University Hospitals of Derby and Burton NHS Foundation Trust

TRUST CAPACITY ESCALATION PLAN

Reference Number: POL-CL/041/12	**Version** 4.0.0	**Status:** **Final**	**Author:** Neil Radford **Job Title:** Associate Director Operations	
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	1	November 2012	Neil Radford	New Policy
	2	October 2013	Neil Radford	Annual review
	3	October 2014	Neil Radford	Annual review
	4	December 2016	Rob Walker	Major update Introduction of Full Capacity Plan Alignment to National Operational Pressures Escalation Levels (OPEL) Framework
Intended Recipients: All Trust staff.				
Training and Dissemination: Available on the Trust intranet. Individual action cards distributed to all relevant staff.				

To be read in conjunction with:

Escalation Planning

- Departmental Escalation Plans
- Trust Full Capacity Plan
- Pan Derbyshire Urgent Care Escalation and De-Escalation Plan
- Critical Care Network Surge Plan
- National Operational Pressures Escalation Levels (OPEL) Framework - 31 October 2016 by NHS England

Operational Policies and Plans

- Trust Transfer Policy
- Trust SOP for the Discharge of Adult Patients
- MAU Allocation SOP
- Outlier SOP

Emergency Planning

- Emergency Planning Policy
- Major Incident Plan
- Business Continuity Plan

In consultation with and date: Internal Senior Management and Clinicians from across the Trust – Escalation Plan Stakeholder Group – October – December 2016.	
EIRA stage One Completed No **Stage Two Completed** No	
Procedural Documentation Review Group Assurance and Date	Yes / No and Date
Approving Body and Date Approved	Management Executive
Date of Issue	December 2016
Review Date and Frequency	~~December 2018, Bi-annually~~ Extended until Apr 2019 EXTENDED DEC 2020
Contact for Review	Associate Director Operations
Executive Lead	Chief Operating Officer

Contents

1.0 Introduction

The Trust Capacity Escalation Plan outlines the systems and processes in place to effectively manage capacity to meet the non-elective demand for admissions to Royal Derby Hospital and maintain patient flow. The plan is designed to ensure that emergency admissions are accommodated safely whilst consideration is given to national targets.

The Plan is set within the context of the national guidance for 'Operational Performance Escalation Levels (OPEL) Framework' – 31st October 2016 by NHS England. This document describes 4 levels of escalation for local health and social care systems, OPEL 1 (able to meet demand), 2 (starting to show signs of pressure), 3 (major pressures compromising patient flow) and 4 (organisations unable to deliver comprehensive care).

The need for sufficient headroom in the hospital bed occupancy is critically important. As non-elective demand, elective demand, length of stay / acuity and delays to discharge fluctuate they can be difficult to predict and there is a need to frequently monitor the operational status of the hospital and respond appropriately. Whilst individual patient pathways vary, the approach to management of capacity is to minimise risk and to retain a position where capacity outweighs demand.

Capacity shortfalls can adversely affect patients, particularly with regards to crowding and delays in the Emergency Department (ED); long-waits for specialist care and cancelled operations. Such factors are known to correlate to mortality and morbidity and DTHFT aims to ensure its escalation management arrangements work to provide a good patient experience and prevent poor health outcomes.

This policy details the triggers used to set the escalation status of the Trust at any point in time and the responsibilities and actions for key staff and departments at each level of escalation to prevent further escalation and reduce pressure in the hospital.

The management of the relationship between demand and capacity involves forecasting and early identification of issues, met with responsive and timely mitigating actions. The ultimate aim is to ensure that the hospital is able to maintain, or return to, the lowest level of escalation.

2.0 Purpose and Outcomes

It is intended that acting upon the triggers and actions detailed in this plan DTHFT will maintain the lowest possible level of escalation and:

- Patients will be cared for in a safe manner and in a clinically appropriate setting
- Capacity will be utilised efficiently and effectively
- Risk to patients in terms of crowding, waiting times and cancellations will be minimised
- Patient flow will be maintained; including efficient safe discharge
- The opportunity to meet national standards for elective and non-elective care will be maximised.

3.0 Scope

The Trust Capacity Escalation Plan considers the escalation status of the Trust as a whole and is relevant to all Trust staff.

Individual Departments will have their own escalation plans that are not described in detail herein, but exist separately. These departmental plans are used to monitor and manage pressures locally in so far as they can be. Where departmental escalation levels continue to rise despite local mitigating actions and mutual aid is needed from other parts of the hospital or health and social care system then the Trust Escalation Status and actions will start to respond.

Specific departmental escalation plans exist for the following departments / services:

- Emergency Department
- Medical Assessment Unit
- Medicine and DME base wards
- Surgical Assessment Unit
- Rehabilitation
- Gynaecology
- Paediatrics, including Childrens Emergency Department and NICU
- Maternity
- Discharge
- Patient Transport

Departments should be carrying out the actions described in their own local plans that are appropriate to the level of escalation they are on.

Further actions will be delegated from the bed meetings or separately by Operations Team or Silver Command as the Trust escalation level increases.

At times of severe pressure, which is likely to be characterised by the Trust being on escalation status OPEL 3 (with no sign of respite) or OPEL 4, together with significant crowding in the Emergency Department which the lead ED Consultant considers to be rapidly approaching or already in an unsafe state, then the Trust Full Capacity Plan (FCP) can be considered. This is not described herein, but exists as a separate plan which can only be activated by the Chief Operating Officer, Chief Nurse, Medical Director or, during the out-of-hours period, by the Director On-call with the agreement of one of the former.

The Trust Capacity Escalation Plan also links to the Pan Derbyshire Escalation and De-Escalation Plan.

4.0 National Guidance and Targets

The Trust is required to meet the national standards for a number of waiting time targets that are affected by patient flow and capacity. The Trust Capacity Escalation Plan should support achievement of these standards. Most notable of the standards are:

Emergency department attendance waiting times:

- Arrival to discharge admission or transfer – 95% within 4 hours
- Decision to admit (DTA) to time of admission or transfer (trolley wait) – 100% within 12 hours

Elective referral to treatment:

- Greater than 92% of patients still waiting for treatment (incomplete) must be less than 18 weeks from referral
- Operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice; and

Cancer standards:

- Review by cancer specialist within less than 2 weeks from GP referral where cancer is suspected or for investigation of breast symptoms even if cancer is not initially suspected
- Less than 1 month wait from diagnosis to first definitive treatment for all cancers;
- Less than 1 month wait for subsequent treatment where the treatment is surgery or radiotherapy or anti-cancer drug regimen;
- Less than 2 month wait from urgent referral for suspected cancer to first treatment for all cancers;
- Less than 2 month wait from referral from an NHS cancer screening service to first definitive treatment for cancer;
- Less than 2 month wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)

The Emergency Department national standards are most directly affected by the effectiveness of the Trust Capacity Escalation Plan. The Trust is required to submit a daily situation report (SitRep) to NHS England providing the following data, including compliance with national standards:

- ED Activity – Number of attendances
- ED activity – Waiting time from arrival in ED to discharge, admission or transfer (95% within 4 hours)
- ED activity – Number of 4-12 hour trolley waits based upon the time when the decision to admit is made or when treatment in A&E is completed (whichever is later) to the time when the patient is admitted or transferred
- ED activity - Number of 12 hour breaches based upon the time when the decision to admit is made or when treatment in A&E is completed (whichever is later) to the time when the patient is admitted or transferred
- ED activity - Number of patients arriving by ambulance
- ED activity - Number of ambulance handover delays of more than 30 minutes
- Trust activity – Number of beds available and occupied
- Trust activity – Number of beds occupied by stranded patients
- Trust activity – Number of beds unavailable due to delayed transfers of care
- Trust activity - Urgent operations cancelled in the previous 24 hours
- Trust activity - Urgent operations cancelled for the second or subsequent time in previous 24 hours
- Trust activity – Number of patients waiting >18 weeks from referral to treatment (92% <18 weeks)
- Trust activity - All patients who are cancelled for non-medical reasons are to be re-admitted within 28 days.
- ED activity - Patients treated at A&E that did not require hospital treatment
- ED activity - Number of patients that could have been treated in primary care
- Trust activity - Patients referred or admitted to Ambulatory Emergency Care service at the same healthcare provider
- Trust activity - Patients streamed to a GP within the same healthcare provider or to other primary care or urgent care setting
- Trust activity - Patients discharged through discharge to assess – defined as NHS run care home for continuing care assessment; or Local Authority care home for continuing care assessment

5.0 Key Responsibilities / Duties

A number of roles and departments are key to the successful implementation of the Trust Capacity Escalation Plan. The following provides an overview of the responsibilities however detailed role-specific actions are available in Appendix 1.

Role	Responsibility
Chief Operating Officer (or Deputy) or Director On-call	To maintain strategic oversight of Trust operational status including: - Maintain regular communication with the Operations Centre or Senior Manager On-call. - Assume Gold Command and chairing Operational Bed Meetings in the event that escalation status is OPEL 3 or higher. - Decision to escalate to or de-escalate from the Trust Full Capacity Plan. To engage with external partners as necessary including: - Management of media / communication issues - Communicating Trust OPEL status and pressures to partner organisations - Seeking mutual aid
Associate Director of Operations, Lead Nurse for Operations (or Deputy) or Senior Manager On-call	To maintain tactical oversight and manage Trust operational status including: - Chairing Operational Bed Meetings at OPEL 1 or 2. - Recognising indicators and determining the Trust Escalation Status - Directing mitigating actions accordingly / in response to the Trust Status. - Assume Silver Command in the event that escalation status is OPEL 3 or higher To communicate with external partners as necessary including: - Timely submission of national SitRep data to NHSE / I as required and data to the Southern Derbyshire A&E Delivery Board.
Patient Flow Managers (supported by Bed Managers and Administrators)	To support with management of patient flow including: - Collecting and communicating accurate information regarding internal departmental status including staffing levels and bed capacity. - Supporting with the determination of the Trust Escalation Status. - Chairing Operational Bed Meetings out-of-hours or when at OPEL 1. - Liaising with operational staff and departments to resolve local demand and capacity issues. - Allocating patients to ensure that flow is maintained. - Tracking outlying patients to ensure clinical review is maintained. - Escalating capacity issues at the earliest opportunity to Senior Management.
Divisional and Business Unit Management Teams	To support with management of patient flow including: - Maintaining and robustly applying internal departmental escalation plans to minimise escalation and facilitate de-escalation. - Ensuring divisional clinical staff are aware-of and adhere-to the Trust Capacity Escalation Plan and the Trust Full Capacity Plan. - Providing Divisional representation at routine Operational Bed Meetings and additional meetings as required. - Implementing actions appropriate to the Trust escalation status and any other specific actions delegated during the Operational Bed Meetings. - Consideration of changing working practices or redeploying resources to reduce pressure during periods of heightened escalation.
Matrons / Nurse in Charge / Ward-Based Staff	To support with management of patient flow including: - Adhering to internal departmental escalation plans. - Ensuring ward staff are aware-of and adhere-to the Trust Capacity Escalation Plan and the Trust Full Capacity Plan. - Maintaining awareness of Trust status and cascading this within clinical teams. - Ensuring current status of local demand / capacity is communicated to the Patient Flow Team. - Providing local leadership and promptly implementing recovery actions delegated at

	the Operational Bed Meetings. - Reviewing daily discharge targets and expediting delays. - Escalating concerns to Patient Flow Team.
All Trust Staff	To adhere to the Trust Escalation and Full Capacity Plan and implement any requested actions efficiently and effectively.

6.0 TRUST ESCALATION PLAN STRUCTURE

The escalation status of the Trust is categorised in to Operational Pressure Escalation Levels (OPEL) 1 - 4 which are referred to internally as colours on a scale. Each level reflects the current status of the hospital in terms of the relationship between capacity (bed availability / staffing) and demand which presents the consequent level of risk to patient safety and experience.

Operational Pressures Escalation Level	Internal Status	Description
OPEL 1	Green	Low risk Capacity is such that the organisation is able to maintain patient flow and is able to meet anticipated demand within available resources
OPEL 2	Amber	Moderate Risk and Signs of Pressure The organisation is starting to show signs of pressure. Focused actions are required to mitigate 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 – and return to green status as quickly as possible.
OPEL 3	Red	High Risk and Major Pressure Actions taken in OPEL 3 have failed to de-escalate the system and pressure is worsening. The hospital is experiencing major pressures compromising patient flow and continues to increase. Further urgent actions are required across the organisation by all partners. This may include escalation to the Trust Full Capacity Plan.
OPEL 4	Black	Very High Risk and Critical Pressure All actions have failed to contain service pressures and the hospital is unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be led and taken at Director level until de-escalation to RED is achieved. This may include escalation to the Trust Full Capacity Plan. The COO or Executive On-Call must be alerted and consulted to enact Black escalation.

The current level of escalation is determined following the assessment of a number of indicators. These indicators include:

- Escalation status of the Emergency Department in accordance with the departmental escalation plan
- Escalation status of the Medical Assessment Unit
- Bed occupancy in Acute Medicine, Specialist Medicine and DME
- Any major or critical capacity issues reported from any other department across the Trust

- The number patients and total bed days of patients who are experiencing a delay to discharge across the Trust
- The number of outliers across the Trust

A more comprehensive list of indicators is provided in Section 8.

The escalation status of the Trust is matter of judgement to be applied by the bed meeting Chair who could be the Patient Flow Manager, Associate Director of Operations or Deputy, Senior Manager On-call, Chief Operating Officer or Deputy or Director On-call. There is no rigid system in place that seeks to prescribe or associate a number of departmental level indicators or escalation status to the Trust escalation status.

6.1 Southern Derbyshire System Escalation Level

The Southern Derbyshire A&E Delivery Board is required to report a System-wide escalation level using the OPEL framework following assessment of the pressures in all local health and social care providers including, but not limited to:

- Derby Hospitals
- Derbyshire Healthcare (Mental Health)
- Derbyshire Community Hospitals
- EMAS
- Derbyshire Health United
- Derby Urgent Care Centre
- Derby City Council (Social Care)
- Derbyshire County Council (Social Care)

Although the pressure in the acute hospital will play a big part in determining the escalation status and OPEL for the Southern Derbyshire system, they need not necessarily always be the same.

7.0 Operational Management of Capacity Escalation

There are a number of processes and structures in place to support efficient operational management of capacity and escalation within the Trust.

7.1 Operations Team

Daily operational management of the Trust is delegated to the Operations Team, led by the Associate Director of Operations. The Operations Team consists of Patient Flow Managers (PFM) supported by Bed Managers and Administrative staff. The Team takes an active role in coordinating bed management and supporting patient flow across the organisation.

7.2 Operational Meetings

Operational meetings take place every day in the Operations Centre at 0900, 1200, 1600 and 2000 with the aim of supporting and maintaining patient flow through the hospital. At heightened levels of escalation the frequency of meetings may increase with additional meetings at 1400 and 1800 (or as required).

7.2.1 Meeting Attendees

The following attendees are required at the Operational Bed Meetings. At times, other attendees will also be required (e.g. Infection Control) and will be invited to attend by the Chair of the meeting.

In-Hours:
Associate Director of Operations (or Deputy)
Lead Nurse Operations (or Deputy)
Patient Flow Manager
Bed Managers
ED Representative
MAU Representative
Patient Transport Liaison Officer
Surgical, Diagnostics & Anaesthetics Division management representative
Medicine & Cancer Division management representative
Integrated Care Division management representative
Discharge Team representative
Operations Team Administrator
At OPEL 3 or above:
Divisional Director for Surgical, Diagnostics & Anaesthetics Division or nominated deputy
Divisional Director for Medicine & Cancer or nominated deputy
Divisional Director for Integrated Care or nominated deputy
Chief Operating Officer / Executive On-Call or Nominated Deputy
Out-of-Hours:
Senior Manager On-Call from (16.00 Monday-Friday and weekends)
Senior Nurse Rota representative (16.00 Monday-Friday and weekends)

7.2.2 Meeting Objectives

The objectives of the meetings are to:

- Identify the internal status of each clinical area / department in terms of beds, acuity, staffing
- Forecast future demand and capacity for each clinical area
- Monitor and support discharge from wards and assessment units
- Review all indicators and identify and communicate the current Trust Escalation Status
- Delegate actions to respond to heightened levels of escalation and mitigate risk
- Respond to operational issues including those of business continuity or emergency planning
- Identify issues which need further escalation to Executive level or externally

7.2.3 Agenda

The agenda will need to be flexible, appropriate to the level of escalation and any other contextual factors. The following suggested agenda items provide a pick and mix list of items for consideration. They are not exhaustive and other issues of operational concern may need to be discussed:

- Reflect on recent performance and contextual factors to raise situational awareness
- Review actions from previous meetings'
- Review of the ED Dashboard and current performance
- Current status of the Emergency Department and imminent forecast (usually in hours)
- Any long waiting patients in ED and any potential or current 12 hour trolley breaches
- Current status of the Medical Assessment Unit and imminent forecast (usually in hours)
- Current and forecast availability of beds across all areas
    - Medicine and DME
    - Cancer
    - Surgery
    - T&O

    - Gynaecology
    - ICU
    - Step Down
    - Paediatrics
    - Maternity
    - NICU
- Community capacity
    - Domiciliary care
    - Virtual ward
    - Residential homes
    - Intermediate care
    - Interim nursing homes
    - Community hospitals
- Review of ward outliers
- Discharge
    - Utilisation of the discharge lounge or sitting out patients
    - Review of EDDs
    - Review of patients with excessive LOS
    - Review of delays to discharge and escalation to partner agencies
- Patient transport capacity and demand
- Review of staffing levels assurance
- Agreement of Trust Escalation level
- Delegation of actions to support maintenance of, or return to, the lowest level of escalation
- Weekend plan (as required)

The current status of departments, specialties or groups of specialties listed above will be reviewed with the help of a spreadsheet driven summary of current and forecast capacity and demand which is fed with information collected and inputted by the Patient Flow Manager and Bed Managers.

The Trust escalation status should be determined following due consideration of the spreadsheet outputs combined with the feedback from departments represented at the bed meeting and other available indicators. As described in Section 6, it is for whoever is chairing the bed meeting to decide what the Trust escalation status is having given due consideration to the indicators described in Section 8.

7.2.4 Communications

The Patient Flow Manager and Administrator will summarise the current status of the hospital together with any actions agreed in each bed meeting and provide this in an email to the Urgent Care Distribution List (see example in Appendix 2).

The Trust escalation status will be clearly described.

Following the 12.00pm, 4.00pm and 8.00pm bed meetings a detailed summary of the capacity and demand for each department will be attached to the email.

At times of increased escalation the Patient Flow Administrator will also text senior operational staff (e.g. Divisional Directors and Chief Operating Officer), Senior Manager On-call, Director On-call and other relevant staff to request their attendance at escalated bed meetings.

7.2.5 Out of Hours Arrangements

All operational actions will be coordinated through the Patient Flow Manager less the period 0200-0745 when this will be the responsibility of the Hospital Out-Of-Hours Team Leader. This approach will continue until February / March 2017, when the Patient Flow Manager team will provide continuous support 24/7.

8.0 Trust Escalation Levels

The Escalation levels describe ascending levels of pressure and risk. Each level of escalation is triggered by a number of indicators that are described below. This is not an exhaustive list of indicators and nor does it constitute a rigid system where criteria must be met sequentially for escalation to take place. It will be the responsibility of the person chairing the Bed meeting to decide the Trust Operational Performance Escalation Level.

Trust Status	OPEL 1 – Green	OPEL 2 – Amber	OPEL 3 – Red	OPEL 4 – Black
Descriptor	Low risk / Normal working Capacity is such that the organisation is able to maintain patient flow and is able to meet anticipated demand within available resources.	Moderate risk / Signs of pressure The organisation is starting to show signs of pressure. Focused actions are required to mitigate further escalation and to return to green status as.	High risk / High pressure Actions taken in Level Amber have failed to de-escalate the system and pressure is worsening. The hospital is experiencing major pressures compromising patient flow. Further urgent actions are required across the organisation by all partners.	Very high risk / Critical pressure The hospital is unable to deliver comprehensive urgent and emergency care. Decisive action must be taken urgently to maintain patient safety and restore flow.
Lead	Patient Flow Manager Chairs Bed Meetings	Associate Director of Operations, Lead Nurse for Operations (or Deputy) or Senior Manager On-Call Chairs bed meetings	Command and Control initiated	Command and Control maintained
Indicators	The ED is in control, patients are being seen in a timely manner and crowding is not a concern. ED Escalation status is OPEL1.	The time for patients to be seen in ED, number waiting to be seen and time to be seen is showing signs of pressure. ED Escalation status is OPEL 2.	The time for patients to be seen in ED, number waiting to be seen and time to be seen is showing significant pressure. ED Escalation status is OPEL 3 or above. ED majors is over-spilling in to minors. There are specific concerns about the volume and / or acuity of patients in ED pitstop, majors or resus.	The lead or ED consultant on-call considers the department to be unsafe. ED Escalation status is OPEL 4 or above ED majors is over-spilling in to minors or adjacent departments (x-ray or fracture clinic). There are major concerns about ongoing arrival of patients to ED.
	Ambulances are able to unload and handover within 15 minutes of arrival.	Experiencing some difficulty taking ambulance handover within 30 minutes and 60 minutes may be compromised.	Experiencing significant difficulty taking ambulance handover within 60 minutes.	Ambulance handovers are being severely compromised and now exceeding 60 minutes.
	There are no exit blocks for ED admission.	There are ED patients with a DTA, ready for departure but no bed available.	There are 10 or more ED patients with a DTA, ready for departure but no bed available.	There are 15 or more ED patients with a DTA, ready for departure but no bed available. 12 hour breaches are occurring or imminent

				due to flow (excludes individual patient specific delays).
	Assessment Units are providing good patient flow and this is not expected to deteriorate. MAU and SAU Escalation statuses are OPEL 1.	Assessment Unit(s) or Specialties have stopped or are anticipated to stop declaring beds for ED. MAU and SAU Escalation statuses are OPEL 2.	Assessment Unit(s) or Specialties have stopped declaring beds and have a significant negative bed forecast. MAU and SAU Escalation statuses are OPEL 3 or above.	Assessment Unit(s) or Specialties have stopped declaring beds and have a significant negative bed forecast. MAU and SAU Escalation statuses are OPEL 4.
	Percentage bed occupancy is sufficient and predicted discharges exceed admissions. Ward / DME Escalation status is OPEL 1.	Percentage bed occupancy is either showing signs of pressure or forecast to deteriorate. Ward / DME Escalation status is OPEL 2.	Percentage bed occupancy exceeds 95% in Medicine and DME. Ward / DME Escalation status is OPEL 3 or higher.	Percentage bed occupancy exceeds 98% in Medicine and DME Ward / DME Escalation status is OPEL 4.
	There are no significant capacity issues across the Trust.	One or more specific areas of the Trust are experiencing high risk / high pressure.	Additional bed capacity has been opened where possible already.	Additional bed capacity has been opened where possible already.
			Delays to discharge are high or increasing.	Delays to discharge are high or increasing.
			Patient flow is significantly compromised.	Patient flow is stagnant.
			One or more specific areas of the Trust are experiencing very high risk / critical pressure.	One or more specific areas of the Trust are experiencing very high risk / critical pressure.
		Capacity pressures on NICU or adult critical care beds.	Serious capacity pressures on NICU or adult critical care beds.	NICU or adult critical care beds are full. Patients are being transferred out across the network or being ventilated in theatre recovery.
	Outlier numbers are nil or reducing.	Outlier numbers are stable and being effectively managed.	Outlier numbers are high or rising and normal plans are being exhausted.	Outlier numbers are high or rising and normal plans have been exhausted. Out of the ordinary options are now being considered.
			Routine elective activity is being compromised by insufficient bed capacity.	Elective urgent and cancer cases are under threat or being compromised by insufficient bed capacity.
		Current or imminent staffing gaps or skill mix issues in ED, MAU or other areas affecting flow are likely to moderately inhibit patient flow.	Current or imminent staffing gaps or skill mix issues in ED, MAU or other areas affecting flow are likely to significantly inhibit patient flow.	Current or imminent staffing gaps or skill mix issues in ED, MAU or other areas affecting flow are likely to seriously inhibit patient flow or compromise patient safety.
Other indicators	Any other relevant factors should be considered when determining the Trust Operational Performance Escalation Level. Some more extraordinary considerations may include example such as the following: Business continuity incidents, e.g., • IT or telecommunication system failures • Pathology or Imaging technology failures			

	• Fire or flood compromising key services or departments • Electrical failure • Bad weather (such as heavy snow) inhibiting the movement of staff and patients Infection control issues. Major incident - if the Trust is on standby or a major incident is declared.			
Actions	Refer to Appendix 1	Refer to Appendix 1	Refer to Appendix 1 Consider implementing Full Capacity Plan (requires Gold approval)	Refer to Appendix 1 Consider implementing Full Capacity Plan (requires Gold approval)

At OPEL 3 or higher the Trust will initiate Command and Control to support with the swift return to lower levels of escalation. All operational staff will be expected to prioritise implementation of the required actions. The key responsibilities of the Command and Control Leadership team are as follows:

<table>
<tr><th>Command</th><th>Roles</th><th>Responsibility</th><th colspan="2">Key Tasks</th></tr>
<tr><td>Gold
(Strategic)
Command</td><td>Chief Operating Officer (or Deputy), Chief Nurse, Medical Director or Executive On-Call.</td><td>To lead the Trust response. To initiate the strategic response to the incident and to support the Silver (Tactical) Commander.</td><td>-Decision to activate and de-activate the FCP.

-Management of communications,

- Responsibility for sign off of financial impact and implications as a result of actions taken.

- Liaison with wider partners external to the trust.</td><td rowspan="2">- Lead in decisions for capacity queries

-Communicating actions to Bronze Leads.</td></tr>
<tr><td>Silver
(Tactical)
Command</td><td>Associate Director of Operations, nominated deputee or Senior Manager On-Call

with
Patient Flow Manager</td><td>To manage the tactical response.</td><td>-Collating and providing intelligence received from Bronze and Silver to focus resource.</td></tr>
<tr><td>Bronze
(Operational)
Command</td><td>Facilities Management and a representatively Divisional General Managers (at least one from each division), or nominated deputies.

With
ED Consultant on-call (ED Clinical Lead)</td><td>To support delivery of the Trust Capacity and Escalation plan under guidance of Silver Command.</td><td colspan="2">-Liaising with key team leaders and clinicians as necessary.

-Feeding information and escalating issues of concern to Silver Command.

-Clinical decision making, including acting as arbiter between specialties where required.</td></tr>
</table>

10.0 De-Escalation

The hospital will continue to be in a state of heightened escalation until the Chief Operating Officer or nominated Director declares a stand down. The PFM will inform members of the Urgent Care Distribution List of the stand down and they must then cascade this information to their own staff. The PFM will be responsible for passing the message on to support services as necessary

11.0 Monitoring Compliance and Effectiveness

Monitoring Requirement :	Retrospective review of the effectiveness and responsiveness of the organisation to bed capacity pressures.
Monitoring Method:	An analysis of the escalation levels, adherence to the actions associated with that level and the effectiveness of those actions to manage the situation.
Report Prepared by:	AD Operations
Monitoring Report presented to	Management Executive
Frequency of Report	Annually

Appendix 1 – Action Cards

Triggers and actions required at each level of escalation are detailed as follows. Actions at each level should usually be completed before escalating to the next level; however it is recognised that under times of increasing pressure rapid escalation may be warranted. The actions detailed here are not exhaustive and reasonable responses to the actual pressures identified at any one time should be instigated.

It should be noted that at each level of escalation beyond OPEL 1 A&E Delivery Boards will be engaging in additional actions – further details can be found in Operational Pressures Escalation Levels Framework (NHS England – 31.10.2016).

At escalation status OPEL 3 or higher Command and Control will be activated to ensure that the Trust is returned to lower levels of escalation as soon as possible.

Internal escalation plans have been developed for various areas of the Trust. Actions stipulated within internal escalation plans should be considered alongside the following Trust-wide actions.

	Chief Operating Officer / Executive On-Call or Nominated Deputy	
Throughout	Maintain oversight of Trust operational status and set any strategic objectives.	
OPEL 1	No specific actions, Trust is operating at safe levels of escalation.	
OPEL 2	Receive and review the Operational Bed Meeting action plan.	
	Act as senior decision maker should issues be escalated.	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
	Initiate Command and Control, assume Gold Command.	
	Chair Bed meetings.	
	Delegate actions to restore the Trust to lower levels of escalation.	
	Consider clinical prioritisation and cancellation of non-urgent elective inpatient cases.	
	Communicate to external partners and the public as needed	
	Consider agreeing escalation to the Full Capacity Plan.	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	
	Provide support to site continuously until lower levels of escalation are achieved.	
	Consider requesting a divert from EMAS. CCG approval needed together with other Hospitals	
	Inform Chief Executive and other Executive members of the Trust status.	

	Associate Director of Operations or Nominated Deputy	
Throughout	Maintain oversight of Trust demand, capacity, pressure points and escalation status. Set tactical actions.	
OPEL 1	Maintain routine demand and capacity management and planning.	
	Receive internal escalation status from each department across the Trust to support oversight.	
	Maintain routine active monitoring of external risk factors.	
	Encourage use of discharge lounge and early daily discharges during Operational Bed Meetings.	
OPEL 2	Continue all actions identified in OPEL 1 above	
	Chair Bed Meetings	
	Ensure actions from previous Bed Meetings have been completed as directed.	
	Ensure departmental actions are taking place appropriate to their escalation level.	
	Agree action plan to reduce escalation level	
	Ensure status and action plan are communicated trust-wide	
	Consider and escalate any mutual aid requirements	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
	Assume Silver Command	
	Ensure bed meetings are escalated	
	Trigger escalation conference call with other agencies if required	
	Consider request of Full Capacity Plan	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	

	Divisional Directors	
Throughout	Follow internal department escalation plan.	
OPEL 1	Maintain oversight of departmental escalation status	
	Maintain awareness of Trust escalation status and ensure this is cascaded through team	
OPEL 2	Continue all actions identified in OPEL 1 above	
	Ensure departmental escalation actions are being completed	
	Ensure any additional actions arising from the bed meetings are being completed as required	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
	Attend the escalated bed meetings	
	Consider any requests or opportunities to provide mutual aid to other Departments or Divisions	
	Consider the implications of a prolonged period of heightened escalation on Departments within the Division	
	Consider the elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	
	Lead the Divisional response to the Full Capacity Plan if activated	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	

	Patient Flow Managers	
Throughout	Take action to maintain efficient flow across the Trust.	
OPEL 1	Chair Operational Bed Meetings (and out-of-hours) if the Associate Director of Operations or Deputy is unavailable	
	Maintain Trust staffing capacity assessment and reallocate staffing as needed	
	Maintain timely updating of demand and capacity information within local information system	
	Liaise closely with ED, MAU, SAU to forecast future demand	
	In liaison with the Bed Management team coordinate bed management across the Trust	
	Ensure any outlying patients have been reviewed	
	Supporting wards with discharge	
	Communicate Trust escalation status and action plan following bed meetings	
	Ensure actions arising from bed meetings are completed as required	
OPEL 2, 3 &4	Continue all actions identified in OPEL 1 above	
	Ensure any actions arising from the bed meetings are completed.	

	Discharge Team	
Throughout	Follow internal department escalation plan.	
OPEL 1	Identify delayed discharges during daily delayed transfers of care meetings	
	Support wards with identifying delays and expediting discharge	
	Signpost and support complex discharge	
	Maintain awareness of Trust status and ensure this is cascaded through team	
	Ensure actions arising from bed meetings are completed	
OPEL 2	Continue all actions identified in OPEL 1 above	
	Attend bed meetings	
	Ensure discharge team escalation actions are being completed	
	Provide support to wards where requested to expedite discharges and restore flow	
	Escalate to partner agencies on a case by case basis as required	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
	Participate in escalation conference calls with partner agencies as required.	
	Escalate delayed transfers of care meetings	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	

	Ward Matrons (or nominated deputy i.e. Nurse-In-Charge)	
Throughout	Follow internal department escalation plan.	
OPEL 1	Maintain awareness of Trust status and ensure this is cascaded through ward teams	
	Provide current information to Bed Managers regarding bed occupancy; definite and potential, discharges; and operational issues	

	Sit patients to be discharged out in the day room or utilise the discharge lounge whenever possible	
	Expedite definite discharges and track delayed discharges	
	Implement SAFER principles and Red / Green working practice	
	Ensure flow is maintained by declaring beds within 15 minutes of becoming vacant.	
	Escalate any delays to discharge to discharge team and Patient Flow Managers.	
	Identify outliers and ensure clinical review is received or escalated	
	Ensure actions arising from bed meetings are completed	
OPEL 2	Continue all actions identified in OPEL 1 above	
	Provide mutual aid to other specialties by accepting outliers where this has been actioned from a bed meeting.	
	Coordinate a re-review of all patients identifying possible patients for discharge.	
	Escalate support service issues which contribute to delayed discharge. Attend DTOC meeting where possible.	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	

	ED / MAU / SAU Senior Nurse Representative	
Throughout	Follow internal department escalation plan.	
OPEL 1	Collect current information regarding internal departmental status; definite, and potential, discharges / admissions; staffing levels to present at Bed Meetings	
	Attend Bed Meetings to escalate issues, provide current status and receive direction to support maintaining efficient flow	
	Escalate areas of pressure to Patient Flow Managers	
	Ensure actions arising from bed meetings are completed	
OPEL 2	Continue all actions identified in OPEL 1 above	
	Inform clinical teams of escalation status	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	

	General Managers / Bed Escalation Managers	
Throughout	Follow internal department escalation plan.	
OPEL 1	Maintain awareness of Trust status and ensure this is cascaded through teams	
	Support with the collection of current information regarding internal department status; definite and potential discharges / admissions; staffing levels	
	Ensure actions arising from Bed Meetings are completed	
OPEL 2	Continue all actions identified in OPEL 1 above	
	Support matron (or nominated deputy) to ensure that additional ward rounds are undertaken to maximise rapid discharge of patients.	
	Support with resolving delays to treatment / transfer / discharge	
	Support with resolving flow issues as identified during Bed Meetings.	
	Liaise with clinicians to support actions which maintain or restore patient flow.	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
	Assume Bronze Command	
	Contact all relevant on-call staff to provide support	
	Consider the option of opening extra beds if available.	
	Arrange for the provision of extra staff if necessary	
	Agree other contingency actions aimed at reducing escalation level. Ensure these actions are carried out within own Business Unit/Division	
	Consider the elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	
	Lead the Business Unit response to the Full Capacity Plan if activated	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	

	Consultant Lead for Each Division / Lead Divisional Nurse	
Throughout	Follow internal department escalation plan.	
OPEL 1	Maintain awareness of Trust status and ensure this is cascaded through teams.	
	Maintain oversight of departmental escalation status	
OPEL 2	Continue all actions identified in OPEL 1 above	

	Ensure departmental escalation actions are being completed	
	Ensure any additional actions arising from the bed meetings are being completed as required	
OPEL 3	Continue all actions identified in OPEL 1 & 2 above	
	In liaison with the Divisional Director, ascertain the requirement for additional nursing staff to assist with the admission and discharge process	
	In liaison with the Divisional Director, review non-essential consultant duties / study leave / annual leave arrangements in order to assure that optimum inpatient reviews/rounds are in place across the whole bed base	
	In liaison with the Divisional Director, consider staffing requirements and re-deployment of available medical staff to the assessment and treatment of acutely ill patients and the discharge of medically fit patients	
	Lead the Division's clinical response to the FCP if activated	
OPEL 4	Continue all actions identified in OPEL 1, 2 & 3 above	
	Attend the escalated Bed Meetings as required by the Chief Operating Officer / Executive on call.	

Appendjx 2- Tryst Statys Commynjcatjon