University Hospitals of Derby and Burton NHS Foundation Trust

Trust Wide Capacity and Escalation Policy

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University Hospitals of Derby and Burton NHS Foundation Trust

Capacity and Escalation Policy

1.0 Introduction

1.1 Providing high quality patient centred care, positive patient experience and maintaining patient safety is of paramount importance at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

1.2 Ensuring proactive and effective management of capacity is essential to ensuring all sites can balance, prioritise, and be responsive 24/7, to accommodate clinical flow through all specialties, whether that be acute emergency, tertiary, elective, or repatriation demand. This ensures patient outcomes are optimised, in parallel to the efficient and timely utilisation of the UHDB in-patient bed base, Emergency Department, Medical/Surgical SDEC's, Receiving Units and other assessment areas.

1.3 The ability of the organisation to achieve this is impacted by organisational pressures compounded by "winter" pressures and the ongoing challenges faced following our response to COVID-19.

1.4 Emergency department attendances and non-elective patient admissions can be unpredictable in nature and pose additional challenges daily and in turn becomes the norm and desensitises staff to work in a different way which can be detrimental to having a proactive response to surge in activity which is fundamental to ensuring patient safety and maintaining flow through the organisation.

1.5 It is essential for UHDB in collaboration with system partners to be able to maintain continuous levels of key and critical services when faced with high levels of demand or capacity management issues. A clear and specific Trust Capacity and Escalation Plan is needed to outline the systems and processes in place to effectively manage capacity to meet both the elective and non-elective demand for admissions to UHDB. The plan is designed to ensure that all admissions are accommodated as safely as possible in conjunction with maintaining expectations of national targets. The policy incorporates the escalation status setting, bed capacity and trust wide action plans to provide safe emergency care whilst maintaining priority elective activity.

2.0 Purpose

2.1 Having a robust, effective capacity and escalation policy is essential to inform those responsible in playing their part to maintain optimal patient flow of their clear roles and responsibilities and to ensure there is early identification of capacity problems to enable a proactive, action focused response with clear responsibilities and ownership to provide resolutions to issues experienced in patient's pathway from admission to discharge.

2.2 The policy supports safe and effective utilisation of assessment areas and inpatient beds to ensure patients who require admission are admitted without unnecessary delay and details of alternative pathway opportunities that can be followed to avoid unnecessary admission to hospital for patients who are well enough to be treated in more appropriate environments.

3.0 Key Principles

3.1 Patient flow is the responsibility of all operational and clinical professional groups of staff at UHDB.

3.2 The process for managing clinical flow is dependent on engagement from front line staff, clinicians, and senior management within all divisions, and by working in partnership with Departments/Teams within Clinical Support Services (CSS) and Local Care Organisations (LCO) to ensure a whole systems approach.

3.3 Decisions to admit will be made based on the clinical needs of the individual patients, where it has been deemed on assessment that their needs can only be managed in an acute care setting.

3.4 Patients should be admitted, transferred or discharged within four hours of attending the Emergency Department (ED) and when requiring admission should have an appropriate bed allocated for their onward journey as soon as possible, the exception to this is where it has been deemed clinically necessary for the patient to remain in ED for clinical stabilisation to be safely transferred from ED to a suitable acute receiving area at a later time.

3.5 There will be times, when Site pressures occur; or in a pandemic situation, where UHDB is in an escalation status, which affects the flexibility of capacity, this will indicate a need to proactively review elective lists in attempt to minimise disruption to essential procedures and allow teams time to contact patients whose procedures will need rescheduling. Decision making will have multifactorial consideration and be in line with triggers related to internal Escalation levels and the overall Trust Operational Pressures Escalation Level (OPEL) score.

3.6 To create capacity earlier in the day and/or, to accommodate admission of acutely unwell patients, all suitable patients being discharged and who fit the criteria in the DAU SOP will have amber icons allocated on Extra med at the RDH site and be directly referred from the wards as fit for transfer on the QHB site to ensure they are expedited to Discharge Assessment Unit (DAU) to facilitate timely discharge.

3.7 The cancellation of elective admissions, due to ward bed base, theatre or critical care capacity pressures is only agreed after assurance this has been discussed within the relevant divisional management teams and all viable options to safely proceed with surgery have been explored. This decision will be escalated to the Chief Operating Officer and/or Deputy Chief Operating Officer to agree and confirm this action is required, all options to create suitable capacity must be considered first.

3.8 Long length of stay discussions are held internally on a weekly basis as a minimum in conjunction with the discharge team across all specialities and escalated accordingly through the ICB to partners when external delays are identified.

3.9 Patients who are medically optimised awaiting transfer to a community setting on pathways 1, 2 or 3 are highlighted to Integrated Discharge Team on site and to the relevant local authority for discharge dates to be confirmed via the daily meetings and via the ICB when delays become excessive.

3.10 To prevent a delay occurring for patients on pathway 0, the responsible clinician within divisions should progress discharge plans for this group of patients, to prevent delays when individuals no longer require an acute hospital stay.

3.11 All available capacity within UHDB will be used efficiently and effectively to ensure that the right patient is placed in the right place at the right time.

4.0 Ownership and Responsibilities

4.1 This policy is owned by the Deputy Chief Operating Officer and the Operations Team who are responsible for reviewing the policy and assuring adherence. The policy is a trust wide document, and all staff are responsible for ensuring their working practices are aligned to the principles within it.

5.0 Policy Statement and Assumptions

Appropriate escalation will be accurate and prompt to facilitate resolution of issues.

For any benefit to be delivered from additional escalation actions, it is essential that the following assumptions are complied with:

5.1 ED

All patients identified or referred for review are appropriate and all alternative options to admission have been explored.

ED will liaise regularly with DHU colleagues throughout the day to ensure all appropriate patients are streamed to UTC (Urgent Treatment Centre) for further care and management.

All other patients who attend ED will be considered for streaming to SDEC (Same Day Emergency Care) at triage and dynamically through their journey and be redirected as appropriate for further care and management.

All appropriate patients will be streamed accordingly to other specialist assessment areas including CTAU (RDH Site only)/Gynae Assessment Unit/Pregnancy Assessment Unit.

The Consultant in charge (CIC) dynamically review the ED workload and undertake safety huddles every four hours with the overall nurse in charge (ONIC).

The CIC will attempt to allocate suitably skilled senior decision makers in Pitstop to support initial assessment and Rapid Triage to expedite appropriate interventions for timely management. This action is a MUST do at times of increased pressure. The ONIC will monitor ambulance offload times and escalate to the Operations Team if there is a significant delay.

The CIC and ONIC will have a cohesive working relationship with the escalation lead of the day and Operations team to ensure all efforts are made to pre-empt any foreseen issues, facilitate movement, and maintain flow.

5.2 All SDEC areas (Medicine / Surgery)

Patients who fit the clinical criteria for SDEC will be streamed directly from ED within 15 minutes of arrival and re-reviewed through the dynamic process of safety huddles for reconsideration of signposting to SDEC if criteria is met throughout their journey.

5.3 Medical Assessment Units (MAU/AMU)

These areas are Consultant led and will work in conjunction with the "Pull" model to ensure patients are seen treated and referred to appropriate subspeciality if discharge is not possible in a timely manner according to patient need.

Clinicians will work in conjunction with MAU/AMU senior Nursing and Ops team to identify patients who MUST be prioritised to specialist wards and who can be allocated best fit base wards according to their clinical need.

Patients, who require a sub-speciality review will be seen or moved to a suitable holding area for review to allow time for a suitable decision can be made for discharge or subspeciality bed identified for admission. This should happen within 60 minutes in line with internal professional standards and to maintain flow in these areas.

Patients identified for ward beds will be moved within 30 minutes of bed identified and EDD set as a priority ready for discharge planning.

5.4 CTAU

CTAU supports hot and cold pathways for haematology and oncology patients with complications following anti-cancer treatment.

See Appendix 1

5.5 GAU

Policy currently being revised at Divisional level.

5.6 PAU

The Maternity Assessment Unit (MAU) at Queens Hospital, Burton and the Pregnancy Assessment Unit (PAU) at Royal Derby Hospital provide a 24-hour triage and assessment service for urgent problems in pregnancy. Patients can either self-refer to the service or be referred by health care providers such as ED community midwives, G.P.'s and doctors.

See Appendix 2

5.7 Wards

All empty beds to be declared to bed managers or Ops team immediately.

All empty beds will be ready for use within 30 minutes (Unless there is a delay with cleaning that should be escalated to the Ops team).

All patients being discharged should be sat out where able or transferred to DAU where criteria met.

Patients awaiting discharge who are not suitable to be transferred to DAU will have transport booked at earliest opportunity to allow for early pick up.

Nurse in charge / ward managers will attend board rounds to support decision making using SHOP Principles.

Wherever possible there will be therapy / pharmacy input to board rounds to ensure MDT approach to patient need.

Nurse in charge of ward to know all patients and work closely with Bed managers, Escalation leads and Discharge team to ensure:

- All escalations are raised to appropriate team for action.
- Discharge planning commenced on admission and discussed at board rounds.
- EDD status accurately recorded and updated on system to reflect patients' status.
- Medically Optimised status clear on system.
- Discharge paperwork completed in a timely manner.
- Discharge checklists completed on all patients.
- All patients requiring transfer to another hospital to be added to repatriation list in the Ops room.

5.8 Site

Daily operational flow, capacity and site management of the Trust is the responsibility of the Operations team, led by the Chief Operating Officer, Deputy Chief Operating Officer and supported by the General Manager for Operations and the Lead Nurse for Operations. The daily site management team consists of Deputy General Managers, Matrons for Patient Flow, Operations Team Service Coordinator (RDH), Patient Flow Managers (RDH), Clinical Site Practitioners (QHB), Patient Flow Coordinators (QHB), Bed Mangers (RDH) and Bed Coordinators (QHB) and administrative staff.

Operational site management is 24/7 365 days a year working alongside on call teams providing operational plans both in and out of core working hours. The Site Management Team are based in the Ops room First floor near main entrance M&S/Costa (RDH site) and on ground floor near ward 7 (QHB site).

Divisions will ensure a representative will be available to fulfil the role of escalation lead to liaise closely with ward areas, bed managers and the Operational site management team. Following actions from cards (**Appendix B**) to ensure consistency in approach across divisions, there will also be a clear escalation process identified within each division to support response as required.

The Ops team will review and agree the hospital OPEL/Escalation site status after each bed meeting and consider the overall site escalation score aggregated against all divisions position based on identified triggers that will be supported by a core set of specified actions that will be taken at divisional level. This will be communicated via email circulation to relevant team members. It is expected that members will enact the appropriate internal escalation actions once OPEL/Escalation score set.

6.0 Triggers

Escalation status is based on triggers relating to demand, capacity and flow with the identified escalation status leading to actions aimed at responding to and deescalating pressure and maintaining site safety and service continuity.

NHS England updated their Operational Pressure Escalation Levels Framework in August and mandated systems to implement reporting against these triggers as of early December 2023.

The following core parameters make up the OPEL assessment for each submission. Each acute hospital with a type 1 ED must complete their own OPEL assessment based on these parameters.

1. Mean ambulance handover time.
2. ED all-type 4-hour performance.
3. ED all-type attendances.
4. Majors and resuscitation occupancy.
5. Time to treatment (TTT).
6. Percentage of patients spending >12 hours in ED.
7. General and Acute (G&A) bed occupancy as a percentage.
8. Percentage of open beds that are escalation beds.
9. Percentage of beds occupied by patients no longer meeting the criteria to reside (NCTR).

Guidance from NHS England suggest the parameters above can be supplemented with other parameters considered to be significant to the organisation as detailed below in relation to their own

pressures for use within locally agreed processes by Acute Trusts, ICS and NHSE regions. However, to foster consistent comparison, measurement, and parity of response, only the OPEL parameters listed above can be used when escalating OPEL assessment scores and when comparing parity of response.

The status of the Trust is categorised into Operational Pressures Escalation Levels (OPEL) 1-4. Each level reflective of triggers outlined below which reflect the relationship between capacity and demand which presents the consequent level of risk to patient safety and experience.

Acute Triggers for Operational Pressures Escalation Level

OPEL Parameters	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Mean ambulance handover time	<15 mins		15-30mins		>30-60mins		>60mins
ED all-type 4-hour performance	>95%	76-95%	60-76%		<60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120% >		>120%
Median time to treatment	≤60 min	>60–90 min	90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2-4%	4-6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

Aggregated OPEL score	**OPEL**	**Clinical Risk**	**Response**
0-11	1	Low	**See OPEL action card** (and local policy/protocols)
12-22	2	Medium	
23-33	3	High	
34-44	4	Very High	

These Triggers are mandated by NHS England and are reflective of NHS Improvement Operational Pressures Escalation Levels Framework and will be reported externally and formulate part of the triggers for determining escalation status of UHDB's internal escalation score.

In all levels, if actions are not providing recovery after 24 hours or sooner if significant concern, then consideration should be given to move to the next level.

University Hospitals of Derby and Burton NHS Foundation Trust work in collaboration with system partners in both Derbyshire and Staffordshire. Queens Hospital Burton (QHB) report their escalation

level daily to the Staffordshire Urgent Care Team using EMS (Escalation Management Solutions, Midlands, and Lancashire Commissioning Support Unit) Acute Triggers and the Royal Derby Hospital (RDH) complete the Derbyshire OPEL reporting daily.

For QHB, the level of OPEL escalation is determined by inputting into the EMS Acute Trigger system that is reflective of the indicators listed above, the site management team are responsible for completing this based on understanding of the operational situation. The internal escalation score will then be calculated based on the Triggers required for reporting as detailed above in conjunction with the internal divisional Triggers identified at local level and agreed through the operational site meetings.

For RDH, the level of OPEL escalation to be reported is determined by data sent to the ICB based on assessment of the indicators detailed above. The internal escalation score will then be calculated based on the Triggers required for reporting as detailed above in conjunction with the internal divisional Triggers identified at local level and agreed through the operational site meetings.

The assessment of both external OPEL and internal escalation scoring will be communicated during the bed meeting and subsequently emailed out for information via a circulation list.

The internal Score for each site within UHDB will be calculated twofold:

- OPEL escalation Triggers levels
- Site escalation level based on Divisionally identified Triggers.

RDH site - level will be determined by 3 or more indicators in a block triggering.

RDH	Escalation 1	Escalation 2	Escalation Low 3	Escalation High 3	Escalation 4
Mean ambulance handover time	*<15mins*	*15-30 mins*	*>30-45 mins*	*>45-60mins*	*>60 mins*
ED all-type 4-hour performance	*>95%*	*>76-95%*	*>68-76%*	*>60-68%*	*>60%*
ED all-type attendances	*<2%*	*>2-10%*	*>10-15%*	*>15-20%*	*>20%*
Majors and resuscitation occupancy (adult)	*<80%*	*>80-100%*	*100-110%*	*110-120%*	*>120%*
Median time to treatment since midnight.	*<60 mins*	*>60-90mins*	*>90-105mins*	*>105-120mins*	*>120mins*
% of patients spending >12 hours in ED	*<2%*	*<2-5%*	*< 5-7.5%*	*<7.5-10%*	*>10%*
% G&A bed occupancy	*< 92%*	*>92-95%*	*>95-96.5%*	*>96.5-98%*	*>98%*
% open beds that are escalation beds	*<2%*	*>2-4%*	*>4-5%*	*>5-6%*	*>6%*
% of beds occupied by patients no longer meeting the criteria to reside (NCTR)	*<10%*	*>10-13%*	*>13-14%*	*>14-15%*	*>15%*
Empty beds on MAU	>8 and zero ED queue	<8 and zero ED queue	<4 and zero ED queue	<10 ED queue	>10 ED queue
HDU bed capacity	24 or more	17-23	12-16	7-12	6 or less
Forecast position Medicine at capacity meeting is	>0	0 to-10	minus 10-20	minus 20 to 30	minus 30 or more
Extra capacity beds open	0	1 or more	PFS beds open	Surge Capacity in use	Super Surge Capacity in use
Outliers beyond agreed winter plan	0	>1	>5	>10	> 20
Patients waiting for repatriation	0	1	2	3	4
Patients held on MAU corridor	0	1 to 4	5	5	9
Delays to discharge/MFFD	0	25	50	100	125
ICU Capacity	<85% of commissioned occupancy	85% of commissioned occupancy	>85% of commissioned occupancy	>85% of commissioned occupancy and cancellation of elective capacity	>85% of commissioned occupancy and cancellation of elective capacity and non-clinical transfer policy enacted
Forecast elective position at 12pm	All electives placed	-2	-5	-10	-15

QHB site - level will be determined by 3 or more indicators in a block triggering.

QHB	Escalation 1	Escalation 2	Escalation Low 3	Escalation High 3	Escalation 4
Mean ambulance handover time	*<15mins*	*15-30 mins*	*>30-45 mins*	*>45-60mins*	*>60 mins*
ED all-type 4-hour performance	*>95%*	*>76-95%*	*>68-76%*	*>60-68%*	*>60%*
ED all-type attendances	*<2%*	*>2-10%*	*>10-15%*	*>15-20%*	*>20%*
Majors and resuscitation occupancy (adult)	*<80%*	*>80-100%*	*100-110%*	*110-120%*	*>120%*
Median time to treatment since midnight.	*<60 mins*	*>60-90mins*	*>90-105mins*	*>105-120mins*	*>120mins*
% of patients spending >12 hours in ED	*<2%*	*<2-5%*	*< 5-7.5%*	*<7.5-10%*	*>10%*
% G&A bed occupancy	*< 92%*	*>92-95%*	*>95-96.5%*	*>96.5-98%*	*>98%*
% open beds that are escalation beds	*<2%*	*>2-4%*	*>4-5%*	*>5-6%*	*>6%*
% of beds occupied by patients no longer meeting the criteria to reside (NCTR)	*<10%*	*>10-13%*	*>13-14%*	*>14-15%*	*>15%*
Empty beds on AMU	>4 and 0 DTA	<4 and 0 DTA	0 and 0-2 DTA	0 and 2-4 DTA	0 and >4 DTA
Available speciality beds	2 CCU and 1 NIV beds	1 CCU and 1 NIV beds	1 CCU and 0 NIV beds	0 CCU or NIV beds	0 CCU or NIV beds
Forecast position Medicine at capacity meeting is	>0	0 to -10	-10 to -20	-20 to -30	-30 or more
Extra Capacity open	0		PFS	Surge	Super Surge
Outliers	0	5 or more	10 or more	15 or more	>15
Community hospital capacity	>6	4 to 6	2 to 3	1	0
Patients waiting for repatriation including stroke repatriation from RDH	0	1	2	3	>3
Delays to discharge/MFFD	0 -15	15- 30	30-40	40 - 50	>50
ICU Capacity	<85% of commissioned occupancy	85% of commissioned occupancy	>85% of commissioned occupancy	>85% of commissioned occupancy and cancellation of elective capacity	>85% of commissioned occupancy and cancellation of elective capacity and non-clinical transfer policy enacted
Forecast elective position at 12pm	All electives placed	-2	-5	-10	-15

The Site escalation score will be calculated by combining the NHS England OPEL framework and the triggers detailed above (site specific) and will determine the internal escalation level and expectation of proportionate response from the whole hospital to pressures identified and be identified as detailed below: -

- **ESCALATION 1 (Green)**
- **ESCALATION 2 (Amber)**
- **LOW ESCALATION 3 (Red)**
- **HIGH ESCALATION 3 (Red)**
- **ESCALATION 4 (Black)**

Escalation 1	Escalation 2	Escalation Low 3	Escalation High 3	Escalation 4
Business as usual	Confirmation Escalation Level 1 actions are implemented	Confirmation Escalation Level 2 actions are implemented	Confirmation Low 3 Escalation level actions are implemented	Confirmation High 3 Escalation Level actions are implemented
All services delivering core business that is self manageable within expected performance parameters.	There are anticipated pressures in facilitating ambulance handovers- UEC team to enact actions from SOP	Divisional plans to be made to ensure Rapid offload of Ambulances can be achieved if required	UEC to utilise extended footprint to support ambulance offload including C-side, corridor on MAU, Quad area, Fracture Clinic	All Surge and Super Surge Capacity in use with robust plans to maintain safety
Good Patient Flow through all Front Door Streams	Reduced performance in UEC Streams	Senior Divisional representative to be made aware of deterioration and support Escalation Leads with focused local actions	Control and Command established with staff identified to fill key Bronze (Control room) Silver (Tactical) Gold (SLT) roles	Control Team to facilitate timely discussions with Divisions around safe expansion of areas including Medical/Nursing models to load level risk across site
Daily bed management cycle established (Battle Rhythm)	Directorate Escalation Leads/Matrons attend and report issues into Bed meetings.	All external delayed discharges to be discussed with ICB for MDT action focused approach	All FCP/PFS and Boarding beds in use- consider use of additional capacity areas	Additional extraordinary actions to be considered to continue to facilitate timely ambulance offload
Clear roles and responsibilities established for key stakeholders through Action Cards	Divisions to instigate local huddles (Bronze calls) where appropriate after bed meetings to review capacity / demand.	Consideration for use of Push for Safety /boarding 1 beds at 0830 bed meeting to create flow	Consider Medical peer review of Long LOS patients.	All external delays discussed with ICB and MDT at Executive level and consideration given to proportional response required
Ward rounds undertaken on every ward where SHOP principles will be applied	Daily board rounds with ward lead and senior decision maker (ST3+) continue	All patients to be reviewed by a Consultant at Ward level to review MFFD and NCR status	Additional ward/board round review to maximise safe on day discharges or plans for next day	Elective activity discussed and plans made to cancel activity to support capacity demand
Weekly long LOS review by MDT (IDT, medical division & external partners- Include Ops team moving forward)	Staffing Levels Amber	Evaluate Elective / Outpatient activity	Consider cancellation of planned and elective activity	All non essential meetings to be cancelled if staff involved will add value to problem solving
Planned Staffing Levels Maintained	Emerging IPC issues	Staff Levels Red- Divisions to confirm plans for safe levels	Divisional Directors/DND's attendance at bed meetings- Role to manage and direct divisional leads & team with specific targetted actions.	Divisional Senior Leaders to be present at bed meetings
No Evidence of IPC issues	Minimal Outliers that are being reviewed without constraint	IPC issues identified and plans to mitigate risk drawn up and shared by IPC team	Staffing levels reviewed by Divisions and plan executed for next 48hours to bolster workforce where thought to be appropriate	All FCP/PFS/Boarding beds enacted and plans to be made for further Escalation at Divisional level for Exec signoff for overnight plans
No outliers- All patients accommodated in correct bed base	If no improvement within 24 hours of implementation, unless significant deterioration consider next level.	Outlier numbers increased and consideration for mutual aide to facilitate decision to be considered	Assess benefit to suspension of training and development sessions for all staff.	Re-Assess benefit to suspension of training and development sessions for all staff.
		If no improvement within 24 hours of implementation, unless significant deterioration consider next level	Outliers to be reviewed and robust plans made for discharges within next 48 hours	Additional medical/specialty in reach to ED
			If no improvement within 24 hours and of implementation consider next level	

Divisional Triggers and Actions

See Appendix B

7.0 Capacity management

The Operations team are responsible for the effective management and coordination of capacity and patient flow across the Organisation, this will be achieved through close working with divisions. It is important that there is effective communication between the Operations team and Divisions to support patient safe and create effective pathways.

It is the responsibility of the site management team to maintain and manage flow by supporting delivery of divisional plans and speciality pathways. The site management team will work in collaboration with the divisions to identify barriers and create resolving solutions when flow is compromised. The team will support cross divisional conversations when additional capacity is required. The team will escalate when resolution cannot be reached.

The Operations team in conjunction with Divisions are responsible for coordinating and managing patient flow and allocation of beds. The operations team have full oversight of the demand and capacity requirements and will work in collaboration with divisions to achieve optimal flow. The operations team are responsible for identifying priorities and communicating this appropriately. It is essential that risks are balanced across the demands for urgent care with admissions from the Emergency Department, assessment areas, same day emergency care, clinics, direct admissions from home into identified pathways, critical care flow and elective demand. All allocation of beds should be coordinated through the operations team to ensure this balance is achieved.

The site management team will identify actions required to maintain flow, this will be done through the Operational Site Meetings and will also be addressed outside of the meetings when this is required. The divisional escalation leads will be expected complete actions and feedback to the site team.

7.1 Bed Meetings

The purpose of the bed meeting is to provide a forum for the operational site team to liaise with divisions to provide a concise situation report of the overall hospital status and to agree key decisions, accountabilities, and escalations. The focus must be to maintain flow into the hospital for all admissions and to maintain safety and quality care for all.

There are four capacity meetings held throughout the day: (NOTE NEW TIMINGS)

- 08.30
- 12.30
- 15.30
- 17.30

The standing agendas for capacity meetings can be found in **Appendix A**.

Divisional representatives will work tactically with the Bed Managers to ensure there are suitable plans in place to maintain and manage capacity across the Trust. Where divisional escalation managers and site managers are unable to improve capacity and flow across sites this will be escalated to the General Manager for Operations Capacity and Flow and Deputy COO to ensure there is senior engagement in plans to further create capacity and flow.

Where it is deemed necessary, the Operations team will escalate the operational site meeting and will communicate this ahead of the meeting, each division will be responsible for ensuring the escalated meetings have the correct level of attendance to ensure key decisions and actions can be made with the right level of support in place. It is expected that there will be senior presence from operational and clinical teams.

The bed management team will work in close collaboration with the ward areas and escalation leads to gather and analyse information relating to admissions and discharges and will identify key areas of concern including where demand outweighs capacity, infection prevention and control issues and speciality requirements.

The bed management team will liaise with wards regarding timely discharges ensuring optimal use of discharge assessment units. Any delays that cannot be resolved will be escalated to the divisional escalation lead.

Each speciality team is responsible for proactively managing their admissions and will work collaboratively with the operations teams to respond flexibly to capacity and demand for their speciality pathways whilst supporting a trust wide response to surges in demand.

7.2 Escalation Leads

Divisional escalation leads will be rostered to provide a senior presence on site and as a point of escalation for any operational or clinical issues facing the divisional services daily.

The escalation leads will work closely with the bed managers and be responsible for facilitating bronze action meetings when this is required and will be responsible for escalation of specific

concerns and will provide an overview of what internal actions have already taken place and what further support is required.

The clinical divisions will be required to keep the operations team updated of any changes or updates to pathways. Where issues are identified, clear plans will be required which will be enacted but the clinical site team out of hours working in collaboration with the Senior Manager on Call.

Each division has agreed an outline of roles and responsibilities for the escalation leads and ensure training and competencies when undertaking the role. (**Appendix B**)

7.3 Capacity and Demand

Demand and Capacity is modelled with plans made around the afore mentioned assumptions however, it is accepted that there will be times where demand is greater than capacity and an extraordinary response is required, this may be in a specific clinical area or could be a wider trust issue.

7.4 Direct Admission to Wards

For some specialities there are already agreed pathways in place for direct admission to speciality wards. For many patients, admission will be through the assessment units prior to onward admission to a speciality ward if further assessment and treatment is required. There may be times where base ward capacity is available and no suitable patients identified in the assessment units to move to base wards. The priority should be to support the assessment areas with allocation to these beds including wards pulling patients however where this is not possible and there is a queue of patients in ED awaiting beds and risk to ambulance handover delays, consideration should be given to direct admission of appropriate patients who have been clerked and have an appropriate management plan. This will be a silver led decision with support from gold where required.

7.5 Emergency Department Capacity

Each Emergency Department will have an up-to-date operating policy relating to management of capacity designed to manage flow with an internal escalation plan (currently being written by Division).

When the Emergency Department reaches full capacity, a trust wide response is required to ensure critical service provision can continue. A trust wide response is required when there is a delay to ambulance handovers and where patients are being held on ambulances. The required response is outlined in The Policy for the Management of Ambulance Handover Delays.

See Appendix 3 - Managing Ambulance Conveyances RDH

See Appendix 4 - QHB Ambulance Offload SOP

7.6 Surgery and Critical Care Capacity

ITU surge capacity will be managed by the Surgery division and Anaesthetics & Theatres Business Unit with support from the operations team and in collaboration with the Critical Care Network

See Appendix 5 - Critical Care Escalation Levels

There are several High Dependency beds across the Royal Derby Site, where there is more high dependency capacity than demand, it may be appropriate to utilise this capacity for patients with a lower level of care needs for a short period of time. The clinical divisions will be responsible for facilitating this in core working hours through divisional escalation leads. High dependency capacity will be reviewed through the operational site meetings and pre-emptive discussions will take place ahead of time to support with utilisation of capacity out of hours. Each division are responsible for ensuring there is a process in place to support the use of High Dependency beds for non-High Dependency patients.

Surgical Division have their own boarding policy as detailed here

See Appendix 6 - Surgery Division Boarding

7.7 Maternity

Awaiting Maternity Services policies

7.8 Paediatrics

Paediatric Operational Services run alongside and in conjunction with the Corporate Operations team, when in escalation Corporate Ops play a pivotal role in providing appropriate support where needed. The paediatric team follow an operational management schedule supported by other key documents as detailed below:

See Appendix 7 - PBU Operational Management Schedule

See Appendix 8 - Triggers and Escalation Safe Care

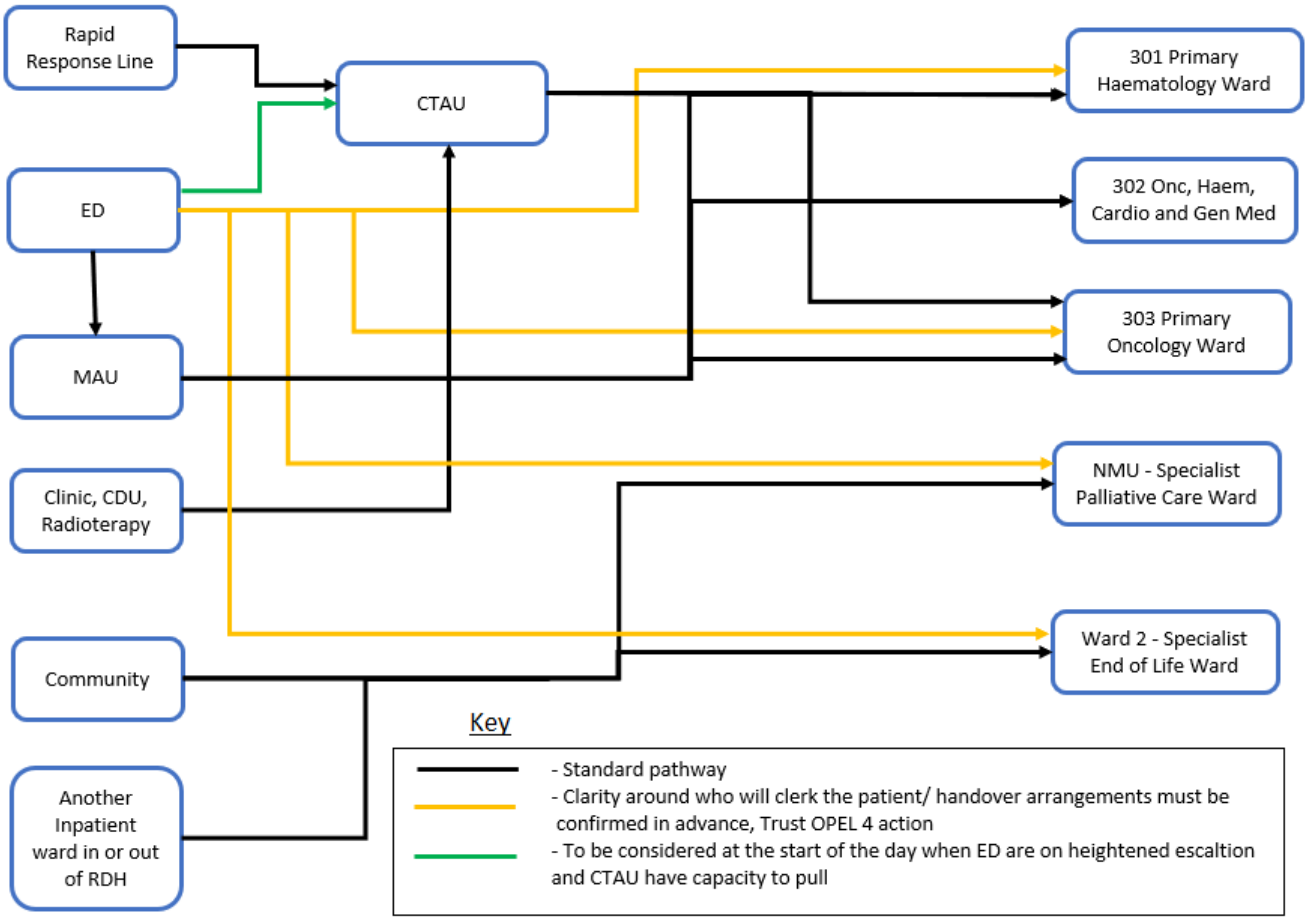
See Appendix 9 - Paediatric Business Unit

See Appendix 10 - Paediatric Opel Bed Status

Policies for CED, Neonatal capacity, Paediatric beds to follow.

7.9 Cancer Services

Non elective Flow through Cancer services is represented in the diagram below:-



7.10 Side Room Capacity

The operations team are responsible for the management of side room capacity and will manage this in collaboration with the Infection Prevention and Control team and the Palliative Care team, Senior Nurses and ward teams. Patients requiring isolation should be allocated a side room where cohorting or barrier nursing in a bay is not possible. When appropriate for patient and family wishes, patients who are recognised as dying (supported by their Individualised Care Plan) should be offered a side room where this is possible. Patients who are in a side room because they are in the last hours of life and expected to die within the next 24hours should not be moved. The palliative care teams will support with this decision making where required and the Extramed 'Dove' icon should be used to support with the identification of patients.

Due to the limited number of side rooms at QHB, the Operations team will review side room occupancy daily and identify the reasons for side room occupancy which will support management, this process will be led by the Matron for Operations. Ward teams should inform the Operations team when patients are in the last hours of life and expected to die within the next 24hours so that this can be highlighted.

Where there is a difference in professional opinion over the allocation of a side room, this should be escalated to the Matron or Lead Nurse for Operations and should be discussed in a private area.

8.0 Additional Capacity

The Operations Site Management team will ensure the recognition of early pressure within the hospital system, utilising data and information gathered through the site operational meetings and monitoring trends in activity.

Each level of escalation requires a different response to either maintain level of escalation, prevent escalation or to support with de-escalation when a high level of escalation has been triggered. Where there is a risk of escalation, the Response to Operational Pressures Table should be reviewed to ensure all actions have been taken.

The Operations team will coordinate and facilitate escalation management and response centrally however each clinical division and business unit should have their own individual operational plans in place to manage surges in demand, sustained pressure and business continuity problems which should be reviewed regularly.

The Operations team will coordinate an escalated operational site meeting where this is deemed necessary, each division should ensure there is senior representation at each escalated site meeting.

A tactical 'silver' meeting will be chaired by the Deputy Chief Operating Officer or nominated deputy when a site escalates and will take place daily until the site is able to de-escalate.

If demand exceeds capacity, it may be necessary to increase capacity by opening additional bed spaces or areas.

There are several different types of escalation beds across University Hospitals of Derby and Burton NHS Foundation Trust sites including full capacity rooms, push for safety spaces, Surge and Super Surge capacity that will be enacted as deemed appropriate.

8.1 Outlying

Where possible, all patients should receive their ongoing treatment in the appropriate speciality ward. However, there will be occasions where due to the pressure of admissions in a particular specialty, it will be necessary to transfer patients to a ward within another specialty.

The Operations team will work in collaboration with the clinical divisions to identify where outlying capacity is available and the divisions will identify the agreed clinical model. The clinical teams will identify the patients who are appropriate to transfer to outlying areas. The operations team will provide a daily list of all patients who have been outlied and the responsible clinical teams based on the information provided.

The clinical divisions will ensure timely review for all outliers and ensure any escalation of care is responded to promptly. (Policy currently under review)

8.2 Escalation Capacity

The use of the different types of escalation capacity will be determined by operational pressures and guided by escalation levels. Certain beds will require executive level of approval as identified within the Standard Operating Procedure for the Opening of Escalation beds.

When making decisions regarding the use of escalation capacity, all core beds across the acute and associated community sites should be reviewed and plans agreed to optimise effective use of core bed capacity. Escalation capacity should be considered where there are identified risks of overcrowding in the Emergency Department, ambulance handovers delays and a delay to admission for patients with a decision to admit. When considering all options, it is expected that there is a clear understanding of the site position, planned and predicted discharges are clearly understood and both internal and external delays have been escalated. Additional clinical and operational support should be requested through escalation leads where necessary.

Steps should be taken to de-escalate and close escalation beds as soon as it is safe and possible to do so. This will be the responsibility of the Operations team to manage in close collaboration with divisions.

9.0 Optimising Capacity and Managing Patient Flow

9.1 Bed Declaration

Beds may become available through planned discharges, anticipated discharges or unplanned and unexpected discharges. Use of the discharge assessment units should be considered for all patients being discharged, not using this area should be an exception with clear clinical justification.

The bed management, patient flow or clinical site practitioner team should be informed of planned and anticipated discharges on the day before discharge where possible and at the earliest contact with the ward on the day. Once anticipated discharges are confirmed, the bed management, patient flow or clinical site practitioner teams should be informed. Any unplanned or unexpected discharges should also be reported as soon as they are confirmed to enable effective site management.

Early identification of capacity enables the operations team to make decisions to ensure we put our patients first and support with our objective of right first time.

The bed management, patient flow or site team should be informed as soon as the patient leaves the ward to ensure that appropriate plans can be made for bed allocation. There will be a 30minute period allowed between declaration and move for the wards to ensure that appropriate preparation of the bed area can be completed. Handover should take place within this 30minute period. Any delay must be reported immediately. The nurse in charge of the ward area is responsible for ensuring a safe clinical area. If they consider a further admission to be detrimental to the safety of the ward, discussion should be held with the operations team so that action can be taken, this should not detract from the wards responsibility to declare the vacant bed to the bed management, patient flow or clinical site practitioner team.

Breach of this is considered a patient safety concern and should be reported accordingly.

9.2 Sitting Out

At points of escalation, it may be necessary to transfer patients to a ward without a bed being immediately available to share risk across the site. Wards will be expected to accept additional patients either by temporarily moving a patient/patient's awaiting discharge into the day room or an appropriate seated area within the ward. This should only be considered when the discharge assessment unit is not an option.

The expectation for sit out patients will be that a patient will be discharged from that ward either home or to the discharge assessment unit that day meaning that the sit out arrangement is for a time limited period. This does not refer to boarding.

The final decision for which patients sit out will be made by the nurse in charge in conjunction with the lead clinician for the ward. Patients should be stable, with a NEWS less than 3, not acutely confused, not receiving oxygen and not requiring isolation.

9.3 Long Length of Stay Review

Reducing Length of Stay aims to provide patients with a better experience by ensuring they are discharged from hospital without unnecessary delay. The detrimental impact of long length of stay for patients is well documented and a reduction in long length of stay can improve overall occupancy.

Each clinical division has plans in place to ensure length of stay is monitored weekly. Any trends and increases in length of stay are also monitored by the Operations team.

9.4 Prevention of Deconditioning and Hospital Acquired Functional Decline

Hospital-acquired deconditioning can occur because of a period of bed rest or reduction in activity due to illness and period of time in hospital. While hospital-acquired deconditioning can occur in people of any age, it is particularly problematic in elderly people, as it can lead to irreversible functional decline. Hospital-acquired deconditioning is preventable with proactive, comprehensive regular assessment and intervention. The time-period of assessment must be short, so that repeated assessments can be made during an acute hospital admission. Prevention of deconditioning and hospital acquired functional decline is the responsibility of all clinical teams and will ensure no unnecessary delays when a patient is medically optimised for discharge.

APPENDIX A
CAPACITY MEETINGS STANDING AGENDAS

08:30, 12:30, 15:30, 17:30 in person and via MS Teams

8.30am meeting:

- Welcome by chair.
- Update of previous day performance, including number of off loads over 1 hour and number of 12-hour DTAs
- Immediate risks to staff, patients, or infrastructure.
- Summary of actions from previous meeting, outcomes, and feedback (ensure action log is displayed on screen) at 12:30 and 15:30 hours.
- Confirm divisional capacity rep details and SMOC on the calls.
- Confirm OPEL and ESCALATION status.

Division	Information	Responsible person
Site	Current site position including: • Patients with confirmed DTA • Bed predictor by calculator for each division (final number) • No. of 12 hr DTA's and any at risk. • Number of repats in and out.	Chair of the Day
ED	• Number in Dept with breakdown of each area • Numbers in UTC (RDH only) • Longest wait to be seen • Numbers still a/w ED review • Any ambulance offload delays? If so- how long • How many patients' a/w admission • Any speciality delays against IPS- Which specialities? • Any staffing issues nursing and medical and mitigations taken for this • Any other escalations and plan for the day	ONIC/ED Matron/Acute Med rep
MAU (RDH)	• Number of Empty Beds • Patients in ED queue/waiting in ED • Patients in GP queue/expected • Patients a/w senior review • Patients a/w clerking • Beds allocated ready • Beds allocated not ready • Speciality Allocated • Definite discharges • Internal delays • Staffing concerns medical/nursing	AMBU Escalation lead

APPENDIX A

AMU (QHB)	• Number of empty beds • Predicted discharges - how many? • Definite discharges - how many? • Internal delays - ie echo's, speciality request (cardio) etc • Mental Health patient bed waits over 24hours • S/R patients- Infected/Non infected • High Acuity/Challenging patients? • Staffing concerns medical/nursing	NIC of ward or Acute Med rep
Short Stay (QHB)	• Number of empty beds • Predicted discharges - how many? • Definite discharges - how many? • Internal delays - ie echo's, speciality request (cardio) etc • Mental Health patient bed waits over 24hours • S/R patients- Infected/Non infected • High Acuity/Challenging patients? • Staffing concerns medical/nursing	NIC of ward or Acute Med rep
Medicine (RDH)	• PDD's for the day (New) • Any closed beds • OPEL appropriate plan and actions. • Create patient list for escalation areas. • Any concerns	Medicine Rep
Surgery	• PDD's for the day. • Any closed beds. • Appropriate plan and actions being taken. • Any concerns	Surgery Rep
Cancer	• In line with SOP	Cancer Rep
W&C	• Plan and actions for Paediatrics. • Gynae position • Maternity position	Chair of the Day or Rep from Division if in high Escalation
ITU	• Dependency and total numbers. • Capacity.	Chair of the Day or Rep from Division if in high Escalation
Discharge Team	• Confirm complex discharges and available capacity	Discharge lead

At 12:30 hrs please ensure that a plan is provided to maximise capacity.

At 15:30 please provide a plan for the night.

Usual meeting etiquette will apply,please be on time/present and prepared.

Appendix B

Site Team Action Card

Escalation 1

- Liaise with divisional representatives to implement required actions, highlighting any deficits to discharge against demand.
- Ensure outflow to assessment areas by maintaining flow to inpatient wards.
- Escalate to relevant divisional reps any barriers to flow/discharge, for example therapies, pharmacy, radiology etc.
- Support the 4-hour target by ensuring patients are moved timely from ED to the appropriate areas.
- Monitor patients at 3 hours in ED and above discussing any delays with ED ONIC and specialties if required.
- Maintain flow out of the assessment areas into inpatient wards by monitoring and moving specialty patients in assessment areas over 24hrs.
- Ensure maximum usage of Discharge Assessment Unit
- Daily review of repatriation list to ensure wait times are kept to a maximum of 72 hrs and that all patients pending transfer are followed up daily with escalation to the COO/Deputy COO care if required.
- Maintain regular communication with ED including overnight, attend ED safety huddle and have a presence in the department as appropriate.
- Out of hours support the redeployment of staff with Senior Nurse across the hospital as appropriate.
- Highlight any nursing gaps raised overnight to the Senior Nurse/staffing lead in time for the nursing staff meeting at 08:00.

Escalation 2 (in addition to the above)

- Chair of the Day or Clinical Site managers assume responsibility for site coordination resolving immediate operational issues within their scope, including active ED breach prevention in conjunction with the ED ONIC
- Highlight all barriers to flow to relevant divisional reps with an expected time for feedback of action.
- Have an overview of escalation areas and outliers, if any and to expedite patients who are for discharge/need to be moved back to a specialty bed.
- Inform the oncoming SMOC of any immediate flow and operational issues.
- Consider the use of escalation areas in accordance with the appropriate policy.

Escalation 3 Low (in addition to the above)

- Support patient flow within the Emergency care pathway, supporting ED, assessment areas and wards.
- With the support of the General Manger for Ops Capacity & flow, divisional reps and bed manager team create advance plans making sure beds are made available in the required areas where able and consider enaction of boarding.
- Discuss with ED ONIC and Matron/Service Manager current pressures and agree immediate action plan.
- Monitor ED/MAU/AMU closely ensuring a regular supportive presence.
- Ensure oncoming SMOC is updated of current pressures.
- OOH's Discuss with ED ONIC and Consultant in charge current pressures within the department and agree plan.
- OOH's monitor pressures throughout the hospital and in discussion with on-call teams & SMOC. Consider escalation to on call consultants.
- Facilitate discussions around the safe use of escalation areas.

Escalation 3 High (in addition to the above)

- Check and challenge divisional plans for supporting flow
- Have oversite of activity in ED assessment areas and wards and support where able/needed
- Support conversations around use of Surge and Super Surge capacity
- Proactively liaise with external partners including ICB and ambulance service to provide assurance around maintaining timely ambulance offload

Escalation 4 (in addition to the above)

- Liaise more formally with external partners

Appendix B

HALO/Ambulance control to ensure full view of inbound patients and those waiting to be handed over, discuss appropriateness of IC's given current pressures.

- OOH If indicated by relevant teams, consider calling in on call consultants to support the safety of patients in ED and wards.
- Keep the SMOC informed of any operational issues.

Appendix B

RDH Adult Emergency Department (ED)
Action Card Overall Nurse in Charge (ONiC), Shift Lead Consultant

Escalation 1

- **All:** update at ED huddles (07:30, 11:00, 15:00, 19:30, 22:00, 01:30) of ED, Medicine Division and Trust OPEL status and associated actions
- **ONIC/Shift Lead Consultant:** monitor handover times (<15 mins) and inbound ambulances
- **Shift Lead Consultant:** review medical staffing ensuring Senior Decision Makers (SDMs) are allocated and present in all areas - pitstop/streaming/majors A/majors B/Resus.
- **ONIC:** review nurse staffing ensuring adequate staffing in all areas.
- **ONIC/Shift Lead Consultant**: ensure ED is streaming to Urgent Treatment Centre (UTC)/assessment units/Same Day Emergency Care (SDEC)
- **ONIC**: timely transfer of discharged patients to Discharge Assessment Unit (DAU)/home.
- **ONIC/Shift Lead Consultant**: focus on time to initial assessment and time to clinician assessment and referral to speciality standards
- **ONIC:** ensure patients are ready to transfer as soon as a bed is declared (within 30 minutes)
- **ONIC/Shift Lead Consultant:** work with specialities to meet Decision to Admit (DTA) Policy standards.

Escalation 2 (in addition to the above)

- **ONIC/Shift Lead Consultant:** review of staffing levels and redeploy to areas depending upon demand.
- **ONIC/Shift Lead Consultant:** move patients to available capacity with the department. Utilise "fit to sit".
- **ONIC:** review Lorenzo to ensure utilisation of fit to sit areas, UTC, assessment units, SDECs and DAU
- **ONIC:** escalate speciality assessment delays and transfer delays to the operations centre and appropriate divisional escalation leads.

Escalation 3 Low (in addition to the above)

- **ONIC/Shift Lead Consultant:** liaise with acute medicine team re possible support for Medical Assessment Unit (MAU) queue.
- **ONIC/Shift Lead Consultant:** minimum care standards on ambulances.
- **ONIC/Shift Lead Consultant:** ensure ED escalation areas are open/utilised (C-side and ward 101)
- **ONIC/Shift Lead Consultant:** identify and escalate non-adherence of DTA policy via bed meeting

Escalation 3 High (in addition to the above)

- **ONIC:** request EMAS Duty Commander on-site
- **ONIC/Shift Lead Consultant:** plan for the use of fracture clinic by identifying appropriate patients as per the Standard Operational Procedure
- **ONIC:** Move patients outside bays in Majors A
- **ONIC/Shift Lead Consultant:** increase Pit Stop trolley capacity

Escalation 4 (in addition to the above)

- **ONIC/Shift Lead Consultant**: face to face safety escalation huddle with management team, in hours and Patient Flow Manager and Senior Manager On-Call (SMOC), out of hours.
- **ONIC/Shift Lead Consultant**: move patients declared outside bays in majors A (maximum 4 patients) and expand and increase pitstop trolley capacity to 11 patients (additional 1 patient in the middle, additional 1 patient on the weigh bridge)
- **ONIC/Operations Centre:** open fracture clinic (17:30 - 07:00) if staffing allows and confirm clinical responsibility between ED and MAU
- **ONIC:** request ambulance diverts via operations centre or SMOC.
- **Operations Centre/SMOC/Executive On-Call:** request ambulance diverts to neighbouring hospitals and ensure ambulance service are aware.
- **ONIC/Shift Lead Consultant:** escalate to management team for specialty consultants to attend ED and review specific patients to facilitate discharge or plans for complex patients who are waiting admission.
- **ONIC/Shift Lead Consultant:** request additional ED doctors to support care of patients.

Appendix B

RDH Medical Assessment Unit (MAU)
Action Card Nurse in Charge (NIC), MAU Shift Lead, Acute Medicine Escalation Lead

Escalation 1

NIC/Shift Lead:

- Review all patients on the unit
- Complete clerking and senior reviews in a timely way
- Declare beds from the Emergency Department (ED) within 15 minutes of a bed becoming available
- Transfer suitable patients to Medical Same Day Emergency Care (mSDEC)
- Transfer admitted patients to baseward beds within 30 minutes of a bed becoming available

Escalation 2 (in addition to the above)

- **NIC/Shift Lead/Escalation Lead:** review medical staffing levels and redeploy to areas depending upon demand
- **NIC:** review nurse staffing levels, attend staffing huddles (08:00, 13:00, 15:00) and escalate if required
- **Shift Lead:** review ED queue to reallocate appropriate patients to mSDEC

Escalation 3 Low (in addition to the above)

- **NIC/Shift Lead/Escalation Lead:** continue to review staffing levels including redeploying medical staffing from Short Stay ward 216 or mSDEC
- **Escalation Lead:** request earlier speciality reviews through Medical Escalation Lead
- **NIC/Shift Lead/Escalation Lead:** postpone GP patients to the following day where possible
- **NIC/Escalation Lead:** request support from the operations centre for portering/cleaning delays
- **NIC/Escalation Lead:** transfer discharged patient to Discharge Assessment Unit (DAU)/home
- **Operations Centre:** support with electronic documentation of patients on the whiteboard
- **NIC/Shift Lead/Escalation Lead:** fully utilise all available bed capacity, including outlier capacity. Escalate to the operations centre if unable to allocate patients to available beds due to speciality/gender/isolation requirements i.e., no patients are deemed suitable for available beds
- Queue up to 4 patients in the MAU corridor

Escalation 3 High (in addition to the above)

- **Shift Lead/NIC:** if unable to match speciality allocated patients to available beds, request wards to select most appropriate patient (enact pull)
- Queue up to 6 patients in the MAU corridor

Escalation 4 (in addition to the above)

- **Shift Lead:** request continuous in-reach from specialities, escalate to Clinical Director/Divisional Medical Director (aspiration)
- **Shift Lead/Escalation Lead:** if required, contact Cardiology for urgent consultant led reviews of patients where demand exceeds current/predicted capacity
- **Operations Centre:** board against moves to DAU/definite discharges to create capacity for queued patients
- **NIC/ Shift Lead/Escalation Lead:** utilise 2 clinic rooms and 2 spaces in the corridor
- **NIC:** declare ED patients against definite transfers off
- **NIC:** expedite transfer to basewards without telephone confirmation.
- Queue up to 9 patients in the MAU corridor

If clerking is under 5 patients and senior reviews are under 10, send a junior doctor into ED to clerk patients.

Escalation level 4 super surge (in addition to the above)

- Queue 9 patients in the MAU corridor

Appendix B

Discharge Business Unit

Escalation 1

- Discharge Assessment Unit (DAU) Nurse in Charge (NIC) / Discharge Support Officer (DSO) to check transport list bookings and identify early pull.
- DAU NIC / DSO to check Medically Optimised for Discharge (MOFD) patients / patients with amber DAU icons and allocate them for collection by the DAU where appropriate.
- (Royal Derby Hospital) Check red & blue DAU icons by 10:00 and liaise with wards to push for change to amber wherever possible.
- Escalate any staffing concerns to DAU Matron at the earliest opportunity.
- Escalate any delays around discharging overnight stay patients (liaise with DAU Matron / Discharge Leads) at 09:00 huddle.
- DAU NIC to attend all bed meetings, update OPEL board and actions.
- Highlight any issues with porter staffing to facilities manager as necessary.
- Hold periodic huddles to include all DAU team representatives.
- Escalate / resolve any actions as identified in huddles.
- Circulate Discharge Pathway Update internally.

Escalation 2 (in addition to the above)

- Liaise with Integrated Discharge Team (IDT) to identify and escalate any significant delays to DAU Matron / Deputy General Manager / General Manager, as required.
- DAU NIC and IDT Leads to ensure staff are made aware of escalated pressure level, additional responsibilities, and processes to be followed.

Escalation 3 Low (in addition to the above)

- Hold additional huddles to support discharge wherever required.
- DAU representative to attend divisional Bronze Action Meetings. (Liaise with DAU Matron to agree who is best to attend.)
- Identify outliers as informed by the bed meetings (liaise with IDT)

Escalation 3 High (in addition to the above)

- Identify MFFD patients suitable for DAU surge areas e.g. pleural room, ward 312 gym etc.
- Provide additional support to identified ward areas.
- Identify and staff medical model in all areas.
- Escalated system partners meetings daily

Escalation 4 (in addition to the above)

- Review transport list regularly and escalate issues / delays to transport liaison and operations team as required.
- Implement additional capacity plans within the DAU where necessary. (Discuss with Snr Sister / Matron / DGM / GM)
- Escalate to Unit Cover / Staffing Sister as to additional staffing requirements to support full capacity plan.
- Matron / Deputy General Manager / General Manager to support with escalations and DAU and IDT operation.
- General Manager to escalate issues or concerns to all external partners, Chief Operating Officer / Divisional Director / Divisional Nursing Director as appropriate.
- Call an urgent Pathway Operations Group Meeting (Derby) / Staffordshire Un-met Demand Call as required.
- Request with ICB to open additional funded bed capacity.

Escalation Super surge (in addition to the above)

- Identify MFFD patients suitable for super surge areas if the decision is made to open these.

Appendix B

RDH Medical Same Day Emergency Care (mSDEC)
Action Card Nurse in charge (NIC), mSDEC Consultant

Escalation level 1

- **NIC/Consultant:** ensure adherence to IPS standards.
- **NIC:** timely transfer of discharged patients to Discharge Assessment Unit (DAU)/home.

Escalation level 2 (in addition to the above)

- **NIC/Consultant/MAU shift lead/Medical Staffing:** safety huddle to review medical and nursing staffing levels and if required, request redeployment of staff from MAU/Short Stay ward 216.

Escalation level 3 (in addition to the above)

- **NIC/Consultant:** alert escalation lead of status
- **Escalation Lead:** consider pausing to ED referrals/pull from ED until waits to be seen are less than 3 hours.
- **NIC:** escalate to operations centre if bed waits are over 3 hours from request or more than 5 patients are waiting for a bed.

Escalation level 4 (in addition to the above)

NIC/Consultant:

- face to face safety escalation huddle with management team, in hours and Patient Flow Manager and Senior Manager On-Call (SMOC), out of hours.
- pause ED referrals/pull from ED until waits to be seen are less than 3 hours.
- escalate to management team for specialty consultants to attend mSDEC and review specific patients to facilitate discharge or complete care plans for complex patients who are waiting admission (aspirational)
- Escalate to surge into Surgical SDEC if demand exceeds capacity.
- **Operations Centre:** board against moves to DAU/definite discharges to create capacity for queued patients.

Appendix B

QHB Adult Emergency Department
Action Card Escalation Manager/Nurse in charge (NIC), Shift lead consultant

Escalation 1

- **All:** ensure awareness at ED huddles of OPEL status to inform both ED and Trust wide actions
- **Escalation Manager/NIC/consultant:** ensure adherence to Decision to Admit (DTA) standards
- **Escalation Manager/Consultant:** review medical staffing ensuring senior decision makers (SDM) are situated in all key areas - Pitstop/Streaming/Majors/ Miami/Resus
- **Escalation Manager/NIC:** review nurse staffing ensuring adequate staffing in all areas with relevant skill mix available
- **Escalation Manager/NIC/consultant**: ensure streaming to assessment areas/SDEC
- **NIC**: transfer discharged patients to Discharge Assessment Unit/home
- **Escalation Manager/NIC/consultant**: ensure time to assessment and time to referral standards are met
- **Escalation Manager/NIC:** ensure patient is ready to transfer as soon as a bed is declared

Escalation 2 (in addition to the above)

- **Escalation Manager/NIC/consultant:** further review of staffing levels and redeployment as necessary
- **Escalation Manager:** review Meditech to ensure utilisation of assessment units, SDECs, fit to sit areas and DAU
- **Consultant/ NIC-** Ensure speciality patients are being seen and reviewed in a timely manner by speciality clinicians and any delays are escalated appropriately
- **Escalation Manager/NIC/Consultant:** Chase any unnecessary delays and ensure all patients have a clear plan
- **Escalation Manager:** Liaise with patient flow to ensure that delays in specialty assessment in ED or transfers to ward/assessment areas are escalated to the Operations team and Divisional escalation managers

Escalation 3 low (in addition to the above)

- **Escalation Manager/NIC/consultant:** Assess pressure point areas within the department and deploy staff/ team to help decompress the challenges.. E.g. Triage over capacity - extra triage nurse deployed. Holding on ambulances - Fit to sit considered and Global Risk Assessment Triage started.
- **Escalation Manager/NIC/Consultant:** Ensure all patients requiring assessment units have been streamed to relevant SDECs if clinically suitable. Any patient not requiring a trolley is stepped down into Fit To Sit/ MIAMI
- **Escalation Manager:** Request Virtual Ward team to identify any patients suitable to go to the virtual ward.

Escalation 3 high (in addition to the above)

- **Escalation Manager/ONIC/consultant:** Consider using SDEC trolleys for ambulance offloads or for patients waiting for admission depending on the current situation

Escalation 4 (in addition to the above)

- **Escalation Manager/NIC/Consultant** STOP Moment with Patient Flow Manager, SMOC and Exec on call, face to face if possible
- **Escalation Manager/ Consultant/ NIC: R**equest additional nurse staffing to allow SDEC Trollies to open out of hours. Waiting room needs to be assessed to ascertain biggest risk area before deploying staff.
- **Escalation Manager: R**equest ambulance divert
- **Patient flow/SMOC/Exec on call:** Request ambulance divert from neighbouring hospitals and ambulance service
- **Escalation Manager/ONIC/consultant: request specialty consultants** attend ED and/or mSDEC to review identified, specific patients to facilitate discharge or complex care plans
- **ONIC:** restrict number of relatives and visitors to decompress crowding

Escalation 4 Super surge (in addition to the above)

- **Escalation Manager/NIC/Consultant** Consider use of fracture clinic for minors to free space for escalations

Appendix B

QHB Acute Medical Unit
Action Card Nurse in charge/ Clinical Decision Maker/ Escalation manager

Escalation 1

- **NIC/Clinical Decision Maker**
- Review all patients
- Complete senior reviews and clerking.
- Declare beds from ED within 15 minutes of bed becoming available on MAU
- Transfer admitted patients to base ward beds within 30 minutes of bed becoming available on baseward

Escalation 2 (in addition to the above)

- **NIC/Clinical Decision Maker/Escalation manager** Review medical staffing levels and re-assign to different areas of MAU if required
- **NIC** review nurse staffing levels, attend staffing huddle at 8am, 1pm, 3pm and escalate if required.
- **Clinical Decision Maker** Review ED queue to see if any patients can be stepped down the virtual ward or discharged home
- **NIC/Clinical Decision Maker** Triage GP patients to SDEC.
- **NIC/escalation Manager** Transfer discharged patient to DAU/home
- **Clinical Decision Maker** Maximise the use of virtual ward

Escalation 3 low (in addition to the above)

- **Escalation Manager/NIC/consultant:** Assess pressure point areas within the department and deploy staff/ team to help decompress the challenges.. E.g. Triage over capacity - extra triage nurse deployed. Holding on ambulances - Fit to sit considered and Global Risk Assessment Triage started.
- **Escalation Manager/NIC/Consultant:** Ensure all patients requiring assessment units have been streamed to relevant SDECs if clinically suitable. Any patient not requiring a trolley is stepped down into Fit To Sit/ MIAMI
- **Escalation Manager:** Request Virtual Ward team to identify any patients suitable to go to the virtual ward.

Escalation 3 high (in addition to the above)

- **Escalation Manager/ONIC/consultant:** Consider using SDEC trolleys for ambulance offloads or for patients waiting for admission depending on the current situation

Escalation 4 (in addition to the above)

- **Escalation Manager/NIC/Consultant** STOP Moment with Patient Flow Manager, SMOC and Exec on call, face to face if possible
- **Escalation Manager/ Consultant/ NIC: R**equest additional nurse staffing to allow SDEC Trollies to open out of hours. Waiting room needs to be assessed to ascertain biggest risk area before deploying staff.
- **Escalation Manager: R**equest ambulance divert
- **Patient flow/SMOC/Exec on call:** Request ambulance divert from neighbouring hospitals and ambulance service
- **Escalation Manager/ONIC/consultant: request specialty consultants** attend ED and/or mSDEC to review identified, specific patients to facilitate discharge or complex care plans
- **ONIC:** restrict number of relatives and visitors to decompress crowding

Escalation 4 Super surge (in addition to the above)

- **Escalation Manager/NIC/Consultant** Consider use of fracture clinic for minors to free space for escalations

Appendix B

Executive on Call Action Card (COO or Deputy COO in hours)

Escalation 1

- Attend 17.30pm capacity meeting for an overview of any operational pressures which may impact patient pathways, safety, and service delivery (e.g., staffing, ambulance waits etc.)
- Agree evening plan in line with escalation processes

Escalation 2 (in addition to the above)

- Liaise with the SMOC to ensure effective flow and early communication if there are surges in demand ensuring early mitigation strategies are in place

Escalation 3 low (in addition to the above)

- Be readily available for Senior oversight when site becomes pressured
- At the 17:30 capacity meeting: ensure any issues relating to patient flow are addressed.
- Liaise with SMOC to ensure if necessary additional escalation bed options have been utilised and are appropriately staffed
- In the event ED is at full capacity or where there are concerns regarding patient safety, ensuring all teams and on call personnel are aware.
- Weekend/OOH's attend additional capacity meetings if required.
- Ensure appropriate support to the ED queue is being provided and there are plans/strategies to ensure ambulance handover delays are kept to a minimum. For example, deploy additional resource to ED to expedite handovers.
- Ensure SMOC has been updated on any capacity and demand issues externally escalated to you.
- Where escalation status is looking to turn OPEL 4 notify the ICB on call and if necessary, instigate teams call with yourself, Site Team, SMOC.

Escalation 3 high (in addition to the above)

- Agree if necessary for SMOC to remain on site with actions to support de-escalation of ED including in reach from specialist teams to assess requested admissions. Expedite discharges where possible.

- Have oversight of capacity usage and if further escalation needed from Surge/Super Surge to Boarding

Escalation 4 (in addition to the above)

- Attend all capacity meetings OOH and weekends
- Liaise with SMOC to ascertain whether ambulance divert needs considering, SMOC to confirm if this can be supported and request through agreed process.
- OOH and weekends, join the ICB conference call on Teams, appraise them of capacity and demand issues.
- Support requests for additional staff to ED/escalation areas to ensure appropriate care of patients in the ED queue, this may mean requesting specialty Drs to provide ward/ED support for discharge/admission avoidance. .
- Consider as suggested by teams any additional options for bed escalation as per policy and review all additional options that are available.
- Ensure that notification has been sent to system partners, on call managers to expedite discharge care packages.
- Request additional consultants/Drs to remain on site to support triage, assessment and discharge.
- Request communication via the on-call comms team member as required

Escalation 4 Super surge (in addition to the above)

- Have oversight of requirement to utilise Super Surge boarding capacity to load level risk within ED and assessment areas

Appendix B

General Manager for Ops Capacity and Flow Action Card
OPEL 1
• Liaise with site team regularly to ensure flow and demand is maintained. • Have an overview of ED flow and wait times, liaising with the site team and ED ONIC/managers as necessary. • Monitor live ED systems to be aware of any surges in demand. • Monitor live ambulance screen and be aware of any offload delays • Ensure that actions set at capacity meetings are followed up by divisions. • Lead for the Trust on the system call highlighting any support required from partners that may facilitate flow. • Maintain operational surveillance. • Support the site team if required to assist with troubleshooting delays both in ED and the ward areas. • Highlight all flow blockers to the relevant divisional triumvirate with an expected time for feedback of action. • Support the site team in ensuring maximum use of the discharge assessment unit and that all patients have this as a default. • Review of repatriation list with the site team to ensure wait times are kept to a maximum of 72 hours and that all patients pending transfer out are followed up daily with escalation to divisions if patients are delayed being transferred to other Trusts.
OPEL 2 (as well as the above)
• Work with divisional representatives/leads to ensure appropriate internal escalation/review and discharge of patients.
OPEL 3 (as well as the above)
• Communicate status to Dep COO and COO • Ensure all system partners are updated on current position. • Maintain close communication with all divisional triumvirates on OPEL status. • Close scrutiny of live ED systems. • Consider requirement for bronze calls or extraordinary capacity meetings with specific attendees for a focussed approach. • Support divisions on opening escalation areas in line with the policy • Liaise with the transport manager to update them of the situation and ensure there are no patient delays in transport. Discuss the use of extra vehicles if required. • Liaise with TOC/ambulance control to discuss the Trusts position and on-going flow issues. • Work with divisional triumvirates to ensure appropriate internal escalation/review of all patients. • Have overview of all possible 12-hour breaches and discuss them with relevant divisional reps/leads. Escalate to Dep COO/COO if 10hrs and no plan. • Use of escalation areas and any other alternative patient pathways to be discussed with divisions. • Consider cancellation of non-essential meetings/clinics /activities allowing focus on capacity and operational pressures
OPEL 4 (as well as the above)
• Ensure communication with Dep COO/COO of status to discuss further actions. • Communicate with divisions and request assistance in managing the provision of further escalation capacity. • Ensure communication has been initiated to cancel all non-essential meetings for those staff required to support any component of de-escalation, provision of care or further bed capacity. This includes seeking assurance that any office-based staff are supporting patient care within the departments clinically. • In discussion with the Dep COO/COO consider cancellation of all non-urgent Trust activities. • Ensure close communication with external system partners.

Appendix B

Escalation Lead Action Card

OPEL 1

- Be a direct support to and be a point of escalation for your respective division and the site team
- Ensure attendance at every capacity meeting. The same person will be expected to attend each meeting in a day to ensure consistency in communications; ensuring clear plans for their division at the capacity meeting are presented.
- Receive escalations from other areas of the hospital regarding specialty reviews that are outstanding and ensure these are resolved.
- Ensure the appropriate responsible consultants are aware of outliers and have capacity to review all patients required of them.
- Receive escalations regarding outstanding actions from medical staff such as TTOs and to liaise with consultant teams to resolve.
- Review elective and emergency demand at earliest opportunity prior to 8.30am meeting, understand discharge numbers and in the event of a deficit consult with the divisional team to support review of electives to make suitable plans to harness use of alternative capacity.
- Ensure outliers are identified by 15:30 hours. (QHB only)
- Ensure teams have consulted with ITU to ensure sufficient capacity for admissions. (Surgical Division only)

OPEL 2 (as well as the above)

- Be aware of any additional areas opened and ensure outlying patients are reviewed by senior clinical teams.
- Where DTAs have been in ED overnight, request early in reach to ED for early post take and decision making.
- Attend board rounds to facilitate maximum discharges.

OPEL 3 (as well as the above)

- Ensure full clinical view of elective list for prioritisation or identification of suitable plans to ensure all patients can be accommodated.
- Be proactive in approach to ward areas to actively facilitate discharges and challenge delays.
- Have awareness of ED/Assessment Units activity and requirements for admission to support with plans and decision making.
- Surgery - Review order of theatre lists to prioritise clinically urgent cases and patients who can be accommodated without being admitted into a main hospital bed.
- Be aware of low declared discharge areas and attend whiteboard rounds where necessary.
- At 15:30 capacity meeting reviews the elective list for the following day where capacity is insufficient. Theatre lists for the following day must be ordered so that urgent/cancer and those prioritised are placed first on lists and all am sessions the following day may start without delay.
- Increase numbers of additional medical staff to support the division and escalation areas.
- Make recommendations regarding elective activity within available bed base or escalate to additional bed capacity if activity cannot be cancelled.
- Where bed deficit of magnitude requires urgent/cancer cases to be cancelled this must be escalated to General Manager for Ops Capacity and Flow. Once cases for cancellation have been agreed the Dep COO/COO must be informed.

- Consider cancellation of appropriate OPA activity to release clinician support in discussion with DOD/ DD
- Cancel all non-essential activity for the division, including CBU meetings and training.

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SMOC Action Card

OPEL 1

- Attend 15:30 and 17:30 capacity meeting to receive handover/updates of any operational pressures which may impact the 4-hr target (e.g., staffing) Agree evening plan in line with appropriate escalation processes or actions.
- Troubleshoot any issues escalated by the site team.
- Forward any escalation where needed to the EOC.
- Ensure all areas have completed or have ongoing green actions.
- Check in with site team before leaving site.
- Join the system call at weekends if required.

OPEL 2 (as well as the above)

- Maintain awareness of the evolving site activity and pre-empt any escalation in activity that could precede deterioration in performance.
- Work with site team to ensure effective flow and early communication in the event of surges of demand ensuring prompt mitigation strategies are implemented.
- Participate in additional capacity meetings as required or requested.
- Ensure all areas have completed or have ongoing amber actions.

OPEL 3 (as well as the above)

- Be on site if requested by the site team or DOC.
- Liaise with site team to ensure additional escalation bed options have been utilised.
- Ensure all areas have completed or have ongoing red actions.
- Request additional capacity meetings if required.
- Ensure patients are being transferred to assessment areas, discharge lounge prior to breach time.
- Liaise with site team to support any delays in assessment/transfer.
- In the event ED is full or there are concerns regarding patient safety; ensure on call teams are supporting in reach to ED/assessment areas MAU/AMU/SAU etc.
- Ensure appropriate support to ED queue is being provided and there are strategies to ensure ambulance handover delays are minimised and is reduced by deploying additional resource to ED to expedite handover.
- Ensure the DOC has been updated on capacity and demand issues and agrees strategies to support de-escalation.

OPEL 4 (as well as the above)

- Agree if necessary additional support from divisions OOHs.
- Request additional nurses to ED/escalation areas to support appropriate care of patients waiting the ED queue and support escalation.
- Request additional capacity meeting as necessary to assess whether de-escalation strategies are working. This meeting should include the DOC.
- Consider additional options for bed escalation as per policy.
- Request additional Dr's to remain on site to support triage, assessment and discharge.

Appendix B

Ward Manager/NIC Action Card
Medicine Wards

OPEL 1

-
- Run ward whiteboard meeting
- Attend long length of stay meetings, ensure all relevant information regarding discharges and delays is brought to the meeting
- Escalate all delays to flow and discharge through the relevant channels
- Ensure all MFFD/ready for discharge patients do so in a timely manner and sent appropriately to the discharge lounge
- All exclusions to the discharge lounge need to be discussed with the capacity coordinator
- Beds are to be declared within ten minutes of discharge
- Escalate to Matron in hours/site senior manager out of hours any staff shortages which may impede flow and discharge
- Liaise with the discharge team to ensure they are aware of all complex medically ready patients for discharge
- Ensure all patients have up to date PDDs
- Ensure appropriate ownership of all actions following board rounds and appropriate escalation in the event of any delays
- Ensure E-track is up dated for each patient within ten minutes of any changes

OPEL 2 (as well as the above)

- If staffing shortages are impeding on transfer/discharging patients, matron to be informed in hours, site team out of hours
- Ensure beds are ready for incoming transfers from ED/assessment areas
- If patients arrive and beds are not vacated patient is to be kept on the ward until this is resolved, if unable contact the site team
- Ensure all discharges for the next day are booked for transport/collection by relative before 10:00 or transferred to the discharge lounge to facilitate flow

OPEL 3 (as well as the above)

- All confirmed patients are to be moved to the discharge lounge where possible to allow incoming admissions from overnight
- Liaise with MDT colleagues to fast-track reviews and assessments on ward patients to facilitate early discharge
- Identify potential patients who could go home to medical teams for early review
- Review staffing levels on the ward and review for the next 24hrs to ensure no/mitigated staffing gaps
- Consider bringing any staff on admin days back to the floor

OPEL 4 (as well as the above)

- Liaise with matron in hours and site team out of hours to see if any staff can be redeployed to ED
- Collect patients from ED/assessment areas where possible
- Ensure all non-essential training is postponed and all staff report to the ward
- Consider staff working additional shifts in liaison with the matron
- Identify any other means of discharge, i.e. family collecting, coming back for TTOs, using the volunteer sector for transport/short term support
- Ensure every action agreed to support flow is adhered to and any concern/barrier preventing patient progress through their pathway is escalated to the divisional capacity rep for the day or site team out of hours

Appendix B

Paediatric Emergency Department Action Card
Escalation for Nurse in Charge and Senior Clinician on Duty
Paediatric Business Unit

Escalation 1

- Normal practice
- 1 Resus beds available - Less than 2 patients waiting for triage or <15 minutes - Clinical review within time as determined by triage - < 20 patients in the department - 4-hour target is met - 0 patients waiting for admission.
- Designated triage nurse for each stream
- Staffing Levels to establishment

Escalation 2

- Board round with Clinician in Charge and NIC to ascertain plans / what is waiting.
- 1 Resus bed available - 3-4 patients waiting for triage or 16- 45 minutes - Category 3-5 patients aren't being seen within correct time frame - 20-36 patients in the department - 2-3 patients waiting for admission.
- Identify patients in department > 180 mins and review plan in place i.e., is bed booked, TTO ordered, discharge plan in place.
- Ring paediatric site practitioner to ascertain inpatient activity.
- For minor injuries ENP to stream all minor trauma from triage
- Second nurse to start triaging.
- Review HCSWs (Health Care Support Worker) to speed up triage by doing observations etc.
- In and out of Hours inform paediatric site practitioner.
- Consider redeployment of RNs from other clinical duties to focus on triage if wait time is above 30 minutes.
- Consider alerting Divisional Management Team (i.e.one of DD, DDD, DND, DMD) if Wait to Be Seen is above 3 hours.

Escalation 3

- Assume all points above already in action.
- 0 Resus beds available - Triage: 5-9 patients or 46 - 60-minute wait - Category 2 patients waiting >1 hour - 37 - 44 patients in the department - 3-5 patients waiting for admission
- **STOP** - what is waiting?
- Escalate to paediatric registrar to continue senior review of patients in department to allow consultant to see and treat.
- Review if additional nursing help is required.
- Out of Hours inform paediatric site practitioner who will escalate to site manager and flow team.
- In hours inform paediatric site practitioner who will escalate to paediatric staffing manager and paediatric Senior Management team to inform Division.
- Transfer of patients awaiting admission if bed capacity allows.
- In the event of high volume or high acuity CAHMS patients, escalate to CAHMS for further support with managing this cohort of patients.
- Consider placing a nurse or HCSW at front door to visually assess patients coming in.
- Message off duty medical or nursing staff to establish if any further support can be provided to the department i.e. to facilitate transfers to the ward or enhance Senior Decision Making Capacity.
- **Inform Divisional Management Team (i.e.one of DD, DDD, DND, DMD) if Dept is moving to OPEL Red.**

Escalation 4

- Assume all points above already in action.
- 0 resus beds available - Triage 11+ patients waiting or >60-minute wait - Category 2 patients waiting >90 minutes - >45 patients in the department - 6+ patients waiting for admission
- In an out of Hours inform paediatric site practitioner who will escalate to site manager and flow team
- Submit IR1 via DATIX.
- In Hours Consultant discussion with paediatric Senior Leadership team and paediatric site practitioner.
- Consultant discussion with Operations team (in hours) Senior Manager on call (out of hours) to request redirecting ambulances until safe.
- Consider declaration of Internal Major Incident

Appendix B

Paediatric Inpatient Beds Action Card
Escalation for Nurse in Charge and Senior Clinician on Duty
Paediatric Business Unit

Escalation 1

- Normal practice. Over 4 beds available over 4 discharges planned
- Staffing Levels to establishment.
- Knowledge of the bed situation in your clinical area with above ratio.
- Identify on day discharges and whether AM or PM.
- Ensure safe care is accurate and up to date (staffing and acuity).
- Be able to identify safeguarding patients, acutely unwell patients, challenging behaviour patients and patients with elevated PEWS.
- Complete NIC checklist.

Escalation 2

- Assume all points above already in action
- Over 4 discharges planned 1-3 beds available, under 3 discharges planned.
- Service week / on-call Consultant/ Registrar and NIC to review board to ascertain any further discharges and/or transfers. Identify delays to discharge which cannot be resolved at ward level and escalate to Site Practitioner.
- Identify patients who are to be discharged, ensure TTO's ordered, discharge letter is complete and transport arranged.
- Contact site practitioner to update with any further movement and keep them updated 24/7.
- Ensure nursing team on ward receive regular huddles with any relevant information.
- Consider if any patients are suitable to move to other areas.
- Assess staffing for the next 24 hours and action any shortfalls (escalate to band 7 of the area and Site Practitioner if not present) if shortfalls cannot be resolved).

Escalation 3

- Assume all points above already in action.
- 0 beds available but discharges expected within the next four hours.
- Escalate situation to Paediatric Service Week Consultant to enable further senior review of patients on wards.
- Review if additional nursing help is required. (escalate to band 7 of the area and Site Practitioner if not present) if shortfalls cannot be resolved).
- Consider opening extra bed capacity with extra staffing to support.
- Contact site practitioner to update with any further movement and keep them updated 24/7.
- Complete additional ward reviews of potential discharges.
- Consider transfer of patients across site.
- Consider elective admissions – are they any suitable for rescheduling?
- Consider cancellation of routine outpatient activity to repurpose medical support for wards.
- Liaise with appropriate members of the MDT to facilitate discharge and escalate any barriers to the Senior Leadership Team.
- Service week consultants at both sites to liaise re bed capacity.

Escalation 4

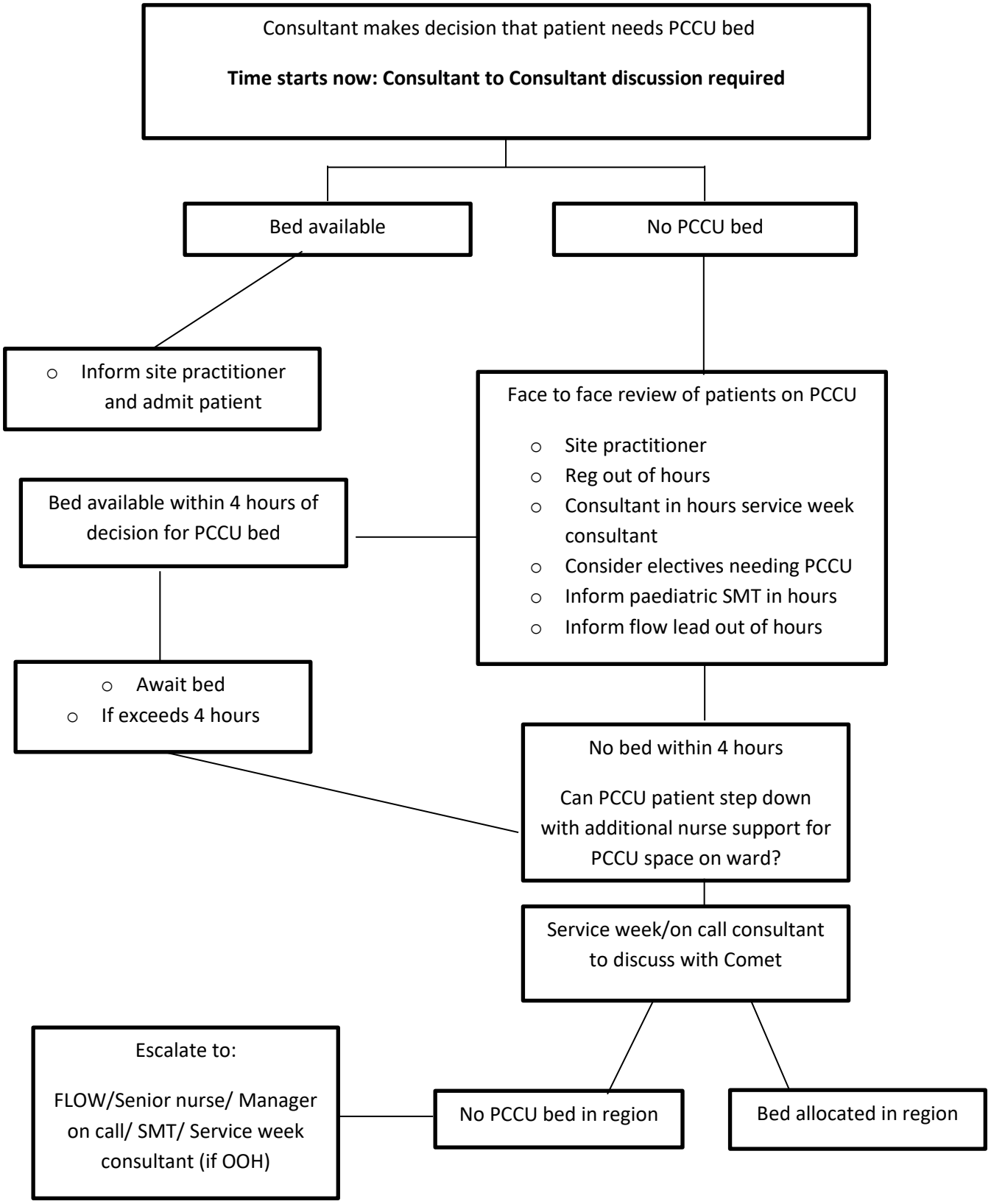
- Assume all points above already in action.
- 0 beds available 0 discharges planned.
- Submit IR1 via Datix.
- Service Week Consultant and Site Practitioner to escalate to Senior Leadership Team in hours.
- Service Week Consultant and Site Practitioner to escalate to Senior Nurse/ SMOC Out of Hours to discuss next steps.
- Paediatric consultants be prepared to stay on site to support paediatric wards to facilitate senior reviews for discharge and support with unwell patients to enable junior medical staff to attend CED and PAU.

Appendix B

HIGH DEPENDENCY BEDS

Please refer to the PCCU policy. Once a decision that a patient requires PCCU has been made by the consultant please follow the flow chart below.

PCCU at RDH



Appendix B

Derbyshire Pathology – Phlebotomy, OPAT & POCT
OPEL 1
□ Business as usual
OPEL 2 (as well as the above)
□ Business as usual
OPEL 3 (as well as the above) – High 3
□ BU representation at bed meetings □ Offer additional CSW & Phlebotomy support to ED □ Consider impact of reduced phlebotomy & CSW support on ward & clinic areas, continue to prioritise medical wards.
OPEL 4 (as well as the above)
□ BU representation at bed meetings (high 3) □ Offer additional CSW & Phlebotomy support to ED □ Offer additional support for POCT □ Consider impact of reduced phlebotomy & CSW support on ward & clinic areas. If long term, reduce phlebotomy clinic appointments and consult with ICB to close satellite clinics. □ Prioritise provision of additional OPAT capacity and escalate to community service.

Appendix B

ACUTE MEDICINE/ED		
STATUS	DESCRIPTION	ACTION
OPEL 1	<u>Low Risk</u> Mean ambulance handover time >15 mins ED all-type 4-hour performance ED all-type attendances Majors and resuscitation occupancy (adult) Median time to treatment % of patients spending >12 hours in ED % G&A bed occupancy % of open beds that are escalation beds % of beds occupied by patients no longer meeting criteria to reside DTA's Staffing levels Nursing Staffing levels Medical	All: ensure awareness at ED huddles of OPEL status to inform both ED and Trust wide actions Escalation Manager/ONIC/consultant: ensure adherence to Decision to Admit (DTA) standards Escalation Manager/Consultant: review medical staffing ensuring senior decision makers (SDM) are situated in all key areas - pitstop/streaming/majors A/majors B/Resus Escalation Manager/ONIC: review nurse staffing ensuring adequate staffing in all areas Escalation Manager/ONIC/consultant: ensure streaming to UTC/assessment areas/SDEC ONIC: transfer discharged patients to Discharge Assessment Unit/home Escalation Manager/ONIC/consultant: ensure time to assessment and time to referral standards are met Escalation Manager/ONIC: ensure patient is ready to transfer as soon as a bed is declared
OPEL 2	<u>Moderate Risk and Signs of Pressure</u> Mean ambulance handover time 15-30mins ED all-type 4-hour performance ED all-type attendances Majors and resuscitation occupancy (adult)	Escalation Manager/ONIC/consultant: further review of staffing levels and redeployment as necessary Escalation Manager: review Lorenzo to ensure utlisation of assessment units, SDECs, fit to sit areas and DAU Escalation Manager/ONIC/consultant:open escalation areas as required Escalation Manager: liaise with patient flow to ensure that delays in specialty assessment in ED or transfers to ward/assessment areas are escalated to the Operations team and Divisional escalation managers

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	Median time to treatment % of patients spending >12 hours in ED % G&A bed occupancy % of open beds that are escalation beds % of beds occupied by patients no longer meeting criteria to reside DTA's Staffing levels Nursing Staffing levels Medical	
OPEL 3	<u>High Risk and Major Pressure</u> Mean ambulance handover time 30-60mins ED all-type 4-hour performance ED all-type attendances Majors and resuscitation occupancy (adult) Median time to treatment % of patients spending >12 hours in ED % G&A bed occupancy % of open beds that are escalation beds % of beds occupied by patients no longer meeting criteria to reside DTA's	Escalation Manager/ONIC/consultant: request Acute medicine inreach (AMED -is this a separate action?) Escalation Manager/ONIC/consultant: further escalation areas to be opened Escalation Manager/ONIC/consultant: enforce DTA policy and escalate any non-adherence to?? Escalation Manager/ONIC/consultant: plan for the use of fracture clinic out of hours (nurse staffing from allocation on arrival nurses, medical staffing to be agreed between shift lead consultant ED and MAU consultants)

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	Staffing levels Nursing Staffing levels Medical	
OPEL 4	<u>Very High Risk and Critical Pressure</u> Mean ambulance handover time over 60mins ED all-type 4-hour performance ED all-type attendances Majors and resuscitation occupancy (adult) Median time to treatment % of patients spending >12 hours in ED % G&A bed occupancy % of open beds that are escalation beds % of beds occupied by patients no longer meeting criteria to reside DTA's Staffing levels Nursing Staffing levels Medical	Escalation Manager/ONIC/consultant safety escalation huddle with Patient Flow Manager, SMOC and Exec on call, face to face if possible Escalation Manager/ONIC/consultant: extension of hours of AMED team input ONIC: request additional nurse staffing to allow Quad to open for fit to sit patients Escalation Manager: request ambulance divert Escalation Manager: request HALO presence from ambulance service (?level 3 action) Patient flow/SMOC/Exec on call: request ambulance divert from neighbouring hospitals and ambulance service Escalation Manager/ONIC/consultant: request specialty consultants attend ED and/or mSDEC to review identified, specific patients to facilitate discharge or complex care plans ONIC: restrict number of relatives and visitors to decompress crowding Escalation Manager: request additional ED doctors to support care of patients in ED Escalation Manager/ACD: ensure consultants on office duty are on the shop floor???

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ACUTE MEDICINE/ MAU		
STATUS	**DESCRIPTION**	**ACTION/OUTCOME**
OPEL 1	**Low Risk** How many patients require Clerking? <4 How many patients require Senior Review? <4 Patients allocated speciality? 10 Number of patients in Fracture clinic? 0 ED Queue < 5 GP Queue <2 Staffing- Nursing Full compliment Staffing- Medical Full compliment How many in the corridor? <2	**NIC/Clinical Decision Maker** Review all patients Complete senior reviews and clerking. Declare beds from ED within 15 minutes of bed becoming available on MAU Transfer suitable patients to Medical SDEC. Transfer admitted patients to baseward beds within ?15 minutes of bed becoming available on baseward
OPEL 2	**Moderate Risk and Signs of Pressure** How many patients require Clerking? <6 How many patients require Senior Review? <6 Patients allocated speciality? 15 Number of patients in Fracture clinic? 0 ED Queue 5-10 GP Queue 3 Staffing- Nursing Minimum safe levels Staffing- Medical -2	**NIC/Clinical Decision Maker/Escalation manager** Review medical staffing levels and re-assign to different areas of MAU if required **NIC** review nurse staffing levels, attend staffing huddle at 8am, 1pm, 3pm and escalate if required. **Clinical Decision Maker** Review ED queue to relocate any patients to Medical SDEC. **NIC/Clinical Decision Maker** Triage GP patients to Medical SDEC.

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	How many in the corridor? 3	
OPEL 3	**<u>High Risk and Major Pressure</u>** How many patients require Clerking? <8 How many patients require Senior Review? <8 Patients allocated speciality? 20 Number of patients in Fracture clinic? 0 ED Queue 11-15 GP Queue 4 Staffing- Nursing Minimum safe levels Staffing- Medical -3 How many in the corridor? 4	**NIC/Clinical Decision Maker/Escalation manager** Continued review of staffing levels, redeploy Medical Staffing from Short Stay Unit or Medical SDEC. **Escalation manager** Request earlier speciality reviews. **NIC/Clinical Decision Maker/Escalation manager** Postpone GP to the following day if possible. **NIC/Escalation manager** request support from patient flow for portering/cleaning delays **NIC/escalation Manager** transfer discharged patient to DAU/home **Patient flow** support with electronic documentation patients on whiteboard **NIC/Clinical Decision Maker/Escalation manager** fully utlise all available bed capacity, including outlier capacity. Escalate to patient flow if no patients are deemed suitable for available beds **Clinical Decision Maker** review allocated patients to determine best fit of patients to available beds
OPEL 4	**<u>Very High Risk and Critical Pressure</u>** How many patients require Clerking? 9+ How many patients require Senior Review? 9+ Patients allocated speciality? 20+ Number of patients in Fracture clinic? 7+ ED Queue 16+	**Clinical Decision Maker** Request continuous in reach from speciality. **Clinical Decision Maker/escalation manager** contact cardiology for urgent consultant led reviews of patients **Patient flow/Operations** Board against moves/discharges to create capacity on MAU **NIC/Clinical Decision Maker/Escalation manager** Utilise 3 clinic rooms and 2 spaces in the corridor.

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[redacted]	GP Queue 5+ Staffing- Nursing Below Minimum Staffing- Medical -4 How many in the corridor? 5+	**NIC?reduced transfer documentation** **Clinical Decision Maker escalate to Clinical Director/Divisional Medical Director for further inreach from specialties**

Appendix B

MEDICINE			
	Description	**Trigger**	**Action/Outcome**
1	Beds available in all specialties including HDU beds	Patients matched to available capacity. Flow maintained	**Medicine Escalation Manager,** **Matron, Bed manager-** Ensure discharges are progressed and Extramed is up to date with EDDs and next day discharges. Review PSAG forms (patient status at a glance). Senior nurse to attend board rounds to offer clinical challenge. Longer length of stay panels to support wards with more complex discharges.
2	Beds available in some specialties including HDU	Mismatch between bed capacity and specialty requirements. Limited impact on flow.	**Medicine Escalation Manager,** **Matron, Bed manager** As above plus: Prioritise discharges from required specialties including transfers to DAU. Review PSAG forms to expedite discharges. Attend wards with low discharge rates to unblock internal delays. Maximise the use of outlier areas to maintain flow
3	Current bed capacity is insufficient for demand. Limited HDU capacity	Flow is restricted due to a lack of bed capacity	**Medicine Escalation Manager,** **Matron, Bed manager, Divisional Leadership Team** As above plus Ensure all wards and medical staff are aware of situation. Use Full Capacity beds. Pull patients into empty beds within 60 minutes. Unblock internal delays on all wards. Use available HDU beds in accordance with SOP. Maximise the use of virtual wards and OPAT capacity.

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4	Current and forecast bed capacity shows a negative position compared to demand. No HDU capacity in some areas	There are insufficient beds for MAU to allocate to leading to a significant queue in MAU and ED. Flow is severely restricted.	**Medicine Escalation Manager,** **Matron, Bed manager, Divisional Leadership Team** As above plus: Follow +1/boarding policy (policy under review). Open additional escalation areas in 312 Gym, pleural room and RAU (RDH) or additional beds (QHB) if staffing allows. All wards to hold consultant-led afternoon board rounds focussing on discharges Specialty consultants to attend ED to review identified specific patients to facilitate discharge or complex care plans.

Appendix B

OPEL Level	CTAU	Cancer Wards	Palliative Care wards
1	- No Action	- No Action	- No Action
2	- Monitor in and out flow to anticipate any future issues, including cancer bed capacity position	- Support bed manager and ward with placement/ decision to proceed for elective patients	- Trust encouraged to identify palliative and end of life patients and raise whiteboard icons
3	- Review position of the department with Cancer Escalation Lead through in department huddle. - Expedite pending admissions - Seek additional nursing/ medical support coming to support the department - Stagger appropriate patient arrival times to aid flow - Escalate to Senior Manager and Senior Nurse if out of hours	- Bronze action station meeting held - Push for safety and FCP spaces in use - CTAU and AOS (Acute Oncology Service) to in reach into MAU and ED pulling across where appropriate - Review outlier position and consider moving off to maintain flow of cancer patients - Escalation lead to visit wards to expedite discharges/ resolve delays to discharge	- NMU, Ward 2 and HPCT (Hospital Palliative Care Team) to proactively identify patients who could move to NMU or Ward 2 - HPCT to establish 'flow list' of suitable alternate patients if struggling to fill beds with core patients
4	- All of the above - Cancer Escalation Lead to ensure bed meeting made aware and support from MAU/ SDEC scoped - Consultant on call to attend CTAU to support decompression of department, decision made regarding whether safe for service to stay open to new attendances for a defined period in conjunction with the bed meeting.	- All of the above - Matron/ DDND to support ward visits to expedite discharges/ resolve delays to discharge - Additional consultant/ medical/ ACP support directed to the ward, reducing elective activity if required - Support with movement of patients from assessment units to base ward beds where portering support insufficient	- All of the above - Consultant on call to review fast track/ other patients to ensure all beds are filled - Open any available bedded capacity on NMU/ Ward 2 in conjunction with consultant on call and Ops Team

Appendix B

Division: Surgery	**RESPONSIBILITY: Divisional Leadership Team**		
STATUS	**DESCRIPTION**	**ACTION**	**EXPECTED OUTCOME**
OPEL 1	**Low Risk** No risk of cancellation of elective surgery on or before the day of surgery Critical Care and Step-down capacity available for elective and emergency admissions Patient flow through from ED to SAU/OAU/SDEC Emergency theatres Internal and External Delays	BAU planning meetings take place. Review of elective lists for the following day Dependency/occupancy within commissioned standards on ICU and GPICS standards being met and no staffing escalations - ICU > 85% occupancy Surgical Lead to check any escalation required. All transfers of care from ICU are managed within 4 hours - Surgical Lead to check in with ICU Ensure the pull patients from ED to assessment areas within 30 minutes - surgical lead to check with the operational team and expedite issues identified. Surgical Lead to confirm with A&T that patients are allocated emergency theatres slots in line with the clinical timeframes. Surgical Lead to liaise with speciality matrons to review all Internal and External delays and escalate and confirm all EDD's have been updated and any issues escalated	Delivery of a responsive emergency and elective service to all UHDB patients
OPEL 2	**Moderate Risk and Signs of Pressure**		

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	Low Risk of cancellation of cancer and urgent elective surgery on or before the day of surgery, some risk to routine elective care Critical Care and Step-down capacity available for elective and emergency admissions - risk to cancellation of elective surgery Patient flow through from ED to SAU/OAU/SDEC Emergency theatres Internal and External Delays below <5% of bed base	BAU planning meetings take place. Review of elective lists for the following day, priority order developed. ICU at 85% occupancy and further admission identified - Surgical Lead to liaise with ICU to support with escalations. All transfers of care from ICU are managed within 4 hours - Surgical Lead to check in with ICU and escalate to the operational team to prioritise patient discharges form ICU Ensure the pull patients from ED to assessment areas within 30 minutes - surgical lead to check with the operational team and expedite issues identified. Surgical Lead to confirm with A&T that patients are allocated emergency theatres slots in line with the clinical timeframes. Surgical Lead to liaise with speciality matrons to review all Internal and External delays and escalate and confirm all EDD's have been updated and any issues escalated.	Priority list of surgical patients identified if cancellations are required. Review priority order of elective ICU cases to inform order of patients. Sufficient capacity for elective and emergency admissions
OPEL 3	**<u>High Risk and Major Pressure</u>** Risk of cancellation of urgent and elective surgery on or before the day of surgery	BAU planning meetings take place. Review of elective lists for the following day, priority order developed and agreed, Surgical Lead to work with operational team on minimising any CODs - to escalate COD to DD/DDD for any cancellations for non-clinical reasons	

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	Critical Care and Step-down capacity available for elective and emergency admissions Patient flow through from ED to SAU/OAU/SDEC Emergency theatres Internal and External Delays >10% of bed base	ICU above 85% occupancy and further admission identified - Surgical Lead to liaise with ICU to support with escalations. All transfers of care from ICU are managed within 4 hours - Surgical Lead to check in with ICU and escalate to the operational team to prioritise patient discharges form ICU Ensure the pull patients from ED to assessment areas within 30 minutes - surgical lead to check with the operational team and expedite issues identified. Surgical Lead to confirm with A&T that patients are allocated emergency theatres slots in line with the clinical timeframes. Surgical Lead to liaise with speciality matrons to review all Internal and External delays and escalate and confirm all EDD's have been updated and any issues escalated.	
OPEL 4	**<u>Very High Risk and Critical Pressure</u>** Possibility of cancellations of all routine surgery over 65 weeks RTT, high risk to cancer and urgent elective surgery on or before the day of surgery No Critical Care and Step-down capacity - nonclinical transfers in place across the critical care netwrok	Surgical Lead to work with operational teams on minimising any CODs - to escalate COD to DD/DDD for any cancellations for non clinical reasons Escalated bronze meeting with DMD/DND/CD to agree patient case selection on IP wards and ICU for priority - plan for the next 48 hours ICU above 100% occupancy and further admission identified - Surgical Lead to liaise with ICU to support with escalations and confirm escalation plan for emergency admissions.	

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	Patient flow through from ED to SAU/OAU/SDEC compromised - over 6 wait for assessment areas from ED Emergency theatres - delays in operations outside the P 0,1,2,3,4 categories Internal and External Delays > 15% of bed base	All transfers of care from ICU are facilitated within 6 hours - Surgical Lead to check in with ICU and escalate to the operational team to prioritise patient discharges form ICU Ensure the pull patients from ED to assessment areas asap Surgical Lead to confirm with A&T that patients are allocated emergency theatres slots in line with the clinical timeframes. Surgical Lead to liaise with speciality matrons to review all Internal and External delays and escalate and confirm all EDD's have been updated and any issues escalated.	

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BUSINESS UNIT: CDCS Pharmacy		RESPONSIBILITY: Pharmacy Leadership Team	
STATUS	**DESCRIPTION**	**ACTION**	**EXPECTED OUTCOME**
OPEL 1	**Low Risk** Capacity is such that the organisation is able to maintain patient flow and is able to meet anticipated demand within available resources.	Maintain operational and clinical pharmacy services across all 5 sites of UHDB.	Delivery of responsive, appropriate and safe pharmacy service to UHDB patients.
OPEL 2	**Moderate Risk and Signs of Pressure** The organisation is starting to show signs of pressure. Focussed actions are required to mitigate further escalation. Enhanced coordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible – and return to OPEL 1 as soon as possible.	Maintain operational and clinical pharmacy services across all 5 sites of UHDB. Monitor responsiveness of service delivery to enable identification and resolution of any concerns e.g. turnaround times, volume of workload, staffing levels and any other operational concerns.	Delivery of responsive, appropriate and safe pharmacy service to UHDB patients.
OPEL 3	**High Risk and Major Pressure** Actions taken at OPEL 2 have not facilitated de-escalation and pressure continues to increase. The hospital is experiencing major pressures compromising patient flow and continues to increase. Further actions are required across the organisation and by all partners.	Active review of activity and capacity across all pharmacy services and sites. Prioritise support for discharge and maintaining patient flow. Actively pre-empt discharges and dispense medication supplies in anticipation of discharge. Ensure appropriate clinical and operational support in place for assessment areas. Ensure appropriate support in place for RDH and QHB discharge assessment units. Nominated contact for RDH and QHB bed meetings for pharmacy escalations.	Pharmacy support prioritised to support discharge, flow and assessment areas to ensure safe and timely medication supply at admission and discharge.
OPEL 4	**Very High Risk and Critical Pressure** All actions have failed to contain service pressures and the hospital is unable to deliver comprehensive care. There is increased potential for patient care and safety to be	Active review of activity and capacity across all pharmacy services and sites. Reallocate non-operational staff to operational commitments as required.	Pharmacy support prioritised to support discharge, flow and assessment areas to ensure safe and timely medication

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[redacted]	compromised. Decisive action must be led and taken at Director level until de-escalation to OPEL 3 is achieved.	Prioritise support for discharge and maintaining patient flow. Actively pre-empt discharges and dispense medication supplies in anticipation of discharge. Ensure appropriate clinical and operational support in place for assessment areas. Ensure appropriate support in place for RDH and QHB discharge assessment units. Nominated contact for RDH and QHB bed meetings for pharmacy escalations. Review staffing over next 4 days during weekday evenings and nights and weekends and consider need for additional staff.	supply at admission and discharge. All staffing resource prioritised to operational service delivery.

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Critical Care QHB			
OPEL Level	Described as	Actions (in critical care)	Actions (outside critical care)
Level 1	• Capacity to admit min 2 patients regardless of any other factors • No delayed discharges over 24hrs • Ability to accommodate elective bookings regardless of other factors (as per process) • Nursing staffing levels able to fully support the above	• Business as usual • Early decision to proceed with elective admission • Timely discharge planning	• Ensure identified discharges are prioritised and bed allocated and available within 4 hr. period by site team
Level 2	• As above • Capacity to admit min 1 patients • Able to accommodate elective patients assuming unit discharges occur in a timely manner	• As above • Review of workforce levels and actions	• Ensure discharges are prioritised
Level 3	• Only 1 emergency bed • Unable to take elective admissions • Above 85% occupancy (dependency 6.5) regardless of staffing • Minimal predicted outflow (i.e. no discharges or patients reducing in levels of care)	• Review of workforce levels and actions • Involvement of Matron and Business Unit operational team re the above • Liaise with other BU teams re possible elective patients and alternative plans • Review elective patients booked over the next 48hrs	• Immediate priority for any discharges and must be managed same as ED decisions to admit • Prioritise discharges at RDH critical care - to support potential need for non-clinical transfer and/or create critical care capacity across the Trust regardless of utilisation
Level 4	• No emergency capacity or at /or above funded establishment regardless of nurse staffing levels	• Priority actions to review/increase workforce levels • Decision planning regarding decompression to other unit /undertake decompression (non-clinical transfer) to other unit	• Support business unit team to facilitate decompression to other critical care units

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Escalation Status	Description	Action	Expected Outcome
OPEL 1 Capacity is such that the Business Unit can maintain patient flow and is able to meet anticipated demand within available resources	**Elective**		
	All elective patients are placed, there are no medically fit patients in delay.	**Ward 206/207 Coordinators** All business as usual actions are taking place, usual processes underway	
	Non-elective		
	There are no speciality referrals in the Emergency Department waiting over 1 hour to be seen.	**Trauma Nurses/Service Managers/Matrons/Deputy General Manager** All business as usual actions are taking place, usual processes underway	
	There is capacity to meet anticipated demand across sub-speciality wards and all non-elective areas are safely staffed.		
	There are no medically fit patients in delay or internal delays to discharge.		
	There are fewer than 10 TCI trauma cases and/or there are no patients waiting over 7 days for their surgery or have a planned date.		
	Suitable Inpatient trauma patients are waiting 24 hours to get to theatre		
	All trauma patients are accommodated on Ward 203/204/205.		
	There is a plan for all repatriation patients		
	FCP beds are not in use		

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	There are no outlying patients into T&O Beds	**Trauma Nurses/Service Managers/Matrons/Deputy General Manager** All business as usual actions are taking place, usual processes underway	
OPEL 2 The Business Unit is stating to show signs of pressure			
	Relying on definite and predicted discharges to accommodate today's admissions.	**Ward 206/207 Coordinators** Review opportunities to use the dayrooms for elective patients who are suitable	
	There are patients in the Emergency Department waiting between 1 and 1.5 hours for speciality plans.	**Service Managers/Deputy General Manager** Escalation to registrar on-call to inform of the delays and offer any support	
	Relying on definite and predicted discharges to accommodate today's admissions.	**Senior Sisters, Matrons & BU Ops Team** Senior Sisters to escalate any delays to Matron's and BU Ops Team	
	All patients in OAU have been reviewed and have a plan. Patients for admission in OAU are allocated a bed awaiting discharges coming up	**Deputy General Manager/General Manager** Escalation to registrar on-call to inform of the delays and offer any support	
	There are more than 10 TCI trauma cases and/or there are patients waiting over 7 days for their surgery with no planned date.	**Trauma Nurses/Service Managers/Deputy General Manager** Trauma Nurse to notify BU Mgt team and Trauma Lead, additional trauma lists to be planned.	
	Inpatient trauma is showing signs of pressure, patients are waiting more than 48 hours to get to theatre	**Trauma Nurses/Service Managers/Deputy General Manager** Review utilisation of Ilkeston ambulatory trauma lists	
	All trauma patients are accommodated on Ward 203/204/205.	**Senior Sisters, Matrons & BU Ops Team** Continue to escalate delays to discharge, internally and externally	

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	Repats delayed but plan in place to accept in the next 24 hours	**Senior Sisters, Matrons & BU Ops Team** Plans to be communicated to Operations Team	
	Outlying		
	Outlying beds are within agreed planned numbers and escalations spaces are empty with no imminent plans to open	**Senior Sisters/Matrons** Any delayed reviews of outliers to be escalated to Medicine Division	
OPEL 3 The Business Unit is experiencing major pressures compromising patient flow			
	There are no empty elective beds, relying on predicted discharges to accommodate today's admissions, but predictions do not meet demand.	**Medical Staffing, Service Managers & Deputy General Manager** Review theatre lists with the view of cancelling patients on the day to accommodate clinically urgent elective cases	
	There are patients in the Emergency Department waiting over 2 hours for speciality plans.	**Medical Staffing, Service Managers & Deputy General Manager** Delays in ED are escalated to the registrar on call and appropriate support arranged for the on-call team	
	There are no/minimal predicted or definite discharges and this will not cover anticipated demand.	**Medical Staffing, Service Managers & Deputy General Manager** Review medical staffing to try to deploy more junior doctors/ACPs to the wards to progress plans	
		Senior Sisters/Matrons Open all FCP beds	
		Senior Sisters/Matrons Review opportunities to use the dayrooms for trauma patients who are suitable discharge	
		DAU/Operations Team, DAU to actively pull from T&O Wards	

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		Deputy General Manager/General Manager Speak to flow team to see if medical outliers can be repatriated to medicine base wards or discharges refilled with trauma patients	
	Patients in OAU are waiting over 4 hours for Orthopaedic review. Patients for admission in OAU do not have a bed allocated or planned	**Deputy General Manager/General Manager** Delays are escalated to the registrar on call and appropriate support arranged for the on-call team	
	There are more than 15 TCI trauma cases and/or there are patients waiting over 14 days for their surgery with no planned date.	**Senior Sisters, Matrons & BU Ops Team** Reference Elective Ringfencing SOP and enact stage one	
	It is not possible to accommodate all trauma patients on Wards 203/204/205.		
	Inpatient trauma is showing signs of pressure, patients are waiting more than 72 hours to get to theatre	**Matrons & BU Ops Team** Trauma Nurse to notify BU Mgt team and Trauma Lead, review elective lists with the view of switching to trauma	
	It is not possible to accommodate all trauma patients on Wards 203/204/205.	**Senior Sisters, Matrons & BU Ops Team** Reference Elective Ringfencing SOP and enact stage one and review plan for next 24 hours to provide plan for the night teams	
	Repats delayed but and no plan in place to create a bed in the next 48 hours.	**Senior Sisters, Matrons & BU Ops Team** Plans to be communicated to Operations Team	
	Escalated bed meetings scheduled by Operations Team	**Deputy General Manager/General Manager** Senior representation on the Bed meeting from BU Management Team	

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		3.15pm bed huddle on OAU to review position for the night Brief the On-Call team of the bed situation and plan for the night	
	Outlying beds have increased to beyond the agreed plan and/or ward rounds of outliers have no taken place.	Escalate through Operations Team and Divisional Management Team	
OPEL 4 All actions have failed to contain service pressures and the Business Unit is unable to deliver comprehensive care			
	There are no empty elective beds and no predicted discharges to accommodate today's admissions	**Service Managers/Deputy General Manager** Cancel elective activity that cannot be accommodated	
	Ring fenced elective beds have been breached, with trauma patients admitted outside of the designated spaces	**Matrons & Consultant on-call** Review infection control implications of the breach, admit no further elective patients to 206 & cancel elective capacity that cannot be admitted to 207	
	All beds are full and there are no predicted discharges, OAU is full and patients are waiting to come into OAU.	**Medical Staffing, Service Managers & Deputy General Manager** Escalate the situation to consultants to support junior doctors with decision making in order to create bed capacity.	
		Deputy General Manager Discuss with surgical bed manager if there is any opportunity to out lie trauma within the surgical bed base.	

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	Escalated bed meetings scheduled by Operations Team	**General Manager** Senior representation on the Bed meeting from BU Management Team 3.15pm bed huddle on OAU to review position for the night Brief the On-Call team of the bed situation and plan for the night	
	Outlying beds have increased to beyond the agreed plan and/or ward rounds of outliers have no taken place.	**Deputy General Manager/General Manager** Escalate through Operations Team and Divisional Management Team	

Appendix C

Response to Operational Pressures Escalation Levels – NHS-E Action Cards

ACUTE TRUST ACTION CARD- from NHS-E
OPEL 1
• Site Operations to review all OPEL actions with hospital teams that require specific oversight or intervention as per local escalation or surge policy. Site Operations to set hospital objectives and ensure these are understood by all hospital teams and reviewed at an agreed meeting cadence. Site operations team(s) will calculate in-patient bed position, ensuring support for assessment units for the next 24hrs. • Follow Rapid Assessment and Treatment (RAT) protocol (or equivalent) to ensure high risk patients are prioritised for ambulance to hospital handover. • Maintain plan that ensures initial assessment is completed within 15 minutes of patient arrival. Diagnostic access at this point should be optimised to ensure results are available or pending for the clinical decision-maker. Provide continual re-assessment of initial assessment waiting times to maintain safe access to emergency care. • Ensure waiting times for all pathways within ED is deemed safe by ED nurse and doctor-in-charge and aim to escalate any operational concerns to Site Operations. • Aim to have patients referred to specialty, transferred to assessment units for clerking within 30 minutes of referral. Patients should not be clerked in ED by a specialty team unless it is indicated by local policy, require organ support or specific clinical intervention. • Site Operations will identify patients overnight who wish to leave or can leave the hospital via the discharge lounge* before 0900hrs. The Site Operations team will monitor the discharge lounge to ensure maximal utilisation and flow throughout the day. • As a minimum update OPEL by 1000hrs daily. • Maintain agreed thresholds of contact with SCC and other providers with the intention of receiving system support in event of rising pressure.

Appendix C

ACUTE TRUST ACTION CARD from NHS-E
OPEL 2
• Review and ensure OPEL 1 actions are followed. • On-site presence of ambulance commander has been considered by the SCC to work in tandem with the Rapid Assessment and Treatment (RAT) protocol (or equivalent). • Patients who have been delayed in the handover process will be jointly assessed between the RAT team and the ambulance service. Patients who are not able to offload from an ambulance trolley within 30 minutes of arrival will be escalated to the SCC who will initiate joint tracking with the ambulance service. • Site Operations will work with hospital teams to ensure that all referred patients not able to move to assessment units (DTA s) are reviewed by specialty within 30 mins of referral. Patients requiring organ support or specific intervention will be pre-allocated to a suitable ward and where possible an agreed time for admission set between the ED and the admitting team. • Update OPEL every 6 hours and maintain agreed thresholds of contact with SCC and other providers with the intention of receiving system support in event of rising pressure. Ensure Chief Operating Officer (COO) is briefed on hospital position. • Initiate non-use of discharge lounge by exception by supporting ward teams to transfer all clinically suitable patients waiting to go home to the discharge lounge (or equivalent). Site Operations should consider requesting that completion of take-home medication and discharge information are completed by specialty teams in the lounge setting.

Appendix C

Acute Trust ACTION CARD from NHS-E
OPEL 3
• Review and ensure OPEL 2 actions are followed. • The senior doctor and senior nurse within the RAT alongside the Site Operations team will initiate a huddle with the ambulance officer to make-ready for patient cohort as per agreed Trust policy. If cohort is initiated, then please follow actions outlined in the OPEL 4 section. • Site Operations will update OPEL every 4 hours and maintain agreed thresholds of contact with SCC and other providers. Ensure COO is briefed on hospital position and a nominated deputy is attending the flow meetings to provide leadership of hospital objectives. This will now include a re-assessment of hospital capacity to make-ready escalation beds and deployment of local surge plans to increase pace and volume of patient discharge. • Ensure most senior specialty clinical decision-maker present in ED to support alternatives to admission where possible (SDEC, planned hot-clinics). The specialty teams will be supported by the specialty operations teams to ensure there is adequate clinical resources to meet both demand and patient acuity. • Site Operations will seek permission from the Chief Pharmacist and Medical Director to enact completion of take-home medication and discharge information by specialty teams in the lounge setting. • Hospital Site Operations will assess emergency care demand and consider whether changing the NHS111 Directory of Services to another provider would benefit patient flow. This will be a joint decision with the SCC who will make contact with NHS111 provider to enact the agreed decision. • Maintain flow through hospital ambulatory care or SDEC areas by ensuring patients requiring in-patient admission are done so within 30 minutes of request. Hospitals should take all steps to ensure these areas are not occupied by patients requiring in-patient care, including escalation to a Director or above if at risk of bedding

Appendix C

Acute Trust ACTION CARD from NHS-E
OPEL 4
• Review and ensure OPEL 3 actions are followed - Review tripartite action card • Patient cohort initiated as per agreed local protocol. The RAT team, alongside the onsite ambulance officer, should dynamically assess patients at risk of deterioration. The RAT team may enact RAT assessment on ambulances. Cohorting or on-ambulance RAT assessment will prompt the Hospital and System to enact the Tripartite OPEL 4 action card. • Site Operations will update OPEL every 2 hours and maintain agreed thresholds of contact and participation with SCC. Ensure COO (Supported by DoN and/or MD) is attending the flow meetings to provide direct leadership of hospital objectives. The Tripartite OPEL 4 action card must be reviewed in readiness for SCC engagement. • Where there is an unmitigated capacity deficit that would result in anticipated ED overcrowding / prolonged patient stays in ED / ambulance handover delays then Site Operations should facilitate a discussion on opening temporary escalation capacity as per local surge plans or full capacity protocol (FCP). • Review of planned elective activity in OPEL 4 should be completed by a hospital team consisting of operational and senior clinical personnel. Hospital planned elective activity and/or cancer treatments should only be rescheduled under COO, or above, direction and will trigger the Tripartite OPEL 4 action card with the SCC.

University Hospitals of Derby and Burton NHS Foundation Trust

Standard Operating Procedures: Combined Triage Assessment Unit

This Standard Operating Procedure (SOP) document sets out the pathway and procedures for staff, and patients who access the Combined Triage Assessment Unit (CTAU). It is designed to keep both staff and patients safe, whilst providing guidance and reassurance to staff. This document should be referred to at all times as the correct and most up to date pathway for haematology and oncology patients accessing CTAU. This document is relevant for all staff members who have patient contact on CTAU.

Utilising this document will:

- Ensure prompt response to medical needs of cancer and non-malignant haematology patients (where appropriate avoid the need for admission).
- Ensure the safety of patients and staff at all times.
- Formalise the opening hours of CTAU and staffing requirements of the unit.
- Formalise admission pathway for haematology and oncology patients out of hours.
- Assist clinical teams in ensuring non-elective haematology and oncology patients get streamlined care, including through internal and external partnership working.
- Formalised escalation pathways for CTAU.

SOP Governance

Department:	CTAU	**Author:**	Matthew Fowler
Version No:	1	**Approved**	Cancer BU Quality and risk group. CDCS Divisional Governance Cancer BU Assistant Clinical Directors for Haematology and Oncology Consultant ACP Cancer Adult Emergency Department Risk and Governance Lead
Version date:	25/05/2023	**Approved by:**	CDCS Divisional Governance
Review date:	25/05/2026	**Type of document:**	Departmental SOP
No pages:	14		

Contents:

General overview:

CTAU opened in April 2021 to create hot and cold pathways for haematology and oncology patients with complications following anti-cancer treatment. Prior to CTAU there was an ‘unwell bay’ on ward 302, staffed by the medical team with limited Advanced Clinical Practitioner (ACP) support however, following the COVID-19 pandemic it was clear a separate pathway was needed to be created for non-elective haematology and oncology patients as the service had outgrown its previous space.

Who this SOP applies to:

- Any cancer patient (Haematology and Oncology) who has a complication arising from their cancer diagnosis or treatment (There are exceptions to this, discussed further on)
- Patients with a non-malignant haematological condition which necessitates same day emergency care that can be safely managed in the ambulatory setting
- Nursing team, Medical staff, Administrative staff, Operational team within Cancer Business Unit and ACPs.
- This SOP also covers the Medical Assessment Unit (MAU) and Emergency Department (ED) pathways as oncology and haematology patients will default to these clinical areas out of hours.

The CTAU Pathway:

1. When is CTAU open?	Monday-Friday - 07:30-20:00 Weekends & Bank Holidays - 08:00-18:00 Christmas day - CTAU is closed BUT service runs via ward 303. **Additional information:** Cover for the unit is demonstrated in table 1 below. Should the clinical need arise, the staffing model/hours of work should be negotiable; ongoing audit will be critical here. In the event that staff (Nurses/ACP's) are required to overstay due to hospital pressures, hours must be recorded on health roster and a DATIX completed. The medical team should liaise with medical staffing directly.

1a. Table 1: Unit cover

Staff Group	Location	Weekday cover	Weekend and bank holiday cover
Nursing CSW	In dept	07:30 to 20:00 (3 RNs, 1 HCA) 1 CSW	08:00 to 18:00 2 RNs, 1 HCA and 1 CSW 09.00-17.00 Weekdays 08.00-18.00 Weekends
F1/F2		12:00 to 17:00	No cover
JSD		09:30-17:30	No cover
Admin support		08:30-17:00	08:00-13:00
ACP		09:00 to 19:00 (1x ACP) 08:00 to 18:00 (1 x ACP) 09:00-17:00 (1 x ACP)	09:00 to 17:00 (2 x ACP) (1 ACP covered via bank)
Haematology Registrar on call	On- call	09:00 to 17:00	09:00 to 17:00 (rota only allows for 3 weekends in 5)
Oncology Registrar on call		09:00 to 19:00	09:00 to 17:00

2. Capacity and facilities	6 treatment chairs + 2 beds (8 patient capacity) Facilities include a waiting area, toilet facilities, a sluice, IV drug preparation area, and small kitchen. The medical/ACP team share a 3-desk office also housing a large FBC analyser.

	Additional information: Whilst we strive to provide single sex accommodation, this is not always possible. If patients require isolation for other reasons Covid/Flu/ESBL/VRE/Loose stools, they can be accommodated in either our isolation room which has a capacity for 2 patients or room 4 (next to toilet) following IPC policy, this does reduce capacity therefore alternative arrangements should be made as soon as possible for these patients.
3. Patients with cardiac complaint	At present there is no cardiac monitoring in CTAU. Any patient triaged with cardiac symptoms noted on the UKONS triage tool will be advised to attend the emergency department. **Additional information:** If a patient presents with cardiac aetiology, then the medical/ACP team will liaise with ED to transfer the patient. The ACP liaises with the medical team and the nurse in charge of CTAU will liaise with the ED coordinator: 07788388435 by phone and where possible the patient will be transferred with ACP and registered nurse to ED and handed over face to face.
4. Referrals and triage	Patients are referred directly to CTAU by haematology and oncology teams. Patients can be referred from any health professional if the patient meets the acceptance criteria and will be triaged by the triage trained nurse. Most of CTAU's patient are referred via the Rapid Response triage line. **Additional information:** The Rapid Response line is covered 24 hours per day/365 days per year by trained haematology/oncology Registered Nurses (RN) who are relevantly trained in Acute Oncology (AO)/Rapid Response triage. The RN should discuss any concerns or queries with the ACP team. In hours this is covered by CTAU, out of hours this is covered by 301 and 303 by triage trained registered nurses.

5. Patient arrivals on CTAU	Monday-Friday - Patients arrive on the unit between 09:00-17:00. Weekends & Bank Holidays - 09:00-15:00 **Additional information:** The cut-off point is at 17:00 weekdays (15:00 on weekends/bank holidays) to allow 2 hours for the ACP to assess, clerk and review any investigations ordered, the nursing team time to admit the patient, and the Oncology Specialist Registrar (SpR) to 'post-take' any Oncology patients. The weekend cut-off point is at 15:00 hours as the ACP finishes at 17:00. Should the ACP/Nursing team believe that a patient can be seen and treated within the last 2 hours then this will be at the discretion of the team. Outside of these hours any patient who requires assessment should be initially discussed with emergency bed bureau and then handed over to the team in ED/AMU as instructed. AO/On call Haematology or on call Oncology team will then ensure review as appropriate on the following day.
6. Haematology patients	Any haematology patient with a suspected haematological diagnosis (malignant or non-malignant) requiring urgent review, should be reviewed on CTAU during operational hours, as opposed to being sent to ED/AMU as we have access to Point of Care Test (POCT) and the haematology team.
7. Unwell patient in an outpatient department	Should a patient become unwell whilst in the cancer services outpatient areas i.e., Radiotherapy department, they will be assessed initially by the clinical team in that area. If stable, they can be referred to CTAU for further assessment. **Additional information:** If patients are transferred to CTAU a member of staff must accompany and hand over safely, ensuring the staff member stays until hand over is completed.
8. Visitors becoming unwell	Visitors to the department, relatives or carers who are unwell must attend the Emergency Department/ own GP.

9. Ward admissions	Unless contraindicated, haematology and oncology patients should be admitted to an appropriate ward on the 3rd floor. The nursing team and operational team need to work closely to expedite all potential issues with beds in a timely manner by notifying the *Cancer Bed Escalation Lead* on 07385343724.
10. Ward admissions (non-haematology/ oncology wards)	When there are no beds available in haematology or oncology then patients must be clerked, medications prescribed on Lorenzo and a senior review must have occurred with a clearly documented plan in place prior to transfer to MAU/allocated bed. Communication with bed bureau/medical or surgical SpR on call as well as nurse in charge of unit is essential.
11. Patients transferred from Burton	If a cancer patient needs to be transferred over from Burton for management of their cancer, then this should be coordinated between bed managers and teams on respective sites to ensure seamless repatriation to one of the haematology or oncology wards at RDH (not to be transferred to MAU, unless under exceptional circumstances)
12. Patients who should not be sent directly to CTAU	Patients with the following conditions should not be sent directly to CTAU: **A.** Chest pain of likely cardiac aetiology **B.** Conditions unrelated to cancer diagnosis/treatment i.e., Exacerbation of COPD **C.** Any condition that is likely to require intensive management by the Surgical/Orthopaedic team. **D.** Head injuries/Seizures/Suspected Stroke **E.** Extensive bleeds **F.** Frank haematuria **G.** Acute dyspnoea **H.** Arrhythmias **I.** Haemodynamically unstable patients **J.** Severe electrolyte imbalances (see parameters acceptable to CTAU in Appendix 3)

13. Process for Burton patients	Any QHB patient who contacts the rapid response 24-hour helpline calls a separate number during hours and will be directed to attend either the day unit at QHB during opening hours or to the ED at Burton. The ED coordinator/ chaser will be contacted. The triage at out of hours for RDH and QHB triage are combined and if assessment is needed the Clinical Site Practitioner at QHB will be contacted to hand over the patient using SBAR
14. COVID-19	If there is a high suspicion of COVID/confirmed COVID from the Rapid Response call and the patient needs to come in for assessment, then a POCT in Consulting Room 1 on CTAU should be performed. CTAU can accommodate two COVID positive patients on CTAU at any one time (In Consulting Room 1).

CTAU Staff - Roles & Responsibilities

Nursing Team	The nursing team comprises of Sisters/Charge nurses, Registered nurses, CSW's and HCA's. The nursing staff are responsible for performing nursing assessments (observations), venepuncture, cannulation, administration of supportive medications, and obtaining specimens as required for analysis/investigations. The nursing team ensure CTAU patients' nutrition and hydration needs are met, all investigations/procedures are explained, and liaise with the bed management/operational team to arrange timely admission of patients. Once RNs have completed pathway training then they will undertake telephone triage (Rapid Response calls) on a regular basis.
ACP/Medical Team	The ACP/Medical team are responsible for assessing all patients who attend CTAU, completing all necessary clerking documentation to a high standard, ordering diagnostics and ensuring all information is communicated to both patient and nursing team. They are responsible for interpreting diagnostic investigations, ensuring a robust management plan is in place and escalating to senior oncology/haematology medical team as required. When patients are discharged home, a discharge letter must be completed for the GP. Equally when patients are admitted to the wards then the ACP/medical team must ensure effective communication between the two areas. For any patient being admitted then AKI/VTE must be completed as well as bloods requested for the following day. Any patient being admitted must be physically reviewed by the SpR on call for Oncology/Haematology prior to transfer to the designated ward.
Administrative Support	Between 08:30 to 17:00 weekdays, and 08:00-13:00 at weekends a ward receptionist is based on the front desk, responsible for booking patients in, completing IT data entry, printing labels and updating Lorenzo. It is crucial the nursing/ACP team keep the ward receptionist updated regarding patient movement, so systems can be updated in a timely manner. The receptionist

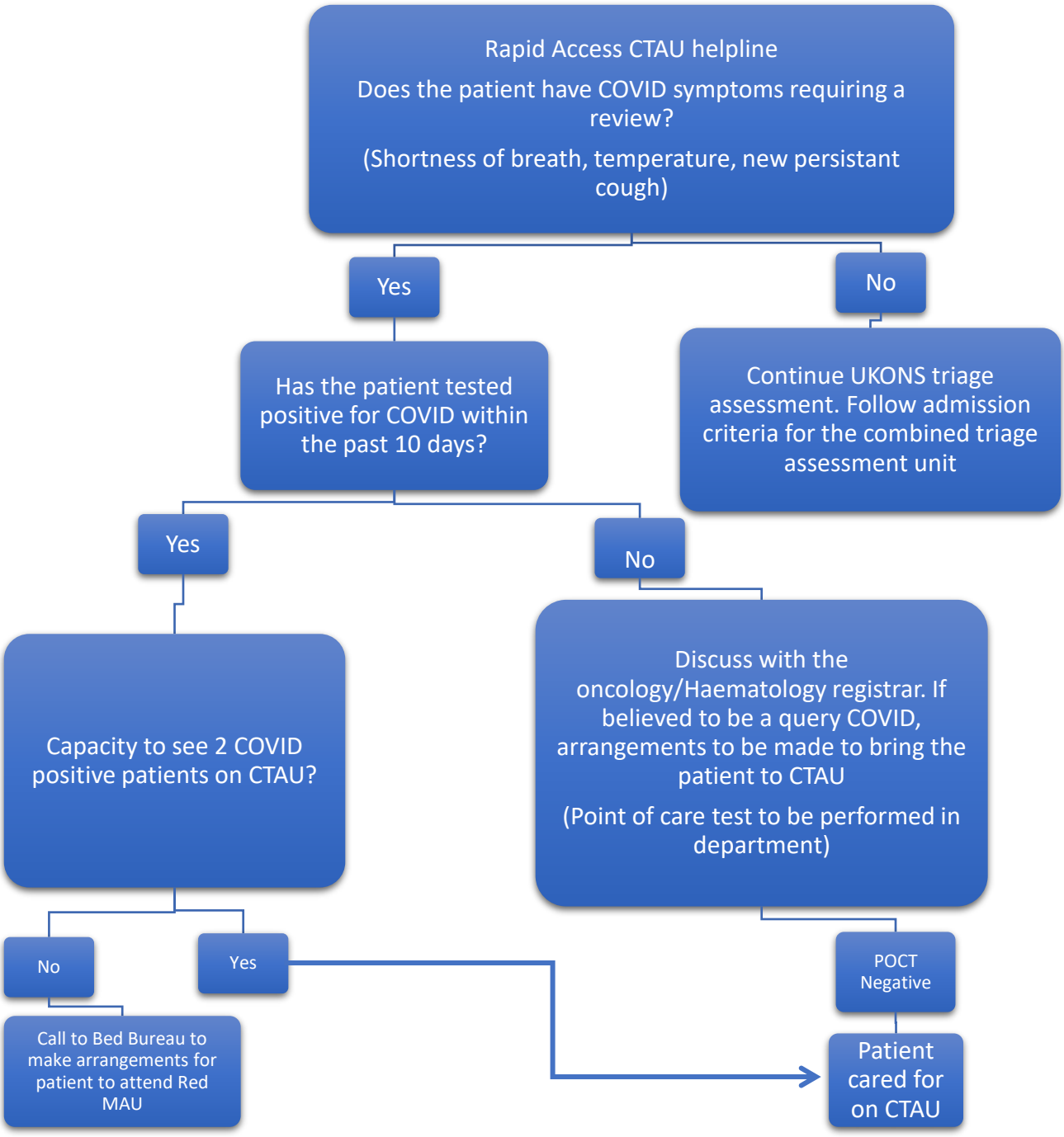
	takes the initial phone call from the rapid response triage line before handing over to a RN.

CTAU Staff - Training

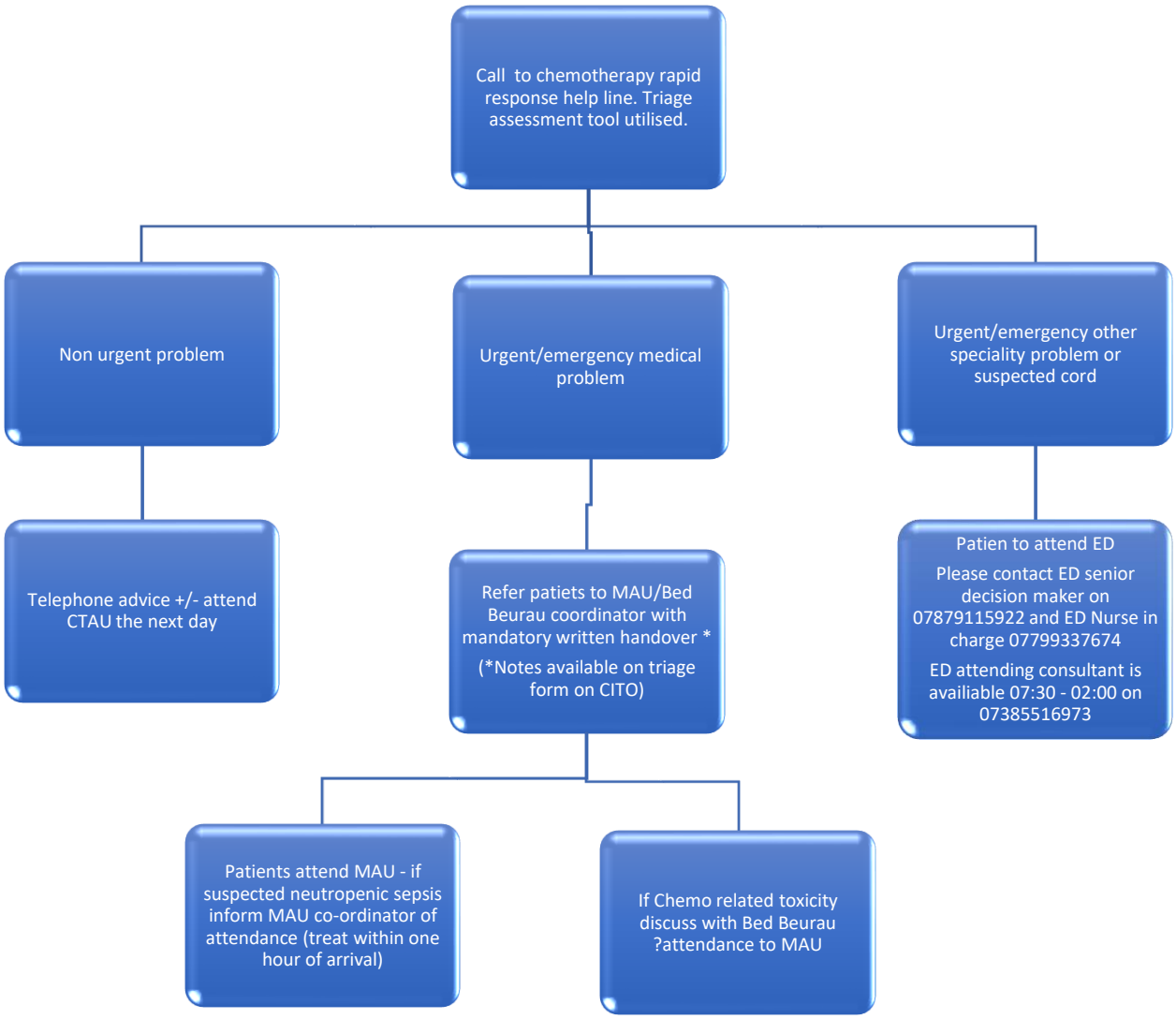
Nursing	All nursing staff complete mandatory training as well as training for the RNs on using the Rapid Response line. CVAD training for RNs. Health Care Assistants (HCA/HCSW) undertake additional training to operate the FBC analyser/blood glucose machine/POCT analyser. In addition to this, Band 3 HCSWs can perform additional duties including performing 12 lead ECGs/peripheral cannulation.
ACP	All qualified ACPs receive 6 hours 'non-clinical' study time per week whereby they can choose to work in different clinical areas to enhance their knowledge, and equally work on the 4 pillars of advanced clinical practice. All trainee ACPs are entitled to 7.5 hours 'non-contact' study per week (not in addition to time to spent at university).

Appendix:

Appendix 1: Flowchart for patients with confirmed/suspected COVID.



Appendix 2: Flowchart for patients out of hours

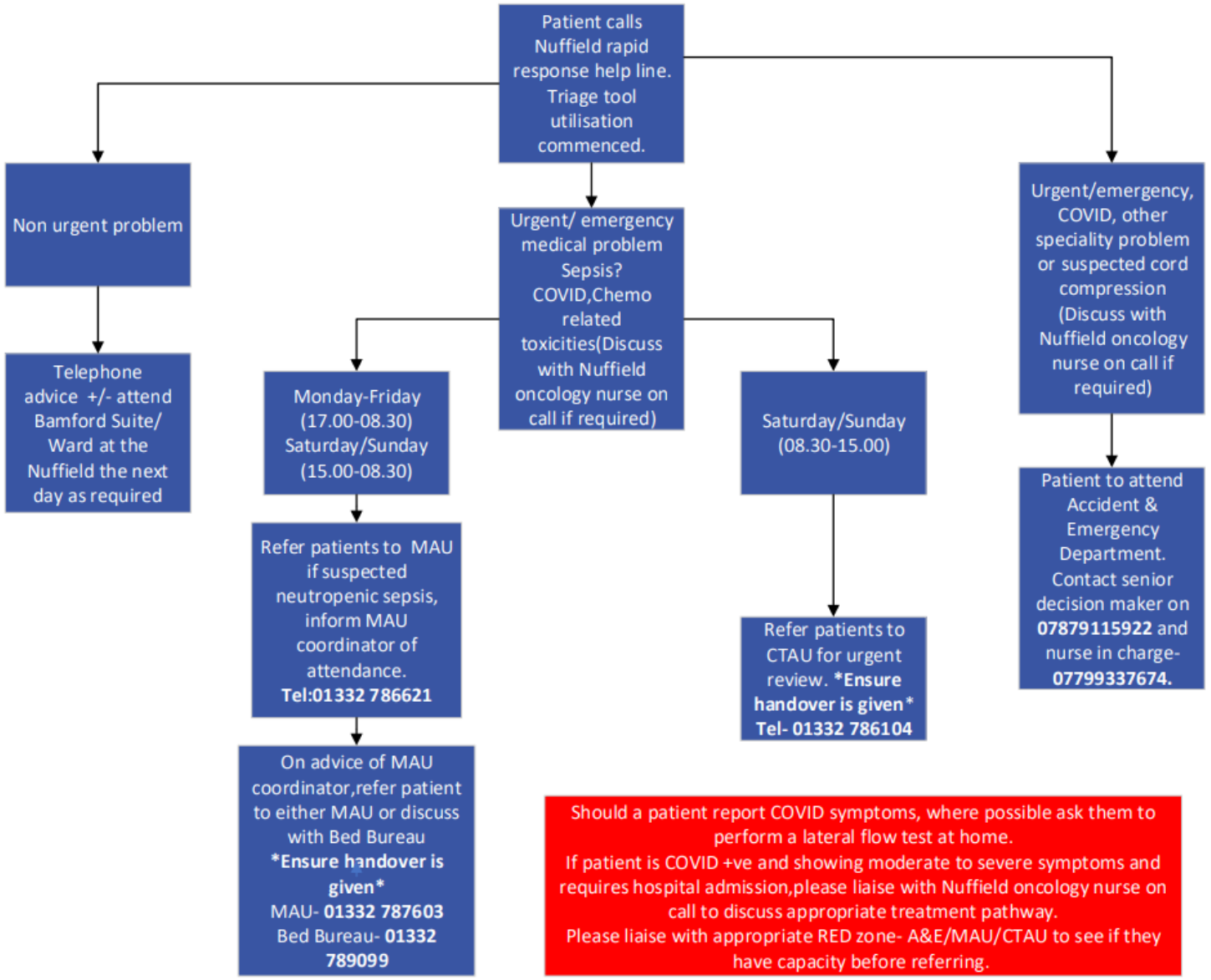


Appendix 3: Parameters for electrolyte disturbances acceptable on CTAU

	Normal range	Acceptable range for CTAU	Symptoms - if symptomatic – discuss with team.	Range which requires ED/MAU
Sodium	133-146	> 125	Confusion, < GCS, Headaches, profuse vomiting	<125
Potassium	3.5-5.3	2.5-6.0	Low – Muscle weakness, Cardiac symptoms, Paralysis High - < renal function, Cardiac symptoms	<2.5 >6.0
Magnesium	0.7-1.0	>0.3	Ventricular Arrhythmias Convulsions, Acute Asthma	<0.3 (Often treatment related)
Adjusted Calcium	2.2-2.6	1.8 - 4.0	Low – Cardiac symptoms, Muscle twitching, spasms. High- Cardiac symptoms Confusion, Seizures, Coma	<1.8 >4.0 (Known oncological emergency)

Appendix 4: Chemotherapy Private Patient pathway

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust



Appendix 2

University Hospitals of Derby and Burton NHS Foundation Trust

Pregnancy Assessment & Maternity Assessment - Full Clinical Guideline

UHDB/PDC/08:21/P7

Contents

1. Introduction

The Maternity Assessment Unit (MAU) at Queens Hospital, Burton and the Pregnancy Assessment Unit (PAU) at Royal Derby Hospital provide a 24 hour triage and assessment service for urgent problems in pregnancy. Patients can either self-refer to the service or be referred by health care providers such as community midwives, G.P.'s and doctors.
Women that require clinical assessment +/- intervention can attend the Maternity /Pregnancy Assessment Units as an emergency or planned appointment.

2. Abbreviations

ANC	-	Antenatal Clinic
APH	-	Ante partum Haemorrhage
CMW	-	Community Midwife
CRP	-	C Reactive Protein
CS	-	Caesarean Section
CTG	-	Cardiotocograph
ECG	-	Electrocardiograph
FBC	-	Full Blood Count
FH	-	Fetal Heart
G&S	-	Group and Save
HVS	-	High Vaginal Swab
IUGR	-	Intrauterine Growth Restriction
LAU	-	Labour Assessment Unit
MSU	-	Mid Stream Urine
NICE	-	National Institute of Clinical Excellence
PAU	-	Pregnancy Assessment Unit
PCR	-	Protein Creatinine Ratio
PDC	-	Pregnancy Day Care
PPROM	-	Preterm Prelabour Rupture of Membranes
PV	-	Per Vaginum

ROM	-	Rupture of Membranes
SROM	-	Spontaneous Rupture of Membranes
USS	-	Ultrasound Scan
UTI	-	Urinary Tract Infection

3. Documentation

Ensure all assessments and individual plans of care are documented clearly in the medical records, the maternity hand held records and if appropriate the maternity clinical system special instructions page.

PAU - Midwives are requested to use the Pregnancy Assessment Tool for all women attending as an urgent admission or alternatively use the Pro-forma for Required Management of altered fetal Movements for all women attending with perception of altered (reduced, changed or absent) fetal movements.

For both tools the front page is designed to be used for the initial assessment on arrival and to then document a plan of care for this visit (i.e. need of CTG, blood tests or other plans). An initial assessment to prioritise care will be due ideally within 15 minutes of arrival.
All care following at a later stage or directly following the initial assessment can be documented on the back and is designed to provide an overview of the visit completed by midwives. Medical staff should document their review if applicable in the handheld records as well as on the white medical notes.

In case of planned visits, documentation should be completed in the medical notes with a short summary in the handheld records prior to discharge.

MAU – The telephone log sheet (Appendix 2) continues to form part of the initial assessment and has space for contemporaneous record keeping. The Pro- forma for reduced fetal movements is also completed as appropriate. Either a ward attendance or admission is completed on Meditech V6 dependant on the outcome of the appointment. A copy of this is printed and attached to the hand held records.

4. Telephone Logs

PAU- Maternity Triage Call log in Lorenzo is completed to document every phone call to PAU and includes details of the person calling/answering, reason for calling, medical details and advice provided.
MAU - individual patient telephone log sheet is used to record phone calls to MAU and includes details of the person calling/answering, reason for calling, medical details and advice provided. Following completion these are then filed into the medical records.

5. Initial Assessment on Arrival

Aim to start the initial assessment within 15 minutes of arrival for all women attending as an urgent admission (does not include women that have an appointment).

Completing this initial assessment can be a rapid process with the aim to establish clinical urgency to prioritise care. Define a plan of care for this admission based on the specific details for the reason for attending MAU/ PAU, including specific investigations to be carried out (i.e. for CTG, serology, BP profile), doctors review etc.

If clinical urgency allows (i.e. normal observations, normal movements, no active bleeding etc) the women can return to the waiting room until a midwife is available to continue care according to the care plan.

6. Investigations, Medical Review and Discharge

Use the back of the documentation tool/V6 admission template/medical records to document all investigations carried out and communication with medical staff if applicable. Use the appropriate CTG sticker to review a CTG .

Situations where discharge can be considered without review by medical staff (this is not meant as a complete list covering all possibilities, please follow appropriate clinical guidelines):

- 1st episode of altered fetal movements in the absence of any risk factors (including any risk factors on the SGA risk assessment tool) if normal CTG and normal perception of fetal movements on admission prior to discharge
- Hypertension only when all following criteria are met:
  - Biochemistry and haematology within accepted ranges for gestation.
  - Urinalysis shows no greater than a trace of protein.
  - Blood pressure settled to normal ranges (see full guideline)
  - If plan of care already in place and woman's condition remains stable.
  - No other signs of changed well being
- Abdominal pain only when all following criteria are met:
  - Pain resolved
  - All findings within normal ranges
  - ≥ 37 weeks gestational age
  - Normal perception of fetal movements
  - No PV bleeding
- Fetal Tachycardia when all following criteria are met:
  - Normal CTG
  - No signs of infection
  - Normal perception of fetal movements
  - All findings within normal ranges
- Prelabour ruptured membranes only when all following criteria are met:
  - Low risk pregnancy ≥37 weeks gestational age
  - All findings within normal ranges
  - No signs of infection
  - Normal perception of fetal movements
- Minor trauma only when all following criteria are met:
  - All findings within normal ranges
  - Pain resolved if applicable
  - Normal perception of fetal movements
  - No PV bleeding

When ready for discharge please check and document:

- Is the next appointment with the CMW or in ANC within a suitable timeframe
- Confirm with medical staff if suitable for MLC on discharge
- Has an ultrasound scan been arranged if needed
- Has advise on altered fetal movements been re-iterated

6.1 Medical review:
This list is not exhaustive covering all possibilities and refer to the specific guidelines.
Registrar/consultant should review situations such as CTG abnormality, suspected preterm labour in twin pregnancies, confirmed preterm prelabour rupture of membranes, scar pain, persistent abdominal pain, see women with recurrent reduced fetal movements.

7. Specific Care Elements and Investigations

Please see the clinical guidelines for guidance on care for women presenting with the following:

- Obstetric Cholestasis
- Hypertension
- Fetal Tachycardia or arrhythmias (fetal monitoring guideline)
- Antepartum Haemorrhage
- Genital tract
- Hyperemesis
- Preterm labour and Preterm Prelabour rupture of membranes
- Altered fetal movements (changed, reduced or absent)
- Suspected Venous Thromboembolism (VTE)
- UTI in pregnancy

- Early labour at term
- Prelabour rupture of membranes ≥37 weeks gestational age

7.1 Abdominal Pain

Women presenting with abdominal pain require assessment and observation.
The following women require immediate admission to Labour Ward **(RDH site)**:-

- Regular painful contractions (established labour/needing analgesia see Care of Women in Labour guideline
- Tender/tense uterus
- Tenderness over previous CS scar

QHB site – as above once labour has established to be transferred to Delivery Suite when bed availability or assessed by doctor for transfer with other above.

Management

All women presenting with abdominal pain who are not in labour should have a full assessment of maternal and fetal wellbeing and an obstetric review
. Additional investigations to be considered

- Ultrasound if clinically appropriate
- MSU to be sent for lab analysis according to UTI in pregnancy guideline

7.2 Minor Trauma

Assessment of fetal wellbeing may be required following a fall/minor road traffic incident/trauma to the abdomen. The woman will require an antenatal assessment including examination and documented. This can be undertaken by the midwife.
Additional investigations to be considered:

- A CTG
- If the woman's blood group is rhesus negative a Kleihauer must be taken. The woman must stay on the assessment unit until the blood bank has determined if Anti D is required or not. If Anti D is required this must be administered before the woman is discharged home.
- FBC if cause of fall appears to be secondary to a faint.

Raise awareness in checking for fetal movements

Medical review is needed for the woman if any deviation from the norm identified e.g. CTG/maternal observations otherwise can be discharged by the midwife. Appropriate follow up should be confirmed – may be suitable to attend an already arranged appointment either with their MW or in ANC, if no suitable appointment arranged this will need to be organised prior to discharge home.

7.3 Shortness of Breath or Chest Pain

Women calling with the above symptoms should be advised to attend ED

7.4 Postnatal readmission

PAU

All women presenting for postnatal review will have been referred to PAU via an obstetric registrar bleep 2206.

All postnatal readmissions will require senior medical review and are not for midwife or junior doctor discharge.

MAU

Direct to ward 11 and bleep 620

MAU/PAU - If query sepsis use Maternity Sepsis tool (Appendix C). If Sepsis 6 triggered; for urgent transfer to Labour ward/HDU and refer to 'babies readmitted with mother' clinical guideline as baby will be at increased risk.

7.5 Postnatal feed query telephone call

When a telephone feeding query is received appendix 4 – an assessment form must be completed "Maternity Telephone Log – Postnatal Infant Enquires" to ensure the wellbeing of babies by appropriate screening and management of feeding issues in new-born babies. is made and the baby if directed into the appropriate service within a prompt time frame. This needs to be considered with the Trust Policy for infant feeding.

The time frame that this assessment cover is from transfer home from hospital until the time of transfer to the Health Visitor, however individual consideration needs to be given to all telephone calls received out of this time frame.

Enable all staff, irrespective of role, to:

- Recognise when the feeding pattern/behaviour of the baby deviates from a well-baby and requires a medical review
- Support women to feed their babies effectively

Appendix A

PREGNANCY ASSESSMENT TOOL

Insert patient sticker or complete: Name: Date of birth: Hospital number:	Arrival in PAU: …….. Referred from: …….. Midwife: …….. Consultant: …….. Previous PAU admissions: ……..... ...…… …..……

Date	Time	Grav/Par	EDD	Gestation	BlGr/Rh	Allergies	BMI

Reason for admission:

Vaginal loss:				Pain:		
Risk factors	Pre-existing			Identified in this pregnancy		
Obstetric						
Medical						
Lifestyle (include smoking, alcohol,safeguarding)						
Blood pressure ……/….....	Pulse: …….BPM	Resp rate: ……/min	Temperature ……..°C	Saturations: …… %	Urinalysis	Oedema
SFH (i/a) ..... cm	Pres / lie:	PP to brim:	Fetal movements:	Fetal Heart rate (Pinnard or handheld Doppler): …….. BPM		

Signs of infection: ☐ NO ☐ YES Amber or Red scores on Meows: ☐ NO ☐ YES:……..

Consider SEPSIS if signs of infection, fetal tachycardia or unwell

Comments:

Plan of care: CTG indicated: ☐ NO ☐ YES Medical review indicated: ☐ NO ☐ Yes, level:

Name: ……. Designation: …… Signature: ……

Patient Name: …….. Hospital Number: ……..

Notes:

Care on discharge: MLC / CLC Next appointment: Date: …….. Location: ……..

Ultrasound scan appointment: ☐ Yes: date: …… ☐ N/A

Medical review completed: ☐ Yes, level …… ☐ Not indicated

Discharged: Date: ……... Time: ……..

Appendix B

MATTL

TELEPHONE LOG

NHS
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NHS Foundation Trust

BOOKING QHB / SJH / OTHER

DATE.....

NAME .....

TIME .....

ADDRESS .....

BOOKING .....

.....

PARITY .....

UNIT NO .....

EDD / GESTATION .....

SPECIAL FEATURES (IE medical history, obstetric history, diabetic, prev CS, SGA, liquor etc)

PRESENTING HISTORY

FETAL MOVEMENTS NORMAL / DECREASED / NONE

PREVIOUS EPSIDOES YES / NO

CONTRACTIONS FREQUENCY /10

LENGTH .....

PAIN .....

CONSTANT / INTERMITTENT

VAGINAL LOSS / DISCHARGE .....

PV BLEED NONE / SLIGHT / MODERATE / HEAVY

BLOOD GROUP .....

SROM YES / NO CLEAR / OTHER

TIME .....

SIGNS OF INFECTION .....

REASON FOR CALL

ADVICE GIVEN

TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE:

999 / OWN TRANSPORT

SIGNATURE .....

Page **1** of **2**

2ND CALL .....

ADVICE GIVEN

TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE: [ ]

999 / OWN TRANSPORT

SIGNATURE .....

3RD CALL .....

ADVICE GIVEN

TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE: [ ]

999 / OWN TRANSPORT

SIGNATURE .....

4RD CALL .....

ADVICE GIVEN

TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE: [ ]

999 / OWN TRANSPORT

SIGNATURE .....

ARRIVAL TIME .....

TIME SEEN BY MIDWIFE .....

ADMISSION OBSERVATIONS

TIME PERFORMED .....

BP / RESPS ..... PRESENTATION .....

PULSE ..... SATS ..... FUNDAL HEIGHT .....

TEMP ..... URINE ..... SIGNATURE .....

MATTL

Page 2 of 2

Sepsis Screening Tool – Pregnant women or within first 6 weeks post birth, abortion or miscarriage

Midwives / Obstetric staff should complete this screening tool if ***possible infection*** is considered

ADDESSOGRAPH	**Name & grade of person commencing form:** Date: ___/___/____ Time: : (24 hour clock) Name : Designation:

Sepsis is life-threatening organ dysfunction as a result of a dysregulated host response to infection. It has a high mortality and is a medical emergency.
Septic shock is persistent hypotension despite fluid challenges.

Tick all boxes that apply

1 Has the MOEWS triggered ☐
OR
Does woman look unwell ☐
OR
If Antenatal: is there fetal tachycardia>160bpm ☐

N → **Low risk of sepsis.**
Follow standard clinical care guidelines

Y ↓

2 Could this be an infection?

Yes, but source unclear	☐
PROM >24 hrs OR PPROM >18 hrs	☐
Urinary tract infection	☐
Abdominal pain (not labour)	☐
Caesarean section wound OR perineal wound	☐
Abdominal distension	☐
Offensive lochia / Endometritis	☐
Mastitis / Breast abscess	☐
Respiratory tract infection	☐
Other (specify):	☐

N → **4 Are any 2 maternal AMBER FLAGS present?**

Respiratory rate 21-30 per minute	☐
Systolic BP 81-90 mmHg	☐
Heart rate 100-120 per minute	☐
Temperature 35°C - 36°C	☐
Not passed urine for 12-18 hours	☐
Pain score 2 - 3 on MOEWS	☐
Immuno suppressed	☐
(Gestational) Diabetes	☐
AKI	☐
Invasive procedure in last 6 weeks (i.e. ERPC, instrumental delivery, c-section, cerclage, MROP)	☐

Y ↓

3 Is ONE maternal RED FLAG present?

Confused /altered conscious level AVPU = P or U	☐
Respiratory rate ≥ 30 per minute	☐
Systolic BP ≤ 80mmHg (or drop of >40 below normal)	☐
Heart rate >120per minute	☐
Temperature ≥38°C OR <35°C	☐
Needs O2 to keep SpO_2 ≥ 95%	☐
Urine output <0.5ml/kg/hr	☐
Cyanosed / grey/mottled skin or non-blanching rash	☐
Lactate≥ 2mmol/l	☐

N → **Escalate to senior Obstetric Registrar level (SpR3) or above**

- Communicate with consultant obstetrician and inform coordinator of ward
- Establish IV access if not already done
- Send bloods for FBC,U&E's, CRP, LFTs, Clotting & consider Lactate
- Prescribe antibiotics
- Record comprehensive management plan
- If any suspicion of PE: consult consultant prior to commencing sepsis bundle

Y ↓

RED FLAG SEPSIS – start SEPSIS 6 Care Bundle IMMEDIATELY (see over)
Action is time critical, urgent response is required
If baby at home, born within the last 90 days, advise to bring baby to CED

SEPSIS 6 Care Bundle

Seek urgent review by senior Obstetric Registrar (ST3) or above/ Consultant and/or Anaesthetist

Consider transfer to Maternity HDU

If woman is still antenatal consider continuous EFM if appropriate

All actions to be completed within 1 hour	*Time & initials*	*Reason not done / variance*
1. Administer Oxygen Aim to keep saturations >94%	Time: Initials:	
2. Take Blood Cultures Consider: urine, sputum, vaginal swab, throat swab, wound site swab, breast milk culture	Time: Initials:	
3. Give IV Antibiotics According to agreed maternity antimicrobial protocol	Time: Initials:	
4. Give IV Fluids If hypotensive / lactate >2mmol/l give 500mls fluid bolus. Ensure anaesthetist is involved with management of women with pre-eclampsia	Time: Initials:	
5. Check serial lactate VGB/ABG	Time: Initials:	
6. Measure fluid input and output Consider indwelling catheter. Ensure hourly fluid balance chart / HDU chart commenced	Time: Initials:	

Current antimicrobial guideline:

If admitted to maternity HDU consider input from critical outreach team

Documentation Control

Reference Number: UHDB/PDC/08:21/P7	**Version:** UHDB 1		**Status:** FINAL	
Version / Amendment	Version	Date	Author	Reason
	1	2003	PDC Team. Dr J Ashworth - Consultant Obstetrician	New guidance
	2	May 2011	PDC Team. Dr J Ashworth - Consultant Obstetrician	Review, merge & update of guidance
	3	Dec 2014	Suzy Thompson – Midwife Chris Doherty – Specialist MW	Merge of PDC/PAU guidelines & update
	4	Sept 2018	Suzy Thompson – Senior Midwife ANS Miss S Rajendran – Consultant Obstetrician Cindy Meijer – Risk Support Midwife	Reviewed
UHDB	1	March 2021	Suzy Thompson – Senior Midwife ANS Miss S Rajendran – Consultant Obstetrician Jo Wallace – Matron ANS	Review / merge. Includes Postnatal readmission from QHB guideline which is now archived
Intended Recipients: All staff with responsibility for caring for women in PAU				
Training and Dissemination: Cascaded through lead sisters / midwives/doctors / Published on Intranet / NHS mail circulation list				
To be read in conjunction with: Referral pathway for women 13-20 week gestation (O11) / Fetal Monitoring in labour (F2) Antenatal Care guideline (A5) OC Guidelines (C6) / Severe Pre-eclampsia-Eclampsia Guideline (E1) / Reduced Fetal Movements guideline (F4)				
Consultation with:	Midwifery Staff			
Business Unit sign off:	29/06/2021: Maternity Guidelines Group: Miss S Rajendran – Chair 12/07/2021: Maternity Development - Miss S Raouf Chair 15/07/2021: Maternity Governance - Mrs K Dent Chair			
Implementation date:	03/08/2021			
Review Date:	July 2024			
Key Contact:	Cindy Meijer – Risk Midwife			

Appendix 3

Managing ambulance conveyances to hospital – Royal Derby Hospital Emergency Department internal escalation plan

Introduction

When the Emergency Department (ED) is full, a decision may be made by the Shift Lead Consultant and Overall Nurse In Charge (ONIC) to delay offloading patients from ambulances. In hours, this needs to be communicated to the General Manager/ Deputy General Manager, Matron, EMAS Duty Commander and Operations Centre. Out of hours this needs to be communicated to the Operations Centre, Senior Manager On-Call, and the Executive On-Call. Once this has been communicated, updates will be provided at the huddles (07:30, 11:00, 15:00, 19:30, 22:00, 01:30).

It is important to note that the ED takes full responsibility for patients held on ambulances and where possible allocates a Clinician, ideally a Senior Decision Maker, to review the patients and prioritise their care alongside those currently within the department. This is as per Minimum Care Safety Standards as outlined in the document: Managing ambulance conveyances to hospital, NHS England, and NHS Improvement.

There are two primary reasons for holding on ambulances; lack of outflow/capacity, in particular the Medical Assessment Unit (MAU) and/or patient demand and therefore delays on decision making (discharge v's admission). What is essential is the early identification of the possible need to hold on ambulances (Pit Stop full, incoming ambulance) and the ability to act in a timely manner to prevent this. The ED is reviewed regularly at handover and at the huddles with the core agenda items being to confirm and discuss flow into and out of ED, and ED occupancy.

Acute Medicine provide support to ED through the Acute Medicine Emergency Department (AMED) reviewing patients on both ward 101 and c-side trolleys. The medical Same Day Emergency Care (mSDEC) team also pull patients from all of ED including those on ambulances.

There are a number of actions that can be undertaken internally to help create space in ED to prevent holding patients on ambulances, to note these are following the department being declared full. The department is declared full when Pit Stop has 9 patients (with additional to 5 "fit to sit" if appropriate), Majors A has 15 patients and Majors B has 28 patients.

Internal ED actions to increases capacity include:

1. Review patients in Pit Stop, Streaming and on ambulances; this is a continuous and dynamic process. The Shift Lead Consultant and ONIC are to review the patients: pushing “fit to sit”, streaming to assessment areas/mSDEC/Urgent Treatment Centre (UTC)/Discharge Assessment Unit (DAU), increased frailty input (if required) and escalating delayed decisions.
2. Ensure ward 101 is utilised to full capacity by moving suitable patients there. The ward has capacity for 6 patients and is used for short stay patients who remain under the care of the ED team and to accommodate patients who are potentially awaiting MAU admission.

3. Ensure c-side trolleys are open and utilised to full capacity with appropriate patients (refer to c-side SOP). There are 9 trolley spaces that can be used to accommodate patients who are waiting for MAU admission.
4. Moving patients declared outside bays in Majors A (maximum 4 patients); these are to be transferred within 15 minutes. The above requires the ED staffing template to be at 24 RNs and 16 HSWs; this is the normal template.
5. Increase Pit Stop trolley capacity to 11 patients (additional 1 patient in the middle, additional 1 patient on the weigh bridge). This would require an additional 1 RN.

In the event of the ambulance crew requiring to attend a category 1 call termed "immediate handover", they are to off-load the patient in the middle of the resuscitation area. To note, this should only be 1 patient at a time and there will be the requirement for a patient in ED to move out to provide capacity.

If this still does not provide sufficient capacity within the ED to offload ambulances, the following options can be considered outside the ED:

6. Open Quad as a holding area for patients awaiting MAU. This has capacity for 7 patients and requires 1 RN and 1 HSW.
7. Ambulance Service will be expected to cohort patients waiting on ambulances. **This will need to be staffed by the Ambulance Service** but will release crews to get back into the community. Number of patients will depend on whether they are on trolley's or "fit to sit".
8. Review internal MAU corridor capacity and declare from the ED queue, maximum 3 beds and maximum 6 "fit to sit". MAU staffing will need to be at template.

If this still does not provide sufficient capacity within the ED to offload ambulances, the following options can be considered; these are outside the Business Unit, led by the Operational Team in hours/Executive On-Call out of hours:

9. Line up trolleys along the x-ray corridor which will allow capacity for approximately 6 patients and would requires 1 RN and 1 HSW.
10. Line up trolleys from entrance 9 through to MAU and potentially along other corridors in the hospital at a ratio of 4 patients to 1 RN.

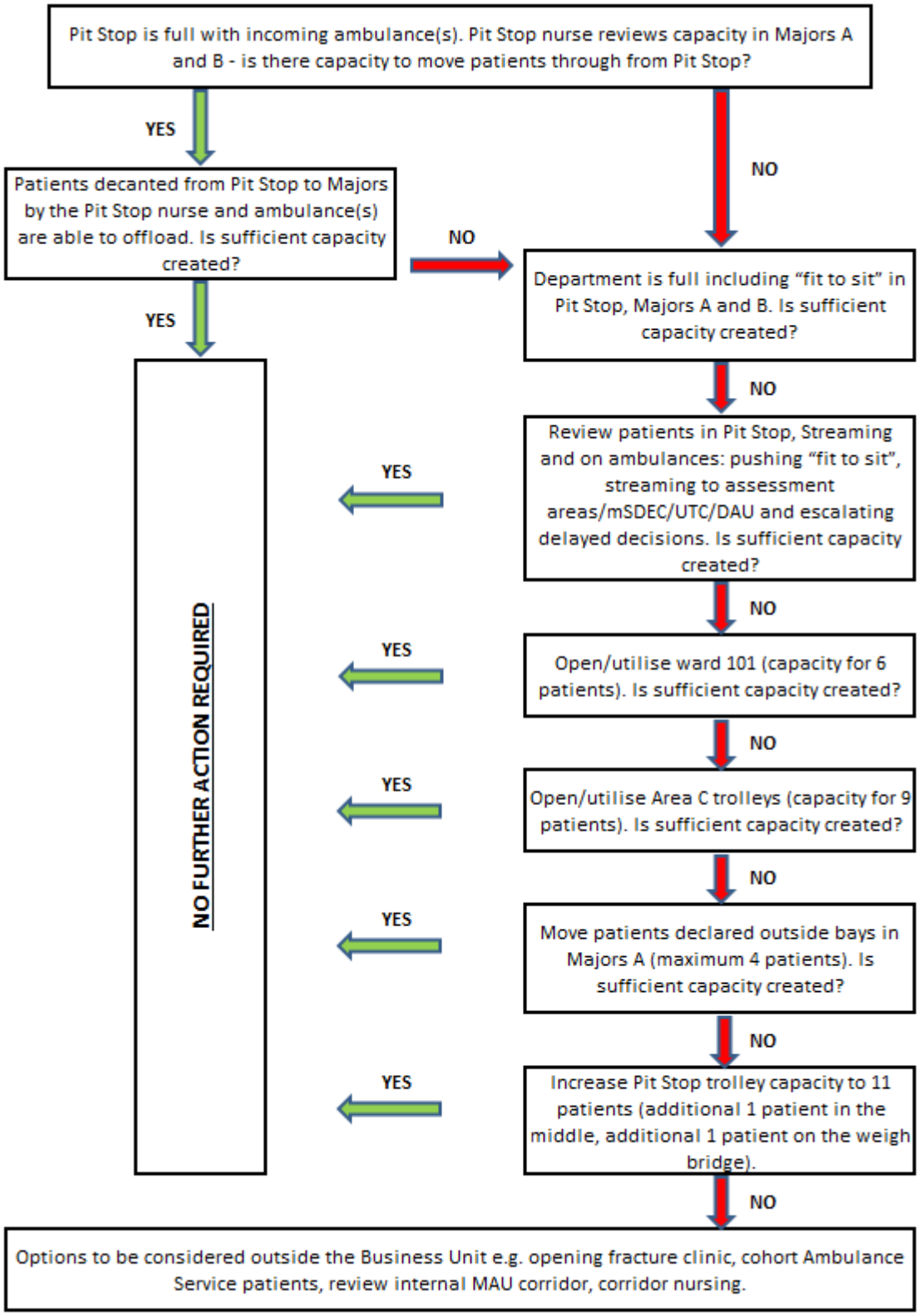
It is important to note that there is a wider Hospital response in such a situation regarding outflow of the MAU and medicine capacity on the base wards. This response and associated actions are led by the Division/Operational Team in hours/Executive On-Call out of hours.

Summary table:

OPEL	Situation	Trigger	Action	Owner
1	Capacity in Pit Stop.	N/A	Monitor handover times (<15 mins) and inbound ambulances.	Shift Lead Consultant. ONIC.
2	Pit Stop full, capacity in Majors A and/or B.	Ambulance handovers 15-30 mins	Minimum care standards on ambulances. Move patients to available capacity with the department. Utilise "fit to sit".	Shift Lead Consultant. ONIC.

3	Pit Stop full, no capacity in Majors A or B.	Ambulance handovers 30-60 mins	Minimum care standards on ambulances. Review patients; "fit to sit", streaming, escalating delayed decisions, frailty input. Open and utilise ward 101. Open and utilise c-side trolleys. Move patients outside bays in Majors A. Increase Pit Stop trolley capacity (additional 1 RN).	Shift Lead Consultant. ONIC. Management Team.
4	Pit Stop full, no capacity in Majors A or B. No outflow. Escalation areas open and full.	Ambulance handovers 60+ mins	Minimum care standards on ambulances. Escalate to Operational Team and explore divert. Speciality in-reach to facilitate discharges. Open and utilise Quad area. Offer Ambulance Service to cohort patients. Review internal MAU corridor. Further corridor nursing to be explored.	Shift Lead Consultant. ONIC. Management Team. Medicine Division. Operational Team.

Managing ambulance conveyances to hospital – Royal Derby Hospital Emergency Department internal escalation plan



Appendix 4

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

QHB Ambulance Offload Operating Procedure/ Holding Procedure/ Cohort Policy

Document filename:	QHB Ambulance Offload Operating Procedure Cohort Policy
Directorate:	Burton Acute Medicine Business Unit, Medicine Directorate
Programme Lead:	Harry Samra (Service Manager), Jamie Douglas (General Manager), Nick Ball (Deputy General Manager), Danielle Murphy (Matron), Dr Venkata Thungala (Associate Clinical Director for ED), Rebecca Nelson (Matron)
Owner:	Jamie Douglas (General Manager), Dr Venkata Thungala (Associate Clinical Director for ED)
Author:	Harry Samra (Service Manager)

Status:	Final
Version:	3
Version issue date:	02/10/2023

EXCEPTIONAL Care Together

Contents

Document Management

1.1 Revision History

Version	Date	Summary of changes
1	Sept 2022	Initial version
2	Dec 2022	Addition of cohort actions during Critical Incident and/or as a result of industrial action by the Ambulance Service
3	October 2023	Review and updated surrounding GRAT Model as well as ensuring safety and when to escalate.

1.2 Approved by

This document must be approved by the following groups/people:

Name	Signature	Title	Date	Version
Acute Medicine Governance Group	N/A	N/A		

1.3 Document Control

The controlled copy of this document is maintained by University Hospitals Derby and Burton. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

2. Background and Context of the Ambulance Offload

Nationally there has been an increased rise and pressure on the ability to offload 999 ambulances into Accident & Emergency departments, which has seen unprecedented delays in allowing ambulance crews to go back out onto the roads and manage patients in the community. The national challenge has seen increased holding times at QHB with ambulances on average holding on a daily basis with up to 1 hour delays and on occasions 2 hours plus. There is a multitude of issues that have led to these delays, with some of these issues boiling down to the inability to discharge patients safely back into the community due to challenges in ascertaining packages of care etc. Furthermore, there is also the challenge surrounding the sheer volume of patients that are attending Accident & Emergency with a vast array of patients with ranging levels of acuity, which is leading to more prolonged stays on the base wards upon their admission.

QHB due to it's geographic location currently provides a service to both West Midlands Ambulance Service and East Midlands Ambulance Service to which roughly 50 ambulances attend the site per day within a 24 hour period. Currently there is no acceptance of Paediatrics via ambulance, however, this continues to be under review.

3. Day Time Ambulance Offload Policy (08:00- 22:00)

Within day time hours Queens Burton Hospital has no designated location to provide a cohort to any ambulance crews that attend the site. However, a STOP moment will be undertaken by the Nurse In Charge/ On Call Consultant/ HALO/ Pit Stop nurse/ Ward Manager/ Acute Lead/ Senior Management in anticipation of any offload issues to ascertain the following:

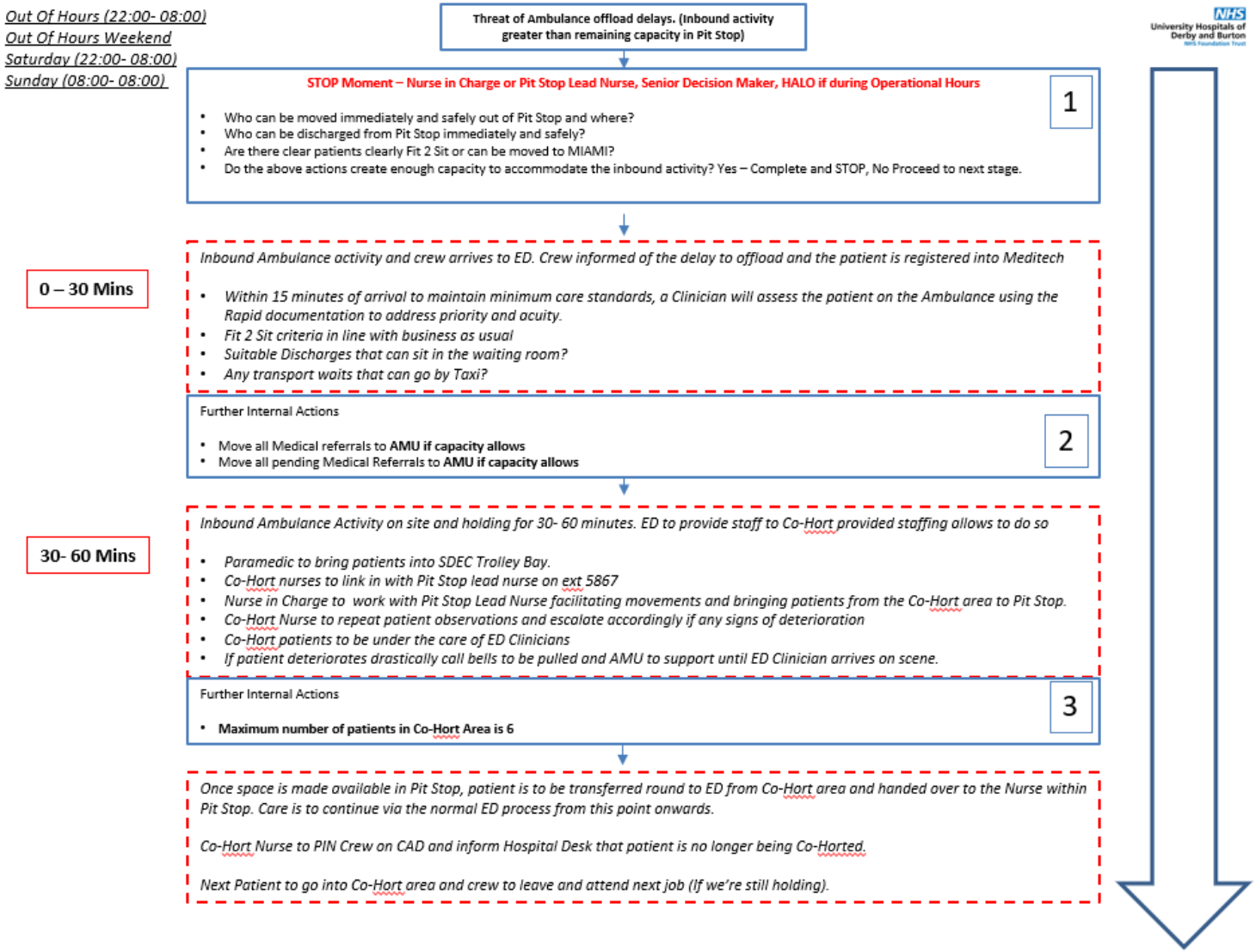
- Who can be moved immediately and safely out of Pit Stop and where?
- Who can be discharged from Pit Stop immediately and safely?
- Are there clear patients clearly Fit 2 Sit or can be moved to MIAMI?
- Are there any patients that are suitable for SDEC?
- Are there any patients that are suitable for SAU?
- Are there any transport waits that can go to DAU?

If no capacity is generated and the department begins to hold ambulances then the following actions are to be undertaken:

- Within 15 minutes of arrival to maintain minimum care standards, a Clinician will assess the patient on the Ambulance using the Rapid documentation to address priority and acuity.
- Are there clear patients clearly Fit 2 Sit or can be moved to MIAMI?
- Are there any patients that are suitable for SDEC?
- Are there any patients that are suitable for SAU?
- Are there any transport waits that can go to DAU?
- Suitable Discharges that can sit in the waiting room?
- Any transport waits that can go by Taxi?

HALO to manage patients on the ambulances and escalate any deteriorating patients to the Nurse In Charge as and when required. Department will bring patients in time order into the department unless a patient is clinically unstable then they will take priority.

4. Out Of Hours Ambulance Offload Policy



5. Queen's Hospital Burton Roles and Responsibilities

Queens Burton Hospital as a site will be responsible for the offload of Ambulances and ensuring that Ambulance Offload issues are minimised at all times. It is the responsibility of the collective hospital to support the A&E in ensuring flow is available to allow for patients to be admitted in a timely manner onto the wards and prevent any delays in relation to flow. Furthermore, it is the responsibility of the A&E department to ensure that all cubicles in the department have been utilised and that the step process outlined in section 3 & 4 are followed in order to support the timely offloads of Ambulance crews. If patients are unable to be offloaded into the department, then it is the responsibility of the Nurse In Charge within A&E to coordinate and initiate a clinician and nurse going out to triage and assess patients as well as begin to provide baseline treatment where deemed appropriate.

If patients are within the cohort area then once a trolley becomes available in A&E, it is the responsibility of the Pit Stop Lead Nurse to inform the Co-Hort Nurse in the cohort area and facilitate a handover over the phone for the patient. Once a handover has been undertaken a HCA and a porter will take the empty trolley to the cohort area and collect the patient that has been handed over and bring them to A&E. This process will be repeated until the cohort area is empty. Patients will be booked in and pinned off the CAD similar to the normal process currently undertaken within Pit Stop. If any call bells were to be pulled for a patient in the area, it is the responsibility of the Ward 9 staff to provide initial support and the Nurse In Charge in ED (Bleep 271) to be contacted to send a Senior ED Clinician to attend.

6. Ambulance Service Responsibility

During Out Of Hours, it is the responsibility of the ambulance service to liaise with staff in the cohort and pit stop area based on the Ambulance Services cohort criteria. In addition, patients who are within the cohort area are to be escorted round to A&E in time order unless trumped by clinical presentation.

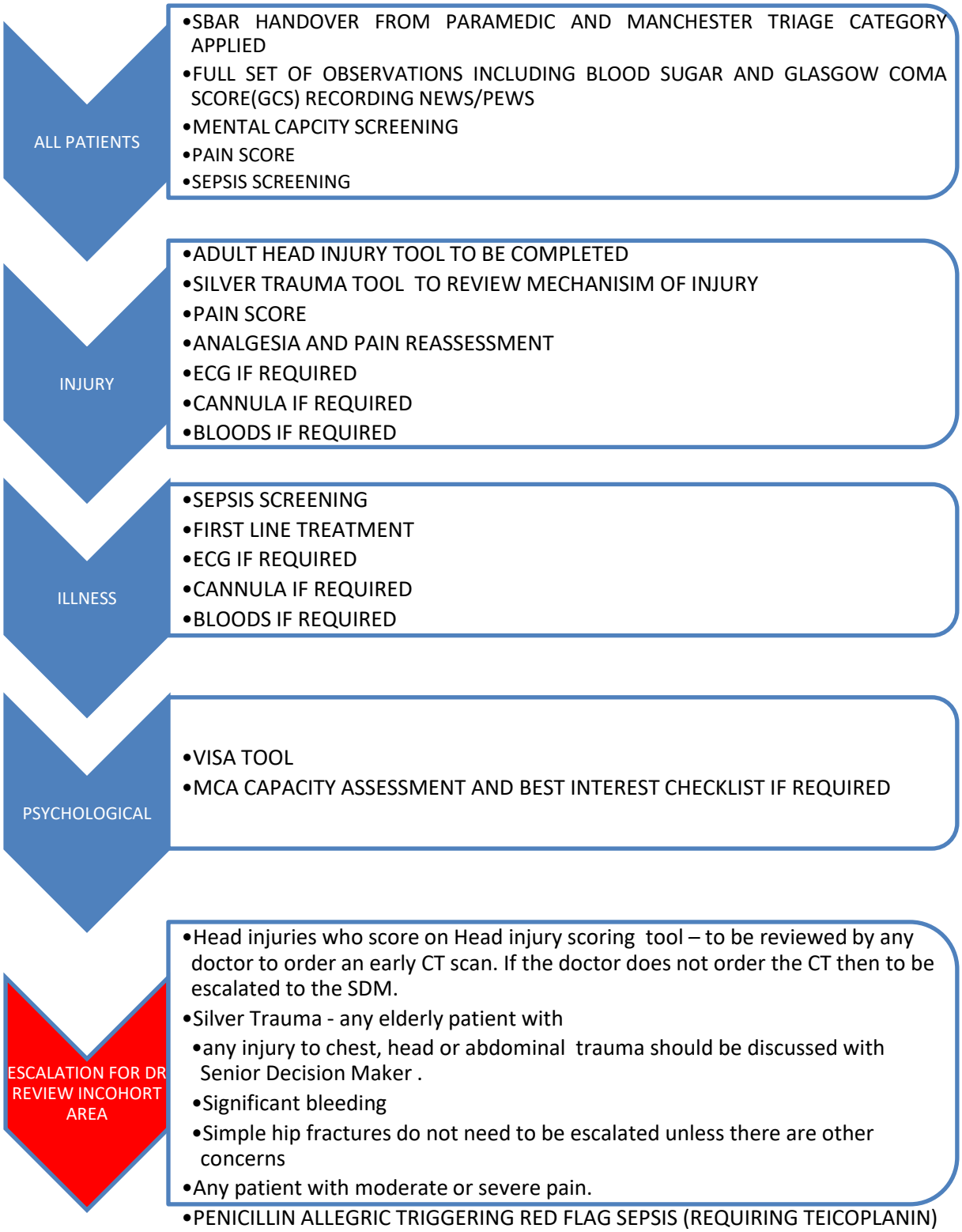
7. Responsibility Of Care

The Emergency Department will take full responsibility for patients based within the Cohort area and if any patient is to deteriorate this is to be escalated to the most Senior ED Clinician who will respond and intervene where necessary.

8. Exclusion Criteria:

- Patients with an infection control risk – Diarrhoea & Vomiting.
- Patients with an infection control risk – COVID +Ve and patients unable to wear a surgical face mask.
- Patients presenting with a Mental Health Condition (However, up to the discretion of the Paramedic Cohorting)
- Patients under any form of Alcohol or Drug Intoxication
- Patients under any form of a 1:1 that cannot be facilitated by the Paramedics

9. Critical Incident (includes Ambulance Service Industrial Action)



- Pit Stop will remain at a 6 Trolley capacity. However, should a requirement for Rapid Offload be required they can then escalate up to 8 Trolley Spaces with "Corridor Care". **This is only an interim model that can only be enacted on Rapid Offload due to a significant number of CAT 1's/ CAT 2's in the community.**

- Ambulance Cohort area still to be utilised as normal during the OOH's
- Ward 5 to increase capacity up to 39 patients by accommodating another patient in room 37. (The patients in this room must be either 2x Covid/ 2x Flu. No mixing of patients)
- Extra staff to be provided to look to assess and treat patients on the back of ambulances (Contingent on getting extra staff).

Appendix 5

Critical Care UHDB (QHB)

Escalation Levels and Actions

OPEL LEVELS as per UHDB declaration and for internal use only. There are other escalation Levels (Crit Con) as used within the Critical Care Network and nationally, but these are broader and don't cover all the following local actions.

OPEL Level	Described as	Actions (in critical care)	Actions (outside critical care
Level 1	• Capacity to admit min 2 patients regardless of any other factors • No delayed discharges over 24hrs • Ability to accommodate elective bookings regardless of other factors (as per process) • Nursing staffing levels able to fully support the above	• Business as usual • Early decision to proceed with elective admission • Timely discharge planning	• Ensure identified discharges are prioritised and bed allocated and available within 4 hr. period by site team
Level 2	• As above • Capacity to admit min 1 patients • Able to accommodate elective patients assuming unit discharges occur in a timely manner	• As above • Review of workforce levels and actions	• Ensure discharges are prioritised
Level 3	• Only 1 emergency bed • Unable to take elective admissions • Above 85% occupancy (dependency 6.5) regardless of staffing • Minimal predicted outflow (i.e. no discharges or patients reducing in levels of care)	• Review of workforce levels and actions • Involvement of Matron and Business Unit operational team re the above • Liaise with other BU teams re possible elective patients and alternative plans • Review elective patients booked over the next 48hrs	• Immediate priority for any discharges and must be managed same as ED decisions to admit • Prioritise discharges at RDH critical care - to support potential need for non-clinical transfer and/or create critical care capacity across the Trust regardless of utilisation
Level 4	• No emergency capacity or at /or above funded establishment regardless of nurse staffing levels	• Priority actions to review/increase workforce levels • Decision planning regarding decompression to other unit /undertake decompression (non-clinical transfer) to other unit	• Support business unit team to facilitate decompression to other critical care units

NB: Declared capacity for RDH QHB is as reported by the unit to the site operational team. Similarly declared capacity may not necessarily be the same as what patient numbers indicate due to side room utilisation, location of patients across the unit, and other workforce /clinical factors.

Appendix 5

Escalation Plan for RDH Critical Care when above funded capacity

Critical Care at RDH is funded for 13.5 Level 3 beds or the equivalent in terms of Level 3 and Level 2 mix.

Summary

Decisions regarding full capacity must include the Consultant Intensivist, Nurse-in charge. In normal hours must also involve Band 7, Matron/Lead Nurse, and business unit operational manager.

Overall, any and all decisions made are to ensure there is emergency capacity and safe care can be provided for all patients without compromising safe staffing standards (GPICS). Capacity needs to be managed within the current funded establishment but there may be situations where the decision and ability to temporarily increase workforce and therefore capacity is deemed the best clinical decision. If this can be achieved through additional staff, then this must be short term (i.e. max 24hrs).

Options

if the unit is at full established capacity (but with empty physical space within the footprint) then you have 2 options

- Try and increase workforce (both nursing and medical to ensure safe staffing as per GPICS) to create additional 1 bed short term emergency capacity (max no more than dependency of 15 Level 3 equiv)
- Decompress the unit by undertaking a non-clinical transfer to another facility to bring the dependency back below the funded level to therefore create emergency capacity

What must be considered before deciding on either of the 2 above paths:

Are there any patients awaiting discharge from critical care to a lower care area (i.e. ward bed) - these must be prioritised by the site team as an immediate action with the same priority as is considered for the front door (ED)

What is the Levels of care of patient currently on the unit - identify patients that may be dischargeable in the next 6/12/24 hours. If yes and this would resolve the capacity, then reasonable to try and increase staffing in the short term (max 16 nurses - 1 above normal numbers of 15) to accommodate the unplanned surge

Consider any potential discharges that may need to be to an 'an early' discharge and plan for this. Consider where the best locations that could safely manage this ie SDU, enhanced care areas within medicine.

Are there any possibilities that early discharges could be mitigated by additional ward CCOT support in the short term

These decisions should be considered and pre-empted where possible when the unit is reaching full capacity so that any plans are ready to be actioned if that point is reached.

If no potential to reduce capacity internally then need to identify if any patients are clinically stable enough to undergo a non-clinical transfer to another critical care unit. QHB should be considered first as closest and within our own Trust then after that as available within the EM Critical Care Network.

Short term increase nurse staffing options (below in discussion and agreement of Band 7 ward manager and Matron /Lead Nurse). If out of hours then the Band 6 or Band 7 nurse in charge, in conjunction with the on call senior nurse would be contacted for this agreement.

Can a RN be moved from QHB or SDU to provide additional support. Review both other areas staffing and capacity, need to consider skill set of individual before doing so and for SDU how this would be backfilled and the impact this may have for their patient care and safety.

Appendix 5

Shifts should already be out to bank. If this needs escalation for approval to speciality agency nurses then this has to be approved by the Divisional Nurse Director. If there is felt a need to escalate to a specific agency i.e. Thornbury this has to be escalated and approved by a Director of Nursing (or on call Exec out of hours) . What must be remembered that the approval of these escalations does not guarantee the shift can be covered.

Elective patients cannot go ahead if the unit is at full capacity unless there is a clear and obvious plan for how this would be resolved. i.e. Accepting the elective would take the unit over capacity but this would resolve once the agreed discharges have taken place.

There must always be counted in the ability for an emergency admission when looking at elective capacity. In real terms the unit needs to be at a max dependency of 11.5 to be able to facility elective admissions and still retain emergency capacity.

Undertaking non-clinical transfers is not best practice but often required for a unit to be able to manage their emergency capacity. There is a network wide established transfer facility (ACCOTS) and understanding across the network when these decisions and actions have to be done to ensure overall patient safety.

Non-clinical transfers should be undertaken to facilitate emergency capacity but not to facilitate elective admissions.

Boarding Standard Operating Procedure - Surgery Division - RDH

1. Overview

The purpose of this SOP is to describe the actions that will be taken to reduce the risk to patients waiting an excessive amount of time for ambulance offload, and those in the community waiting for ambulance assistance. Also, to reduce overall length of stay for surgical and orthopaedic patients in the Emergency Department (ED) and assessment unit areas, ensuring patients reach ward care in a timely manner. The policy also supports a reduction in patients being cancelled on the day of their surgery in the Division of Surgery and in turn elective recovery.

The safe and effective flow of emergency and elective care patients (irrespective of speciality) is critical to ensuring patients receive high quality care. The distribution of risk is essential to ensure that no one group of patients or staff are adversely affected, the dynamic assessment of risk is essential for delivering a responsive and safe service. This operating policy links to the Trust Escalation Policy and the Division of Surgery Escalation Triggers

The Process of BOARDING of Patients in the Surgery Division:

a) BOARDNG of patients can occur when:

   a. all the actions have been exhausted linked to emergency flow from the ED department to SAU/SDEC and OAU
   b. when elective patients are fit to sit prior to their surgery,
   c. non-elective and elective patients who have a confirmed discharge that are fit to sit out of their bed space.

b) Surgery Assessment Unit: up to a maximin of 4 patients to be accommodated. Following the SOP for medical outliers in SAU identifying which patients are suitable.

c) **Ward 307:** overnight extra capacity room x 1 patient where a surgical discharge has failed overnight, and the patient cannot be accommodated elsewhere. There must be a clear plan to move the patient from this room safely by 7am the next morning. It must be recognised that this room can only be used after 9pm at night without significant impact on the treatment room activity and may still impact on the ability to move patients from ED to 307 overnight for HNEP examination by the on-call team due to the patient blocking access to essential equipment.

d) **Elective Surgery Wards:** Suitable patient's will be sat out in the dayroom / referred to DAU awaiting TTO's etc if beds are required for post operative patients with no bed allocation. Patients will have a confirmed discharge agreed from the medical or nursing team for that day. Up to a max of 2 patients per day room. This does not include ward 202 (EPU) due to the ward not having a day room.

e) Non Elective Surgical Wards: Suitable patient's will be sat out in the dayroom / referred to DAU awaiting TTO's etc if beds are required for patients in SAU. Patients will have a confirmed discharge agreed from the medical or nursing team for that day. Up to a max of 2 patients per day room. This does not include ward 313 due to the ward not having a day room.

f) OAU & Trauma Capacity: where there is no bed available on the orthopaedic wards at the time of the decision to admit from ED, the patient may board on the OAU following the assessment of the clinical suitability of the patient. Patients waiting at home to come in for their planned emergency operation and who are waiting at home are reviewed daily (virtual ward), these patients may board on the ward before their planned trauma procedure. #NOFs do not dit the criteria for boarding and will not be considered

g) Elective Orthopaedic Wards: Suitable patient's will be sat out in the dayroom awaiting TTO's etc if beds are required for patients attending for their planned elective procedure. Patients who do not need to access a bed prior to their procedure will board om the ward until they are called to theatre a return to a bed post operatively

PROCESS:

- The surgical lead and bed manager will liaise with the Bleep holder in Surgery and Orthopaedics/Trauma Nurse to identify where patients are boarded, and this will be highlighted on extra med - process in Appendix A

- Ward Nurses in Charge to identify suitable patients to board. This will be dependent on the sex mix of the incoming patient admissions and wards that are appropriately staffed.

- All Medical and Nursing documents, medication and property should transfer with the patient to the ward they will be BOARDING.

- The leads will communicate regularly with the ops team to ensure that BOARDED patient placement information is up to date.

- Patients are identified as Fit to Sit there will be transferred within 30 minutes.

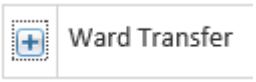
- Patients will continue to have timely, on-going treatment or continued discharge planning whilst BOARDING on inpatient wards and assessment areas.

- Patients identified for BOARDING must have seen a Consultant already during that admission to ensure medical clerking and a treatment plan/ e-medications have been confirmed.

- The following groups of patients will be excluded from BOARDING:

  a. Clinically unstable with an early warning Score (EWS >4)
  b. Patients with an EWS of 3 in one parameter
  c. Patients requiring Humidified, High flow oxygen, NIV or oxygen therapy.
  d. Patients requiring High Dependency Unit level care.
  e. Patients requiring cardiac monitoring.
  f. Patients with severe cognitive impairment i.e. restless/agitated, delirium, requiring 1:1 care.
  g. Patients with complex Learning Disabilities
  h. Patients in the last few days of Life
  i. Patients who require isolation because they are at risk of transmitting or acquiring an infection.

Appendix A:

ICON	When to use it	Who is responsible for adding to Extramed	Where Can I find the ICON
	To alert all members of staff that the patient is in an Extra Capacity Bed – which may be in a dayroom or a space that has been accepted as suitable on the ward The patient will be assigned to the 'Day Room' on the Whiteboard, with this additional icon, in order to differentiate between patients genuinely in the Day Room.	All staff with appropaite access – to ensure clear auditing of the proceedure.	

Paediatric Business Unit Operational Management Schedule

Time	Meeting	Location	Attendees	Led By
06:30	Bed E-mail – Site Practitioner			
07:00-07:30	Handover	2nd Floor site practitioners' office	• Out going site practitioner • Incoming site Practitioner • Matron	Out going site Practitioner
07:30-08:15	Site Practitioner and Matron visit all areas			
08:30	**Matron attends Cross site meeting on Teams**			
08:50	Operational meeting	PBU Seminar Room	• Site Practitioner • Matron • Operational team	Site Practitioner
09:00	Ward round	PBU Seminar room	Consultant/medical staff/ site practitioner/ pharmacy.	Consultant & Night team.
11:30	Bed E-mail – Site Practitioner			
12:00	Flow meeting	Teams	Operational Team	Flow team
15:00	Safe Care	Teams	Matron	Flow team
15:30	CED Huddle	CED	• CED Consultant • CED NIC • Site Practitioner • Operational team • Matron	CED NIC - Sitrep
16:00	Flow meeting	Teams	Operational team	Flow team
16:30	Ward round	PBU Seminar room	Consultant/medical staff/ site practitioner	Consultant & Day Team
17:30	Bed E-mail – Site Practitioner			
18:00	Site Practitioner attends Cross site meeting on Teams			
19:00	Handover	2nd Floor site practitioners' office	• Outgoing site practitioner • Incoming site Practitioner	Out going site Practitioner

Trigger	Actions by Senior Sister or Nurse in Charge (NIC) in her absence	Actions - by Site Practitioner, or Matron, prior to bed meeting	Actions – at bed meeting
Green Actual staffing is equal or greater than planned	• Complete Safe Care • Report to Site Practitioner and Matron and bed meeting.		
Green Actual staffing numbers and skill mix is less than planned However assessment of patient acuity against staffing numbers and skill mix does not pose a risk to patient care provision	• Shift by shift basis assessment of staffing and skill mix in relation to patient acuity. • Complete Safe Care • Report to Site Practitioner and Matron and bed meeting.		
Amber Actual staffing is less than planned and there is prediction that nursing care may be affected e.g., late administration of medication	• Review unavailability to include office days and study days. • Complete Safe Care. • Report to Site Practitioner and Matron and attend bed meeting.	• The Senior sister /NIC carry out a risk assessment of numbers of staff against acuity of patients and number of beds open. • The Senior Sister/NIC assess predicted bank staff required. • Matron to e-mail OOC	• Share actions taken locally to address shortfalls. • Declare amber status at the bed meeting and request assistance from other areas across the PBU. • Ensure that DHS have contacted all appropriate staff.

Amber Actual staffing is in line with planned levels but acuity is higher (Acuity is determined using professional judgement and knowledge of local context and patient needs)	• Review unavailability to include office days and study days and redeploy as necessary. • Complete Safe Care. • Report to Site Practitioner and Matron and attend bed meeting.	• Examine areas that support ward/department and deploy staff to short, staffed area e.g. outpatients, community With the Senior sister /NIC carry out a risk assessment of staff against acuity of patients and number of beds open. • The Senior Sister/NIC assess predicted bank staff required. • Matron to e-mail OOC • Matron escalation for external agency.	• Identify support staff with advanced care competencies & redeploy appropriately. • Determine feasibility of transferring patients to other settings, if clinically appropriate. • Determine feasibility of closing beds for a predetermined time – to be discussed with HOP/DGM or GM for area. • IF AMBER REMAINS CONTACT HOP/GM.
RED Only to be activated once all controls and actions in amber have been implemented and exhausted and discussed with the Head of Paediatric Nursing	As above	As above	As above
Is less than established which will have a direct impact on patient safety At least 1 of the following may apply; • Unintentional omission of medication			**In hours.** • Escalate to HOP /DND • Discuss hospital response – link into staffing meetings. • escalation procedures

• Observations not assessed and recorded in line with care plan • Patient diet and fluid intake not assessed or recorded as outlined in care plan • Not able to address patient and family expectations for more than 3 patients Dependent on the ward area the following may also apply:- • Less than 2 registered nurses on ward shift •Less than 25% of planned registered staff present			• Complete Datix describing details, actions and impact **Out of hours- Site Practitioners.** • Escalate to Senior Manager on-call and advise of actions to date and impact if remains unresolved • Complete Datix describing details, actions, and impact. • Email relevant Matron/ Head of Nursing and DND • Site Practitioner to inform Senior Manager to advise Executive on-call

APPENDIX 9

PAEDIATRIC BUSINESS UNIT OPERATIONAL PRESSURE -ESCALATION LEVELS-STATUS

Operational pressures Escalation level -Status	Description	Action
OPEL 1	**Low Risk** All beds open. Discharges facilitated supporting elective and emergency flow. No Action Required	1. Site Practitioner to ensure patients are accepted from CED on referral. 2. Site Practitioner to provide Matron on for staffing and operational manager with regular updates on bed state and capacity. 3. Nurse staffing to be evaluated by Matron of the Day for maximum beds to be open. 4. Bed closures to be escalated by Matron to the Head of paediatric Nursing and the General manager to assess the impact on flow from CED. 5. This will be communicated to CED via CED huddle.
OPEL 2	**Moderate Risk** **NEAR CAPACITY** Persistent excess pressure requiring significant action to facilitate discharges and ensure that flow is maintained from the Childrens hospital.	1. Site Practitioner to ensure patients are accepted from CED on referral. 2. Site Practitioners to provide Matron on for staffing and operational manager on for the day with regular updates on bed state and check capacity with the nurse in charge in the in-patient areas. 3. Site Practitioner informs the matron of the day (in hours), manager of the day (in hours)/manager on-call (out of hours) that the escalation is OPEL 2. 4. Operational Manager of the day escalates to the hospital operational team. 5. Head of Paediatric Nursing to liaise with ward matrons to review beds open and opportunity to open further beds. Check staffing for the following 24 hours against projected acuity. 6. All patients to be reviewed by senior decision maker before midday. 7. Matron/Manager of the day arranges an additional huddle in CED with key staff members: Consultant (in hours), consultant on-call (out of hours), Manager of the day (in hours), manager on-call (out of hours), site practitioner, Nurse in Charge. 8. Communication via ED huddle from this is paramount. 9. Identify discharges, additional capacity, workforce resource required, escalate significant safety issues. Escalate to flow team. 10. Decision on whether to reduce elective activity the following day to be considered by the manager of the day (in hours) and is to be raised with the manager on call (out of hours). 11. Must Be approved by Divisional Director 12. Manager of the Day and Heads of service to review whether to request medical and

APPENDIX 9

PAEDIATRIC BUSINESS UNIT OPERATIONAL PRESSURE -ESCALATION LEVELS-STATUS

		nursing staff to return from training days and SPA to ensure discharges, patient safety and maximise open beds and increase flow. 13. Cancel all non-essential meetings. 14. Bed closures to be escalated by matron to the Head of Paediatrics, General Manager 15. to assess the impact on flow from CED. 16. DND and Divisional Director to be informed. 17 This will be communicated to CED via CED huddle.
OPEL 3	**High Risk** **Full Capacity** Opel 3 or CED on RED and CH on Opel 2 equivalent. Severe and /or prolonged pressure requiring maximum action and support from internal/external agencies to address demand/congestion facilitate discharges and ensure flow from CED.	1. Please refer to points 1 -17 in Amber escalation. 2. Cancel elective activity either on the day or for the following day. This must be escalated to DND and DD prior to cancelation (in hours) or on call executive out of hours. 3. Matron/Manager of the day (in hours) to update the flow team and Head of Pead's, GM and DND and DD. 4. Manager of the Day and Heads of service to review whether to request medical and nursing staff to return from training days and SPA to ensure discharges, patient safety and maximize open beds and flow. 5. Cancel all non-essential meetings. .
OPEL 4	**Critical Incident** The children's hospital including CED, and other departments are clinical unsafe.	1. Please refer to points 1-3 in Red escalation. 2. Women and Children's GOLD representative/Head of Ops/Deputy Head of Ops will attend the UHDB Internal Critical Incident Process with Consultant on call. 3. Please ensure the following actions are taken if 'Critical Incident Stand Down' is stated. 4. Take direction from Women's & Children's Clinical Management Group Critical Incident Lead 5. Notify Nursing Staff of Critical Incident Stand Down 6. Collate any documentation and information relating to the incident and pass on to the Women's & Children's Clinical Management Group Lead. This does not include patients notes. 7. Initiate recovery of disrupted services – Liaise with Women's & Children's Clinical Management Group lead as necessary. 8. Ensure appropriate debriefs are taking place across the Service

APPENDIX 10

Paediatrics - Bed Capacity Status

OPEL 1

ED/Assessment Areas

CED	OPEL 1
In Department	
Outflow	
Waiting To Be Seen	
Arrivals in Last Hour	
12+ Hours in Dept	
Attendances Today	
4 Hour Performance	

PAU	OPEL 1
In Department	
Outflow	
Waiting To Be Seen	
Arrivals in Last Hour	
12+ Hours in Dept	
Attendances Today	

Derby Empty Beds	2
Burton Empty Beds	0
TOTAL EMPTY BEDS	2

SMT Lead	
Staffing Lead	
Bleepholder Day	
Bleepholder Night	
Bleepholder contact	Mobile 07766697397 Bleep 6516

Inpatients

	Ward 1 8 Beds	Puffin 12 Beds	Dolphin 12 Beds			PCCU 4 Beds
	OPEL 4	OPEL 3	OPEL 1			OPEL 1
Total Patients	10	14	14			4
Patients on Home Leave						
TCI's / Electives						
Potential discharges						
Confirmed Discharges						
Total empty beds/cots						
					No of Level 1	
					No of Level 2	
					No of Level 3	

Neonates

	NICU 24 cots	NNU 8 cots
	OPEL 1	OPEL 1
Total Patients	13	5
Patients on Home Leave		
TCI's / Electives		
Potential discharges		
Discharges		
Total empty beds/cots		
No of Level 1		
No of Level 2		
No of Level 3		