The Royal Wolverhampton NHS Trust

OP65
Capacity Management Policy

Contents

Appendices

Attachment

1.0 Policy Statement (Purpose / Objectives of the policy)

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

The Plan is set within the context of the national guidance for 'Operational Pressures Escalation Levels '(OPEL) Framework 31st October 2018 by NHS England. This document describes 4 levels of escalation for local health and social care systems, OPEL 1 (able to meet demand), 2 (starting to show signs of pressure), 3 (major pressures compromising patient flow) and 4 (organisations unable to deliver comprehensive care).

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

minimise risk and to retain a position where capacity outweighs demand ensuring the safe and effective utilisation of inpatient capacity.

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

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

The primary objective of this policy is to ensure that all staff in the Trust and key contacts outside the Trust understand their responsibilities and those of the Capacity Team in the effective utilisation of beds.

1.1 Purpose and Outcomes

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

- To ensure the safe and clinically appropriate placement of patients in line with infection prevention and same gender guidelines.
- To ensure patient flow through ED is maintained to reduce the risks

associated with overcrowding.
- To maintain ambulance handovers in a timely manner.
- Capacity will be utilised efficiently and effectively.
- Patient flow will be maintained, including efficient safe discharge.
- The opportunity to meet national standards for elective and non-elective care will be maximised.
- To maintain ambulance handover in a timely manner.
- To be flexible and respond to abnormal variations.

1.2 Policy Scope

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

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

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

- Paediatrics,
- Maternity
- Neonates
- ICCU

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

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

2.0 Definitions

Capacity Team: Controls and co-ordinates patient flow through RWT

ED: Emergency Department

EDD: Estimated date of discharge

Elective admission: Planned admission on a date agreed with the patient.

Emergency admission: Patient requires immediate admission.

EMS: Escalation Management Solution. A reporting system to the Regional Capacity Team which measures operational pressures and effectively coordinates patient flow throughout the health economy.

MFFD: Medically Fit for Discharge

OPEL: Operational Pressures Escalation Level

Teletracking: The electronic bed management system utilised by the Trust.

TOC: Transfer of Care form: referral for patients requiring ongoing support / care upon discharge from hospital

Trust: The Royal Wolverhampton NHS Trust

Urgent admission: Patient required admission within 24 hours.

WMAS: West Midlands Ambulance Service

3.0 Accountabilities

3.1 Chief Executive

The Chief Executive has overall responsibility for the strategic direction and operational management of the Trust and takes overall responsibility for this Policy. This responsibility is delegated to the Chief Operating officer.

3.2 Medical Directors

It is the responsibility of the Medical Director to oversee the monitoring and application of this policy, and to report as necessary to Trust Board, via Trust Management Team Meeting.

3.3 Clinical Directors

Clinical Directors are responsible for ensuring that Consultants within their directorates understand the policy and ensure that it is applied within their practice.

3.4 Directorate Management Teams

The Directorate Management Teams are responsible for implementing and communicating the Capacity Management policy in their directorate areas.

3.5 Matrons

Matrons are responsible for ensuring that all nursing staff within their remit complies with the Capacity Management Policy.

3.6 Line Manager [Ward / Departmental Manager]

The Line Manager is responsible for ensuring that all ward / departmental staff are aware of the Capacity Management Policy.

4.0 Policy Detail

4.1: Operational Management of Trust Capacity

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

4.1.1 The Capacity Team

The Capacity Team has the delegated authority to manage emergency and elective bed activity on behalf of the Chief Operating Officer and Trust Management Team. The only exception to this is for some Oncology and Haematology patients where the elective admission date is fixed due to sequential and timed treatments, this will remain the responsibility of the Clinicians within those areas; information will be given to the Capacity Team
The Capacity Team is responsible for the allocation of beds for all categories of admission utilising Teletracking.

Their aim is to accommodate patients onto the appropriate specialist ward whenever possible. When there is not a bed available on the specialist ward the next most appropriate bed will be allocated [taking into account the patient's clinical needs, nursing expertise required, and discussion with patient's Consultant].
The Trust's bed complement includes all specialist beds. The Capacity Team will have the authority to utilise all beds regardless of specialty (excluding ICCU, Paediatrics, Maternity and the designated elective admissions ward) if necessary to accommodate emergency admissions.
The Capacity Team are responsible for maintaining a live capacity status throughout the 24-hour period ensuring that the Teletracking system is kept updated.
It will be the responsibility of the nurse in charge of the respective wards to report any changes in bed situation utilising the Teletracking board; ensuring that pending and confirmed discharges of patients are identified on their wards board. The nurse in charge of the ward is also responsible for creating transfer requests for patients who require transfer to another ward / specialty via Teletracking.
Patients requiring admission from an outpatient setting must be referred to the Capacity Team for allocation of a bed in the most appropriate available ward. The urgency of the admission must be stated at the time a request for a bed is made.

4.1.2 Specialty Outliers

The Capacity Teams aim is to place the patient 'right place, right time' to the appropriate specialist ward. When there is not a bed available on the specialist ward the next most appropriate bed will be allocated [taking into account the patient's clinical needs, nursing skills and expertise required and with agreement by the Patients Consultant or On call Consultant / On call Registrar with delegated responsibility.

In order to ensure sufficient capacity for wards to take patients who require their speciality or when capacity is pressured within a specific speciality patients will be required to outlie to other speciality areas

Patients on medical wards will be assumed to be suitable to outlie to other speciality wards **unless** it documented in the patients medical notes that they are not clinically suitable.
When making an assessment of where patients identified to outlie will be placed the nursing skills and expertise of the outlying ward will be taken into consideration to ensure that they can safely meet the patients' needs.
The ongoing clinical management of medical outliers will be in accordance with the

twinned ward arrangement which is managed by the Divisional Medical Directors (Located on the Trust Internet>Departments >Medical and Emergency Services)

The decision for suitability to outlie patients from other areas will take place in accordance with the Trust Outlying Matrix (appendix 1) and the decision must be documented on the tool and placed in the patients notes.

The following speciality beds are ring fenced and should not be used as outlying capacity unless at full capacity and with agreement by the On Call Management Team:

- 2 x Cardiology PPI beds
- 2 x Stroke beds

The Capacity Team will complete a daily ward outliers list which will be distributed to the relevant Consultants by 0900 hours daily in order that outlying patients will be reviewed in a timely manner.

4.1.3 Overnight Transfers

Every effort will be made to minimise the movement of patients after 2000hours. The Capacity Team will collate data on the moves that have occurred and provide a report each night detailing the time and reasons patients were moved (appendix 2)

4.1.4 Transfers in and out of hospital

For routine transfers from other hospitals, patients must be referred to and accepted by the speciality Consultant before the Capacity Team accepts the referral. Transfers will only be accepted if a bed is available for the patient unless the patient is being repatriated from another country. If a transfer needs to happen on clinical grounds regardless of current Trust Capacity the accepting Consultant must liaise with the Capacity Team and/or Directorate Manager and Divisional Manager. Where a resolution cannot be found the Medical Director or in his absence the designated deputy will make the final decision.

It will be normal practice for transfers from another hospital's inpatient facility to go directly to the appropriate ward in accordance with infection prevention guidelines. Placement of patients from other Trusts or repatriations from abroad must be done in accordance with Infection Prevention guidelines.

4.1.5 Cancellation of elective surgical admissions on the day of surgery.

Please refer to Trust policy OP82: Prevention of Cancelled Operations on the day of surgery

4.1.6 Capacity Reports and Meetings

It will be the responsibility of the Capacity Team to compile a report of capacity across the Trust. This report will be completed and distributed at 06:00 and 18:00 hours daily. (appendices 3 & 4)

The Capacity Team will complete a mandatory report externally via the Escalation Management Solution (EMS) system to the Regional Capacity Team twice daily reporting the Adult and Paediatric Trust escalation but will be completed at any time to escalate or de-escalate the Trust status.
A capacity management meeting will be held daily Monday to Friday at 1000 for the Emergency and Medical Division and a Trust wide meeting will be held at 12:30 and 16:00 hours with the aim of supporting and maintaining patient flow through the hospital. The Trust capacity escalation status will determine whether any additional capacity meetings are required.
During the weekend and Bank Holidays one meeting will take place at 12:00 which will be led by the Trust On call Management Team. Escalation triggers will determine if there is a requirement for further meetings.

The objectives of the meetings are to:

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

4.3: Key Responsibilities and duties in the management of Trust Capacity (Attachment 1)

4.4 Trust Capacity Escalation

The escalation status of Trust capacity is categorised in accordance with the EMS which are referred to internally as escalation levels 1-4

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

- Available capacity within the ED department
- Ambulance turnaround times
- Available capacity within assessment areas
- Any major or critical capacity issues reported from any other department across the Trust
- The number of outliers across the Trust
- Critical care Capacity
- Number of patients who are MFFD

The full set of EMS indicators are attached as appendix 5

The Trust EMS Level feeds into the Operational Pressures Escalation Levels (OPEL) 1-4. The OPEL system categorises the capacity of the Wolverhampton

Health Economy as a whole following assessment of the pressures in all local health and social care providers including:

- Acute Services
- Paediatric Acute
- Community Services
- Walk-in Centre
- Social Care

The OPEL level categories are detailed as below table and will inform the response required.

OPEL 1 (GREEN)
Low levels of pressure. Relevant actions taken in response if deemed necessary. No support required from partners.
OPEL 2 (AMBER)
Moderate pressure with performance deterioration. Escalation actions taken in response with support required from partners.
OPEL 3 (RED)
Severe pressure with significant deterioration in performance and quality. Majority of escalation actions available are taken in response and increased support required from partners.
OPEL 4 (BLACK)
Extreme pressure with risk of service failure. All available escalation actions taken and potentially exhausted. Extensive support and intervention required.

Actions required by each sector of the Wolverhampton health economy to reduce the OPEL level to the lowest level of escalation possible are detailed in attachment 2 :Mitigating Actions at Each OPEL Level.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy requires additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

The screening checklist has been completed. Reasonable efforts have been made to eliminate any possible Equality and Diversity discrimination occurring.

An equality analysis has been carried out and it indicates that:

Tick	Options
X	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include:

7.0 Maintenance

This policy will be the responsibility of the Matron Capacity and Patient Flow. It will be reviewed in line with Trust Policy OP01 every 3 years or following any significant changes to the way Trust Capacity is managed.

8.0 Communication and Training

- An electronic copy of this policy will be available on the trust intranet
- All staff will be notified of a new or renewed procedure
- Patient flow management will form part of the induction programme of all staff
- The document will be included in the Royal Wolverhampton NHS Trust publication scheme in compliance with the Freedom of Information Act 2000.

9.0 Audit Process

Responsibility for the monitoring of effective use of the policy and supporting protocols lies with the Matron Capacity and Patient Flow who will provide a report back to the Division.

Criterion	Lead	Monitoring method	Frequency	Committee
Audit of non-elective flow data	COO	Monitored via Divisional Leads	Monthly	Non-Elective Flow Improvement Group (NEFIG)

10.0 References - Legal, professional or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

All references to appendices and attachments within the body of the document must be highlighted in blue and all hyperlinks inserted.

- Acute medical care: The right person, in the right setting – first time – Royal College of Physicians 2007.
- Improving Patient Flow: Evidence to help local decision makers: Department of Health 2015
- Wolverhampton Health Economy Escalation/Surge Plan 2019-2020
- OPEL Framework: 6th December 2018 NHS England
- The Hospital Discharge Service Policy and Operating Model 2020 NHS England

Part A - Document Control

<table>
<tr><td>Policy number and Policy version:

OP65 V.6.0 June 2023</td><td colspan="2">Policy Title:

Capacity Management Policy</td><td colspan="2">Status:

Final</td><td>Author: Matron for Capacity & Patient Flow

Chief Officer Sponsor: Chief Operating Officer</td></tr>
<tr><td rowspan="7">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td colspan="2">Reason</td></tr>
<tr><td>V1</td><td>August 2006</td><td>Capacity Manager</td><td colspan="2">Policy Creation</td></tr>
<tr><td>V2</td><td>October 2009</td><td>Capacity Manager</td><td colspan="2">Review and amendment</td></tr>
<tr><td>V3</td><td>October 2012</td><td>Capacity Manager</td><td colspan="2">Review</td></tr>
<tr><td>V4</td><td>May 2018</td><td>Integrated Health & Social Care Manager</td><td colspan="2">Review and update of Content</td></tr>
<tr><td>V5</td><td>August 2019</td><td>Integrated Health & Social Care Manager</td><td colspan="2">Review and update of Content</td></tr>
<tr><td>V6</td><td>August 2023</td><td>Integrated Health & Social Care Manager</td><td colspan="2">Review and update of content</td></tr>
<tr><td colspan="6">Intended Recipients: All Staff</td></tr>
<tr><td colspan="6">Consultation Group / Role Titles and Date: Divisional Management Teams, Executive Director, Policy Review Group, Chairs for approving Committees</td></tr>
<tr><td colspan="3">Name and date of Trust level group where reviewed</td><td colspan="3">Trust Policy Group August 2023</td></tr>
<tr><td colspan="3">Name and date of final approval committee</td><td colspan="3">Trust Management Committee September 2023</td></tr>
<tr><td colspan="3">Date of Policy issue</td><td colspan="3">September 2023</td></tr>
<tr><td colspan="3">Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)</td><td colspan="3">August 2026 - 3 yearly</td></tr>
<tr><td colspan="6">Training and Dissemination: Trust Intranet</td></tr>
</table>

To be read in conjunction with: 1. 12 Hour Breach Escalation Standard Operating Procedure 2. Teletracking user guide 3. Black Country Inter Hospital Transfer Concordat 2017 4. OP82: Prevention of Cancelled Operations on the Day of Surgery/Admission/Treatment 5. CP05: Transfer of Patients between wards, departments, specialist units and other hospitals. 6. CP04 Discharge Policy 7. OP81 Same Sex (Gender Accommodation Policy) 8. SOP 28: Discharge Lounge
Initial Equality Impact Assessment (all policies): Completed Yes **Full Equality Impact assessment (as required): Completed No**

Monitoring arrangements and Committee	Policy Group and the Trust Management Committee
Document summary/key issues covered. Management of Trust Capacity and patient flow	
Key words for intranet searching purposes	OP65 Capacity

NHS
The Royal Wolverhampton
NHS Trust

Patients Suitability to Outlie in next 24 hours

(Suitability to be assessed by Consultant, Registrar or Matron)

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Signature: .....

Designation: .....

Stamp:

Date: .....Time: .....

Suitable

- Confirmed EDD on Teletracking
- Patient has a confirmed discharge plan
- Medically fit for discharge awaiting social care package/placement and D2A completed
- Views of 4 or less, stable for past 48 hours
- Clinically stable patient awaiting INR stabilisation
- Patients receiving long term IV Therapy awaiting capacity availability by OPAT / Hospital at Home to continue therapy in the community

Unsuitable

- 2 or more moves of ward (excluding AMU / SEU)
- Dementia
- Pts undergoing assisted withdrawal from alcohol
- High risk of suicide / Adult Mental health
- Acute Confused State ECS >7
- Unstable fractures
- Spinal injuries
- Requires specialist care in own specialty unless agreed by consultant
- Intercostal chest drain (other than to CTW, or respiratory ward)
- DKA acute phase
- Ongoing major complaint
- Major abdominal wounds
- In need of specialist airway management
- Views score of greater than 4 (other than COPD patients)
- Patient with infectious symptoms of unknown origin
- Patients receiving EOL care.
- Patients with a transmissible infection in the red sections on the IP Isolation Matrix

Checklist:

Consultant Aware of Transfer ☐

Patient Aware of Transfer ☐

Relatives / Carers Aware of Transfer ☐

Recorded on Teletracking ☐

Suitable to outlie to:

Surgical Ward ☐ T&O Ward ☐ Heart & Lung Centre ☐ Other Base Ward ☐

Final nurse check immediately prior to outlying transfer that the above has been completed

Signature: ..... Designation: ..... Stamp: Date: .....

Patient Transfers after 20:00 Hours

Non-clinical reasons for transfer after 2000hours

1. **Awaiting Clerking/Post Take**
2. **Capacity/Non Clinical**
3. **Outlying of patients to create capacity** to facilitate flow in emergency portal (This should only be used in exceptional circumstances – e.g. E.D full no capacity ,unable to offload ambulances)
4. **Delay in transferring ward giving patient handover**
5. **Delay in receiving ward taking patient handover**
6. **Portering delay**

Clinical reasons for transfer after 2000hours

7. **Clinical Need** (This is a move to a ward which meets patient's specific clinical needs or to deliver specialist clinical care e.g. NIV patient, transfer to ICCU, cardiology)
8. **Infection Prevention** (such as patient requires Side Room, or waiting HPV)

Gender	Time	Transferred from	Transferred to	Time of Bed Allocation	Time of handover	Time porters Booked	Code and reason 1	Code and reason 2

DETAILED BED STATUS REPORT

Date:

Time:

WARD	Empty	Confirmed	Pending	Blocked
C15 (21)				
C16 (28)				
C17 (16)				
C18 (23)				
C19 (23)				
C14 (26)				
C26 (26)				
C22 (20)				
C24 (28)				
C25 (28)				
C41 (27)				
A8 (28)				
C39 (18)				
Deansley (17)				
CHU (22)				
C21Stroke (39)				Primary =
AMU (49)				
Total Medical	**0**	**0**	**0**	**0**
B8 CTW (31)	Number on ward			
B14 (42)				Primary =
B9 ICCU				
D7 (30)	Number on ward			

WARD	Empty	Confirmed	Pending	Blocked
A12 (25)				
A14 (25)				
B7 (16)				
SEU (37)				
TOTAL SURGICAL	**0**	**0**	**0**	**0**
A5 (27)				
A6 (27)				
TOTAL ORTHO	**0**	**0**	**0**	**0**
A21 (26)				
PAU (14)				
WEST PARK/CANNOCK				
WARD 1 (21)				
WARD 2 (23)				
NRU (10)				
FAIR OAK (27)				

TOTAL

Empty	Confirmed	Pending	Blocked
0	**0**	**0**	**0**

06:00 Bed State Report

Report Information	
Date	
Time	
Manager On Call	

Last 24 Hours	
Number of ED Attendances past 24 hours	
Number Redirected to UTC	
Number of 4 hour Breaches	
% Compliance (4 Hour Target)	
Number of admissions via ED	
Admission Rate (%)	

Current ED Situation	
Escalation Level	3
Number of 4 Breaches today	
Total no of patients in ED (Including SDEC)	
Total no of patients in SDEC	
No. of patients through ED	
No of patients admitted today	
Current Admission Rate	

Area Breakdown				
	Medicine	Surgery	Ortho	Paediatrics
Requests from other Departments				
ED requests				
GP (referred but not arrived)				
STAR - 4014 (no. of patients in clinic)				
Total to come in + TCI				
Total Beds (Confirmed)				
Potential Beds (Unconfirmed)				
Worst Scenario				
Best Scenario				

Total other beds available across Trust	
	0

EMS Triggers - Acute

	Level 1 - Planned Operational Working		Level 2 - Moderate Pressure		Level 3 - Severe Pressure		Level 4 - Extreme Pressure	
	Acute		Acute		Acute		Acute	
4hr A&E Performance Target	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.
Ambulance Handovers within 15 minutes	2	Mean time of transfer for Ambulance patient care is shorter than 15 minutes.	2	Mean time of transfer for Ambulance patient care is between 15 and 30 minutes.	2	Mean time of transfer for Ambulance patient care is between 31 and 60 minutes.	2	Mean time of transfer for Ambulance patient care is longer than 60 minutes.
Time to Initial Assessment – percentage within 15 minutes	3	More than 95% of patients received initial assessment within 15 minutes	3	80% - 95% of patients received initial assessment within 15 minutes	3	50% - 79% of patients received initial assessment within 15 minutes	3	Less than 50% of patients received initial assessment within 15 minutes
Average (mean) time in Department	4	Mean time in department is below 4 hours	4	Mean time in department is between 4 hours and 8 hours	4	Mean time in department is between 8 hours and 12 hours	4	Mean time in department more than 12 hours
Patients spending more than 12 hours in A&E	5	No Patients at risk of waiting 12 hours or more from time of arrival	5	Risk of one or more patients waiting 12 hours or more in the next 2 hours from time of arrival	5	One or more patients now waiting longer than 12 hours from time of arrival but plan in place to resolve.	5	One or more patients now waiting longer than 12 hours from time of arrival and no plan in place to resolve.
Resuscitation Bays	6	More than 1 resuscitation bay available for immediate use.	6	Only 1 resuscitation bay available for immediate use.	6	No formal resuscitation bay available in A&E for the next 30 minutes.	6	No formal resuscitation bay available in A&E for next hour.
Cubicles in A&E	7	Cubicles in A&E are less than 80% occupied.	7	Cubicles in A&E are 80% -100% occupied.	7	All Cubicles in A&E are full and patients are waiting in planned overflow areas.	7	All Cubicles in A&E are full and patients are expected to wait in unplanned overflow areas.
DTA in department	8	20% or less of patients in ED have a DTA and are awaiting a bed	8	Between 21% and 35% of patients in ED have a DTA and are awaiting a bed	8	Between 36% and 45% of patients in ED have a DTA and are awaiting a bed	8	More than 45% of patients in ED have a DTA and are awaiting a bed
Expected capacity vs expected demand	9	Expected capacity greater than expected demand for the next 24 hours.	9	There is an expected capacity deficit of less than 10% of expected demand for the next 24 hours.	9	There is an expected capacity deficit of between 10% and 20% of expected demand for the next 24 hours.	9	There is an expected capacity deficit of more than 20% of expected demand for the next 24 hours.
Elective Work	10	Elective work proceeding as planned.	10	Elective and urgent inpatient work cancelled for the next 24 hours.	10	Elective and urgent inpatient work cancelled for the next 48 hours.	10	Elective and urgent inpatient work cancelled for the next 72 hours.
Beds in Assessment Areas	11	Beds in Assessment Areas are less than 90% occupied.	11	Beds in Assessment Areas are 90%-99% occupied.	11	No Assessment area beds for up to 3 hours minimum.	11	No Assessment area beds for more than 3 hours.
Medical Outliers	12	Medical outliers form less than 0.5% of total inpatient population.	12	Medical outliers form between 0.5% and 1% of total inpatient population.	12	Medical outliers form between more than 1% and 3% of total inpatient population.	12	Medical outliers form more than 3% of total inpatient population.
Critical Care Capacity	13	Critical care capacity less than 80% occupied.	13	Critical care capacity is 80%-100% occupied.	13	All formal critical care capacity occupied and planned overflow areas in use.	13	All formal critical care capacity occupied and planned overflow areas in use. Potential transfers identified but unresolved.
G&A Bed occupancy (%)	14	G&A bed occupancy is 87% or below	14	G&A bed occupancy is between 88%-91%	14	G&A bed occupancy is between 92%-99%	14	G&A bed occupancy is above 100%
Planned Additional Bed Capacity	15	Planned additional bed capacity on standby.	15	Planned additional bed capacity open and less than 80% occupied.	15	Planned additional bed capacity open and more than 80% occupied.	15	All planned additional bed capacity open and full; unplanned capacity in use.
Infection Prevention and Control	16	No loss of admission bed capacity due to infection control measures.	16	Between 1 - 3% closed to admission or discharge due to infection control measures.	16	Between 4% and 10% closed to admission or discharge due to infection control measures.	16	More than 10% closed to admission or discharge due to infection control measures.
Staffing	17	Planned staffing levels in place.	17	Actual staffing levels at more than 90% of planned staffing.	17	Actual staffing levels at 80-90% of planned staffing.	17	Actual staffing levels at less than 80% of planned staffing.
Patients not meeting criteria to reside	18	Patients not meeting criteria to reside form less than 9% of the inpatient total.	18	Patients not meeting criteria to reside form between 9% and less than 11% of the inpatient total.	18	Patients not meeting criteria to reside form between 11% and 13% of the inpatient total.	18	Patients not meeting criteria to reside form more than 13% of the inpatient total.

Regional Capacity Management Team
T: 0121 612 1727 / 1733
E: RCMT@nhs.net
Website: https://emsplus.nhs.uk

EMS Triggers

EMS+ Acute Paediatric Triggers

		Level 1 - Planned Operational Working	Level 2 - Moderate Pressure	Level 3 - Severe Pressure	Level 4 - Extreme Pressure
1	Ambulance Handovers within 15 minutes	Mean time of transfer for Ambulance patient care is shorter than 15 minutes.	Mean time of transfer for Ambulance patient care is between 15 and 30 minutes.	Mean time of transfer for Ambulance patient care is between 31 and 60 minutes.	Mean time of transfer for Ambulance patient care is longer than 60 minutes.
2	Time to Initial Assessment – percentage within 15 minutes	More than 95% of patients received initial assessment within 15 minutes	80% - 95% of patients received initial assessment within 15 minutes	50% - 79% of patients received initial assessment within 15 minutes	Less than 50% of patients received initial assessment within 15 minutes
3	Average (mean) time in Department	Mean time in department is below 4 hours	Mean time in department is between 4 hours and 8 hours	Mean time in department is between 8 hours and 12 hours	Mean time in department more than 12 hours
4	Patients spending more than 12 hours in A&E	No Patients at risk of waiting 12 hours or more from time of arrival	Risk of one or more patients waiting 12 hours or more in the next 2 hours from time of arrival	One or more patients now waiting longer than 12 hours from time of arrival but plan in place to resolve	One or more patients now waiting longer than 12 hours from time of arrival and no plan in place to resolve.
5	4hr A&E Performance Target	ED target of 95% being maintained	ED target is beteen 94% -90% with breaches occurring	ED target is <90% with breaches occuring.	ED target is <70% with breaches occuring.
6	Cubicles in A&E	Cubicles in A&E are less than 80% occupied.	Cubicles in A&E are 80% -100% occupied.	All Cubicles in A&E are full and patients are waiting in planned overflow areas	All Cubicles in A&E are full and patients are expected to wait in unplanned overflow areas.
7	Trolley Waits	No trolley waits over 4 hours	Trolley waits over 4 hours occurring, with a plan in place	Trolley waits over 4 hours occurring, with no plan in place and at risk of 12 hours	12 hour trolley waits are imminent or have occurred
8	Resuscitation Bays	More than one resuscitation bays available	Only one resuscitation bay available	No resuscitation bays available at present, and likely to become available in 2 hours	No resuscitation bays available at present, and unlikely to become available for over 2 hours
9	DTA in department	10% or less of patients in ED have a DTA and are awaiting a bed	10% or more of patients in ED have a DTA and are awaiting a bed	20% or more of patients in ED have a DTA and are awaiting a bed	40% or more of patients in ED have a DTA and are awaiting a bed
10	G&A Bed occupancy (%)	G&A bed occupancy is 80% or below	G&A bed occupancy is 85% or above	G&A bed occupancy is 90% or above	G&A bed occupancy is 95% or above
11	Capacity Deficit	Capacity Deficit - Mild	Capacity Deficit - Moderate with plan in place	Capacity Deficit - Moderate with no plan in place	Capacity Deficit - Severe
12	PICU	PICU has capacity to accept	PICU has no capacity and flow issues, but with future issues expected	PICU has some capacity and flow issues	PICU cannot discharge, cannot accept in house emergency or elective activity.
13	Staffing	Staffing is adequate for acuity and capacity	Staffing pressure with potential impact on patient safety with a plan	Staffing pressure with potential impact on patient safety with no plan	No capacity, no flow, staffing pressure will impact on patient care. All plans exhausted
14	Referrals	All tertiary referrals have a plan to admit	Tertiary referral without a plan to admit occurring	More than 1 Tertiary referral without a plan to admit occurring	More than 4 Tertiary referrals without a plan to admit occurring
15	Medical Outliers	Medical outliers form less than 2% of total inpatient population.	Medical outliers form between 2% and 4% of total inpatient population	Medical outliers form between more than 4% and 8% of total inpatient population.	Medical outliers form more than 8% of total inpatient population.
16	Elective Work	Elective lists proceeding as scheduled	Elective lists under review - potential for cancellations	Cancellation of elective lists, urgent electives under review	Cancellation of urgent electives
17	Infection Prevention and Control	No loss of admission bed capacity due to infection control measures.	Between 1 - 3% closed to admission or discharge due to infection control measures.	Between 4% and 10% closed to admission or discharge due to infection control measures.	More than 10% closed to admission or discharge due to infection control measures.

EMS Triggers

EMS+ Paediatric UnitTriggers

		Level 1 - Planned Operational Working	Level 2 - Moderate Pressure	Level 3 - Severe Pressure	Level 4 - Extreme Pressure
1	4hr A&E Performance Target	No paediatric patients waiting longer than 4 hours	A risk of paediatric patients waiting longer than 4 hours in ED.	One paediatric patient waiting longer than 4 hours in ED.	More than one paediatric patient waiting longer than 4 hours in ED.
2	Time to Initial Assessment - Percentage Within 15 Minutes	More than 95% of patients received initial assessment within 15 minutes	80% - 95% of patients received initial assessment within 15 minutes	50% - 79% of patients received initial assessment within 15 minutes	Less than 50% of patients received initial assessment within 15 minutes
3	Average (mean) time in Department	Mean time in department is below 4 hours	Mean time in department is between 4 hours and 8 hours (inclusive)	Mean time in department is greater than 8 hours and up to 12 hours (inclusive)	Mean time in department more than 12 hours
4	Mean time in department more than 12 hours	Mean time in department more than 12 hours	Mean time in department more than 12 hours	Mean time in department more than 12 hours	No spare capacity in assessment areas, and is unlikely to be available for over 2 hours.
5	DTAs in Department	20% or less of patients in ED have a DTA and are awaiting a bed	Between 21% and 35% of patients in ED have a DTA and are awaiting a bed	Between 36% and 45% of patients in ED have a DTA and are awaiting a bed	More than 45% of patients in ED have a DTA and are awaiting a bed
6	Capacity Deficit	Capacity Deficit (inpatient beds) - Mild	Capacity Deficit (inpatient beds) - Moderate with plan in place	Capacity Deficit -(inpatient beds) - Moderate with no plan in place	Capacity Deficit (inpatient beds) - Severe
7	Direct Referrals	No new or outstanding direct referral. No impact	Minimal direct referrals requiring assessment and action	Moderate direct referrals requiring assessment and action.	Maximum number of direct referrals requiring assessment and action. High impact.
8	Specialist Beds/Intensive Care Support	No issues in waiting for specialist beds/intensive care support.	Potential issues in waiting for either specialist beds or intensive care support in the next few hours.	1 or more patient waiting 24 hours for a specialist bed or waiting 2 hours for intensive care support.	1 or more patient waiting 48 hours for a specialist bed or waiting 4 hours for intensive care support.
9	Repatriations	No current issues with repatriations.	There is a plan to repatriate within 24 hours.	There is a plan to repatriate within 48 hours.	There is no plan to repatriate a patient in the next few days.
10	Infection Prevention & Control	No loss of admission bed capacity due to infection control measures.	Between 1% and 3% beds closed to admission or discharge due to infection control measures.	Between 4% and 10% (inclusive) closed to admission or discharge due to infection control measures.	Greater than 10% closed to admission or discharge due to infection control measures.
11	Staffing	Staffing is adequate for acuity and capacity (i.e. NQB 10 expectations).	Staffing pressure with potential impact on patient safety with a plan.	Staffing pressure with potential impact on patient safety with no plan.	No capacity, no flow, staffing pressure will impact on patient care. All plans exhausted.

EMS Triggers - Hospital Social Care

	Level 1 - Planned Operational Working		Level 2 - Moderate Pressure		Level 3 - Severe Pressure		Level 4 - Extreme Pressure	
	Social Care (Community Teams)		Social Care (Community Teams)		Social Care (Community Teams)		Social Care (Community Teams)	
Staffing	1	Planned staffing levels for the day available		Less than 80% of planned staffing levels for the day available		Less than 60% of planned staffing levels for the day available		Less than 40% of planned staffing levels for the day available
Skill Mix	2	No issues with skill mix to meet service requirements	2	Skill mix appropriate against service specification	2	Skill mix tolerable against service specification	2	Skill mix inappropriate against service specification
Caseload	3	Incoming workload at planned levels	3	Up to 10% above normal team caseload levels	3	10 to 30% above normal team caseload levels	3	More than 30% above normal team caseload levels
Completion of Assessments	4	More than 90% of assessments completed within 48 hours of discharge notification being received		70% - 90% of assessments completed within 48 hours of discharge notification being received		50% - 70% of assessments completed within 48 hours of discharge notification being received		Less than 50% of assessments completed within 48 hours of discharge notification being received
External Service Impact	5	No external services resulting in delayed dicharges .	5	External service impact causing delays of up to 48 hours	5	External service impact causing delays of up to 48 - 72 hours	5	External service impact causing delays over 72 hours
Environmental Factors	6	No Impact on planned work	6	Short term disruption expected for up to 24 hours	6	Medium term disruption expected for between 24 to 48 hours	6	Long term disruption expected for longer than 48 hours

Regional Capacity Management Team
T: 0121 612 1727 / 1733
E: RCMT@nhs.net
Website: https://emsplus.nhs.uk

EMS Triggers

EMS Triggers - Urgent care Centres/Minor Injury Units/Walking Centre

Trigger Title	Level 1 - Planned Operational Working		Level 2 - Moderate Pressure		Level 3 - Severe Pressure		Level 4 - Extreme Pressure	
Staffing / Skill mix	1	Service specification staffing levels in place. No issues with skill mix	1	Staffing levels at > 80% of service specification levels. Skill mix appropriate	1	Staffing levels between 70 - 80% of service specification levels. Skill mix tolerable	1	Staffing levels at < 70% of service specification levels. Skill mix intolerable
Ability to triage within timeframe	2	Capacity to triage patients in a timely fashion (within 15 minutes or less of arrival)	2	Capacity to triage patients within 15 - 30 minutes of arrival	2	Capacity to triage patients within 30 - 45 minutes of arrival	2	Capacity to triage patients above > 45 minutes of arrival
Wait to be Seen Time	3	Wait to be seen time is < 1 hour	3	Wait to be seen time is between 1 - 1.5 hours	3	Wait to be seen time is between 1.5 - 2 hours	3	Wait to be seen time of > 2 hours
Treat & Discharge Time	4	Time to treat and discharge any patient is < 2 hours	4	Time to treat and discharge any patient is between 2 - 3 hours	4	Time to treat and discharge any patient is between 3 - 4 hours	4	Time to treat and discharge any patient is > 4 hours
Capacity Vs Demand	5	Attendances within expected levels with appointment availability to meet demand	5	10% increase in patient presentations against forecasted hourly activity	5	>20% increase in patient presentations. Enlist additional resource to meet increase in demand	5	Inability to see all patients within operational hours. Patients now being advised of alternative care pathways
Incoming Referrals (from alternative pathways / other sources)	6	No new or outstanding UEC referrals from alternative pathways requiring action. No impact	6	Up to 1 hour of clinical appointment time allocated to UEC referral assessment and action	6	Up to 2 hours of clinical appointment time allocated to UEC referral assessment and action	6	> 4 hours of clinical appointment time allocated to UEC referral assessment and action
Patients awaiting transfer via Ambulance	7	There are no patients awaiting transfer via ambulance to an alternative provider	7	There is 1 or more patients awaiting transport via ambulance to an alternative provider	7	There are 2 or more patients awaiting transfer via ambulance to an alternative provider, with a response time of > 30mins	7	There are 2 or more patients awaiting transfer via ambulance to an alternative provider, with a response time of > 60mins

Regional Capacity Management Team
T: 0121 612 1727 / 1733
E: RCMT@nhs.net
Website: https://emsplus.nhs.uk

EMS Triggers - Community Services

West Midlands

	Level 1 - Planned Operational Working Community Services		Level 2 - Moderate Pressure Community Services		Level 3 - Severe Pressure Community Services		Level 4 - Extreme Pressure Community Services	
Staffing (against service specification)	1	Service spec staffing levels in place. No issues with skill mix.	1	Staffing levels at > 90% of service specification levels. Skill Mix appropriate	1	Staffing levels at 80 - 90 % of service specification levels. Skill Mix tolerable	1	Staffing levels at < 80% of service specification levels. Skill Mix inappropriate
Expected Capacity versus Expected Demand	2	Expected capacity greater than or equal to expected demand for the next 24 hours	2	There is an expected capacity deficit of less than 10% of expected demand for the next 24 hours	2	There is an expected capacity deficit of 10-20% of expected demand for the next 24 hours	2	There is an expected capacity deficit of greater than 20% of expected demand for the next 24 hours
Response	3	Able to respond to scheduled work and referrals within service standard	3	Scheduled care being delivered with delays. Urgent care unaffected	3	All patients (including urgent and scheduled) being prioritised to meet demand	3	Emergency visits only. Business Continuity Plan Enacted
Non-Direct Patient Care	4	Able to deliver all usual non direct patient care activity	4	Delays to non direct patient care within standard working hours	4	Non-direct patient care taking place outside of standard working hours	4	Only able to deliver direct clinical care and working outside of standard working hours
Environmental Factors	5	No impact on planned work	5	Short term dispruption expected <24hrs	5	Medium term disruption expected. > 24 hours < 48hrs	5	Long term disruption expected. > 48 hours

Regional Capacity Management Team
T: 0121 612 1727 / 1733
E: RCMT@nhs.net
Website: https://emsplus.nhs.uk

EMS Triggers

EMS Triggers - Ambulance

	Level 1 - Planned Operational Working		Level 2 - Moderate Pressure		Level 3 - Severe Pressure		Level 4 - Extreme Pressure	
	Ambulance		Ambulance		Ambulance		Ambulance	
Call Pick Up	1	Calls answered (mean) < 5 seconds & or 95th percentile < 5 seconds	1	Calls answered (mean) > 20 seconds & or 95th percentile > 40 seconds	1	Calls answered (mean) > 40 seconds & or 95th percentile > 60 seconds	1	Calls answered (mean) > 60 seconds & or 95th percentile > 120 seconds
Catagory 1 Response	2	Catagory 1 response: mean = <7 mins and/or 90th Percentile = <15 mins	2	Category 1 response Mean = 7 -10mins and/or 90th Percentile = 15 -20 mins	2	Category 1 response Mean = 10-15 mins and/or 90th Percentile = 20-25 mins	2	Category 1 response Mean = >15 mins and/or 90th Percentile = >25 mins
Category 2 Response	3	Category 2 response: mean = <18 mins and/or 90th Percentile = <40 mins	3	Category 2 response Mean = 18 -24 mins and/or 90th Percentile = 40 -50 mins	3	Category 3 response Mean = 25-29 mins and/or 90th Percentile = 50-59 mins	3	Category 3 response Mean = >30 mins and/or 90th Percentile = >60 mins
Category 3 Response	4	Category 3 response: mean = <60 mins and/or 90th Percentile = <120 mins	4	Category 3 response Mean = 60 -70 mins and/or 90th Percentile = 120-130 mins	4	Category 2 response Mean = 71-80 mins and/or 90th Percentile = 131-140 mins	4	Category 2 response Mean = >80 mins and/or 90th Percentile = >140 mins
REAP	5	Reporting REAP level 1	5	Reporting REAP level 2	5	Reporting REAP level 3	5	Reporting REAP level 4
Surge. Level	6	Reporting Surge. Level 1	6	Reporting Surge. Level 2	6	Reporting Surge. Level 3	6	Reporting Surge. Level 4
Calls Awaiting Dispatch	7	Calls awaiting dispatch against resources on duty < 33%	7	Calls awaiting dispatch against resources on duty between 34% & 66%	7	Calls awaiting dispatch against resources on duty between 67% - 100%	7	Calls awaiting dispatch against resources on duty > 100%
Handover Time	8	Average arrival to handover time in the last 12hrs within 30 mins > than 95%	8	Average arrival to handover time in the last 12hrs within 30 mins between 71% - 94%	8	Average arrival to handover time in the last 12hrs within 30 mins between 61% - 70%	8	Average arrival to handover time in the last 12hrs within 30 mins less than 60%
Ambulances at Hospital	9	<20% of actual resources at Hospital awaiting to handover	9	21% - 35% of actual resources at Hospital awaiting to handover	9	36% - 50% of actual resources at Hospital awaiting to handover	9	> 50% of actual resources at Hospital awaiting to handover

Regional Capacity Management Team
T: 0121 612 1727 / 1733
E: RCMT@nhs.net
Website: https://emsplus.nhs.uk

12 Hour Breach Escalation Guide

Developed: August 2014 Last Reviewed April 2023 (Matron Capacity & Patient Flow)

Access to the following is required:

- Access to the Capacity Team Drive: W:\Division 2\Capacity & Planning Mgmt\Capacity Team
- Access to the Capacity Team communal email address: rwh-tr.CapacityTeam@nhs.net
- Access to the Patient First MMS System: "C:\Program Files\MSS\PF\PF_Menu.exe"
- Access to the A&E Screen

It is mandatory for the Trust to report all 12-hour breaches post DTA in ED to the Integrated Care Board (ICB)

Definition of 12-hour breach: 12 hours from decision to admit (DTA)
The breach is attributable to the date the patient arrived in ED

The decision to admit (DTA) time must be clearly stated on the MSS system. If it is not clearly stated then communicate with ED to ensure a DTA has been agreed.

Escalation process:

- In hours if a patient is between 10-11 hours from DTA to admit with no plan please contact the Directorate Management Team for ED and then contact the Divisional Management Team for whom that patient's speciality falls.

- Out of hours inform the on-call manager each time a 12-hour breach is expected to occur unless prior discussions and agreement has taken place regarding frequency of escalation. The on-call manager will then contact the on-call Director. The on call Director will inform the ICB

  1 hourly update must be given to the on-call manager with an action plan on how we are trying to resolve the issue unless prior discussions and agreement has taken place regarding frequency of escalation .This must continue until the situation is resolved

- This must be repeated for each individual breach

12 Hour Breach Report Completion and Submission

The Patient Flow Manager must complete the 12-hour breach escalation spread sheet whenever a 12-hour breach has occurred. (The spread sheet is kept on the Capacity drive)

Each 12-hour breach that has occurred within the 24 hour period must be detailed individually on the spread sheet. **NB**. The record will be read by external colleagues, please ensure all information is relevant, brief, and accurate and maintains confidentiality.

.

Prior to submitting the spread sheet, please discuss any queries with the ED Management Team.

The 12-hour breach report is to be sent to the distribution list '**12 -Hour Breach Report'** within the Capacity Team emails.

Key Responsibilities / Duties

A number of roles and departments are key to the successful implementation of the Trust Capacity Policy. The following provides an overview of the key roles and responsibilities.

Role	Responsibility
Chief Operating Officer (or Deputy) or Director On-Call	• To maintain strategic oversight of Trust operational status • Maintain regular communication with the Capacity Team or Manager On-call. • Chairing Operational Bed Meetings in the event that escalation status is EMS 3 or higher. • To engage with external partners as necessary at strategic level • Management of media / communication issues • Communicating Trust EMS status and pressures to partner organisations at Strategic level • Seeking mutual aid
Matron for Capacity & Patient Flow	• To maintain operational oversight of Trust operational status • Determination of the Trust Escalation Status (In Collaboration with the COO/Divisional COO or On Call Director) • To engage with external partners as necessary at operational level • Communicating Trust EMS status and pressures to partner organisations at operational level • Have an oversight of all patients that are MFFD and reasons for delay leading actions to prevent /mitigate the delay in discharge. • Submit data to internal, regional and national databases in relation to capacity status and discharge delays • Lead author for Trust policies relating to capacity management, patient movement and discharge
Clinical Capacity Manager (Capacity Team)	• Collecting and reporting accurate information regarding internal departmental bed capacity. • Supporting with the determination of the Trust Escalation Status including submissions to Regional Capacity via the EMS system • Leading operational bed meetings • Liaising with operational staff and departments to resolve local demand and capacity issues. • Control the Teletracking system to ensure that flow is maintained. • Tracking and reporting outlying patients to ensure clinical review is maintained. • Escalating capacity issues at the earliest opportunity to Senior Management. • Escalating 12 hour breach risks in accordance with the escalation guidance and submitting 12 hour breach reports to the ICB when occurred (appendix 6)
Directorate Management Teams	• Maintaining and robustly applying internal departmental escalation plans to minimise escalation and facilitate de-escalation. • Ensuring directorate clinical staff are aware of and adhere to the Trust Capacity Policy • Providing directorate representation at routine operational bed meetings and additional meetings as required. • Implementing actions appropriate to the Trust escalation status and any other specific actions delegated during the operational bed meetings. • Consideration of changing working practices or redeploying resources to reduce capacity pressures

Key Responsibilities / Duties

A number of roles and departments are key to the successful implementation of the Trust Capacity Policy. The following provides an overview of the key roles and responsibilities.

Ward Consultant	• Timely review of patients and ensure that patients are assigned an Estimated Date of Discharge (EDD) with clear discharge/management plans recorded. • Ensure the medical team prepare patients discharge requirements in a timely manner eg.TTOs • Establishing Criteria Led Discharge where appropriate. • Reviewing outliers in a timely manner
Matrons	• Adhering to internal departmental escalation plans. • Ensuring their ward/department staff are aware of and adhere to the Trust Capacity Policy maintaining awareness of Trust capacity status • Ensuring current status of local demand / capacity is communicated to the Capacity Team • Providing local leadership and promptly implementing recovery actions delegated at operational bed meetings.
Ward Managers	• Ensure every patient is provided with the leaflet 'Planning Your Discharge from Hospital.' • Ensure that all of their patients have an EDD • Discharge planning of the patient should commence at the ;point of admission • Ensuring that the ward Teletracking board accurately reflects all pending and confirmed discharges. • Ensure that each patients Criteria to Reside status is updated daily • Ensure that all patients that are MFFD are identified daily on the huddle tool and the reason for delay reported. • Ensure that Transfer of care (TOC) referrals are submitted as soon as a patient is identified as MFFD (where there is a care need identified) • Utilise the discharge lounge for all patients on the day of discharge unless they meet the **exclusion** criteria (Refer to Discharge Lounge SOP: SOP 28)

Mitigating actions at each OPEL level

The following list of actions for each level of escalation are not exhaustive and should be added to at the local level as needed. When a decision is taken to move to a higher level of escalation, the following actions (and any additional locally determined actions), should be implemented or considered.

Escalation level	Whole system	Acute trust	Commissioner	Community Care	Social care	Primary care	Mental Health
OPEL One	• Named individuals across Local A&E Delivery Board to maintain whole system coordination with actions determined locally in response to operational pressures, which should be in line with business as usual expectations at this level • Maintain whole system staffing capacity assessment. • Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases • Active monitoring of infection control issues • Maintain timely updating of local information systems. • Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken • Proactive public communication strategy e.g. Stay Well messages, Cold Weather alerts • Maintain routine active monitoring of external risk factors including Flu, Weather.						
OPEL Two	•All actions above done or considered •Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate	•Undertake additional ward rounds to maximise rapid discharge of patients • Clinicians to prioritise discharges and accept outliers from any ward as appropriate. •Implement measures in line with Trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place. • Open additional beds on specific wards, where staffing allows. • Notify ICB on-call Director to ensure that appropriate operational actions are taken to • Maximise use of criteria led discharge. • Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	• Expedite additional available capacity out of hours, independent sector and community capacity. • Co-ordinate the redirection of patients towards alternative care pathways as appropriate •Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers)	• Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. • Maximise use of reablement/intermediate care beds •Task community hospitals to bring forward discharges to allow transfers in as appropriate. • Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals.	• Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements. • Ensure all patients waiting within another service are provided with appropriate service. • Where possible, increase support and/or communication to patients at home to prevent admission. Maximise use of reablement/intermediate care beds	• Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community. • In reach activity to ED departments to be maximised • Alert GPs to escalation and consider alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service. • Where possible, increase support and/or communication to patients at home to prevent admission

OPEL Three	•All actions above done or considered •Utilise all actions from local escalation plans Trust CEOs / ICB AO involved in discussion with Regional Director / Deputy / On- Call Director and agree relevant recovery actions and their ongoing tracking.	• ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff • Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • ED to open an overflow area for emergency referrals, where staffing allows. • Notify ICB on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages Active management of elective programme including clinical prioritisation of non-urgent elective inpatient cases	• Local regional office notified of alert status and involved in discussions • ICB to co-ordinate communication and co- ordinate escalation response across the whole system including chairing the daily teleconferences • Notify ICB on-call Director who ensures appropriate operational actions are taken to relieve the pressure • Notify local DoS Lead and ensure NHS111 Provider is informed. • Cascade current system- wide status to GPs and OOH providers and advise to recommend alternative care pathways.	• Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible • Community providers to expand capacity wherever possible through additional staffing and services, including primary care	• Social Services on-call managers to expedite care packages • Increase domiciliary support to service users at home in order to prevent admission. • •Ensure close communication with Acute Trust, including on site presence where possible	• OOH services to recommend alternative care pathways • Engage GP services and inform them of rising operational pressures and to plan for recommending alternative care pathways where feasible • Review staffing level of GP OOH service	• To review all discharges currently referred and assist with whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission
OPEL Four	• All actions above done or considered •Contribute to system-wide communications to update regularly on status of organisations (as per local communications plans) • Provide mutual aid of staff and services across the local health economy. If OPEL 4 continues for more than 3 days consider an • Extraordinary AEDB meeting. • Stand-down of level 4 once review	• All actions from previous levels stood up • ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff •Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly. • Surgical senior clinical decision makers to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7. • Ambulance service review all referral pathways and ensure all possible alternatives are considered• An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the ICB and neighbouring trusts to agree ambulance divert.	• Local regional office notified of alert status and involved in decisions around support from beyond local boundaries Regional Operations Lead provides briefing to National Operations Room • The ICBs will act as the hub of communication for all parties involved. • **Post escalation:** Complete Root Cause Analysis and lessons learned process	• Ensure all actions from previous stages enacted and all other options explored and utilised. • Ensure all possible capacity has been freed and redeployed to ease systems pressures	• Senior Management team involved in decision making regarding use of additional resources from out of county if necessary. • Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including supporting ED re prevention of admission & turn around. Identification via board rounds and links with discharge team & therapists. • Hospital Service Manager/Deputy Director to monitor escalation status, taking part in teleconferences as required.	• Ensure all actions from previous stages enacted and all other options explored and utilised. • Ensure all possible actions are being taken on-going to alleviate system pressures	• Ensure all actions from previous stages enacted and all other options explored and utilised. • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible

	suggests pressure is alleviating. • **Post escalation:** Contribute to the Root Cause Analysis and lessons learned process						