-TW-APF&EP, Issued 22nd March 2023 to Review Date January 2024		
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Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Operations		
Position of Person able to provide Further Guidance/Information	• Steve Jenkins, Divisional General Manager, UEC • Janine Foxhall, Associate Director of Operations - Urgent Care		

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CONTENTS

1.0 INTRODUCTION

A proactive response to managing non-elective demand and capacity is fundamental to ensure patient safety. As Emergency Department (ED) attendances and non-elective admissions to the Trust can be unpredictable in nature, it is vital that flow through the Trust is maintained at all times to prevent potential harm caused by crowding in ED and delays in ambulance handovers, and to ensure patients who require admission receive appropriate care under the correct specialty in a timely manner.

2.0 POLICY STATEMENT

- Patient safety and experience are our priority. This policy is intended to support clinical decision making, not to replace it.
- Patients are expected to be admitted or discharged within 4 hours of arrival in ED, unless there is a valid clinical reason to remain in ED.
- Same Day Emergency Care (SDEC) will provide an alternative care pathway for some conditions, avoiding unnecessary inpatient admission.
- 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 emergency flow is significantly challenged, as detailed in the escalation policy and Full Capacity Protocol, additional capacity and outlying capacity will be used to maintain flow throughout the hospital.
- The movement of patients will comply with the Trust Infection Control Policies.
- The Discharge Lounge will be used for every patient who meets agreed clinical criteria unless the discharge lounge is at maximum capacity.

The above objectives rely on the following assumptions:

- Divisional Leadership Teams will manage their own non-elective and elective demand through their daily Bronze rota and weekend planning process.
- Wards will ensure they are aware of their expected non-elective and elective demand and have daily plans to manage this, proactively pulling patients from ED or the Assessment wards as soon as a bed becomes available.
- Divisions will have operational action plans in place to support this policy and the Trust during the stages of escalation.
- The processes included in this document will be managed through the Capacity and Flow Meetings in collaboration with all Divisions.
- Ward MDT will maintain Nervecentre and accurately record MSFT to enable prompt issuing of TTOs and transport booking.

3.0 DEFINITIONS / ABBREVIATIONS

AHP	Allied health professional
BAU	Business as usual
BOC	Bronze on call
BRAG	Black, red, amber, green

BRAN	Benefits, Risk, Alternatives, Nothing
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
EAU	Emergency Assessment Unit
ED	Emergency Department
PDMS	Predicted Date Medically Safe
EMAS	East Midlands Ambulance Service
EPRR	Emergency Preparedness Resilience and Response
FCP	Full Capacity Protocol
GOC	Gold on Call
IDAT	Integrated Discharge and Assessment Team
MDT	Multi-Disciplinary Team
MSFT	Medically Safe for Transfer
NEMS	GP out of hours provider
OPEL	Operational Pressure Escalation Levels
PC24	Primary Care 24
SAFER	Patient flow bundle incorporating 5 elements of best practice
SAU	Surgical assessment unit
SBAR	Situation, Background, Assessment, Recommendations
SDEC	Same Day Emergency Care
SFH	Sherwood Forest Hospitals
SHOP	Sick, Home, Other, Plan (Principles for Board Rounds)
SOC	Silver on call
TCI	To come in
TOCH	Transfer of Care Hub
TTO	Medicine ‘To Take Out’ when discharged

4.0 ROLES AND RESPONSIBILITIES

The management of bed capacity and flow is the responsibility of the Chief Operating Officer and this responsibility is disseminated through a Silver/Gold on call structure, which is in place 24/7, 365 days per year.

During working hours, the management of patient flow remains the responsibility of the COO and Deputy (as Gold), Senior Corporate Operations Team (as Silver), Duty Nurse Managers (as Bronze) and the Divisional Leadership Teams (DLT) in accordance with the Capacity and Flow Meetings SOP.

Out of hours, the Duty Nurse Manager (DNM) is accountable for the management of flow supported by Silver and Gold on call as required.

The day-to-day process and roles and responsibilities of these individuals are outlined below:

Chief Operating Officer (and Deputy) - Overall accountability for patient flow throughout the Trust and for achieving and maintaining key performance standards.

Associate Director of Operations – Urgent Care – Responsible for oversight of patient flow (DNM) and discharge (IDAT) teams, ensuring clear systems and processes in place across the Trust to ensure effective flow. Lead on partnership working and escalation to system partners to support flow.

Site Management Team (DNMs) - Responsible for making robust plans with divisions to manage capacity and flow effectively. Proactively support the clinical teams Trust-wide as appropriate, to maintain efficient flow, deploying bed capacity and respond to escalation issues when identified by divisional teams. Supports the Divisional Bronze team to maintain effective flow across each campus. Support Divisions with elective and emergency admissions, ensuring emergency capacity is always available for key areas.

I**ntegrated Discharge and Assessment team (IDAT)** – Responsible for maximising supported discharges by working with partners in the Transfer of Care Hub (TOCH) to agree discharge arrangements, allocate capacity and reduce delays. Support ward teams with complex discharge processes.

Divisional Leadership Teams - The Divisional Leadership Teams (DLTs) ensure effective allocation of resources and capacity to meet demand and manage flow through their beds. They must ensure appropriately senior representation at Capacity and Flow Meetings, according to the escalation status, and ensure that their agreed escalation actions are implemented across their Division.

Clinical Chairs - Accountable for ensuring all medical staff understand and adhere to this policy and ensure, with their teams, senior visible medical leadership in times of pressure.

Divisional Directors of Nursing - Accountable for ensuring all nursing staff understand and adhere to this policy and ensure, with their teams, senior visible nursing leadership in times of pressure.

Divisional General Managers - Accountable for ensuring all managerial, clerical and administration staff understand and adhere to this policy and ensure, with their teams, senior visible operational leadership in times of pressure.

Head of Service/Consultants - Ensures that board and ward rounds take place, start on time, are decision-oriented, focus on proactive discharge planning and ensure that all relevant Nervecentre fields are kept up to date. Adhere to the Professional Standards and ED Principles.

Ward Teams - Managing their patient cohort through the SAFER principles, board rounds and maintaining accurate information on Nervecentre. To work with the DNM at all times to ensure that beds are used efficiently and effectively, and that patient safety is paramount. To minimise any delays on the day of discharge through advance planning, early preparation of TTOs and booking of transport. To promptly escalate any delays to care (e.g. diagnostic tests) and discharge.

Clinical Support teams (e.g. Pharmacy, Therapies, Diagnostic services) - To adhere to the agreed professional standards for their service and escalate any issues within one hour to the Site Management Team which would prevent standards being met.

Bronze - Manages the creation of bed capacity for each division and liaises regularly with the Site Management Team to maintain patient flow. Ensures that the SAFER principles are being followed and address any issues on a daily basis. Ensures appropriate staffing levels, central point of escalation within Division and link to Flow Room. Out of hours, the DNM will assume the Bronze role, supported by any senior Divisional staff on site.

Silver on call (Out of Hours) – Act as point of point of escalation for Bronze and Site Management Team (DNMs), ensuring robust plans in place across Trust to maintain flow and ensure patient safety. Liaise with Silver counterparts in other organisations where support required (e.g., diverts, repatriations, extended mental health bed waits) and attend system calls as requested. Silver Command in time of incident, responsible for leading emergency response.

Gold on Call (Out of Hours) - Act as point of point of escalation for Silver, ensuring robust plans in place across Trust to maintain flow and ensure patient safety. Liaise with Gold counterparts in other organisations where support required and attend system calls as requested. Decisions regarding emergency ED diversion during a major incident, if required, will be made at this level. Gold Command in time of incident, primarily responsible for managing external relations and planning for recovery.

5.0 APPROVAL

The policy has been consulted on by the Divisional Leadership Teams; Lead Duty Nurse Manager; Discharge Team; Capacity and Flow Team; and EPRR Lead with final approval being by the Trust Management Team.

6.0 PATIENT FLOW AND ESCALATION

6.1 Normal working

All Trust staff are required to actively contribute to the timely admission and safe discharge of patients from hospital. All patients should have a consultant approved care plan containing a predicted date of medically safe (PDMS) set within 14 hours of a patient's admission to help co-ordinate and plan for discharge in a timely manner.

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

Once a patient has achieved their clinical and functional goals, the consultant and MDT can confirm that a patient is medically safe for transfer (MSFT).

Patient progress towards MSFT should be assessed every day at a board round led by a senior clinical decision maker (normally the consultant) as per the agreed ward schedule.

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?
3. What do I need to achieve to get me home?
4. When should I expect to go home?

All members of ward / departmental teams should be able to discuss and explain the plan for each of their patients.

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 MDT, consisting of doctors, nurses, pharmacists, therapists, and other allied health professionals, should provide dedicated time to participate in board and ward rounds, with clarity about individual roles and responsibilities during and after ward rounds. Board Rounds are undertaken daily in line with SHOP principles (Sick, Home, Other, Plan) and should be finished in most wards by 09:30 to enable teams rapidly to assess the progress of every patient in every bed and the positive actions that must be taken to progress their care that day. Delays to treatment and discharge should be escalated through the MDT lead to the divisional bronze. An afternoon huddle should be conducted to ensure board/ward round actions are in place or progressing as appropriate.

Medical staff must ensure that board and ward rounds are complete in a timely manner and patients who are MSFT identified. Ward rounds should follow the core recommendations and principles in accordance with the latest best practice.

Potential and definite discharges should be declared on Nervecentre as soon as known to allow the Site Management Team to plan for incoming demand. Ward staff should transfer all patients to the discharge lounge unless they are a medical exception, or the discharge lounge is full to ensure that beds are released to accept acute admissions.

Normal working includes:

- Completed morning Board Rounds before 09:30 using SHOP (Sick, Home, Other, Plan) principles.
- Setting a patient's clinically agreed PDMS within 14 hours of admission
- Commence discharge planning upon the patient's admission and submit Discharge to Assess form to TOCH 48 hours before PDMS.
- Completion of TTO requests to Pharmacy and recording on Nervecentre at least the day before the patient's discharge
- Document when a patient is MSFT on Nervecentre
- 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 identify patients for Newark Hospital and Mansfield Community Hospital wards (Divisions and IDAT to lead).
- Proactively review all the patients with a LoS of over 7 days daily
- Move the patient within 30 minutes of the bed being made available.
- Adhere to the Professional Standards SOP

6.2 Attendance and Admission

6.2.1 Streaming

The majority of emergency patients will arrive at the Emergency Department either as walk ins or by ambulance. To ensure patients are entered into the correct pathways, ED streaming will remain in operation 24/7 to effectively place patients in the correct setting for their needs e.g. PC24, SDEC and other processes such as hot clinics.

6.2.2 Ambulance Escalations and Peripheral Diverts

Ambulance handover times should not exceed 15 minutes, handover escalation in and out of hours should follow the relevant national and local guidance.

Neighbouring Trusts may request a full or partial divert if they are at OPEL 4 or crowding in their ED is a patient safety issue. Diverts should be agreed with the Consultant in Charge of ED and through Silver/Gold on call out of hours and the COO or nominated deputy in hours and should have an agreed review time.

The East Midlands Ambulance Responsible Operating Manager should be informed of the agreed divert, duration and Trust involved. This information should be communicated to the on-call managers and ED teams.

6.2.3 Ambulatory Care

GPs can refer ambulatory patients directly to ED or SDEC which provides general medical assessment. Patients requiring admission will primarily be transferred to EAU and should wherever possible be admitted in time order alongside patients awaiting admission in ED.

Ambulatory care is also provided direct from GP admission through the Surgical Assessment Unit (SAU) for surgical patients and for paediatric patients, through Childrens Assessment Unit (CAU).

6.2.4 Emergency Admission

In the emergency department, Decision to admit (DTA) will be made by a senior decision maker who will request a bed in the appropriate specialty.

The ED Consultant has the right to decide on the most appropriate specialty for an admitted patient – refer to the Trust's Professional Standards SOP. Where specialty input is required, specialities should attend ED within 60 minutes of referral. Where this does not happen, the ED Consultant can decide on the most appropriate specialty to admit to, and the patient should move directly to the ward.

Patients admitted from ED will be transferred to an admission unit (EAU, SAU, GAU, CAU) or a specialty bed (e.g. Cardiology, Respiratory, Stroke). Transfers from assessment areas to wards will be undertaken within 30 minutes with bed availability and booking done through Nervecentre.

6.2.5 Elective Admission

Elective admission will be arranged by Divisions in line with clinical urgency and access targets. Cancellation due to bed availability should be considered a last resort and any decision to cancel for non-clinical reasons must be escalated to a member of the relevant Divisional Leadership Team before the cancellation is agreed. Cancellation of patients due to bed availability must be agreed with Silver/Gold (in hours, the COO and/or her team). The risk of cancelling clinically urgent and cancer patients must be considered alongside the risks of delaying admission for emergency patients.

In escalation, patients will be prioritised for available capacity in the following order:

a. Clinical urgency including Cancer
b. Previous cancellation on the day of admission
c. RTT waiting time.

Consideration will also be given to the complexity of the arrangements, for example, joint cases or where specialist equipment has been hired.

6.3 Bed Management

6.3.1 Capacity Management

The Site Management Team will run Capacity and Flow Meetings at specified times throughout each day. Divisions must be represented with their bronze on call at each meeting and will field a member of the DLT on OPEL 4. Capacity and Flow Meetings will:

a. Review demand for beds and establish current and forecast capacity
b. Set priorities to create capacity and agree actions with Divisional representatives
c. Review trigger points and set the Trust escalation level, ensuring relevant actions are being taken
d. Agree communications required across the Trust to ensure all relevant staff are aware of the escalation level and actions required.

Divisions are responsible for creating capacity to meet expected demand for their beds. The Site Management Team is responsible for ensuring that it is deployed effectively to meet demand across the Trust.

6.3.2 Specialty identification and ward transfers

Patients who are assessed by ED or admission areas to require a specialty bed are tagged for the appropriate specialty at the time of senior review. Patients will then be admitted to an appropriate admission area according to tagging.

Where there is capacity on base wards, patients should be pulled immediately with an expectation that no patient should reside longer than 18 hours in admission areas.

Where there is no capacity on the base ward, the identified speciality is required to conduct daily senior reviews of the patients on the assessment ward.

6.4 Internal Flow

6.4.1 Transfer to Wards

Wards are expected to actively 'pull' patients from ED or assessment areas. The Nurse in Charge should be aware of any patients requiring a bed on their ward. Vacated beds must be made ready and declared within 30 minutes of the previous patient leaving. This should all be orchestrated through Nervecentre which must be kept up to date at all times.

6.4.2 SAFER

SAFER describes the nationally recognised principles which underpin good practice to maintain patient flow and ensure timely decisions and intervention are achieved. All ward areas are expected to comply with the principles of SAFER and will be monitored on achievement of the standards.

6.4.3 Nervecentre

All relevant Nervecentre fields must be kept up to date and maintained by clinical teams and reviewed at least daily during board and ward rounds or updated each time a decision is made/changed.

Every patient should have a management plan documented in their records with clear details of the actions required to support the safe and timely transfer of care from hospital.

6.4.4 Staffing

Staffing within clinical areas should be managed by Divisions in hours and any staffing risks out of hours should be conveyed to the Site Management Team in advance with clear contingency plans. Forward planning by divisions to ensure safety of our wards is paramount.

The staffing application will be kept up to date by wards enabling the Site Management Team to plan for any areas which lack staff. Available staffing will be prioritised to minimise any risk to patients and with consideration of the impact on patient flow.

6.4.5 Same sex accommodation

All patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex and will have separate toilets and bathrooms that they can reach without having to pass through (or close to) opposite sex areas. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in the critical care unit).

Patients in Critical Care may share accommodation for as long as they require Level 2 or 3 care. As soon as any patient in a bay is ready to step down to a base ward, the bay must be returned to same sex accommodation as soon as possible, and at the latest, by 10pm on the same day.

6.4.6 Critical Care

Patients discharged from critical care should be stepped down to an acute ward within 4 hours of being deemed ready and should take priority for inpatient bed allocation. Any delays to step down will be managed through the daily Capacity and Flow Meetings.

6.4.7 Outlying

Outlying can increase the risks of healthcare associated infection and can reduce capacity by increasing length of stay. There is emerging evidence of a correlation with increased mortality rates. For these reasons, outlying is not preferable and the number of patients outlied should be kept to a minimum.

Where it is necessary for the safety of more critically ill patients, decisions to outlie must be based on the patient's current clinical and mental health needs, their level of acuity, dependency and the clinical capability of the receiving area. This decision should be ratified by the consultant responsible for their care, recorded on Nervecentre and clearly documented in the patient's notes. Relatives must be informed of all decisions to move patients and must be given details of the ward to which the patient has been transferred.

Divisions are required to keep up to date outlier lists to ensure specialty capacity can be created where required.

Patients who are placed outside of their normal specialty areas are entitled to the same level of care and treatment that they would receive if cared for within their specialty areas. Every effort will be made to ensure that outlying patients are reviewed by nursing and medical teams from their specialty on a daily basis during Monday to Friday and, where possible, at weekends.

The number of bed moves during each patient's stay must be minimised. Ideally once a patient has been outlied from their original ward they should not be moved again except under exceptional circumstances.

6.4.8 Home Leave

The Trust supports the use of 'home leave' for patients as part of a programme to promote independence and a safe transfer of care. However, the bed of a patient on such (planned) leave will be declared as available for use and a plan to ensure that a bed is available on the patient's planned return will be negotiated by the ward with the Site Management Team.

6.5 Discharge

6.5.1 Discharge Process

Patients will be discharged from SFH when medically safe and any necessary equipment and either additional nursing or social support is in place.

For 'simple' discharges, patients should be discharged as early as possible on the day they become MSFT. Divisions will review any delayed simple discharges (greater than 12 hours) to ensure that they are correctly categorised and that the appropriate actions are being taken.

For supported discharges, discharge planning must occur as early in the patient's journey as possible to prevent delays to discharge. All patients requiring a Discharge to Assess pathway should be referred to IDAT (Integrated Discharge and Assessment Team) a minimum of 48 hours prior to being medically safe. Following this referral, a triage process will ensue to facilitate timely discharge to the appropriate setting.

Unless not clinically appropriate patients should be taken to the discharge lounge and discharged as early in the day as possible.

For all patients simple and supported wards should ensure that the necessary arrangements have been made for TTOs and transport to avoid unnecessary delays.

Once a patient is ready for discharge their Nervecentre record should be update indicating that they are leaving hospital.

Once patients have left the hospital Nervecentre should be updated immediately so that it is clear that the bed is now free and available for another patient.

6.5.2 Discharge Lounge

The discharge lounge is open from 7am til 9pm, Monday to Friday. Wards should ensure that suitable patients are identified the day before discharge and transferred to the discharge lounge by 10am or earlier if possible.

Where possible, TTOs should be written prior to transfer to the Discharge Lounge but can be dispensed on the Discharge Lounge. On OPEL 4, patients can be transferred without the TTO being written however it remains the responsibility of the original team to ensure that the TTO is written at the earliest opportunity.

6.5.3 Choice Policy

Once a patient is MSFT, remaining in an acute hospital setting is undesirable for the patient and can increase dependency and the risk of acquiring infections.

A system wide Choice Policy is in place which describes the process to be followed when a patient or their family declines an offer of interim care made by a social worker. The Choice Policy comprises a series of letters intended to explain the need to leave the hospital, the options available and ultimately enables the hospital if required to insist upon the patient leaving the hospital bed.

All letters are now available to download from the Intranet and can be found embedded within the Discharge Policy.

6.5.4 Repatriations

All patients should be repatriated to their receiving Trust within 24 hours of being assessed as ready for transfer. Divisions are responsible for ensuring that PDMS are notified to the receiving hospital and that the status of patients requiring repatriation is monitored.

If the receiving hospital has not created capacity for the patient within 24 hours of the patient being ready for transfer, the Divisional Bronze on call will escalate to the Duty Nurse

Manager who will liaise with their equivalent at the receiving Trust. At 48 hours, the Duty Nurse Manager will escalate to a senior member of the Operations Team in hours and Silver on Call out of hours to initiate a Silver-to-Silver discussion with the receiving Trust. If this fails, escalation may include up to Gold on call and notifying the System Control Centre of the delay.

Hospitals requesting the repatriation of a patient to SFH should be accommodated within 24 hours of the request being received.

6.5.5 Transport

Transport should not be routinely offered. Patients and their carers are responsible for their own transport out of hospital unless there is a reason to require a stretcher or wheelchair transport facility. Carers should be encouraged to collect patients from the discharge lounge where possible. Wards are responsible for ensuring that appropriate transport is booked at the earliest possible opportunity to facilitate timely discharge. Any failure of transport must be escalated immediately to the Site Management team.

Consideration should be given to the time the transport is arranged. Unless clinically appropriate or the Trust is in escalation, transferring patients between the hours of 10pm and 6am should be avoided.

6.6 Escalation

6.6.1 Objectives

When demand exceeds capacity, either by means of a surge of emergency admissions or a failure to deliver sufficient discharges, this undermines the Trust's ability to deliver to its operational standards and to care safely for individual patients in the correct environment.

Levels of escalation and supporting actions are described in Appendices A and B. Once the trigger has been met for the next level of escalation, action cards must be followed promptly. Details of the triggers for escalation are kept in the Flow Room and will be used at each Capacity and Flow Meeting to establish a current status.

The objectives of escalation are:

- To keep patients safe
- To ensure safe and clinically appropriate placement of patients requiring an acute inpatient bed, in line with infection control and same sex accommodation 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 risk of harm associated with overcrowding.
- To reduce overcrowding in ED thereby allowing safe and timely assessment of patients
- To turn ambulances around safely and in a timely manner to avoid delays to treatment and ensure ambulances are released swiftly to respond to calls from the public.

Patients should only be placed in clinical accommodation that is appropriately staffed and equipped to manage their presenting condition.

Divisional Leadership Teams are responsible for the management of capacity within their own bed base and to establish, implement and manage plans for each level of escalation.

6.6.2 Escalation triggers

SFH uses the NHS Operational Pressures Escalation Levels Framework 2023/24 (OPEL) to determine the overall trust escalation level and appropriate actions. These are agreed at each Capacity and Flow Meeting and ratified by the Chief Operating Officer or nominated deputy. The OPEL score is only a guide that is taken into account when setting the OPEL status and actions outside of the OPEL action card can be enacted in the interest of patient safety.

The Trust escalation scoring system is included in Appendix A.

On Call Teams and Divisional Leadership Teams will need to deploy actions, supported by this policy, that will help to regain control over the Trust's flow and capacity. Patient safety will always take priority and this may require a rebalancing of risk across the organisation.

6.6.3 System Calls

A daily system call is in place for providers across health and social care when they remain on high OPEL escalation. The call will be attended by a senior member of the Site Management or Operations team in hours, and the DNM and Silver on Call out of hours, and a summary of the Trust pressures, internal actions, and escalations for support from the system will be conveyed.

6.6.4 Full Capacity Protocol

In the event the Trust has declared OPEL 4, and after implementing all the Level 4 actions, is unable to de-escalate, the **Full Capacity Protocol** should be enacted. This will be authorised by the Chief Operating Officer or nominated deputy, or Gold on call out of hours.

6.6.5 Opening and closing additional capacity

The decision to open or close additional capacity will be agreed with the Chief Operating Officer or nominated deputy, or Gold on call out of hours, and in conjunction with the divisional leadership teams, in line with the OPEL 4 action cards and the Full Capacity Protocol.

6.6.6 Declaring an Internal Critical Incident

The decision to declare an internal incident due to capacity pressures will be made by the Chief Operating Officer or nominated deputy in hours, and Gold on call out of hours.

The decision to step down an internal incident will follow the same decision-making route.

During an internal incident, regular command meetings will be held across sites, chaired by the Chief Operating Officer, her deputy or Silver on call. Staff will be called upon to forgo non-clinical duties (including training) and participate in clinical activity.

6.6.7 Declaring a Major Incident

The decision to declare a major incident will be made in line with the Major Incident policy.

6.6.8 Communications

Communications regarding capacity and flow will be managed by the Site Management Team and the Communications Department. These will be shared as appropriate.

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 Chief Operating Officer or nominated representative in the bed meeting.

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 (eg 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 POLICY 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 Associate Director of Urgent and Emergency Care and team.

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. MDT members involved in board and ward 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 Appendix D
- This document has not been subject to an Environmental Impact Assessment

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

Related *SFH* Documents:

- Capacity and Flow Meetings SOP
- National OPEL Framework
- ED Overcrowding SOP
- Full Capacity Protocol
- 'One Over' SOP
- Mental Health Escalation Process
- Midlands Inter-Hospital Transfer Procedure Policy
- Maternity OPEL Framework
- Major Incident Plan
- Women's and Children's Escalation Policies
  - Maternity Escalation and Suspension of Acute Maternity Services Policy
  - Ward 25 and CAU Capacity Management and Escalation SOP
- Infection Prevention and Control Policy
- Discharge Policy
- Integrated Discharge Team SOP
- Decision Support Tool
- Clinical Site Management Team SOP
- Criteria Led Discharge SOP
- Patient assessment for suitability of taxi transport home SOP
  - Checklist for transfer of patient in private taxi for the purpose of discharge
- Discharge Lounge (KMH) Operational Policy (including criteria at section 6.5)
- Professional Standards SOP

11.0 KEYWORDS

Bed Management, Gold, Silver, Bronze, On-call, Full Capacity Protocol, and, Outlier, Outlying, outlied, Opel, Red, Amber, Escalate, Ward Pairings, discharge review tool, decision, additional, to meet demand, including, plan, for, BRAN.

12.0 APPENDICES

Appendix A	Local SFH Escalation Triggers
Appendix B	Escalation Action Cards
Appendix C	Level 4 and Full Capacity Protocol Highlights
Appendix D	Equality Impact Assessment

Appendix A - Local SFH Escalation Triggers

	SCORE 1		SCORE 2		SCORE 3		SCORE 4	
ED:	RESUS <6		RESUS 6-8		RESUS 9-11		RESUS >11	
	MAJORS <25		Majors 25-30		Majors 30-35		Majors >35	
	LOS 4-6 HOURS		LOS 6-8 HOURS		Los 8-10 HOURS		LOS >10 HOURS	
	BED WAITS <3		BED WAITS < 5		BED WAITS < 7		BED WAITS >8	
	WTBS < 1 HOUR		WTBS <2 HOURS		WTBS < 3 HOURS		WTBS > 3 HOURS	
ED performance	>95%		95-90		90-85		<85%	
Ambulance turn around	<30min		30 min		45 min		>45 min	
SURGERY:	CAPACITY >5		CAPACITY 4		CAPACITY 3-1		CAPACITY 0	
	ICU STEP DOWN <2		ICU STEP DOWN 2-4		ICU STEP DOWN >4		ICU STEP DOWN NO FLOW OUT	
	ELECTIVE CANCELLATIONS 1		ELECTIVE CANCELLATIONS >1 / CANCER					
MEDICINE:	CAPACITY >10		CAPACITY >8		CAPACITY <4		CAPACITY 0	
SPEC BEDS:	SPECIALITY BEDS 4		SPECIALITY BEDS 2-3		SPECIALITY BEDS 1		Speciality beds 0	
LOS waits in EAU ➢ 18 hrs	<2		2-4		4-8		>8	
PEADS:	>3		2		1-0			
MATERNITY:	AMBER		RED		BLACK			
OUTLIERS:	<5		<10		>10		>15	
BEDS CLOSED:	1-2		3-4		5		>5	
MSFT:	<22		<30		<35		>35	
Covid +ve patients in trust:	< 20		<30		<60		>60	
*Super Surge capacity open (beyond winter capacity)							yes	
TOTAL SCORE:								
RANGE:	0-23		24-39		40-54		>55	

Appendix B - Escalation Action Cards

Action Card for Local Escalation Level 2	
Current position	The local health and social care system is starting to show signs of pressure. Organisations will be required to take focused action in showing pressures 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 England 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. **Actions are to be monitored/reviewed by Silver On Call within individual organisations**

Level 2 Action Card	
Urgent and Emergency Care Division	• Ensure that clinicians are using all possible methods for admission avoidance e.g., referring to SDEC etc. • Ensure that senior streaming takes place. • Nurse in charge in SDEC to visit ED and EAU to proactively pull/identify patients for SDEC pathways. • Work with clinical teams escalating and responding to any delays. • Ensure specialty reviews have taken place promptly.
Medicine Division	• Second BR / Huddle to take place on every ward -/+ Consultant presence to follow up on actions and escalations.
Women`s and Children`s Division	• 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. • Escalate issues to Specialty and Divisional Teams to mitigate blockages to discharge. • Ensure all patients reviewed by Senior Decision Maker within 12 hours.
Clinical Services, Therapies and Outpatients Division	• Communicating alert status to staff and services. • Responding to patient delays impacting on decision to admit e.g., therapy, pathology and radiology. • Support Discharge Lounge with completion of take-home medication being completed in the lounge setting. • Identify beds which will be available until afternoon and can be used medically in interim. • Senior ad hoc board round to identify and aid early discharges e.g., senior review, discharge planning, commencing TTO, etc. • Chase any outstanding investigations required to support discharge.

Senior Operations Team	• 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 Escalation Level status to the ICB • Join system call as necessary. • Ensure all MSFT have a plan. • Responding to patient delays impacting on discharge, e.g., dietetic review, therapy and pharmacy assessment, radiology, speech and language therapy	
Duty Nurse Manager	• 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 • Update OPEL score every 6 hours.	
GOLD	• Maintain oversight of Trust operational status and set any strategic objectives	
SILVER	• Maintain oversight of Trust demand, capacity, pressure points and escalation status • Set any tactical actions. • Attend the 08:00 am, 17:00pm and 20:00 pm Capacity and Flow Meetings. • Out of hours – see Capacity and Flow Matron actions.	

Action Card for Escalation Level 3	
Current position	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in LEVEL 2 have not succeeded in returning the system to LEVEL 1. Further urgent actions are now required across the system by all organisations, Gold On Call, and increased external support may be required. Regional teams in NHS England will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. The National team will also be informed by DCO/ Sub-regional teams through internal reporting mechanisms. **Head of Urgent Care Resilience to chair a System Call involving provider/organisations winter representatives/tactical leads at 11:30am**

Divisional Actions

Level 3 Action Card	
Urgent and Emergency Care Division	**Divisional Bronze supported by Divisional Leadership Team to ensure LEVEL 2 plus:** • 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. • ED Senior streamer to initiate a huddle with Ambulance officer to make-ready for patient cohort if required due to delayed handover times (if ambulances are held) • Consider post-taking of patients to occur within ED. • 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 outlied within the hospital or to community setting e.g., transfer to assess or integrated care team. • Consider patients on FLAP pathway to move to SAU. • Discharge Lounge liaise with Bronze & DNM to identify priority areas to pull from
Medicine Division	• Targeted approach to Board Rounds having oversight from a Matron, DDN, DGM or operational manager. • Confirm & challenge PDMSs. • Confirm & challenge if the patient can have next step in an alternative pathway or setting (e.g., access OPAT, MDCU, outpatient clinic appointment or diagnostic). • Escalate delayed scans, reviews, other next steps for discharge. • Completion of discharge letters and TTO's to be completed on Discharge lounge.
Surgery Division	• ST3+ oversight of all admissions in ED • Completion of discharge letters and TTO's to be completed on Discharge lounge. • 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 43. • Review patients within division suitable to 'Out lie' to Ward 14 • 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)
Women`s and Children`s Division	• Review the option of extending the opening hours of GAU/CAU to maximise reducing admissions. • Completion of discharge letters and TTO's to be completed on Discharge lounge. • On call Consultants to assist with ward reviews and new admissions • Nurse in charge to have oversight of potential patients in ED to decide if they can be reviewed and turned around in ED rather than attending the assessment areas. • Review of planned activity for next day (including overnight sleep studies) to be led by Nic and Divisional Bronze • Outliers (gynae only) identified. • Review acuity/capacity on NICU to move a nurse. • Early escalation to increase nurse staffing overnight to maintain flow. • Nurse in Charge to inform Consultants to review possible patients for discharge. • Peer review to take place to review all patients in a bed.
Clinical Services, Therapies and Outpatients Division	• Priority to be given to ED and admissions areas for diagnostic appointments and other service clinical reviews, e.g., pharmacy and therapy. • Priority to be given to inpatient areas for assessment and diagnostics. • Pharmacy to prioritise urgent activities to provide additional support for discharge e.g., TTOs.
Senior Operations Team	• Chair the Capacity and Flow meeting and enact Divisional Level 3 action cards. • Take action to ensure all patients have a consultant review face to face. • Take action to contact Social Services, Call For Care and Community Intermediate Care Team to proactively discharge patients out of the KMH, 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.
Duty Nurse Manager	• 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). • Ensure all beds are declared and filled within 45 minutes. • Update OPEL score every 4 hours.
GOLD	• Maintain oversight of Trust operational status and set any strategic objectives. • Confirm and challenge Divisional plans if requested by Associate Director of Urgent and Emergency Care (Silver on Call OOH). • Consider rescheduling of elective admissions where appropriate. • Consider utilisation of additional capacity. • Issue communications internally and externally, ensuring clinical leaders are aware and cascade to teams.
SILVER	• Maintain oversight of Trust demand, capacity, pressure points and escalation status • Set any tactical actions. • Attend the 08:00 am, 17:00pm and 20:00 pm Capacity and Flow Meetings. • Out of hours – see Capacity and Flow Matron actions.

Actions to be taken when the SYSTEM is at LEVEL 3:

- Ensure rapid ambulance handover areas are continually accessible.
- Make use of alternative transport providers to supporting discharges
- Lead consultants to review patients awaiting admission to their speciality to determine if all admissions are still required.
- Undertake a review of all patients assigned for a pathway 1 discharge to see if any can be converted to discharge pathway 0

Action Card for Escalation Level 4	
Current position	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 UEC 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 England 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 LEVEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered. **Urgent Care Director to chair System Calls to determine a System Wide Response**
Divisional Actions	

Level 4 Action Card	
Urgent and Emergency Care Division	• Divisional Leadership Team to attend capacity and flow meetings. • Increase shop floor medical capacity if required 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. • Open EAU to 46 beds. • Utilise Overcrowding SOP for ED space. • Go 'One Over' on definite discharges as per 'One over' SOP. • All Board Rounds to have oversight from a Matron, HoN, DGM or operational manager. • SSU Ward Manager/Senior nurse to try and pull already post-taken suitable patients directly from ED. • Discharge Lounge leader when not in the daily establishment will support walking the wards to take handover and pull patients.
Medicine Division	• Divisional Leadership Team to attend capacity and flow meetings. • All planned inpatient admissions to medical bed to have a clinical review in view of admitting patient without the need for an inpatient stay. For example. • If patient through Cardiac Catheter Suite could an admission be avoided if list scheduling were changed by bringing patients in earlier, etc. OR • All planned day case admissions to be reviewed ascertain if at risk of requiring admission, these include; Endoscopy, Cardiac Catheter Suite, MDCU, Welcome Treatment Centre (WTC), Interventional Radiology, Diabetes & Endocrine fasting studies and sleep studies. Consideration of long waits/ clinical urgency and balancing of risk. • If no alternative pathway, risk assessment for cancellation to take place and follow Medicine Division SOP for cancellations. • All Board Rounds to have oversight from a Matron, Head of Nursing, DGM or operational manager to Confirm & challenge PDMSs / CLD. • Confirm & challenge if the patient can have next step in an alternative pathway or setting (e.g., access OPAT, MDCU, outpatient clinic appointment or diagnostic) Escalate delayed scans, reviews, other next steps (once the Chair of BR has confirmed on ICE) • All second Board Rounds / Huddles to have consistent oversight to feedback on actions/escalations in afternoon. If increased demand for services such as OPAT/ Virtual Ward to facilitate discharge; slot times for patients to be safely reduced to enable increased capacity. • A consultant face to face review of all patients who are not MSFT to take place to facilitate discharge; cancellation of other activity (elective, SPA or study leave) may need to take place to facilitate this. • Consultant leading the Board Round to allocate one Tier 1 Doctor to do focus on discharge tasks outside of Board/Ward Rounds to ensure tasks are completed to ensure early and safe discharge. • Go 'One Over' on definite discharges as per 'One over' SOP. • Review the potential of opening additional capacity. o Medical Day Case Unit up to 8 beds. o Stroke Unit - 4 beds. o Flexibility to outlie onto W31 (in addition to existing medical outlier cohort on W32) • Review capacity required for Full Capacity Protocol (FCP)

	○ Stroke Unit - up to 7 beds. ○ Cardiac Catheter Suite - up to 8 beds ○ Lindhurst - up to 24 beds: an additional 5 ○ Use every available bed in the organisation, e.g., flex onto W14 if surgical capacity to outlie has been exhausted.
Surgery Division	• Divisional Leadership Team to attend capacity and flow meetings. • Ensure all patients have Consultant review prior to admission from ED. • Review of planned elective activity with view of potential cancellation. • Ensure consultant face to face review of all inpatients. • Go 'One over' on all patient discharges as per the 'One Over' SOP. • Collate list of Trauma patients with clear swabs for moving to Ward 43 • Consider opening DCU to 18 beds (Minimum staffing of 3 x RN) • Review capacity potentially required for FCP. • All Board Rounds to have oversight from a Matron, HoN, DGM or operational manager. • Consultant review of all patients in Acute bed base within 4 hours if not already reviewed that day.
Women`s and Children`s Division	• Divisional Leadership Team to attend capacity and flow meetings. • Early escalation to GP colleagues to encourage advice and guidance where clinically appropriate. • Consultant review of patients requiring potential admission from ED. • Redirect GP referrals to alternate hospital with permission from that hospital. • 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 reviewing patients at the front door. • Nurse in charge to notify all Consultants that ward is full and not able to accept new patients and request patient review where necessary. • Review nurse to bed ratio with clinical team support to increase bed base. • Review case mix to cohort older children with a dedicated adult nurse • Nurse in Charge to complete Escalation form within Escalation folder. Update book 2 hourly • Re-open at the earliest opportunity • Review the potential utilisation of Ward 25 beds supported by Derogation- up to 4 beds. • Review at KMH and decision made to refer on to alternative hospital. • Arrange ambulatory appointment. • Give telephone advice.
Clinical Services, Therapies and	• Divisional Leadership Team 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 nonurgent OP activity to free up clinical staff to support patient flow and safety. • Potential utilisation of Radiology with ED trolleys as per FCP.

Outpatients Division	• Divisional medical staff to prioritise vetting of requests, reporting and clinical advice to ward areas. • Provision of additional or extended services if required. • Case by case review of discharging patients without TTO medications • Review outpatient scanning to facilitate inpatient scans.
Senior Ops Team	• Chair the Capacity and Flow meeting in the absence of the Chief Operating Officer • Ensure long wait patients in ED are safety and receiving care and comfort. • Maintain contact with EMAS ROM to effectively manage the pressures and instigate a deflect where possible. • Maintain a complete and accurate evaluation of patient admission, discharge, and transfers. • Maintain and communicate all long waiting patients to the COO. • 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 MSFT. • Attend the system call and liaise with partners for action- admission avoidance, MSFT spot purchase • Implement any further action to avoid or address ambulance handover delays. • Ensure Level 4 Pop up alert is instigated Trust wide. • Consider the need for additional escalation (surge/FCP) beds and additional discharge capacity. • Ensure all specialties review in ED within the hour of referral or deploy admitting rights to assessment areas.
Duty Nurse Manager	• Maintain a complete and accurate evaluation of patient admission, discharge, and transfers, to be readily available upon request. • Maintain log of long waiting patients and salute accordingly • Clinically support in the event of crowded ED or ambulance delays as per ambulance delay protocol • Respond as requested by Assoc. Dir of Operations – Urgent and Emergency Care. • Update OPEL every 2 hours.
GOLD	**Maintain oversight of Trust operational status and set any strategic objectives as LEVEL 3 plus:** • Chair Capacity and Flow Meetings. • Ensure elective admissions have been reviewed and, where possible / appropriate, rescheduled or cancelled. • 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. • Consider opening escalation capacity. • Converse with system directors for support • Gain assurance for safety on non-elective pathway. • Gain assurance of success of operational plans and staffing levels • Make the decision to declare an escalation incident.
SILVER	**Maintain oversight of Trust demand, capacity, pressure points and escalation status and set any tactical actions as LEVEL 3 plus:**

	• Attend the 08:00 am, 17:00pm and 20:00 Capacity and Flow Meetings. • Out of hours – see Capacity and Flow Matron actions.

Actions to be taken if the SYSTEM is at LEVEL 4:

- Medical Director on site of most area of concern
- Implement Command and Control structure.
- Track status of all planned discharges for the day

Appendix C – OPEL 4 and Full Capacity Protocol Highlights

	OPEL 4	FCP
All	• Go 'one over' on Wards with definite discharges • Go 'one over' on Wards with potential discharges if insufficient definites *(see One-Over SOP – only enact Mon-Fri or when a Medical Matron is on site on a weekend (usually Sunday).* • Consultant face to face review of all non MSFT patients • Review elective activity • Board rounds to have senior Divisional presence • Divisional Leadership Team to attend capacity and flow meetings • Review non-urgent clinical activity to free clinical staff to attend wards where helpful	• Go 'one over' on all Wards as per policy. • Specialty Consultant review of patients in ED requiring admission
UEC	• Open EAU to 46 beds • Utilise Overcrowding SOP for ED space • Directly admit post taken patients from ED to SSU (bypassing EAU)	• Open (EAU to 52 beds • *Open 16 overnight beds on the Discharge Lounge (date tbc)*
Medicine	• *Medical Day Case Unit up to 8 beds *.* • Flexibility to outlie into Surgery	• Medical Day Case Unit up to 12 - 14 beds. • *Open 7 additional beds on the Stroke Unit ** • *Open 5 beds on Lindhurst **
Surgery	• Collate list of Trauma patients with clear swabs for moving to Elective Orthopaedics • Consider opening DCU to 18 beds (Minimum staffing of 3 x RN)	• Open 8 additional beds on Day Case Trolley side
Women's & Childrens	• Utilise additional beds on Ward 25 Paediatric Ward supported by derogation • Review case mix to cohort older children with a dedicated adult nurse	• Consider pts >16yrs to transfer to adult provision if appropriate • Utilise GAU beds as appropriate (2 beds) on Ward 14 • If limited appropriate surgical pts to outlie, discussion for transfer of medical pts to ward 14
CSTO	• Cancel any non urgent OP activity if advised by Divisions • Case by case review of discharging patients with TTO medications to follow • Review outpatient scanning to facilitate inpatient scans.	• Potential utilisation of Radiology with ED trolleys as per SOP • FP10s distributed for discharge

** Opened as part of Winter Plan so not available as FCP action until April 2024.*

NB - Opening additional beds on Cardiac Catheter Suite (8) and Endoscopy (8) has been removed as a routine action from FCP due to poor patient experience, but may be considered in extremis (including if a Critical Incident is called) if they represent a lower risk than continued crowding in ED, and having taken into account impact on cancer and urgent patients utilising those facilities.

APPENDIX D – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed:	Patient Flow and Escalation Policy		
New or existing service/policy/procedure:	Existing		
Date of Assessment:	February 2024		
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? • Shared at Trust Management Team meeting, Divisional Leadership Forums and Emergency Care Steering Group
What data or information did you use in support of this EqIA? • Deprivation and health inequalities information along with Urgent Care, Discharge and NEL data
As far as you are aware are there any Human Rights issues be considered 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: Steven Jenkins – Divisional General Manager
Signature:
Date: February 2024