University Hospitals of Derby and Burton NHS Foundation Trust

Burton Hospitals

POLICY DOCUMENT

BED MANAGEMENT AND ESCALATION POLICY

Approved by:	**Trust Executive Committee**
On:	**25 January 2017**
Next Review Date:	**Apr 2019 EXTENDED DEC 2020**
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Clinical / Non Clinical	**Clinical / Non-Clinical**
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⌄ Information for:	**All Staff and Partner Organisations**
Policy Number:	**238**
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Signature:	 **Chief Executive**
Date:	

Burton Hospitals NHS Foundation Trust

POLICY INDEX SHEET

Title:	**Bed Management and Escalation Policy**
Original Issue Date:	**September 2008**
Date of Last Review:	**December 2014**
Reason for amendment:	**Policy review**
Responsibility:	**Director of Operations**
Stored:	**Intranet and all Wards and Departments**
Linked Trust Policies:	**Major Incident Policy, Business Continuity Management Policy**
E & D Impact Assessed	**EIA 326**
Consulted	**Head of Capacity, Capacity Team and Emergency Preparedness Manager.**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
2	Review of Escalation Procedure.	20 June 2013	The Escalation Procedure was updated to account for local changes to job titles, roles and responsibilities and department location and name changes.
3	Update to Bed Management and Escalation Policy.	25 July 2013	This document has been updated after Trust wide staff feedback/comment on content.
4	Update to Bed Management and Escalation Policy.	8 August 2013	This document has been updated after Trust wide Executive and Senior Management feedback/comment on content.
5	Update outliers - page 13 (Paragraph 4.3) Update Appendix A and contents to reference Appendix A.	11 October 2013	Outliers have been updated for identification and monitoring. Appendix A has been changed to match updated regional escalation levels. Action cards have been updates.
6	Policy review	2 January 2015	Document text and appendices have been changed to match updated regional escalation levels. Action cards have been updates.
7	Review	July 2016	Change of CEO + Minor changes to job titles, bed escalation procedures, terminology and action cards.

POLICY FRAMEWORK

Contents

Burton Hospitals NHS Foundation Trust

ESCALATION POLICY

1. CHIEF EXECUTIVE'S STATEMENT

During each year, there may be several occasions when the demand for emergency and elective bed capacity outweighs bed availability. There are a numbers of reasons why these pressures may occur;

- An increase in medical and surgical emergency admissions
- An increase in the length of patient stay
- An increase in patients whose transfer of care or discharge is delayed

During this time, Burton Hospitals NHS Foundation Trust (BHFT) will be efficient, ensuring compliance with pre-determined key performance targets and improve patient flow through the trust, as a whole, and across the health economy.

Chief Executive	
Name: Helen Scott-South	**Signature:**

2. POLICY OWNER

This document is owned by the Chief Operating Operations who is responsible for ensuring that it remains up to date and subject to ongoing review.

3. INTRODUCTION

The Bed Management and Escalation Policy, and accompanying documentation, is designed to address areas of demand and will focus on how the trust can escalate and de-escalate to deal with demand.

The success of this document will be based on the following three processes working in parallel:

1. Emergency Department (ED) escalation
2. Trust escalation
3. Regional capacity management

The triggers for escalation, and the actions to support de-escalation, are designed to ensure that the trust maintains a high standard of care and comprehensive safe service for patients. This will be balanced with the above here processes.

This document will ensure that the trust can meet key performance indicators and can respond when any of the above processes are put under pressure.

To this end, this document will use the following 3 points which will assist staff:

1. Bed Management and Escalation Policy
2. EMS Acute Triggers
3. Escalation Level 3 and 4 action card

The purpose of the above 3 points is to ensure that, during acute bed shortage, staff are familiar with their role and responsibilities around escalation and are able to make informed decisions around optimising capacity, through appropriate admission and discharge processes.

3.1. Aim

The aim of the Bed Management and Escalation Policy is to provide the reader with guidance on how the various levels of escalation are managed across Staffordshire, see Appendix A.

3.2. Objectives

The following underlying escalation objectives should always apply and support this document, irrespective of the escalation level at the time:

- The trust must adopt a policy of pro-active discharge, where possible, before 10:00 each day

- There must be timely access to emergency diagnostic tests and results throughout any 24 hour period

- Doctors, with decision making skills, must be available to see emergency referrals, at any time and within an hour of referral

- Patients referred from a nursing home must be assessed by a GP, prior to referral being made, thus ensuring that an acute setting is an appropriate one. when possible, patients documentation should accompany the patient

- Daily operations meetings will provide a forum for staff communication and discussion around escalation considerations, decisions and actions

- All capacity white boards must be up- to date, detailing Predicted Discharge Date (PDD), Outliers, Length of Stay (LOS) and all constraints within the patients journey

- Medicine - Post take ward rounds must begin in the Acute Assessment Centre (AAC) and the Emergency department at 08:00hrs and medical outliers must be seen prior to speciality ward patients with a plan of action and a PDD for each patient

- Surgery - Post take ward rounds must begin at 08:00hrs, Theatres will continue with elective surgeries as per appendix K.

- Critical Care patients will take priority in being transferred to ward areas, thus ensuring that there is an appropriate bed for elective and emergency cases

- Consistent vigilance is required within the ED at all escalation levels to prevent breaches of the 4 hour standard

- The EMS Acute Triggers will be calculate, when necessary, to determine risk and the escalation status for the trust

- Duty of care to patients will always take priority, thus ensuring that the potential risk to patients in terms of safety is always mitigated

- Measurement of the pressure that the trust is under will be a combination of the actual number of available staffed beds and take into account the number of expected emergency and elective admissions

- The AAC and Short Stay Unit (SSU) will have priority across the acute bed base and within operational delivery to ensure that flow is effective from the front door. LOS will be closely monitored with patients requiring a deeper admission following initial review within each clinical area. .

  This information will be available from by the Head of Capacity via the Flow Coordinator and Bed Manager who will work together to ensure flow

- The available bed complement, within the trust, will include all speciality beds and will exclude; maternity, paediatric, observation beds and blocked beds for private patients

- Intermediate care and rehabilitation beds will be available in the community in a number of areas, including; Barton, Lichfield, Tamworth, Ashbourne, Swadlincote and Ashby

- In hours, it will be the responsibility of the Head of Capacity to coordinate the escalation for the trust with the support of the Deputy Director of Operations, or nominated deputy

- Out of hours, it is the responsibility of the Clinical Site Practitioner (CSP) with support from the Duty Sister and On Call Manager to assess and escalate. This should be discussed with the On Call Executive.

3.3. Scope

This document will describe the response methods to the various levels of escalation for the trust, including; Queen's Hospital Burton (QHB), The Treatment Centre (TC), and both Samuel Johnson (SJH) and Sir Robert Peel (SRP) Community Hospitals.

The Bed Management and Escalation Policy, and information contained within, can be accessed and activated 24/7.

3.4. Accessibility of the Escalation Policy

The Bed Management and Escalation Policy, and associated documentation, is available on the trust intranet and a paper copy should be available in each department.

3.5. Confidentiality

Staff confidentiality and the protection of the staff contact details will remain paramount in accordance with the Confidentiality Policy and associated regulations.

3.6. Local Capacity Service Management

Local capacity service management will be monitored by the Chief Operating Officer (COO).

The COO will ensure that essential matters are discussed and communicated to the Executive Management as necessary.

Task and finish groups will occasionally be required to address various capacity service projects and these groups will be chaired by the Head of Capacity or a senior member of the Operations Team.

Careful consideration will be given to how escalation dovetails into other Emergency Preparedness and Business Continuity Management (BCM).

4. ESCALATION MANAGEMENT

Escalation management is coordinated locally by the Operations Team, under the Head of Capacity.

Their responsibility is to track all emergency and elective patients presenting to the Trust against bed capacity and availability of staff and resources.

Through collaboration with others, the Operations Team will appraise and create available capacity by horizon scanning and predicting problems and doing their best to mitigate and, where necessary, looking at the potential for opening of extra beds. This will give the best chance of patient flow and operational normality at any time of that year.

4.1. Operations Meetings

The Operations Room, next to the staff restaurant, is the name used to describe the room where the Operations Team will convene for meetings.

From Monday to Friday, operations meetings will take place at 08:30hrs, 11:00hrs, 14:00hrs, 16:00hrs and a 17:00hrs if necessary. A meeting will also take place at 11:00hrs on both Saturday and Sunday.

A daily assessment will be made of whether a 17:00hrs meeting is required. This will be decided at the 16:00hrs meeting. During higher escalation levels, meetings outside of these times may also be organised.

The medical and surgical leads are expected to attend all operational meeting.

4.2. White Boards

The Operations Room white boards are a real time status of all emergency and elective patients that are attending or admitted to the trust at any time 24/7.

The white board will display the following:

- Names of all wards
- Number of funded bed available for each ward
- Number of empty beds on each ward
- Actual number of discharges for each ward for that day
- Predicted number of discharges from each ward for that day
- Number of escalation beds in use

Specific areas information, such as Critical Care and Coronary Care, Neonatal, stroke and Non-Invasive Ventilation beds will also be displayed to ensure capacity and step-out plans can be put in place as appropriate.

The Operations Team will update white boards as vital information is communicated throughout the day.
A Weekend Planning meeting will be held at 12:30hrs every Friday in the operational room, chaired by the Head of Capacity or nominated other. This meeting will ensure a comprehensive plan is in place for the on call teams over the weekend. The plan will then be emailed out by the operational team by 1600 to all relevant parties.

4.3. Outliers

Outliers are patients that have been identified as medically fit or clinically stable enough to be moved to a ward unrelated to their illness or specialty. This will be due to a reduced number of acute beds available at the time. In accordance with ward board reviews, these patients must have completed their acute phase of treatment and have a comprehensive management plan and discharge plan in place.

It is the responsibility of the Senior Nurse from all medical wards, including the CCU, to identify a minimum of one Female and one Male medical outlier each day. Outlier details must be recorded on the Operations Room white board by 14:00hrs each day and a 'Safer Form' completed by the senior nurse and collected by the Medical Lead.

Bed Managers will collate a list of all outlying patients by 8am the following morning.

The ongoing care of outliers will be delivered by the ward where the patient is residing. All surgical wards have an allocated medical consultant assigned to manage the care of outliers. The consultant or their team will review the patient daily.

Matrons must monitor the management of outlying patients and escalate any issues at the 11am operational meeting.

4.4. Emergency Department Tracker

The ED Tracker is a method of patient monitoring that is part of the trusts computerised MEDITECH System. The Tracker will permit staff to follow a timed journey of each patient that presents to the ED.

The Tracker will permit the user to monitor the progress of patient flow through the ED.

The Tracker will also list the time for casualty officer to specialities referral and response times as per agreed professional standards.

The Tracker is colour coded and patient details will change colour in accordance with the length of time that each patient remains in the ED.

Please see the table below for the Tracker colours that relate to varying LOS within the ED:

Length of Stay	Colour
1-2 hours	No colour
2-3 hours	Green
3-4 hours	Red
Over 4 hours	Blue
Patients with similar details	Yellow

4.5. Non Clinical Breaches

Non-clinical breaches occur when patients remain in the ED for longer than the recommended 4 hours. This may be due to no bed availability, late referral to specialty or untimely investigation, treatment or observation.

The Decision to Admit (DTA) is the point at which it has been decided that a patient presenting to the ED is to be admitted.

A DTA must be carried out within a timely manner, ensuring that each patient spends less than 4 hours in the ED.

To this end, steps must be completed within the following time periods, thus aiming to achieve the 4 hour standard, preventing ED breaches:

- **0-2 hours** - The patient is seen and assessed, tests ordered and referred to appropriate speciality. Flow Coordinator and Bed Manager are contacted and are responding to potential admissions from the ED

- **Trigger** - Patient waiting to be seen by Doctor or Emergency Nurse Practitioner >1.30 hours and/or excessive numbers of patients presenting to minors

- **Response** - ED Doctor, Middle Grade or above, asked to review all waiting patient and direct referral to appropriate team within 10 minutes. Nurse in Charge to ensure all patients have appropriate tests ordered to assist in a timely DTA

- **2-3 hours** - The patients is seen and assessed by appropriate team, DTA made with a medical management plan and the Head of Capacity has been informed

- **Trigger** - 3 or more patients waiting more than one hour to be seen by a specific speciality team

- **Response** - ED Senior Nurse to contact the Registrar of the respective team to ensure staff mobilisation and review takes place within 10 minutes

- **3-4 hours** - A bed has been identified and the patient transferred to appropriate ward area

- **Trigger** - Patient waiting longer than one hour from DTA to bed allocation

- **Response** - ED Senior Nurse to escalate to ED Nurse Manager, who will contact Head of Capacity with strategy

The ED daily Performance (%) will be collated and displayed prior to each operations meeting (08:30, 11:00, 14:00 and 16:00).

A log of key issues and actions will be provided on a daily basis to ensure learning and allowing thematic analysis to be appraised . This will be emailed to the senior Division team and relevant on call staff.

4.6. Clinical Breaches

Clinical breaches are defined as patients within the ED that have been identified as unstable and due to their clinical decision it may not be possible to complete their treatment within 4 hours.

A number of patients that fall into this category may be awaiting transfer to a specialist site. However, this situation may impact on ED and the Operations Team ability to adhere to the 4 hour standard.

4.7. Acute Assessment Centre - Patient Flow Pathway

- **Trigger** - When less than 2 trolleys available on the AAC or becoming available within 1 hour (20 % of trolley capacity will be ring fenced to optimise assessments of patients at all times).

- **Response** - Consultants and Registrars will be contacted to carry out ward rounds, patient review and ensure treatment plans and decisions are documented to expedite patients.

  The Head of Capacity will contact the Discharge Team to review all patients on ward areas regarding their potential for discharge

  Social Care and complex discharges must be identified at the 08:30hrs operations meeting by the attending Social Worker to ensure appropriate bed utilisation and optimum use of the Discharge Lounge as part of acute capacity

  The Head of Capacity will escalate any discharge issues during each Ops meeting and endeavour to decant or discharge appropriate patients from the AAC to ward areas with a documented discharge details and treatment plan

4.8. On Call Executive

In hours, the Chief Operating Officer, or nominated deputy, will support the information contained in the document.

Out of hours, the On Call Executive will be notified of potential Trust pressures and high escalation level via the On Call Manager.

4.9. Chief Operating Officer

In hours, the Chief Operating Officer is responsible for the operational functioning of the trust. The operations team will be supervised by the divisional director for medicine who will seek support from the Clinical Commissioning Group, where appropriate.

4.10. Divisional Directors

The Divisional Directors will supervise and ensure that all actions are taken and monitored by each respective division.

Divisional Directors or Divisional Nurse Directors will be expected to be present at all operations meetings when the Trust is at Escalation Level 3 or above.

They will be present to undertake the necessary decisions required to expedite flow and to support actions that will ensure de-escalation.

4.11. Divisional Nurse Directors

Divisional Nurse Directors will promote and ensure clinical standards are maintained and assess acuity and 1:1 requirements. They will support the clinical teams to identify appropriate patients for discharge.

Clinical concerns identified by the Divisional Nurse Directors should be raised at the operations meetings and discussed to promote appropriate clinical standards and the delivery of safe patient care.

Divisional Nurse Directors are ultimately responsible for the provision of data that is collected by Ward Managers/Matrons this is inclusive of effective ward board reviews, outlier provision and early supported discharges to the community hospitals/discharges home from their wards, thus maximising capacity.

Divisional Nurse Directors or Divisional Directors will be expected to be present at all operations meetings when the Trust is at Escalation Level 3 or above.

They will be present in a capacity to undertake the necessary decisions required to ensure that effective de-escalation occurs.

4.12. On Call Manager

The On Call Manager will be made aware of trust actions being taken and attend each operations meeting from 14:00hrs and carry any actions into the evening.

Out of hours, the On Call Manager will communicate potential trust pressures and high escalation level to the On Call Executive.

There will be a hand over of all trust, capacity and staffing activity between the On Call Manager and the CSP or Senior Sister each week day at 18:00 hrs.

4.13. Medical and Surgical Leads

The Medical and Surgical leads will monitor and carryout actions and, as appropriate, updating the Operations Team and senior division staff during each operations meeting and where relevant outside of this process to optimise patient flow.

Elective cancellations will be captured each day by the Surgical Lead in the key issues log. No elective cancellation should occur without prior consultation with the respective Divisional Director or nominated deputy.

4.14. Head of Capacity

The Head of Capacity is the senior point of contact for all matters relating to Operations Team activity and escalation management.

They will support the Flow Coordinator and Bed Managers and work with Medical and Surgical Leads to ensure a timely and safe service.

At times of increasing demand, the Head of Capacity will ensure that appropriate patients are admitted according to their clinical need. This will be done in association with the relevant teams. For example, patients with cancer, or whose clinical need is urgent, will be placed alongside a patient who has management priorities, such as previous cancellation and risk to their 18 week pathway.

The Head of Capacity is responsible for liaising the Discharge Team, Social Services, Patient Transport Services, Pharmacy and Intermediate Care Teams, regardless of the current escalation level. They will take an active role in pursuing delayed transfers.

The post holder is responsible for completing a daily (key issues) and weekend plan for all concerns encountered. When necessary, the respective plan should incorporate any forward bank holiday planning.

The Head of Capacity is responsible for recording and collating a weekly list of all delayed transfers of care in the form of a Situation Report (Sit Rep). The Discharge Team will send a Sit Rep via UNIFY2 to NHS England.

The Head of Capacity is also responsible for a daily Sit Rep which is required in the winter months.

4.15. Clinical Site Practitioner

Out of hours, the CSP will act as Head of Capacity will liaise with the On Call Manager to ensure appropriate and timely escalation in accordance with this document and associated documentation.

4.16. Duty Sister

Between 16:00hrs and 19:30hrs, the Duty Sister will support patient flow, through ward areas, by addressing clinical issues. The post holder will prioritise duties in accordance with the On-Call Manager as part of the 16:00hrs Operations Meeting.

The Duty Sister will accompany the Bed Manager during their evening ward round to identify and expedite the safe discharge of patients.

4.17. Flow Coordinator

The Head of Capacity will support the Flow Coordinator in overseeing access to all beds, managing emergency and elective bed demand, supporting clinical decision making and safe patient care.

Priority will be given to the Flow Coordinator in order to maintain patient flow. Deep admissions should be routed to base ward beds. Short stay patients, up to 72 hours should be routed through the emergency pathway.

The Flow Coordinator will provide live information on AAC and short stay status, pending admissions and discharges and effectively communicate information to all key areas with the aim of prioritising patient flow and meeting the 4 hour standard.

The post holder will allocate the correct patient in the correct bed in, while supported by the relevant clinician, in accordance with their health care needs, and while liaising with the respective clinical team.

The Flow Coordinator will monitor the LOS of each patient admitted to AAC and ensure that their stay is within the agreed 48/72 hour timeline for short stay.

4.18. Bed Manager

The role of the Bed Manager is to coordinate the overall bed management function across the Trust. The Head of Capacity will support this role in overseeing access to all beds, and managing emergency and elective bed demand.

Bed Managers will provide live information on bed status, pending discharges, effectively communicating information to all key areas. They will also chase early decisions and discharges to optimise patient flow

The Bed Manager will place the correct patient in the correct bed in, accordance with their health care needs, whilst liaising with respective clinical teams.

Repatriations will be accommodated through the Operations Team as will requests for beds from outpatient areas.

There can be no direct admissions/step downs from wards, clinic or the catheter lab without going through the Bed Manager. Primarily, this applies to the Haematology Suite and Coronary Care Unit as the beds may already have been allocated.

As a priority, all patients must be allocated a bed according to their clinical need.

4.19. Senior Nurse - Emergency Department

It is the responsibility of the ED Senior Nurse to manage the timely escalation of patients in accordance with the emergency department internal escalation plan. Working alongside the ED consultant and ED matron/operational manager to identify delays to patient flow and formulating a plan to minimise further need for escalation.

4.20. Senior Nurse - Acute Admissions Centre

The AAC Senior Nurse will support the timely escalation of issues, in accordance with this documentation, working closely with the Flow Coordinator to identify and accurately feedback on any delays to patient flow. The AAC nurse in charge is responsible for prompt allocation of beds required within the emergency department, in accordance with the 4hour target.

4.21. Senior Nurses

The Senior Nurse, Senior Sisters/Matron, in charge in each area, is responsible for ensuring that their areas white board is up to date and an action log is being used.

The Senior Nurse will promote nurse led discharge to ensure that each patient has a discharge plan with a clearly defined Predicted Discharge Date (PDD) within 12 hours of admission and agreed by the respective team.

The Senior Nurse in charge for each area will identify a ‘golden patient’ to be sent to the discharge lounge by 10:00hrs and all other patients to be discharged as early as possible with a minimum of 2 patients (male & Female) by 10:00 identified every day.

The Senior Nurse, Ward Manager/Matron, will be responsible for expediting the discharge of all patients and “pulling” suitable patients from the emergency pathway into the relevant speciality ward beds.

4.22. Doctors

There will be an expectation for daily Consultant or Registrar led ward rounds across the Trust ensuring that all patients are reviewed and have a plan of treatment in place.

All ward round should take place during the morning. Where a full ward round is not possible, 'the sick and the quick' patients should be reviewed.

Patients will be discharged home or have a definite nurse led discharge date set and action in place for early morning discharge by the Senior Nurse.

Ward nurses should be notified of any patient who has been deemed medically fit during or immediately after each ward round to expedite discharge. Anything that prevents the timely discharge of a medically fit patient must be escalated to the Matron for the speciality area.

During escalations levels 3 & 4, on-call Medical and Surgical Consultants will be contacted by Speciality Leads.

4.23. Discharge Team

The Discharge Team will support the wards to appropriately escalate any internal and external delays and feedback to the Operations Team any issues that require further support for resolutions.

4.24. Radiography

Radiography will prioritise investigations to encourage a timely patient discharge. Delays will be efficiently fed back to the Operations Team throughout each day.

Formal reporting from Radiography Department will occur at 11:00 to ensure the correct prioritisation of patients both clinically and to optimise discharges.

A representative will be expected to attend the operational room meeting at escalations level 4.

4.25. Physiotherapy

The Physiotherapy Department will endeavour to prioritise patient reviews in accordance with pending discharges.

A representative will be expected to attend the operational room meeting at escalations level 4

4.26. Occupational Therapy

The Occupational Therapists will prioritise patients for review pending their discharge and highlight any equipment delays that may create barriers to discharge.

The occupational therapists will also provide information for patients who have been identified as complex.

A representative will be expected to attend the operational room meeting at escalations level 4

4.27. Porters

The Portering Department will endeavour to identify and prioritise their work load to aid patient flow.

Portering Supervisor will be expected to attend bed meetings when the trust has reached escalation level 3 or 4.

4.28. Hospital Ambulance Liaison Officer

The Hospital Ambulance Liaison Officer (HALO) is an employee of West Midlands Ambulance Service (WMAS).

They will endeavour to prioritise and escalate any issues with service delivery to the Operations Team as soon as identified.

They will support WMAS with the timely release of emergency vehicles from ED by enabling them to off load patients into the ED when busy.

The HALO will be expected to attend bed meetings when the trust has reached escalation Level 3&4.

4.29. Domestics

The Domestics will prioritise areas to be cleaned to support the flow of patients and review their Deep Clean Program in conjunction with the Operations Team request at times of high escalation levels, such as 2 & 3.

Out of hours fogging will be provided so that side rooms can then be re-utilised as part of patient flow. Latest time for fogging to commence is 17:45hrs to enable to safety checks to be made before the evening shift finishes. Fogging outside of these hours will be done as part of escalation with the clinical site practitioner in conjunction with the on call manager.

5. THE STANDARD OPERATING PROCEDURE (EMS ACUTE TRIGGERS)

The success of this document will be based on the effectiveness of the EMS Acute Triggers, see Appendix A.

The EMS Acute Triggers can be used as a reference tool, thus ensuring that all staff is working to the same escalation status.

The EMS Acute Triggers will ensure that each level of escalation, 1 to 4, escalation level triggers and definition.

The person responsible for triggering the Bed Management and Escalation Policy and declaring trust escalation is the Head of Capacity, or nominated deputy.

In hours, It is imperative that the Chief Operating officer or Divisional Directors are notified to authorise any escalation level above level 3. The Divisional Directors will be contacted by the Head of Capacity so that they are aware of the need for escalation. Out of hours, the On Call Manager and/or CSP should determine the need for escalation and request authorisation from the On-Call Executive.

There will be a daily assessment of the Trusts status at the 11:00hrs and 1600hrs operations meeting every day led by the Head of Capacity or nominated deputy.

During the operations meeting, up to date information will be disseminated to staff via the Tracker, other respective core roles and EMS Acute Triggers. Actions will be agreed, and cascaded to core roles and, when necessary, communicated to the Clinical Commissioning Group.

5.1. Escalation Level 1

Escalation Level 1 reflects the ‘normal’ position on bed capacity which is always regarded as being under ‘mild’ pressure.

Beds will be available to accommodate elective activity, emergency admissions and spatiality patients. However, vigilance is always required as patients are at risk of breaching the 4hr standard.

5.2. Escalation Level 2

Escalation Level 2 demonstrates that the position on bed capacity is regarded as being under ‘moderate’ pressure.

There will be less availability to accommodate elective activity, emergency admissions and speciality patients. .

The Operations Team will develop strategies to ensure that patient flow is not compromised.

5.3. Escalation Level 3

Escalation Level 3 reflects that the trust is currently under ‘severe’ pressure.

There will be limited availability to accommodate elective activity and emergency admissions.

Escalation level 3 poses a potential risk to patient safety within the trust and should be treated very seriously with all possible actions explored to reduce the escalation level.
Please see Escalation Level 3 triggers in Appendix A

5.4. Escalation Level 4

Escalation Level 4 reflects that the trust is now under ‘extreme’ pressure. Escalation Level 4 is the highest level on the EMS Acute Triggers and immediate actions will be required to manage de-escalation.

The Trust will liaise with the Local Area Team who will enlist help from the health economy to dispatch patients across a wider collective bed base It is vital that on call Medical and Surgical Consultants are asked to immediately deploy Doctors to re-review patients.

Heads of Departments and Service Managers, Surgical and Medical Leads and Head Nurses and Matrons will be asked to gather as much information as possible from respective wards regarding any predicted discharges and patients that have been deemed medically fit and should be discharged. This will afford opportunities for the Operations Team to identify issues and try to expedite patients

Please see Escalation Level 4 triggers in Appendix A

5.5. Emergency Department Escalation

The ED staff should escalate in accordance with their internal escalation process.
Appendix

Internal escalation should include agreeing mitigating measures and the maximum time to specialist review. In addition to the above, the ED can activate the Crowding Policy to manage any sudden rise in ambulance attendances. This will prevent prolonged corridor waits before an area for assessment becomes available.

6. THE ESCALATION MANAGEMENT RESPONSE

Authorisation of Escalation Level 3 and 4 refers to the act of declaring that additional arrangements need to be implemented to ensure the delivery of services by Chief Operating Officer, Divisional Director or On Call Executive.

The respective executive should notify the On Call Director for the Local Area Team before declaring level 4.

On escalation to Level 3 or 4 alerts must be immediately communicated to the switchboard and the communication team. The switchboard will cascade the alert to the following members of the Operations Team.

In hours:

- **Chief Operating Officer** - phoned or emailed by Head of Capacity
- **Divisional Directors** – phoned or emailed by Head of Capacity
- **Divisional Nurse Directors** – phoned or emailed by Head of Capacity
- **Head of Capacity** - via pager
- **Flow Coordinator** - via pager
- **Bed Managers** - via pager
- **Medical Lead** - via pager
- **Surgical Lead** - via pager
- **Matrons** - via pager
- **ED Nurse Manager** - via pager
- **HALO** - briefed by ED Flow Coordinator
- **Senior Nurse ED** - via pager
- **ED Consultant** - via pager
- **On Call Medical Consultants** – Informed by Specialty
- **On Call Surgical Consultants** - Informed by Specialty Leads
- **Discharge Team** - via pager
- **Senior Nurse AAC** – Informed by Flow co-ordinator
- **Porters** - via pager
- **X-Ray** - via pager
- **Therapies** - Informed by Specialty Leads
- **Theatre Coordinator** - via pager
- **Pharmacy** – Informed by Surgical Lead
- **Pathology** - via pager

Out of hours:

- **On Call Executive** - phoned by On-Call Manager
- **On Call Manager** - phoned by CSP
- **Clinical Site Practitioner** - via pager (the CSP will alert switchboard and use the Head of Capacity action card)

- **Duty Sister** - via pager (17:00 to 19:30)
- **Senior Nurse ED** - via pager
- **ED Consultant** - via pager
- **Senior Nurse AAC** – In formed by CSP
- **Porters** - via pager

Once contacted, the Operations Team will convene in the Operations Room, next to the staff restaurant for a briefing.

The Head of Capacity or nominated deputy will also contact the Communications Team and ask respectively for the level 3 or 4 screensaver and for a global e-mail to be sent out to Trust staff. The Communications Team must also be notified during de-escalation.

6.2. Switchboard

On receiving an Escalation Level 3 or 4 alert, from the Operations Team, the switchboard will activate the Escalation Level 3 or 4 group pager message.

Depending on the respective escalation level, each member of the Operations Team will immediately be informed:

ESCALATION LEVEL XX, PLEASE REPORT TO THE OPS ROOM, ESCALTATION LEVEL XX, PLEASE REPORT TO THE OPS ROOM AT (TIME)

During de-escalation, the switchboard will activate the same group pager message. The trust will immediately be informed of the level that the trust has de-escalated to.

A communications test of the information contained in this document will be conducted every 6 months.

6.3. Core Roles

Appropriate expertise should always be assembled in support of actions and decisions confronting the trust during all escalation levels.

The early stages of level 3 or 4 will require the Operations Team to facilitate a smooth transition from a level 2 to the full activation of core roles in support.

6.4. Escalation Beds

Escalation beds are allocated to create additional trust capacity during high escalation levels. However, this process should not be implemented for any longer than a 48 hour period.

The following has been designated as escalation beds:

- **AAC** – One male and one female can be opened when required in the trolley bays.
- **SSU-** One bed can be opened, either male or female (depending on what sex is currently in the Short Stay Bays)

- **Endoscopy** - Can take up to 6 patients of the same sex who are low level care and are to be discharged by the following day. New admissions must not be placed in this area. Endoscopy is for patients being discharged the following morning or being collected from the discharge lounge at 08:00.

- **Burton Clinic** - At times of significant pressure, there may be a requirement to utilise Private Patient Beds. This may also require cancelling private patient bookings

  This decision will be taken by the Director of Operations & Divisional Director, or nominated deputy, in hours or On Call Executive out of hours

Escalation beds should only be opened when:

- Capacity is perceived to be insufficient to accommodate the volume of patients expected or currently in the ED and AAC

- There is an infectious outbreak that is likely to compromise capacity or will require a short-term reconfiguration of trust beds

- All other capacity has been exhausted, at which point the Director of Operations or On Call Executive, in consultation with the Chief Executive, should ensure robust internal/external communications and clinical/managerial staff availability, in order to satisfy internal escalation

The Bed Manager will endeavour to maintain one bed within speciality at all times. If this is likely to be compromised the Bed Manager will escalate to the Head of Capacity and On Call Manager.

If agreement is not reached by both parties then the Deputy Director of Operations, Divisional Director and On Call Manager will discuss the situation with Head Nurses and the Director of Operations, or On Call Executive, who will be responsible for the final decision.

If all available capacity is utilised and pressures continue, the Head of Capacity or On Call Manager will contact the Director of Operations, or On Call Executive, to discuss the option of re-opening closed beds or escalation areas.

During the hours of 09:00hrs to 17:00hrs, Monday to Friday, escalation beds must not be opened without prior discussion with the Head of Capacity and the respective Matron. Out of hours, the Bed Manager or CSP will liaise with the On Call Manager and On Call Executive.

To this end, the appropriate Matron or CSP, out of hours, will be responsible for ensuring that additional staffing is also available.

The Head of Capacity, in conjunction with the Deputy Director of Operations, Divisional Director and respective Divisional Nurse Director and Matron will monitor the activity and will be responsible for ensuring that the escalation area is closed once no longer required.

The following is criteria for opening an escalation area:

- All community bed capacity open are utilised
- Every appropriate, vacant, bed has been utilised
- Staffing has been identified by the relevant Matron. The number and skill mix of staff required will be dependent upon the amount of beds opened and acuity of patients
- The area is fully equipped to ensure patients safely
- The respective situation has been discussed with the Infection Prevention and Control Team
- The ward has been cleaned as per Infection Prevention and Control guidance
- It has been agreed who has the management responsibility of the area.
- Supporting services have been notified, such as Porters, Domestics, Catering and administrative staff are able to support the area to be opened
- The Operations Team must be utilised to incorporate patients regardless of specialty and without compromising patient safety or the quality of care

6.5. Response Sustainability

During the early stages of Escalation Level 3 or 4, the Operations Team will decide whether a sustained effort will be required and, if necessary, arrangements must be put in place to contact and standby other staff members. Shift patterns and handover arrangements should also be agreed at this point.

6.6. Out of Hours

The Trust has a reliable 24/7 rota for core roles who will play a pivotal role when managing escalation.

6.7. Logging

During Escalation Level 4, it is recommended that an official log be kept. This will be decided at the time. Loggist contact details can be obtained from the major incident box in the Operations Room.

6.8. Debriefing

In order to support staff and learn from events, it is vital that we give all staff an opportunity to feedback.

It is advisable for each department head to organise an immediate hot debrief of their staff which would be expected to take place following a response to Escalation Level 4.

Further details on the types of debrief and advice on debriefing can be obtained from the trust Major Incident Plan.

7. TRAINING AND EXERCISEING

The Chief Executive of each NHS organisation should ensure that arrangements are in place to enable adequate training and exercising of the information contained within this document.

Training will be available for all staff to ensure that the workforce has a better Trust wide understanding of the Bed Management and Escalation Policy and its associated documentation. Training can be organised through contacting the Head of Capacity.

BHFT will ensure that the workforce is suitably trained and competent 24/7 to manage all levels of escalation.

8. MONITORING AND REVIEW ARRANGEMENTS

This policy contains largely operational information which will be reviewed every 3 years and updated versions will be available for all interested parties.

An urgent review can be requested due to organisational changes or changes to legislation, statute or guidance.

It is the responsibility of each department to ensure that any changes which affect the content of this document are communicated to the Head of Capacity via their line Manager.

Appendix A

EMS ACUTE TRIGGERS - CHART			
Level 1 - Mild Pressure (Planned Operational Working)	**Level 2 - Moderate Pressure**	**Level 3 - Severe Pressure**	**Level 4 - Severe Pressure**
1. No current risk of a patient waiting more than 4 hours to be seen in ED.	1. Risk of one or more patients waiting more than 4 hours in ED within the next hour.	1. One or more patients waiting more than 4 hours a decision is unlikely to be made for the next hour.	1. One or more patients waiting more than 4 hours and a decision is unlikely to be made for the next 4 hours.
2. Transfer of Ambulance patient care is shorter than 15 minutes.	2. Transfer of Ambulance patient care is between 15 and 30 minutes.	2. Transfer of Ambulance patient care is between 31 and 60 minutes.	2. Transfer of Ambulance patient care is longer than 60 minutes.
3. Expected admission capacity greater than or equal to expected admission demand for the next 24 hours.	3. There is an expected admission capacity deficit of less than 10% of expected demand for the next 24 hours.	3. There is an expected capacity deficit of between 10% and 20% of expected demand for the next 24 hours.	3. There is an expected capacity deficit of more than 20% of expected demand for the next 24 hours.
4. Elective work proceeding as planned.	4. Up to 10% of elective and urgent inpatient work cancelled on the day.	4. 10% to 90% elective and urgent inpatient work cancelled for the next 24 hours.	4. More than 90% elective and urgent inpatient work including oncology patients cancelled for the next 24 hours.
5. Patients subject to a decision to admit not at risk of 8 hour trolley waits.	5. Risk of one or more patients subject to decision to admit at risk of waiting 8 hours on a trolley in the next 2 hours.	5. One or more patients subject to decision to admit now waiting longer than 8 hours on a trolley.	5. One or more patients subject to decision to admit now waiting longer than 8 hours on a trolley and at risk of waiting longer than 12 hours.
6. Medical outliers form less than 0.5% of total inpatient population.	6. Medical outliers form between 0.5% and 1% of total inpatient population.	6. Medical outliers form between 1% and 3% of total inpatient population.	6. Medical outliers form more than 3% of total inpatient population.
7. Cubicles in ED are less than 80% occupied.	7. Cubicles in ED are 80% -100% occupied.	7. All Cubicles in ED are full and patients are waiting in planned overflow areas.	7. All Cubicles in ED are full and patients are expected to wait in unplanned overflow areas.
8. More than 1 resuscitation bay available for immediate use.	8. Only 1 resuscitation bay available for immediate use.	8. No formal resuscitation bay available in ED for the next 30 minutes.	8. No formal resuscitation bay available in ED for next hour.
9. Beds in Assessment Areas are less than 90% occupied.	9. Beds in Assessment Areas are 90%-99% occupied.	9. No Assessment area beds for 3 hours minimum.	9. No Assessment area beds for more than 3 hours
10. Planned additional bed capacity on standby.	10. Planned additional bed capacity open and less than 80% occupied.	10. Planned additional bed capacity open and more than 80% occupied.	10. All planned additional bed capacity open and full; unplanned capacity in use.
11. No loss of admission bed capacity due to infection control measures.	11. Partial or whole ward closed to admission or discharge due to infection control measures	11. More than one ward closed to admissions or discharge due to infection control measures with local restrictions on visiting.	11. More than one ward closed to admissions or discharge and whole hospital closed to visitors due to infection control measures.
12. Critical care capacity less than 80% occupied.	12. Critical care capacity is 80%-100% occupied.	12. All formal critical care capacity occupied and planned overflow areas in use.	12. All formal critical care capacity occupied and planned overflow areas in use. Potential transfers identified but unresolved.
13. Gender specific beds available as planned.	13. Patient moves required, expected within 1 hour	13. Patient moves required, expected within 4 hours	13. Patients waiting for appropriate gender beds; non-planned.
14. Medically fit for discharger cases form less than 9% of the inpatient total.	14. Medically fit for discharge cases form between 9% and less than 11% of inpatient total.	14 Medically fit for discharge cases form between 11% and 13% of the inpatient total	14. Medically fit for discharge cases form more than 13% of the inpatient total.

Head of Capacity ESCALATION: LEVEL 3 and 4

(Action card to be used by Head of Capacity/Discharge, Duty Sister (17:00-19:30) or CSP (19:30-07:30))

ES AC 001

Consider Issuing the level 3 and 4 action cards to core roles as they report to the Operations Room.
Consider a personal log at level 3 or request a Loggist at level 4.
Contact the Communications Team and ask for the Escalation Level 3 or 4 screensaver and global email to be sent out.
Inform: DOO or On Call Executive, Deputy DOO, DDs, Divisional Nurse Director , On Call Manager, On Call Consultants (Medical & Surgical).
If necessary, liaise with Porters (901, out of ours: 904, 905 and/or 906) Pathology (367 or 368), Pharmacy (5111, out of hours: via switch), Radiology (5160 and/or 294), Physiotherapy and Occupational Therapy (5129) and Infection Prevention and Control Team (4046, 356, out-of-hours: via switch) and Domestic Supervisor (In hours: 372).
Support the Flow Coordinator, Bed Manager (371, 258 and 601) and Discharge Team (in hours 347).
In hours: liaise with respective staff to prepare for opening extra capacity if situation shows signs of deteriorating.
Ensure the procedure for opening Endoscopy is in place.
Ensure CCG on call teams are made aware of patients with extended bed waits or extended length of time in ED. Complete agreed information template and send to all relevant recipients.
Out of hours: (Clinical Site Practitioner): Refer to Flow Coordinator, Bed Manager, and Discharge Team action cards. Liaise with Night team and prioritise clinical workload, assess overall Trust position and allocate resources. Liaise with Duty Sister, On Call Manager and Pharmacy, as appropriate. Consider need to open extra capacity should situation deteriorate.
Avoid inappropriate moves leading to increased risk for patients.

Op's Room ext. 5029/2317

Head of Capacity (In hours) ESCALATION: LEVEL 3 and 4

ES AC 002

Ensure that the EMS Acute Triggers has been calculated.
Review bed state every hour, keep an accurate record. If escalation level changes, immediately inform the Head of Capacity (In hours) and On Call Manager (Out of hours).
Ensure that all white boards are updated for all agreed operational meeting times.
Investigate the use of side rooms on wards. Liaise with Infection Preventions and Control Team and report Monday to Friday re: forward plan from Friday for Saturday and Sunday.
Complete all routine daily reports and cascade the relevant information to appropriate staff.
Outlie home ward patients, as appropriate.
Ensure an effective line of communication between Flow Coordinator and wards regarding issues that may impede flow (moving patients, making beds, etc).
Liaise with Head of Capacity, Divisional Directors and Operational Managers and consider needs around supporting extra capacity and a need for extra staff/resources, if necessary.
Avoid inappropriate moves leading to increased risk for patients.

Op's Room ext. 5029/2317

Complex Discharge Team (In hours) ESCALATION: LEVEL 3 and 4

ES AC 003

Attend ward board reviews.
Attend all operational meetings
Assist wards with complex discharges.
Escalate any issues regarding delays to discharge or admission avoidance, with the Head of Discharge.
Work with DD and AAC to set up short term packages of care.
Advise medical and surgical teams of services available to them.
Notify Social Services of any potential patients who will require support to facilitate discharge.
Review section 2's and 5's numbers and plans for discharges across the week.
Actions:

Op's Room ext. 5029/2317

Flow Coordinator (In hours) ESCALATION: LEVEL 3 and 4

ES AC 004

Ensure that the HALO, WMAS and EMAS are aware the Trust is at Escalation Level 3 or 4.
Attend all operational meetings and give an up to date state of the ED. Highlight any issues regarding flow and waiting times and AAC, GP Area and SSU capacity.
Contact bed management 1 hourly with update.
Anticipate trolley waits, monitor DTA's and escalate.
Explore the potential for Consultants to take GP calls in AAC and SSU.
Inform bed management of any constraints within individual breach times.
Discuss any possible staffing issues / fundamental aspects of patient care with ED Clinical Leads.
Access Emergency Discharge Coordinator (#6916) as appropriate in order to facilitate timely discharge.
Inform bed management and AAC nurse in charge of these times to avoid any breaches.
Avoid inappropriate moves leading to increased risk for patients.

Op's Room ext. 5029/2317

Head of Department/Service Manager ESCALATION: LEVEL 3 and 4

(Action card to be issued to Heads of Departments/Service Managers, Surgical and Medical Leads, Head Nurses and Matrons)

ES AC 005

Attend all Operations Meetings
Gather as much information as possible from respective wards regarding any predicted discharges and patients that have been deemed medically fit and should be going home. How can the Operations Team help to expedite?
Address all departmental problems or issues related to elective admissions.
Ensure awareness of accurate overview of speciality area to include staffing, patient safety, clinical risk issues, capacity, etc.
Follow through on any identified actions from operations meetings to Head of Capacity, Head of Discharge and Discharge Team or On Call Manager, out of hours.
Review elective activity over the next 24 hours and its impact.
Review nursing resource and allocation/redistribute if appropriate to areas of clinical need.
Escalate to Head of Capacity, Head of Discharge and Discharge Team any issues re: discharge or Social Services.
Liaise with Head of Capacity, Head of Discharge, Operations Managers (Medicine: 450 and Surgery: 286) and Senior Ward Nurses re: preparation for opening extra capacity if situation shows signs of deteriorating.
Actions:

Op's Room ext. 5029/2317

Senior Nurse (Wards) ESCALATION: LEVEL 3 and 4

ES AC 006

Proactively liaise with AAC to identify patients to be transferred to wards.
Ensure that ward boards are complete, up to date and ready for board meeting (Outliers identified: x2 per ward and PDD are set for all patients - within 24 hours of admission).
Escalate diagnostic and specialist review delays to your Matron.
Utilise the Discharge Lounge for appropriate patients. Suitable patient for discharged to be noted before 11:00.
Immediately escalate any issues regarding admission, discharges, transfers or treatment to your Matron or Head of Capacity.
Senior Nurse to attend all ward rounds and feedback to nursing team.
Highlight all patients that can be transferred to the Discharge Lounge first thing the following morning by 16:00 the previous day.
All vacated beds must be made ready for the next admission within 30 minute.
Highlight at least two patients to outlie with the appropriate consultant teams.
Establish with the consultant teams when ward patients will be re-reviewed. This should be immediate during level 3 and 4.
Ensure that all outlier patients have their plans of care/ and discharge completed.
Escalate any staffing and patient care issues to the appropriate Matron or Head of Capacity.
Actions:

Op's Room ext. 5029/2317

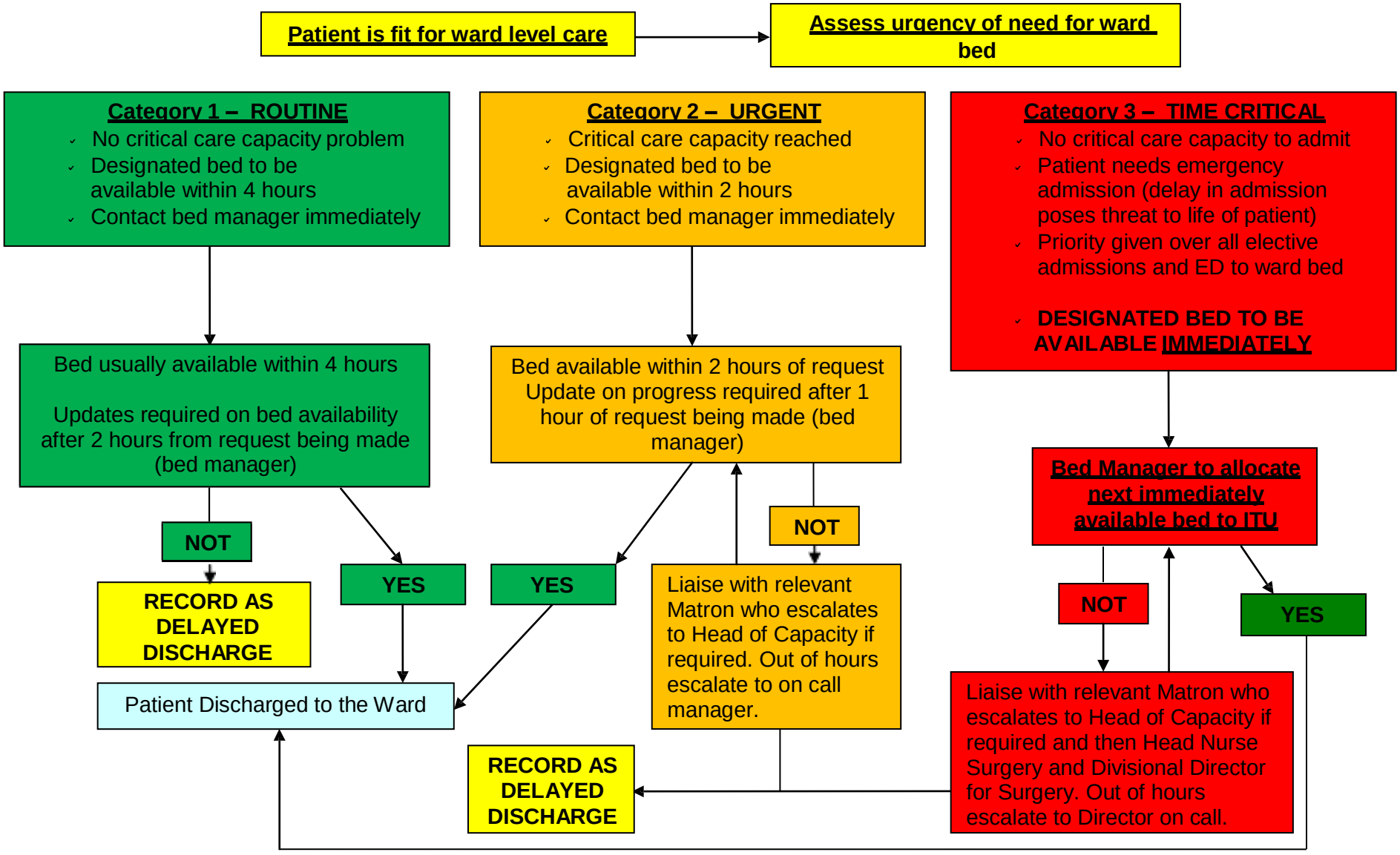
On Call Managers (Out of hours) ESCALATION: LEVEL 3 and 4

ES AC 007

Ensure that the EMS Acute Triggers have been calculated
Liaise with On Call Executive Regarding any issues and concerns.
Attend handover with Bed Managers and Duty Sister at the 18:00hrs Operational Meeting. Formulate and create overnight plan and to be apprised of any resource/capacity issues.
Be available for advice and support out of hours for Bed Manager, Duty Sister and Clinical Site Practitioners. Consider the additional capacity and opening extra beds in accordance with this document.
Agree at time to phone Clinical Site Practitioners for update at the end of the evening. Formulate evening/overnight plan to apprise any resource/capacity issues.
Keep the On Call Executive informed of any issues relating to capacity, staffing etc.
Liaise with CSP or Senior Sister.
Actions:

Op's Room ext. 5029/2317

ALGORITHM FOR PRIORITISING ITU TO WARD DISCHARGES



Appendix J

LIST OF ABBREVIATIONS

AAC	Acute Assessment Centre
BHFT	Burton Hospitals NHS Foundation Trust
CCU	Coronary Care Unit
CIT	Community Intervention Team
CSP	Clinical Site Practitioner
DTA	Decision to Admit
ED	Emergency Department
EMS	Escalation Management System
HALO	Hospital Ambulance Liaison Officer
LOS	Length of Stay
MIP	Major Incident Policy
NHS	National Health Service
PDD	Predicted Discharge Date
SJH	Samuel Johnson Community Hospital
SOP	Standard Operating Procedure
SRP	Sir Robert Peel Community Hospital
SSU	Short Stay Unit
TC	Treatment Centre
QHB	Queen's Hospital Burton

Appendix K

Theatre Escalation Process

Weekly Sessional Meeting:

Consider lists for transfer to the TC

Level 1:

Send for first patient and continue with lists

Level 2:

Send for first patient and continue with lists

Level 3:

Send for first patient and continue with lists

Work with operational teams to review lists for the next day – consider transfer & cancellations

Level 4:

Wait for confirmation to send for first patient

Work with operational teams to review lists – consider transfer & cancellations