NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

TRUST FULL CAPACITY PLAN

<table>
<tr><td>Reference Number:
CL</td><td>Version:
Version 3.0</td><td>Status:
Final</td><td colspan="2">Author: Caitlin Richens
Job Title: Integration Project Manager</td></tr>
<tr><td rowspan="4">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1.0</td><td>23.01.2017</td><td>Caitlin Richens</td><td>New Policy</td></tr>
<tr><td>2.0</td><td>14.02.2018</td><td>Jed Lee</td><td>Inclusion of MAU as a potential trigger and focus of response</td></tr>
<tr><td>3.0</td><td>03.01.2019</td><td>Caitlin Richens</td><td>Update to include integration of legacy DTHFT and BHFT policies</td></tr>
<tr><td colspan="5">Intended Recipients: All clinical staff, Divisional Managers, Flow Team and Executive Team</td></tr>
<tr><td colspan="5">Training and Dissemination: Available on the Trust intranet.</td></tr>
<tr><td colspan="5">To be read in conjunction with:
Trust Capacity and Escalation Plans, inclusive of:
˅ Departmental Escalation Plans
˅ 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</td></tr>
<tr><td colspan="5">In consultation with and date:
Internal Senior Management and Clinicians from across the Trust at each revision</td></tr>
<tr><td colspan="5">EIRA stage One Completed No
Stage Two Completed No</td></tr>
<tr><td colspan="4">Procedural Documentation Review Group Assurance and Date</td><td>No</td></tr>
<tr><td colspan="4">Approving Body and Date Approved</td><td>Trust Operational Group</td></tr>
<tr><td colspan="4">Date of Issue</td><td>January 2019</td></tr>
</table>

Review Date and Frequency	July 2019 EXTENDED JAN 2023
Contact for Review	Associate Director Operations
Executive Lead	Chief Operating Officer

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST

FULL CAPACITY PLAN

Contents

1.0 Introduction 4

2.0 Purpose and Outcomes 5

3.0 Key Responsibilities/ Duties 5

4.0 Summary Flowchart 6

5.0 Full Capacity Plan.... 7

6.0 FCP at RDH 8

6.1 Activation at RDH....8

6.2 Command and Control at RDH....9

6.3 Pre-emptive Actions 11

6.4 FCP Actions 11

6.4.1 Cancellation of Non-Clinical Activity at RDH 11

6.4.2 Review of Clinical Activity at RDH....11

6.4.3 In-Reach to ED / MAU at RDH....12

6.4.4 Daily Senior Review to Facilitate Discharge at RDH 14

6.4.5 Transfer of Patients to Wards whilst Awaiting a Bed at RDH....14

6.4.6 Cancellation of All Consultant SPA Activity at RDH 16

6.4.7 Diversions at RDH....16

6.4.8 Increasing capacity at London Road Community Hospital (LRCH) 16

6.4.9 De-Escalation at RDH 16

7.0 FCP at QHB 18

7.1 Activation at QHB....18

7.2 Command and Control at QHB....19

7.3 Pre-emptive Actions at QHB....20

7.4 FCP Actions at QHB 20

7.4.1 Cancellation of Non-Clinical Activity at QHB 20

7.4.2 Review of Clinical Activity at QHB....20

7.4.3 In-Reach to the ED / AAC at QHB....21

7.4.4 Daily Senior Review to Facilitate Discharge at QHB 22

7.4.5 Transfer of Patients to Wards whilst Awaiting a Bed at QHB....22

7.4.6 Additional capacity in the Endoscopy Unit at QHB....24

7.4.7 Cancellation of All Consultant SPA Activity at QHB 25

7.4.8 Diversions at QHB....25

7.4.9 De-Escalation at QHB 25

8.0 Communication 27

8.1 Cascade....27

8.2 Activation Meeting....27

8.3 Ongoing Trust-Wide Communications 28

9.0 Escalation at both RDH and QHB 28

10.0 Monitoring Compliance and Effectiveness 28
11.0 Appendix 1- Action Cards 30
12.0 Appendix 2 –FCP Activation Meeting....32
13.0 Appendix 3 – Operating Procedure for Escalation Spaces....33
13.0 Appendix 4 – Endoscopy Unit SOP for QHB....36
14.0 Appendix 5 – Hot Debrief Agenda 38

1.0 Introduction

Purpose

The University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) Full Capacity Plan (FCP) outlines the key actions to be taken when the Trust is operating at full capacity.

Such circumstances may arise due to a prolonged or sudden increase in demand and/or loss of capacity. The plan is designed to ensure that potential risk to patient safety is not concentrated in one area, but is instead minimised and distributed across the Trust to ensure the continued provision of high quality care.

The intention of the FCP is to be able to quickly flex staffing and bed capacity to meet patient demand, and therefore, it is also important to de-escalate out of FCP as soon as possible.

UHDB

UHDB currently operates two Emergency Departments (EDs), one at the Royal Derby Hospital (RDH) and one at Queen's Hospital Burton (QHB). It is difficult to influence or restrict the number of patients presenting in ED, and there are times when the departments are deemed to be over-capacity. This is often associated with periods of exit block for patients who require admission.

When an ED is required to operate under such pressures there is heightened risk to patient safety, and this risk increases as more patients present. It is well documented that crowding in EDs correlates to adverse outcomes for patients. Such circumstances cannot therefore be safely sustained.

Similarly, there are times when the Medical Assessment Unit (MAU) at RDH or the Acute Assessment Centre (AAC) at QHB are deemed to be over-crowded due to an exit block caused by a lack of capacity on base wards. It is well documented that such overcrowding increases patient risk in the departments affected.

Furthermore, overcrowding in one department has corollary effects on others, so that if MAU or AAC becomes crowded it is likely that other areas, especially the EDs, will become crowded too, with consequent adverse effects on patient safety.

Response

In response to these challenges, it is understood that the Trust may need to take special measures to share risk across the hospitals to prevent it from being concentrated in either the EDs, MAU/ AAC or both.

Within the context of the Trust operating at its highest escalation levels (i.e. demand significantly outweighing capacity) and actions taken so far failing to contain service pressures, a hospital-wide response must be initiated; the situation cannot be solely managed within the ED or MAU / AAC alone.

The Full Capacity Plan (FCP) describes the necessary actions to be taken when either the EDs, MAU / AAC or both have more patients than can safely be cared for.

The resulting actions are intended to restore patient flow and promote safety via 3 means:

- management and coordination of the response;
- clinical support for assessment/ care-giving within the department affected;
- focus on discharge

The FCP will only be enacted when the Trust is on Escalation Level 3 or 4. Escalation to the FCP will be an Executive decision following careful consideration of a number of indicators / triggers.

2.0 Purpose and Outcomes

The purpose of this document is to detail situational indicators which may require the Trust to escalate to the FCP and to describe the actions to mitigate patient safety risks.

The indicators and actions listed are not necessarily exhaustive, other indicators may be used and other appropriate actions may be considered to support operational safety.

It is intended that escalating to the FCP will allow the hospital to act promptly to care for high volumes of patients as safely as possible whilst restoring patient flow. It is recognised that in order to achieve this, departments will be required to operate in a different manner than at lower levels of escalation.

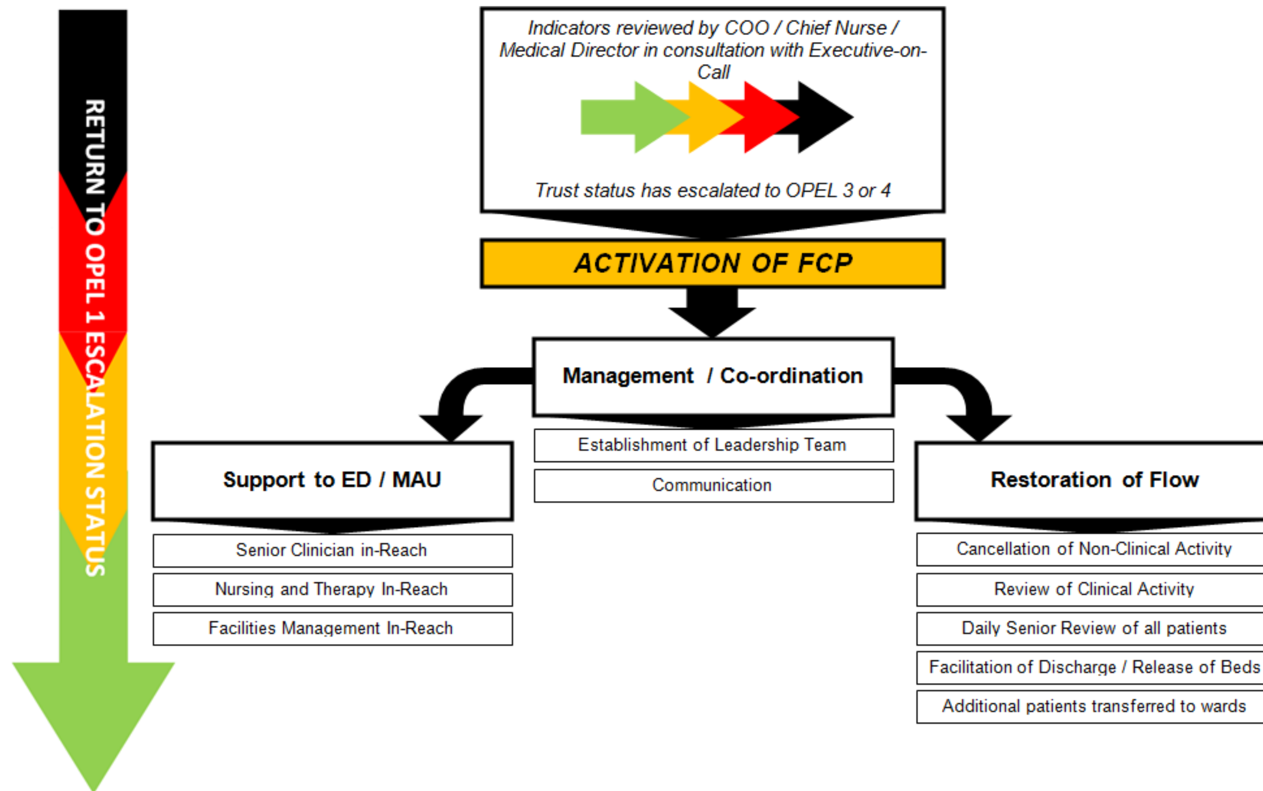
When the FCP is activated the Trust will be in a "Command and Control" situation and all operational staff will be expected to prioritise implementation of the required actions.

3.0 Key Responsibilities/ Duties

Further details of responsibilities and duties can be found in sections 5.1 and 5.2. In summary the following key responsibilities are relevant to the FCP:

Chief Operating Officer (or deputy), Chief Nurse, Medical Director, or Executive On-Call	To assume Gold Command and support with relevant actions as detailed in Section 5
Associate Director of Operations, Lead Nurse for Operations, or Senior Manager On-Call	To assume Silver Command and support with relevant actions as detailed in Section 5
General Managers (or nominated deputies)	To assume Bronze Command and support with relevant actions as detailed in Section 5
ED Lead Consultant	To provide clinical leadership and support with relevant actions as detailed in Section 5
All Trust Staff	To adhere to and implement the protocol once activated

4.0 Summary Flowchart



5.0 Full Capacity Plan

It is acknowledged that both RDH and QHB have previously had existing plans and policies for managing and responding to surges in demand and operating whilst under extreme pressure. In addition, each of the acute sites has a bespoke patient flow model and as such the actions to be taken when either site has escalated to the FCP are different.

For clarity, the activation and proposed actions of the FCP are different for the two acute sites and are detailed separately as follows.

6.0 FCP at RDH

6.1 Activation at RDH

Activation of the FCP will be deemed to be a critical, but not a major, incident. It will be activated when there is such crowding in the hospital that it is deemed to be unsafe and when all other restorative internal actions have been deemed unsuccessful.

Triggers
Specifically, the FCP will only be triggered when the RDH site is operating at Operational Pressures Escalation Level (OPEL) 3 or 4 – and the situation is expected to remain the same or deteriorate.

The process of escalation from OPEL 1 to 4 is detailed in the Trust Capacity Escalation Plan, which is aligned to the national OPEL Framework (NHS England).

In addition to the RDH site escalating to OPEL 3 or 4 the following indicators should be considered to support a decision of whether to activate the FCP:

- ED Internal Escalation Status is OPEL 4 (Black) overall, i.e. any one of the areas within ED is triggering black escalation:
  - *13 patients in Pitstop* or
  - *16 patients in department awaiting a bed assignment more than 15 minutes after referral and 12 majors patients on a trolley not in a majors bay* or
  - *6 patients in Resus for ≥4 hours* or
  - *6 consecutive hours with more than 20 patients arriving*
- There is no remaining space for ambulances to offload into the ED Pitstop and handovers are greater than 60 minutes.
- There are patients in the ED with decisions-to-admit and no capacity for MAU to declare a bed.
- MAU Internal Escalation Status is OPEL 4 (Black) overall, i.e.:
  - *A-B<=-15, OR A-B<=-10 AND 'Outflow Escalation' has been triggered, where:*
    A = The number of empty beds on MAU at the time of calculation
    B = the total number of patients to come in, i.e. those expected to arrive on MAU through bed bureau, ED or other routes.
    N.B. if there are patients on the MAUT corridor and no beds on MAU, the department is in negative balance e.g. if 3 patients are on the MAUT corridor and there are 0 beds on MAU, this gives a bed status of -3.
- There are a large number of patients within MAU 'ready to go', but with no bed allocated due to lack of base ward capacity.

Activation
Based on the above indicators of over-capacity the Chief Operating Officer (or deputy), Chief Nurse, Medical Director or the Executive On-Call, may consider escalation to the FCP. However, this list of indicators is not definitive and the Senior Manager On-Call and either the ED Consultant On-Call or the MAU Consultant On-Call may request Executive approval of escalation to the FCP at other times; for instance if overall levels of acuity in the ED/ MAU are deemed high risk regardless of absolute patient numbers.

The FCP will usually be activated during normal working hours (8.00am to 6.00pm, Monday to Friday) whilst a broad range of staff are on duty to respond

and implement the definitive and any discretionary actions.

In the event that it may be predicted within normal working hours that there may be such a rise in pressure during the out-of-hours period that it may be necessary to activate the FCP out-of-hours, certain actions may be taken pre-emptively in order to assist implementation of the plan later on.

Warning signs during normal working hours that the FCP may be required to be activated out-of-hours include:

- Rising or high medical and general bed occupancy
- A significantly adverse medical bed forecast together with concerns regarding insufficient discharges, insufficient community capacity or insufficient outlier bed capacity to close the gap.

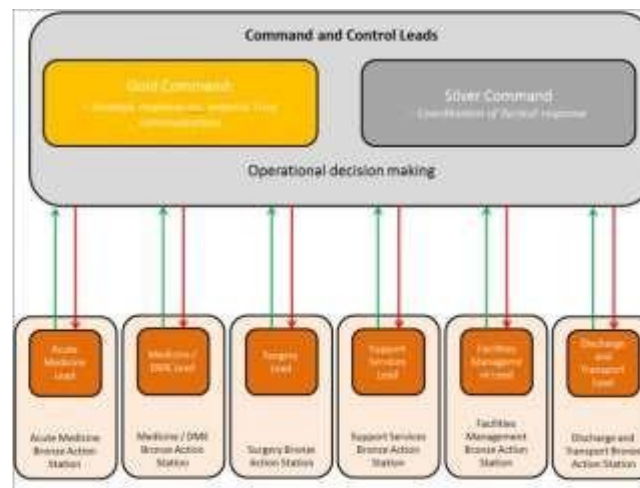
Pre-emptive actions that may be taken during normal working hours in order to assist the implementation of the plan later on during the out-of-hours period include:

- Matron, Divisional Nurse Director or rostered Senior Nurse assessment of treatment rooms to evaluate which are suitable to house patients based on staffing levels and the acuity of patients on each ward
- Preparation of identified treatment rooms to safely house patients.

In the event of an unpredictable rise in pressure during the out-of-hours period the FCP can still be activated, but some of the actions may be more limited due to the availability of relevant staff groups. In such circumstances, the Senior Manager On-Call and Executive On-Call will need to clearly define and assign the actions needed, calling in additional support if required.

6.2 Command and Control at RDH

Upon activation of the FCP a leadership team will be established:



FULL CAPACITY PLAN - RDH

The team will remain established throughout the period that the FCP is active, or until Gold Command advise otherwise.

The following key responsibilities and initial actions are expected of the FCP leadership team:

Command	Roles		Responsibility	Key Tasks	
Gold (Strategic) Command	Chief Operating Officer (or Deputy), Chief Nurse, Medical Director or Executive On-Call.		To lead the Trust response. To initiate the strategic response to the incident and to support the Silver (Tactical) Commander.	-Decision to activate and de-activate the FCP. -Management of external communications, mutual aid and resources.	*Gold and Silver Command will work closely to support decisions made throughout activation of the FCP. The following actions will be supported by Gold and Silver Command working in conjunction:*
Silver (Tactical) Command	Associate Director of Operations, Nominated deputee or Senior Manager On-Call Patient Flow Manager Information Manager. *This will be any available General Manager. DGM or AGM available to support.* Administrative Support		To manage the tactical response.	- Informing Bronze and other key individuals the FCP has been activated. -Collating and providing intelligence received from Bronze and Silver to focus resource.	-Senior presence on-site within 30 minutes of activation of the FCP (and remain ng on site as requred). - Lead in decisions for capacity queries -Communicating actions to Bronze Leads.
Bronze (Operational) Command	Acute Medicine Action Station	Acute Medicine Lead ••• Designated Bed Manager ••• Acute Medicine Action Station Support	To support delivery of the FCP actions and the operational response under the guidance of Silver Command.	- Implementing the FCP definitive actions and any discretionary actions under the direction of Silver Command. -Coordinating service adjustments and corresponding with specialty clinicians to action the requirements of the FCP. -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.	
	Medicine / DME Action Station	Medicine / DME Lead ••• Designated Bed Manager ••• Medicine / DME Action Station Support			
	Surgery Action Station	Surgery Lead ••• Designated Bed Manager ••• Surgery Action Station Support (to include ICU)			
	Facilities Management Action Station	Facilities Management lead ••• Facilities Management Action Station Support			
	Support Services Action Station	Support Services Lead ••• Support Services Action Station Support			
	Discharge and Transport Action Station	Discharge and Transport Lead ••• Discharge and Transport Action Station Support			

Individuals undertaking the roles detailed above will maintain responsibility throughout the activation of the FCP, however where the FCP remains active

for a prolonged period of time a rota system will be established by Gold Command.

6.3 Pre-emptive Actions

It is acknowledged that there may be circumstances where significant operational pressures are being managed at RDH (using the Trust Capacity and Escalation Policy and associated procedures) but there is an anticipated continued or rising demand.

In these circumstances, in order to promote patient safety, there is a need to take pro-active steps to ensure that RDH is responsive to the presenting situation and can prevent the position from deteriorating further. There may be a requirement to consider utilising any of the FCP Actions (detailed in section 6.4) in advance of fully escalating to the entire FCP. Taking actions pre-emptively is intended to allow the hospital to manage pressures as safely as possible - with recognition that actions taken within-hours may prevent challenging circumstances out-of-hours which are more difficult to manage (for instance due to decreased staff presence).

At the discretion of the Chief Operating Officer (or Executive On-Call) in collaboration with the Chief Nurse, Medical Director and Associate Director of Operations (or deputy) each of the FCP Actions (detailed in section 6.4) may be considered based on their effectiveness in relieving pressures and responding to the specific circumstances the hospital is managing at that time.

6.4 FCP Actions

6.4.1 Cancellation of Non-Clinical Activity at RDH

Upon escalation to the FCP, all but the most urgent meetings, sub-committees and committees that require the attendance of clinical staff and operational managers will be cancelled. The lead for each action station is responsible for cascading the necessity to cancel all meetings within their area.

In the circumstance that the chair feels the meeting should continue they should correspond with Silver Command for confirmation. Cancellation of meetings should allow for further clinical and managerial support to be directed towards supporting the FCP.

6.4.2 Review of Clinical Activity at RDH

Once the FCP has been activated, Silver Command will liaise with Bronze Command to discuss the potential for releasing resource in the form of staff or escalation space (most likely bed capacity and ED overflow). This may include the cancellation of non-urgent elective surgery and outpatient activity, considered on a case-by-case basis with a view to identifying escalation space or staff to support the restoration of patient flow. The final decision to cancel elective activity will be taken by Gold Command.

As a general rule, day-case surgery will not be considered for cancellation due to the limited impact on non-elective patient pathways and flow.

6.4.3 In-Reach to ED / MAU at RDH

Depending on which department is facing sufficient pressure to justify the activation of the FCP, in-reach into EITHER the ED, OR MAU, OR both will be required from:

- Senior Clinicians
- Nursing and Therapy
- Facilities Management

Senior Clinicians

Upon activation of the FCP a number of specialties will be expected to provide additional support to either the ED, or MAU, or both. Senior clinical decision makers from both the ED and MAU are required to be present in their department at all times during the period of activation. This support will be expected at the point of activation of the FCP and throughout until de-escalation.

The support required will depend on the nature of patients present in the ED/ MAU. However, Bronze Command should be prepared to identify a nominated clinician from the following areas who can visit either the ED, or MAU, or both regularly:

Acute Medicine
Cardiology
Respiratory
Gastroenterology
DME
Stroke
Renal
General Surgery
Urology
ENT
OMF
T&O
Gynaecology
Imaging
Other (contacted as necessary)

It will be necessary for multiple specialties to in-reach in to ED/ MAU in order to relieve the pressure on the department. The response should not be limited to those specialties associated with any exit block or high patient volumes.

It is expected that the nominated specialty individual will be a senior clinical decision maker who can support with any of the following activities as directed by the Clinical Leads in either ED or MAU.

Where required, specialty clinicians will receive assistance from the resident junior medical teams to support with the execution of clinical plans.

ED:	MAU:
- Triage of patients (particular consideration to be given to assessing needs of	- Triage of patients

Minors patients and encouraging them to attend other services where appropriate) - Review of patients relevant to specialty (not necessarily seen yet or referred by ED) - If the specialty is ambiguous then the ED Clinical Lead will make the final decision about the admitting specialty - Admission-avoidance actions - for instance arranging for early / immediate outpatient clinic appointments (even if this results in clinics being overbooked) and expediting procedures and investigations - Support to expedite discharge	Review of patients on MAU, especially those relevant to specialty Clerking of patients Completing TTOs Support to expedite discharge .

Nursing and Therapy	
Upon activation of the FCP, nursing and therapy teams will be asked to provide additional in-reach to either the ED floor, or the MAU floor, or both within 30 minutes. Bronze Command will be responsible for identifying Registered Nurses and Therapists to be deployed to the ED. In particular, consideration should be given to how non-patient-facing roles can support. The teams that will be asked to provide support will include, but not be limited to: Therapy FEAT Integrated Discharge and Transfer Team Non-Ward Based Nurses / AHPs / ACPs Imaging Clinical Staff It is expected that the nursing and therapy staff deployed will support any of the following activities in ED or MAU. ED:	MAU:
Nursing duties / care support / treatments Escort and transfer of patients Support to expedite discharge	Nursing duties / care support / treatments Escort and transfer of patients Support to expedite discharge Clerking of patients Whiteboard handovers

Non-Clinical
Facilities Management: Upon activation of the FCP, Silver Command will liaise with Bronze Facilities Management to review the provision of additional resources such as equipment (e.g., trolleys and beds) and FM Staff to either the ED, or MAU, or both: Additional porters will ideally be deployed to support transfer of patients within 30 minutes. The support of additional housekeepers, catering staff, supplies and volunteers will also be considered.
Transport: Upon activation of the FCP, Silver Command will liaise with the Transport / Discharge Bronze Action Station to ensure that additional resource is requested.

6.4.4 Daily Senior Review to Facilitate Discharge at RDH

Senior review of patients will be prioritised during the activation of the FCP. This will be communicated to the relevant clinicians via Bronze Command. Whilst the FCP is activated, every patient in the hospital should receive a daily review from a senior doctor (Registrar or Consultant). Patients should be prioritised for review in terms of acuity / clinical urgency and potential to discharge.

Early discharge should be considered where appropriate for patients who require additional investigations that could be provided through an outpatient review or transfer to the Virtual Ward.

During activation of the FCP on-call consultants will be required on-site to lead the clinical response for their specialty. Silver Command will liaise with Bronze Command to direct clinical support to the area in which they should support i.e. assisting with ward rounds, clinics or support directly within the ED.

6.4.5 Transfer of Patients to Wards whilst Awaiting a Bed at RDH

In extreme circumstances, in order to satisfy the risk-sharing rationale expressed above, it may be necessary to transfer patients from either the ED, or MAU, or both to a ward without a bed being immediately available. This will usually be mandated for Medicine and DME wards when the Trust is operating at OPEL 3 or OPEL 4, there is an expectation of unrelenting or increasing pressure, and all other actions have been implemented and assessed and have failed to restore safety within the ED/ MAU.

Ideally, patients will transfer to wards from MAU only. However, if it is necessary to directly move patients out of the ED to a ward it is essential that they have been clerked or that there is a clear plan for them to be clerked on the receiving ward. It may also be necessary to transfer additional patients to surgical wards to create additional medical outlier capacity.

In the event that additional escalation beds are opened up the protocol *“Operating Procedure for Escalation Spaces”* should be used (see Appendix 3).

Wards that are already full will be expected to accept additional patients either by temporarily moving a patient/ patients awaiting discharge today into the day room (termed ‘sit-out’ patients) or by opening an escalation space.

Wards should consider their capacity for housing sit-out patients BEFORE considering opening an escalation space. All wards housing patients in this way will receive further clinical review (i.e. an additional daily ward round) with the expectation that every patient is reviewed within 12 hours of the ward being over-capacity.

The following should be considered when accepting additional patients either through sit-out or through opening an escalation space:

- Any ward accepting additional patients should have had a clinical risk assessment conducted and documented arrangements for how patients will be received and cared for.
- Only one additional patient will be received by the identified wards.
- Consideration will be given for privacy and dignity including adherence to single-sex requirements.

- All ward staff should be appropriately trained on the process and reason for escalating to this action.
- Where needed, Silver Command will liaise with Bronze Command to support with the identification of additional beds, meals, trolleys and other equipment to care for patients.

Sit-Out Patients:

All wards will consider whether they can sit-out an outgoing patient.

- The expectation for sit-out patients will be that a patient will be discharged from that ward either home or to the Discharge Lounge that day; meaning that sit-out is a short-term arrangement.
- The final decision on which patient sits-out will be made by the Nurse-In-Charge in conjunction with the lead clinician for the ward.
- Patients are eligible to be sit-out patients only if they are over the age of 16; stable – NEWS less than 3; not acutely confused; not receiving oxygen; not undergoing continuous cardiac monitoring; and not requiring isolation.

Opening up an Additional Escalation Space (FCP beds):

A number of wards have undergone a clinical risk assessment and been identified as having the potential to accept additional patients into an escalation space.

- Patients should only be housed where there is a call bell and oxygen and suction are accessible.
- Only 1 patient will be cared for per escalation room.
- Bathrooms and offices are not appropriate escalation spaces.
- Paediatric beds will be considered for patients aged 16-18 years old.
- Any escalation space that houses an electronic whiteboard should have the whiteboard turned off for information governance purposes as per Caldicott guidelines.
- The Nurse-In-Charge will be responsible for assigning a named nurse to care for the additional patient and explaining the circumstance to the patient / carer / family as necessary.
- The Business Unit Matron and / or Senior Nurse (outside of normal working hours) will be responsible for monitoring and tracking all patients boarded into the identified additional capacity areas.

The following wards have undergone a clinical risk assessment and been identified as having the potential to accept additional patients into an escalation space:

Medicine	216
	302
	304
	305
	306
	311
	401
	402
	404
	405
	406

	408
	409
Surgery	203
	205
	206
	308
	309
	310

NB – regarding Ward 303: room has emergency call bell only, temporary fix needs to be put in place for nurse call should this room be utilised.

However, to promote safety, this suitability will need to be re-assessed on the basis of current local activity and demand by a clinical member of Bronze Command at the point of escalating to FCP.

The decision to de-escalate an escalation space will be made during the FCP operational meetings attended by Gold, Silver and Bronze command leads. This decision will be communicated to relevant areas by the Bronze Action Station Lead.

6.4.6 Cancellation of All Consultant SPA Activity at RDH

At the discretion of the Trust Medical Director (or deputy) all consultant SPA activity will be cancelled and consultant time will be focussed on supporting the FCP.

6.4.7 Diversions at RDH

At the discretion of Gold Command, Southern Derbyshire Clinical Commissioning Group (SDCCG) and neighbouring Trusts, the Ambulance service will be approached to divert patients to other EDs. This request can only be made if the Trust has exhausted all internal support options and these have failed to relieve service pressure. Further details are provided in Pan Derbyshire Urgent Care Escalation & De-escalation Plan and National Operational Pressures Escalation Levels Framework.

6.4.8 Increasing capacity at London Road Community Hospital (LRCH)

At the discretion of Silver and Gold Command, it may be necessary to ensure that the five additional escalation beds on Ward 5 at LRCH are opened to accept patient transfers from RDH. Furthermore, any actions deemed necessary to safely discharge or sit-out in day rooms patients at LRCH, thereby releasing bed capacity to enable transfer of patients from RDH, should be taken.

6.4.9 De-Escalation at RDH

It is essential that RDH de-escalates out of FCP as soon as possible and that normal operations and activity resumes. This is to ensure that the FCP does not become “business as usual” and is only used in times of extreme demand to maintain patient safety.

The FCP will be de-escalated once the hospital is able to operate safely again. The decision to de-escalate will be at the discretion of the Chief Operating Officer (or Deputy), Chief Nurse, Medical Director or Executive On-Call who is fulfilling the role of Gold (Strategic) Command. Prior discussion and agreement will have taken place with the Lead ED consultant or the Lead MAU Consultant, or both, and Silver Command.

De-escalation will be communicated to the appropriate individuals by Silver Command via text message, email and telephone call.

A Hot De-Brief will be conducted in the Operations centre with attendance from Gold Command, Silver Command and Bronze Action Station Leads. Bronze Action stations will conduct their own internal hot de-briefs.

7.0 FCP at QHB

7.1 Activation at QHB

Activation of the FCP will be deemed to be a critical, but not a major, incident. It will be activated when there is such crowding in the hospital that it is deemed to be unsafe and when all other restorative internal actions have been deemed unsuccessful. Specifically, the FCP will only be triggered when the Trust is operating at Escalation Level 3 or 4 – and the situation is expected to remain the same or deteriorate.

The Trust process of escalation from level 1 to 4 is detailed in the Trust Capacity Escalation Plan, which is aligned to the Escalation Management System (EMS).

In addition to the Trust escalating to Escalation level 3 or 4, the following indicators should be considered:
ED Escalation Status is Escalation Level 4 (Black) overall, i.e. any one of the areas within ED is triggering black escalation:

- There is no remaining space for ambulances to offload into the ED Pitstop and handovers are greater than 60 minutes.
- There are patients in the ED with decisions-to-admit and no capacity for AAC to declare a bed.
- AAC Escalation Status is Escalation Level 4 (Black) overall
- There are a large number of patients within AAC 'ready to go', but with no bed allocated due to lack of base ward capacity

Based on the above indicators of over-capacity the Chief Operating Officer (or deputy), Chief Nurse, Medical Director or the Executive On-Call, may consider escalation to the FCP. However, this list of indicators is not definitive and the Senior Manager On-Call and either the ED Consultant On-Call or the ACC Consultant On-Call may request Executive approval of escalation to the FCP at other times; for instance if overall levels of acuity in the ED/AAC are deemed high risk regardless of absolute patient numbers.

The FCP will usually be activated during normal working hours (8.00am to 6.00pm, Monday to Friday) whilst a broad range of staff are on duty to respond and implement the definitive and any discretionary actions.

In the event that it may be predicted within normal working hours that there may be such a rise in pressure during the out-of-hours period that it may be necessary to activate the FCP out-of-hours, certain actions may be taken pre-emptively in order to assist implementation of the plan later on.

Warning signs during normal working hours that the FCP may be required to be activated out-of-hours include:

- Rising or high medical and general bed occupancy
- A significantly adverse medical bed forecast together with concerns regarding insufficient discharges, insufficient community capacity or insufficient outlier bed capacity to close the gap.

Pre-emptive actions that may be taken during normal working hours in order to assist the implementation of the plan later on during the out-of-hours period include:

- Matron, Divisional Nurse Director or rostered Senior Nurse assessment of treatment rooms to evaluate which are suitable to house patients based on staffing levels and the acuity of patients on each ward
- Preparation of identified surge rooms to safely house patients.

In the event of an unpredictable rise in pressure during the out-of-hours period the FCP can still be activated, but some of the actions may be more limited due to the availability of relevant staff groups. In such circumstances, the Senior Manager On-Call and Executive On-Call will need to clearly define and assign the actions needed, calling in additional support if required.

7.2 Command and Control at QHB

Upon activation of the FCP a Leadership team will be established. This will include the following Bronze action stations:

Medicine
Surgery *To include:* - *Women's & Children's* - *Representatives from other departments as required (for instance Facilities Management)*

The team will remain established throughout the period that the FCP is active, or until Gold Command advises otherwise. The following key responsibilities and initial actions are expected of the FCP leadership team:

Command	Roles	Responsibility	Key Tasks	
Gold (Strategic) Command	Chief Operating Officer (or Deputy), Chief Nurse, Medical Director or Executive On-Call	To lead the Trust response. To initiate the strategic response to the incident and to support the Silver (Tactical) Commander	- Decision to activate and de-activate the FCP - Management of external communications, mutual and resources	*Gold and Silver Command will work closely to support decisions made throughout activation of the FCP. The following actions will be supported by Gold and Silver Command working in conjunction.* - Senior presence on site within 30 minutes of activation of the FCP (and remaining on site as required) - Lead in decisions for capacity queries - Communicating actions to Bronze Leads
Silver (Tactical) Command	Associated Director of Operations, nominated deputee or Senior Manager On-Call *with* Patient Flow Manager *with* Information Manager *This will be any available General Manager, Deputy General Manager or Assistant General Manage available to support* with Administrative Support	To manage the tactical response	- Informing Bronze and other key individuals the FCP has been activated. - Collating and providing intelligence received from Bronze and Silver to focus resource.	
Bronze (Operational) Command		To support delivery of the FCP actions and the operational response under the guidance of Silver Command	- Implementing the FCP definitive actions and any discretionary actions under the direction of Silver Command - Coordinating service adjustments and corresponding with specialty clinicians to actionthe requirements of the FCP - 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	

Individuals undertaking the roles detailed above will maintain responsibility throughout the activation of the FCP, however where the FCP remains active for a prolonged period of time a rota system will be established by Gold Command.

7.3 Pre-emptive Actions at QHB

It is acknowledged that there may be circumstances where significant operational pressures are being managed at QHB (using the Trust Capacity and Escalation Policy and associated procedures) but there is an anticipated continued or rising demand.

In these circumstances, in order to promote patient safety, there is a need to take pro-active steps to ensure that QHB is responsive to the presenting situation and can prevent the position from deteriorating further. There may be a requirement to consider utilising any of the FCP Actions (detailed in section 7.4) in advance of fully escalating to the entire FCP. Taking actions pre-emptively is intended to allow the hospital to manage pressures as safely as possible - with recognition that actions taken within-hours may prevent challenging circumstances out-of-hours which are more difficult to manage (for instance due to decreased staff presence).

At the discretion of the Chief Operating Officer (or Executive On-Call) in collaboration with the Chief Nurse, Medical Director and Associate Director of Operations (or deputy) each of the FCP Actions (detailed in section 7.4) may be considered based on their effectiveness in relieving pressures and responding to the specific circumstances the hospital is managing at that time.

7.4 FCP Actions at QHB

7.4.1 Cancellation of Non-Clinical Activity at QHB

Upon escalation to the FCP, all but the most urgent meetings, sub-committees and committees that require the attendance of clinical staff and operational managers will be cancelled. The lead for each action station is responsible for cascading the necessity to cancel all meetings within their area.

In the circumstance that the chair feels the meeting should continue they should correspond with Silver Command for confirmation. Cancellation of meetings should allow for further clinical and managerial support to be directed towards supporting the FCP.

7.4.2 Review of Clinical Activity at QHB

Once the FCP has been escalated, Silver Command will liaise with Bronze Command to discuss the potential for releasing resource in the form of staff or escalation space (most likely bed capacity and ED overflow). This may include the cancellation of non-urgent elective surgery and outpatient activity, considered on a case-by-case basis with a view to identifying escalation space or staff to support the restoration of patient flow. The final decision to cancel elective activity will be taken by Gold Command.

As a general rule, day-case surgery will not be considered for cancellation due to the limited impact on non-elective patient pathways and flow.

7.4.3 In-Reach to the ED / AAC at QHB

Senior Clinicians

- Each speciality shall provide a nominated individual who may be called upon to visit the Emergency Floor and liaise with the AAC NIC, ED NIC and Flow co-ordinator.
- In hours all medical patients in ED and AAC will be reviewed by the Acute Physicians on Duty.
- The Acute physician will take the decision regarding the speciality the patient is to be reviewed by or the decision to admit to the relevant clinical area
- Out of Hours the on-call surgical and medical teams will take responsible for response to the Emergency Care Floor
- The ED and AAC Consultant/Nurse in charge will assist with the provision of intelligence to the specialities via a circulated list of what the pressures are for each speciality to help target resources appropriately and avoid clinician visiting needlessly. However, it is still expected that the minimum attendances above are adhered to.
- Useful activities include the review of specialty-type patients (regardless of a decision to admit), triage, admission avoidance actions including the provision of early/immediate outpatient/ambulatory care clinic appointments, expediting procedures and investigations.
- Specialty teams visiting the ED should expect assistance from the junior medical teams in the delivery of their management plans.
- The Medical Director or nominated Deputy in-charge will act as a Clinical Arbiter for cases where there is potential dispute as to which team looks after which patients.
- On-call consultants and their associated junior on-call teams will be expected to be present in the Trust from at least 0800 – 2200 as a minimum during the period of activation of the Full Capacity Protocol. They must check in with Silver Command via telephone or in person and be directed by them to the location they can be of greatest use to the whole system. This may be in the ED or on the wards. The Executive On-Call may allow specialties and individual teams to step down if they are no longer required.

Nursing and Therapy

Upon activation of the FCP, nursing and therapy teams will be asked to provide additional in-reach to the EITHER the ED floor or the AAC floor, OR both within 30 minutes. Bronze Command will be responsible for identifying Registered Nurses and Therapists to be deployed to the ED. In particular, consideration should be given to how non-patient-facing roles can support.

The teams that will be asked to provide support will include, but not be limited to:

- Therapy
- FEAT
- Discharge Team
- Non-Ward Based Nurses / AHPs / ACPs
- Imaging Clinical Staff

It is expected that the nursing and therapy staff deployed will support with the following activities in the ED or AAC.

ED:	AAC:
Nursing duties / care support / treatments Escort and transfer of patients Support to expedite discharge	Nursing duties / care support / treatments Escort and transfer of patients Support to expedite discharge

Non-Clinical

Facilities Management:

Upon activation of the FCP, Silver Command will liaise with Bronze Facilities Management to review the provision of additional resources such as equipment (e.g., trolleys and beds) and FM Staff to EITHER the ED, OR AAC, OR both:

Additional porters will ideally be deployed to support transfer of patients within 30 minutes.
The support of additional housekeepers, catering staff, supplies and volunteers will also be considered.

Transport:
Upon activation of the FCP, Silver Command will liaise with the relevant Bronze Action Station to ensure that additional resource is requested.

7.4.4 Daily Senior Review to Facilitate Discharge at QHB

Senior review of patients will be prioritised during the activation of the FCP. This will be communicated to the relevant clinicians via Bronze Command.

Whilst the FCP is activated, every patient in the hospital should receive a daily review from a senior doctor (Registrar or Consultant). Patients should be prioritised for review in terms of acuity / clinical urgency and potential to discharge.

Early discharge should be considered where appropriate for patients who require additional investigations that could be provided through an outpatient review.

During activation of the FCP on-call consultants will be required on-site to lead the clinical response for their specialty. Silver Command will liaise with Bronze Command to direct clinical support to the area in which they should support i.e. assisting with ward rounds, clinics or support.

All community intervention teams' e.g Rapid Response and social services will be asked to come into the Trust and "pull" patients out to the services they provide and provide advice on supporting earlier discharge.

7.4.5 Transfer of Patients to Wards whilst Awaiting a Bed at QHB

In extreme circumstances, in order to satisfy the risk-sharing rationale expressed above, it may be necessary to transfer patients from EITHER the ED, AAC or both to a ward without a bed being immediately available.

This will usually be mandated for Medicine and DME wards when the Trust is operating at EMS level 3 or EMS level 4, there is an expectation of unrelenting or increasing pressure, and all other actions have been implemented and assessed and have failed to restore safety within the ED / AAC.

Ideally, patients will transfer to wards from AAC only. However, if it is necessary to directly move patients out of the ED to a ward it is essential that they have been clerked or that there is a clear plan for them to be clerked on the receiving ward.

In the event that additional escalation beds are opened up the "Operating Procedure for Escalation Spaces" should be used (see Appendix 3).

Wards that are already full will be expected to accept additional patients either by temporarily moving a patient/patients awaiting discharge today into the day room (termed 'sit-out' patients) or by opening an escalation space.

Wards should consider their capacity for housing sit-out patients BEFORE considering opening an escalation space. All wards housing patients in this way will receive further clinical review (i.e. an additional daily ward round) with the expectation that every patient is reviewed within 12 hours of the ward being over-capacity.

The following should be considered when accepting additional patients either through sit-out or through opening an escalation space:

- Any ward accepting additional patients should have had a clinical risk assessment conducted and documented arrangements for how patients will be received and cared for.
- Only one additional patient will be received by the identified wards.
- Consideration will be given for privacy and dignity including adherence to single-sex requirements.
- All ward staff should be appropriately trained on the process and reason for escalating to this action.
- Where needed, Silver Command will liaise with Bronze Command to support with the identification of additional beds, meals, trolleys and other equipment to care for patients.

Sit-Out Patients:

All wards will consider whether they can sit-out an outgoing patient.

- The expectation for sit-out patients will be that a patient will be discharged from that ward either home or to the Discharge Lounge that day; meaning that sit-out is a short-term arrangement.
- The final decision on which patient sits-out will be made by the Nurse-In-Charge in conjunction with the lead clinician for the ward.
- Patients are eligible to be sit-out patients only if they are over the age of 16; stable – NEWS less than 3; not acutely confused; not receiving oxygen; not undergoing continuous cardiac monitoring; and not requiring isolation.

Opening up an Additional Escalation Space (FCP beds):

A number of wards have undergone aclinical risk assessment and been identified as having the potential to accept additional patients into an escalation space.

- Patients should only be cared for ~~housed~~ where there is a call bell and oxygen and suction are accessible.
- Only 1 patient will be cared for per escalation room.
- Bathrooms and offices are not appropriate escalation spaces.
- Paediatric beds will be considered for patients aged 16-18 years old.
- Any escalation space that houses an electronic whiteboard, or patient/ward information should have the whiteboard turned off/information removed for information governance purposes as per Caldicott guidelines.
- The Nurse-In-Charge will be responsible for assigning a named nurse to care for the additional patient and explaining the circumstance to the patient / carer / family as necessary.
- The Business Unit Matron and / or Senior Nurse (outside of normal working hours) will be responsible for monitoring and tracking all patients boarded into the identified additional capacity areas.

The following wards have undergone a clinical risk assessment and been identified as having the potential to accept additional patients into an escalation space. However, to promote safety, this suitability will need to be re-assessed on the basis of current local activity and demand by a clinical member of Bronze Command at the point of escalating to FCP.

Ward 3
Ward 4
Ward 7
2 beds in dayroom - Anna Ward
2 beds in dayroom - Darwin Ward
2 beds in dayroom - Phillip Ward

In the event that additional escalation beds are opened up the "Operating Procedure for Escalation Spaces" should be used (see Appendix 3).

The decision to de-escalate an escalation space will be made during the FCP operational meetings attended by Gold, Silver and Bronze command leads. This decision will be communicated to relevant areas by the Bronze Action Station Lead.

7.4.6 Additional capacity in the Endoscopy Unit at QHB

In extreme circumstances and as part of the FCP, in order to satisfy the risk-sharing rationale expressed above, it may be necessary to create additional capacity in the Endoscopy Unit for patients overnight who are being discharged the following day. However, consideration of using Endoscopy will be specifically based on the prevailing bed state at QHB. **As a general rule the Endoscopy Unit should only be considered if the bed state is reported to be in minus double figures at the 2pm operational bed meeting.**

A full operational SOP for opening the Endoscopy Unit is available (see Appendix 4). The following key points apply:

- The decision to open the Endoscopy Unit will only be taken by an Executive as per the activation criteria for the FCP described in Section 5.2.1.
- Opening of the Unit must take place before or at the 16.00 operational meeting.
- A maximum of 7 patients can be transferred to the Endoscopy Unit overnight.
- There must be a minimum of one Trust contracted nurse on the shift who is familiar with Trust policies and procedures
- Patients can be transferred to the Endoscopy unit from 19.00.
- Patients will be transferred from the Endoscopy Unit to the Discharge Lounge at 08.00 the following morning to await transport.
- The "Eliminating Mixed Sex Accommodation Policy" should be adhered to at all times

Only some patients are suitable for transfer to the Endoscopy Unit. The following clinical criteria must be adhered to when considering whether a patient can be safely transferred to the Endoscopy Unit:

- Only 2 patients maximum may be bed-bound as all patients will be transferred to the Discharge Lounge the following morning.
- Patients must be selected from the acute wards, ED or AAC
- Patients must be fit to be discharged the following day with a clear discharge plan in the notes
- TTOs must be written up in electronic prescribing
- Patients must require no clinical review prior to discharge
- Patients must fit the criteria for the Discharge Lounge
- Patients must have no existing diarrhoea/vomiting

- Patients must have no previous/existing C-Difficile
- Patients must be haemodynamically stable on observation charts
- All discharge information must be completed by the transferring ward
- Clear handover of patients must be given from the ward to staff within the Endoscopy Unit
- Any patients transferring to the Community Hospital must have a verbal handover provided from the ward to the Community Hospital
- Patients nursed on Hi/Low beds are not suitable for the Endoscopy Unit
- Patients who currently have 1:1 care should not be transferred to the Endoscopy Unit
- Patients with any level of cognitive impairment, where possible, should not be transferred to the Endoscopy Unit. Should this be necessary, justification must be documented.
- Patients who have fallen within the last 24 hours should not be sent to the Endoscopy Unit

7.4.7 Cancellation of All Consultant SPA Activity at QHB

At the discretion of the Trust Medical Director (or deputy) all consultant SPA activity will be cancelled and consultant time will be focussed on supporting the FCP.

7.4.8 Diversions at QHB

At the discretion of Gold Command, Staffordshire CCG and neighbouring Trusts, the Ambulance service will be approached to divert patients to other EDs. This request can only be made if the Trust has exhausted all internal support options and these have failed to relieve service pressure. Prior to this the Trust should request assistance from WMAS to provide an onsite HALO and further assistance so that a single crew can be identified to continue supervision, allowing other crews to be released.

7.4.9 De-Escalation at QHB

It is essential that RDH de-escalates out of FCP as soon as possible and that normal operations and activity resumes. This is to ensure that the FCP does not become “business as usual” and is only used in times of extreme demand to maintain patient safety.

The FCP will be de-escalated as soon as possible once the hospital is able to operate safely again. The decision to de-escalate will be at the discretion of the Chief Operating Officer (or Deputy), Chief Nurse, Medical Director or Executive On-Call who is fulfilling the role of Gold (Strategic) Command. Prior discussion and agreement will have taken place with the Lead ED consultant OR the Lead ACC Consultant OR both AND Silver Command.

De-escalation will be communicated to the appropriate individuals by Silver Command via text message, email and telephone call.

A Hot De-Brief will be conducted in the Operations centre with attendance from Gold Command, Silver Command and Bronze Action Station Leads (see Appendix 5 – Hot De-Brief Agenda).

Bronze Action stations will conduct their own internal hot de-briefs.

8.0 Communication

8.1 Cascade

In the event that the FCP is activated, the Operations Centre will notify Switchboard who will begin the cascade to communicate the activation to appropriate individuals either through text message or direct to bleepholders.

Where possible, the Operations Centre will also text key individuals taking up Bronze, Silver or Gold action stations notifying them where and when to meet, with the expectation that all individuals will meet within 30 minutes of activation of the FCP.

Activation of the FCP will be communicated via the following message:

Full Capacity Plan at SITE is Activated Time / Date Prepare Bronze Action Stations and inform your teams. Gold, Silver and Bronze Leads only to attend FCP Activation meeting Time /

De-activation of the FCP will be communicated via the following message:

Full Capacity Plan at SITE is stood down Time / Date Inform your teams. Stand down FCP actions as soon as appropriate. Gold, Silver and Bronze Leads only to attend FCP Hot Debrief Time / Venue

Bronze Leads are responsible for cascading activation of the FCP to all appropriate individuals within their areas.

8.2 Activation Meeting

Upon establishment of the leadership team, Gold, Silver and the Lead for each Bronze Action Station individuals will meet as per communications provided by the Operations centre.

The agenda for the initial meeting is pre-set and is detailed in *Appendix 2 – FCP Activation Meeting*. It is acknowledged that these items are not definitive and that action during the activation of the FCP must be responsive to the particular circumstance.

The FCP activation meeting will supersede regular operational bed meetings for the period that the FCP is active or until Gold Command advise otherwise.

Throughout activation of the FCP specific communication lines must be adhered to:

- Gold Command and Silver Command will liaise closely with each other.

- Bronze Action Station individuals should escalate issues to their Bronze Action Station Lead.
- Bronze Action Station leads will liaise closely with Gold and Silver Command to escalate issues and to receive instruction / action.

It is important that whilst Command and Control is established these communication pathways are adhered to ensure that appropriate decisions are taken to de-escalate from FCP as quickly as possible.

8.3 Ongoing Trust-Wide Communications

The Operations Centre, under the direction of Silver Command, will be responsible for circulating, via email, ongoing bed, patient and flow information in response to the FCP meetings.

The Communications team and IT team, under the direction of Gold Command, will lead all generic trust-wide FCP communications and external communications. For example, during periods of FCP activation the on-call Clinical Systems and IT Managers will be contacted to go ensure the FCP screensaver goes live and other screensavers are disabled for the duration of the FCP.

9.0 Escalation at both RDH and QHB

In the event that there are high levels of escalation at both RDH and QHB the level of senior presence on site should be considered. Each of the divisions should report the senior representative for the RDH and QHB site for each working day to Silver Command. The expectation of the senior representative will be to provide presence at the individual sites managing operational pressures, attend operational bed meetings as required and support the surgical and medical bed managers when actions are required for escalation.

10.0 Monitoring Compliance and Effectiveness

During the activation of the FCP, bed, patient and flow numbers will be captured as per usual business. Notes from the FCP activation meeting will be logged and used to inform future practice regarding the FCP. Hot (end of shift or at de-escalation) and cold (within 7 days) debriefs should take place in relevant teams and departments with feedback provided to the Operations Team. Activation of the FCP will be regularly monitored and updates will be provided as required; particular focus will be on:

- Situational awareness
- Events leading up to activation of the FCP and whether further mitigating actions could have prevented it.
- What measures / indicators / triggers there were at the time and the appropriateness of the decision to activate the FCP.
- The effectiveness of Command and Control

- Definitive actions
- Whether the response provided met the spirit of the actions described in the FCP
- What impact the actions had
- Whether any improvements could be made
- What discretionary actions were taken, response, impact and improvements
- The rationale for decision-making throughout the activation of the FCP

11.0 Appendix 1- Action Cards

The below list of actions is not definitive and actions will need to be responsive to the triggers / pressures that have influenced escalation to the FCP. All actions taken should be detailed on the action log to record situational awareness, actions, response and the rationale for any decisions taken.

1a) Gold Command

Gold Command
Key Lines of Communication - Silver Command (to cascade coordination) - South Derbyshire Clinical Commissioning Group - External-to-Trust partners - Communications Team
Decision to activate the FCP
Communicate decision to escalate to Silver Command to begin cascade to Bronze Command and Trust-wide
Communication decision to escalate to Communications Team to begin preparation for internal and external communications.
Attend Operations Centre to establish Command and Control.
Chair FCP Activation Meeting and Ongoing FCP Operational Meetings
Initiate strategic coordination of Trust response
Notify CCG and other relevant external partners of decision to escalate to FCP and agree future liaison / communications.
Develop external communications plan
Risk assess longer term impact of FCP (i.e. including consideration of workforce rota)
Review need to request mutual aid
Maintain oversight of financial impact of incident
Decision to de-escalate
Support for capacity decisions in close conjunction with Silver Command
Chair FCP Hot and Cold De-briefs

1b) Silver Command

Silver Command
Key Lines of Communication - Bronze Action Station Leads (to cascade coordination)
Communication decision to all relevant individuals including Bronze Action Station Leads.

Communication to on-call Clinical Systems and IT Managers to support with Trust-wide screen saver communications.
Collate detailed information received from Bronze Command
Attend FCP Activation Meeting
Initiate tactical coordination of Trust response
Receive queries / items of escalation from Bronze Command
Communicate actions to Bronze Command as per FCP
Collate and provide intelligence received from Bronze to focus resource
Implement any additional actions under the direction of Gold Command
Maintain oversight of health and safety of staff
Communicate decision to de-escalate to all relevant individuals including Bronze Action Stations.
Attend overall FCP Hot and Cold De-briefs

1c) Bronze Action Stations

Bronze Command Lead
Key Lines of Communication - Silver Command (to escalate issues and receive action) - Other Bronze Command
Communication decision to escalate to FCP within divisions
Provide detailed information on status of local area to Silver Command
Attend FCP Activation Meeting
Communicate decision to cancel non-clinical activity and review clinical activity within area.
Determine location for Bronze Command to be based and communicate this to Silver Command Initiate operational coordination of Trust response
Implement FCP definitive actions and any discretionary actions as detailed in FCP or internal Bronze action station action plan, under the direction of Silver Command.
Provide information and escalate issues to Silver Command
Coordinate service adjustments and corresponding with specialty clinicians
Manage local health and safety of staff
Attend overall FCP Hot and Cold De-briefs
Conduct within-action-station Hot De-brief.

12.0 Appendix 2 – FCP Activation Meeting

Gold, Silver and Bronze Action stations will be expected to meet within the Operations centre within 30 minutes of escalation to the FCP. This will be communicated upon activation of the FCP as per section 5.2.

The initial meeting will be chaired by Gold Command and the agenda should include, but not be limited to, the following:

1.0	Register - Confirmation that escalation has been communicated and Gold, Silver, Bronze action stations are present.
2.0	Activation of FCP - Confirmation of reasons for escalation to FCP current status, clinical assessment of organisational pressure - Description of risk assessment of escalating to FCP (versus not) to include, assessment of the potential immediate and forthcoming consequences.
3.0	Forecast - Approximate forecast of length-of-time that FCP actions are likely to remain active
4.0	Gold, Silver, Bronze Command - Outline of the overall responsibility and remit of each level of command.
5.0	Communication - Confirmation of where Gold, Silver and Bronze action stations will be based Confirmation of communication methods between Gold, Silver and Bronze Command
6.0	Actions - Identification and delegation of actions as per FCP sections 5.3 and 5.4 - To include responsibility and timescales review effectiveness of actions at each meeting
7.0	Meetings - Confirmation of frequency and location of meetings at each level of Command
8.0	De-Escalation - Confirmation of at what point de-escalation is expected (i.e. what measures are intended to be used to determine this) and how it will be communicated to action stations.

13.0 Appendix 3 – Operating Procedure for Escalation Spaces

Operating protocol for opening treatment rooms to care for additional Inpatients.

Introduction:

The decision to create additional beds in treatment rooms is made when the Full Capacity plan is triggered. Please remember that the patients placed in Treatment rooms should not be patients direct from MAU or SAU– they should be existing patients on the ward who are deemed suitable

Preparing the Rooms:

Action	Person responsible
1. Walk around each ward to scope the rooms and discuss the plan with ward staff.	Bronze command
2. Ensure each room is cleared of items that are not to be used by the patient who will occupy the room eg patient records, stored items and posters that are not appropriate to display in a patient space. *If the room is normally used to treat patients (eg dressings or procedures) all efforts should be made to ensure it is satisfactory for inpatient use. * It is recognised that some items can continue to be stored in cupboards in the room in which case the cupboard must be locked	Nurse in charge of ward
3. Full capacity rooms do not require a clean before the patients are placed there as they are cleaned on a daily basis. Obviously if there is any are visibly dirty / soiled a clean should be requested via the domestic supervisor	Nurse in charge of ward and matron
4. The room should have the following items; o Qxygen and suction points and connectors/tubing ready for patient use o Call bell o Bed o Bed table, o Locker o Privacy screen o Chair for patient and/or relatives o Overhead light	Nurse in charge of ward
5. Treatment rooms must never be used to isolate patients for infection reasons and this includes patient admitted with 'loose stool, query cause'	Bronze command

During the patient stay in the Treatment:

Action	Person responsible
6. The patient should be assessed for suitability taking into consideration the size of the room and the patients wishes	Bronze command and Nurse in charge of ward
7. Good communication with the patient and their carer is essential. The patient should be given the Trust written information and also there should be verbal communication re the suitability of the room on a daily basis. See patient information below.	Nurse in charge of ward?Matron
8. All members of the MDT should be informed of the room change when they next visit the ward	Nurse in charge of ward
9. The matron should be informed as soon as possible if the patient or carer is unhappy being in the room, and alternative bed space found as soon as practically possible	Nurse in charge of ward
10. The treatment room is being used as a patient space and therefore, under no circumstances must the room be used for anything other than what will benefit that specific patient. There should be minimal disturbance of the patient by ensuring items that are regularly used are removed prior.	Nurse in charge of ward
11. The nurse staffing on the ward should be maintained at least at the planned level during the period the ward has an additional patient. There may be occasions when additional staff are required and this should be discussed with the Matron, or Senior Nurse for the Trust out of hours	Nurse in charge of ward
12. The treatment room will continue to be cleaned as per the ward schedule for cleaning patient spaces	Nurse in charge of ward
13. The room will be cleaned as per the normal bedspace schedule once the patient leaves the room and before another patient is place in the room	Nurse in charge of ward
14. The identity of the patients who are cared for in the rooms must be given to the Matron so that a record is kept and this returned daily to the Operations room	Nurse in charge of ward and matron

After De-Escalation:

Action	Person responsible
15. Rooms should have a deep clean, including hydrogen peroxide decontamination prior to reverting the room back to the original purpose. This will ensure any consumables / packaging as well as the room are fully decontaminated	Nurse in charge of ward
16. The normal equipment, including appropriate posters should be placed back in the room	Nurse in charge of ward
17. All of the additional equipment should be returned to a central area in the Trust.	Nurse in charge of ward

Patient and Carer information

Our hospitals are currently extremely busy and as a result, we are caring for some of our patients in additional rooms which have been adapted to provide a safe space where our medical and nursing staff can look after you.

The care and treatment you will receive from our nurses and doctors will be exactly the same as it would be in other areas of the ward/department. Regular checks will take place to monitor your condition throughout your stay. We aim to provide safe and compassionate care to all our patients, wherever they are receiving treatment in our hospitals.

You will only be cared for in this room until the numbers of patients in the Emergency Department has reduced.

If you have any questions whatsoever please do not hesitate to ask the nurse in charge of the ward. You can also ask to speak to the Matron. If you have any continuing concerns, please contact Jim Murray, Director of Nursing (Operations) University Hospitals of Derby and Burton NHS Foundation Trust Direct Dial – 01283 593293 or 01283 511511 Ext 3293

Thank you.

Cathy Winfield, Executive Chief Nurse and

Dr Magnus Harrison, Executive Medical Director

13.0 Appendix 4 – Endoscopy Unit SOP for QHB

Standard Operating Policy (SOP) for opening extra capacity in the Endoscopy Unit

Overnight Only - Operational Hours Sunday-Thursday 1900-0800

This SOP is for the use of all staff working within and involved in the setting up of the extra capacity in endoscopy.

The extra capacity should not be opened on a Friday or Saturday night. If the Trust escalates into the Full Capacity Plan the decision should be made at the nearest operational meeting, in conjunction with the senior management and executive team, to open the extra capacity in the endoscopy unit, as an extended discharge lounge. Out of hours this decision will be made by the Clinical site practitioners, in conjunction with the on call manager and Executive.

In the week the decision to open the endoscopy unit must be made before or at the 16:00 operational meeting. If the facility is to be opened on a Sunday evening this must also be decided before 16:00 by the clinical site practitioners and On Call Teams.

A maximum of 7 patients can be transferred to endoscopy extra capacity overnight. Eliminating Mixed Sex Accommodation policy should be adhered to at all times. All patients will be transferred to the discharge lounge at 0800 the following morning to await their transport, due to this only 2 patients can be bed bound. All patients will be nursed in bed overnight but need to be able to sit and transfer into chairs once in the discharge lounge.

Extra capacity folder to be kept within the endoscopy unit which details the SOP and templates.

Opening of the Endoscopy Unit for extra capacity overnight

Staff will be requested by the chair of the daily Operations meeting, Mon-Fri until 1700. OOH the On Call Team will request staff during the weekend and Bank holidays.

- Staff required- **2 Registered Nurses and 1 Health Care Worker**, of these staff a minimum of 1 of the registered Nurses must have a contract with the trust. Either permanent or on the Bank. **Working hours for endoscopy are 1900 until 0800**
- If staff booked are all agency it will be the responsibility of the Duty sister, with support from Senior Nursing teams, to arrange an appropriate swap. The ward providing the swap should be made aware
- Porters will be made aware of the need for beds by the Operation team, Mon-Fri until 1700. OOH the CSP's will inform the Porters.
- Medical and Surgical Leads will be asked to highlight patients suitable for transfer to endoscopy
- Medical/surgical leads to complete appendix 4 with patient details. This form is to then be kept in the ops room, in a folder called 'extra capacity'.
- At heightened levels of escalation if the medical/surgical leads are unable to provide names for transfer then the clinical teams will be asked to provide a second review
- Patients should be transferred to endoscopy with their beds and wards/areas back filled with beds sourced from other areas
- Beds should firstly be used from the basement and corridors, then discharge lounge. There are beds that can potentially be used from other clinical areas but only after discussion with nurse in charge. For example- paediatrics, maternity and oncology. Clinical site practitioners will be able to ultimately make the decision on where is clinically safest to move beds from.

- Wards with patients highlighted for transfer to endoscopy should ensure all discharge paper work is completed and TTO's ordered.
- If patient transferring to the community hospitals then it is the responsibility of the ward to provide handover to the community hospital staff prior to the patient moving to endoscopy
- Duty sister is responsible for meeting staff at endoscopy and ensuring staff know the area and have what they need for the night
- Duty sister will liaise with wards that have highlighted patients safe for transfer and ensure all discharge paperwork is completed and the patient is ready for transfer to the endoscopy from 19:00
- Switch board will be notified by the Ops team that the endoscopy is open overnight, for purposes such as relative enquiries, cardiac arrest calls and fire alarms
- Clinical Site Practitioners will inform Medical, Surgical and Emergency clinical teams at handover if extra capacity is open over night
- Staff working in the extra capacity area must complete a paper handover form, from the information provided from the transferring ward's verbal handover. This form must follow the patient to the discharge lounge.
- Staff within the endoscopy managing the patients must document within the care plans adding where the patient was transferred from
- Overnight endoscopy staff to update patient risk assessments

Criteria for the transfer of patients to the endoscopy overnight, for the purpose of extra capacity/extended discharge lounge

- Eliminating Mixed Sex Accommodation Policy guidelines must be adhered to
- Patients must be selected from the acute wards, ED and AAC
- Patients must be fit to be discharges the following day with a clear discharge plan in the notes
- TTO's must be written up in electronic prescribing
- The patient requires no clinical review prior to discharge
- The patient must fit the criteria for the discharge lounge
- The patient has no existing diarrhoea/vomiting
- The patient has no previous/existing C-Difficile
- Patients must be haemodynamically stable on observation charts
- All discharge information must be completed by the transferring ward
- Clear hand over of patients must be given from the ward to endoscopy staff
- If patient is transferring to the Community Hospital transferring ward must provide verbal handover to ward staff at the community hospital
- All patient belongings should be transferred with the patient to endoscopy
- Patient own medication, excluding CD's, should be transferred with the patient and kept behind a locked door within endoscopy, CD's should remain in the transferring wards CD cupboard and transferred to the discharge lounge by trained staff the following morning
- Patients nursed on Hi/Low beds should not be transferred to endoscopy
- Patients who currently have 1:1 care should not be transferred to endoscopy
- Patients with any level of cognitive impairment, where possible should not be transferred to endoscopy. Should this be necessary, justification must be documented.
- Patients who have fallen within the last 24 hrs should not be sent to endoscopy
- It is the transferring wards responsibility to explain why patients are being moved to endoscopy

14.0 Appendix 5 – Hot Debrief Agenda

1.0	Register - Confirmation that escalation has been communicated and Gold, Silver, Bronze action stations are present.
2.0	De-Activation of FCP Test - Confirmation of reasons for escalation to FCP i.e. triggers, pressure points, clinical assessment of organisational pressure Description of risk assessment of escalating to FCP (versus not) to include, assessment of the potential immediate and forthcoming consequences.
3.0	FCP Test Exercise:
3.1	FCP Test Exercise – Feedback of Positives: - Gold Command - Silver Command - Bronze Command - Loggists / Evaluators
3.2	FCP Test Exercise – Feedback of Improvements needed: - Gold Command - Silver Command - Bronze Command - Loggists / Evaluators
4.0	FCP Actions:
4.1	FCP Actions – Feedback of Positives: - Gold Command - Silver Command - Bronze Command - Loggists / Evaluators
4.2	FCP Actions – Feedback of Improvements needed - Gold Command - Silver Command - Bronze Command - Loggists / Evaluators
5.0	Confirmation of Future Report / Actions
6.0	Any Other Business