University Hospitals Birmingham NHS
NHS Foundation Trust

QEHB OPERATIONAL ESCALATION RESPONSE

CONTROLLED DOCUMENT

Category:	Procedure
Classification:	Operational Delivery
Purpose:	To set out the principles of escalation status and response by staff group, managing the site capacity and demand across all areas of the Trust.
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Contents

1.0 INTRODUCTION

This procedure incorporates the escalation status setting using the Escalation Management System (EMS) system; bed capacity and emergency department trigger points, and associated escalation action plans.

2.0 PURPOSE

The establishment of an effective escalation policy will contribute towards the following:

- Early identification of capacity problems
- Proactive rather than reactive response
- Concise and clear actions for all staff groups
- Defined responsibilities

This escalation procedure enables the Trust to deal effectively with fluctuations in demand and capacity so that it can manage associated clinical risk within acceptable limits. The procedure is designed to help mitigate the risk of further escalation and ensure an appropriate response from key staff members to contribute to a reduction in escalation status.

The procedure aims to maintain high standards of patient safety, patient experience and performance against key waiting time and quality standards of care.

3.0 ESCALATION STATUS SETTING

A single escalation status will be set for both the QEHB and Heritage buildings. At any one time, the site would be on an escalation status ranging from 1 to 4.

The Site Manager will review the Escalation of the Trust at least twice a day; before 09:00hrs and before 16:30hrs. Additional updates will be made to the EMS level where appropriate by the Site Manager and Head of Operations.

The response to EMS level 4 is most effective during normal working hours and when implemented early in the day. The Head of Operations, in conjunction with Directors of Operations and the Deputy Chief Operating Officer/Chief Operating Officer will be responsible for monitoring the site status and discussing the need to proactively escalate to Level 4.

3.1 Approval to Escalate

The Clinical Site Manager will seek approval from the following before increasing the Escalation level.

Level 1	• No approval required
Level 2	• No approval required
Level 3	• Head of Operations during normal working hours • On Call Manager out of normal hours
Level 4	• Head of Operations will contact the COO / Deputy COO during normal working hours • Duty Director on call(DDOC) Out of normal hours

3.2 EMS system Triggers

There are 14 triggers in the EMS system that are used to define the Escalation status of the site. The following 7 triggers are related to Acute Bed capacity:

(1) Expected capacity Vs expected demand
(2) Beds in assessment areas
(3) Planned additional bed capacity
(4) Critical Care capacity
(5) Elective activity
(6) Medical outlier – Please read Outlier Policy in Appendix E
(7) Infection control measures

The following 5 triggers are related to the Emergency department:

(1) 4 Hour Breaches
(2) Transfer of Ambulance patient care
(3) 8 Hour trolley waits
(4) Cubicles in ED department
(5) Resus bays in ED

The following 2 triggers are also available within the EMS system but are not considered for the calculation of the escalation status:

(1) Gender specific bed availability
(2) Delayed transfer of care

4.0 PRINCIPLES OF GOOD FLOW (At all EMS Levels)

The principles of good flow management are laid out in Appendix 1.

All Trust members of staff are required to actively contribute to the timely and safe discharge of patients from hospital. Ward staff should make use of the following tools to help facilitate this process:

Tool	Rationale
Outstanding length of Stay (OLOS) on	To help coordinate and plan for discharge in a timely manner

PICS	
Ward Viewer	To help coordinate capacity availability throughout the Trust by tracking progress on discharge

Medical staff should ensure that morning ward rounds/ board rounds for discharge decision/planning have been completed by 10:00hrs and review is updated within PICs. Medically fit patients and patients fit for discharge the next day must be identified; TTOs and GP letters must be completed wherever possible the day before discharge and patients should be referred for early transfer to the Discharge Lounge to ensure that beds are freed up to accept acute admissions.

The Nurse in Charge must update the PICS system and Ward Viewer in real time. Beds must be declared to Capacity Managers within hours and Site Managers out of hours. Out of hour discussions with Nurse in Charge and the Clinical Site team must take place using Ward Viewer as a tool

5.0 TRUST ESCALATION – NORMAL WORKING HOURS (Appendix 1)

5.1 EMS 1 & 2

All of the principles of good flow management should be delivered as laid out in Appendix 1

5.2 EMS 3

All of the principles of good flow management should be continued.

Additional actions to be taken specifically at EMS 3 during normal working hours are laid out in Appendix 1

5.3 EMS 4

All of the principles of good flow management should be continued.

The additional actions to be taken at EMS 4 during normal working hours are laid out in Appendix 1, and Action Cards Appendix 2.

At EMS 4 a Senior Operational Manager will be identified as the Incident Controller. They will organise a Cross Divisional Escalation Meeting to establish the current situation and to develop an operational plan.

The operational plan will be disseminated through separate Divisional Meetings with actions being taken at Triumvirate level.

6.0 TRUST ESCALATION – OUTSIDE OF NORMAL WORKING HOURS

If the Site is already at EMS 3or EMS 4 when it switches from normal working hours (NWH) to outside of normal working hours (ONWH) the Clinical Site Manager, with support from the On Call Manager and the Duty Director On call, should implement the plans provided by the Divisional Management Teams, and ensure the principles of good flow management are adhered to.

If the escalation status needs to be enhanced to an EMS level 3 or level 4 ONWH then the following actions should be taken:

6.1 The On Call Manager (OCM) is required to authorise movement to EMS 3. The Duty Director is required to authorise movement to level 4 (section 3.1 above)

6.2 The Clinical Site Manager (CSM) will update the EMS level and will communicate the change in escalation status to the organisation and to the Urgent Care Intelligence Centre

6.3 The CSM will ensure a robust site status report is collated including bed availability, staff availability, Emergency Department status, and will document all of the flow issues.

6.4 The CSM and OCM will discuss the site report, prioritise the list of flow issues and develop an action plan.

6.5 In developing the action plan the CSM and OCM should consider the following:

- Are the principles of good flow being adhered to in all areas?
- Has the Divisional plan been fully implemented?
- What is the status of the predicted discharges?
- Are the beds that are available being used to support the list of priorities for the whole Hospital?
- Can extra beds be made available using the one up rooms, Wellcome or Ambulatory Care?
- Do staff need to be moved to support a particular bottleneck.
- Is there an action plan for elective admissions and inter hospital transfers?
- Do any Access beds (Stroke, Cardiac, Trauma, Shock room) need to be used to prevent 12 hour breaches?
- Do any on call consultants need to be asked to come back on site to support patient flow?
- Can any speciality doctors be released to support ED. For example can Acute Medicine assess patients waiting for CDU beds, can Trauma specialities see minor injuries?
- Is a conversation needed with on call managers at neighbouring hospitals to expedite repatriations?
- Are there any additional measures required to safeguard patient care for patients waiting in ED, possibly on the corridor?

- Has the West Midlands Ambulance Control desk been notified of the pressures?

6.6 If the escalation is to EMS level 4 the CSM and OCM should also consider:

- Are additional beds required that may improve patient flows over the coming days (for example Wellcome & Ambulatory Care), and how can they be staffed.
- Is a teleconference required with each of the on call consultants to utilise expertise within specialty?

6.7 The OCM will share the action plan with the Duty Director On Call (DDOC) for agreement.

6.8 The CSM, with support from the OCM as required, will enact the agreed plan.

6.9 The CSM and OCM will communicate at regular intervals and will update the DDOC as required.

6.10 The DDOC will provide early notification to senior operational teams by e-mail via the HOO, COO, DCOO, DD's, DOPS, DDOPS, DHON, HOP