

**CONTROLLED DOCUMENT**

**STANDARD OPERATING PROCEDURE FOR  
 TRUST CAPACITY ESCALATION**

<b>Category:</b>	Procedure
<b>Classification:</b>	Emergency Preparedness
<b>Purpose:</b>	To set out the principles and escalation status when managing the site capacity and demand across all areas of the Trust.
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### **Glossary:**

**SCSM:** Senior Clinical Site Manager

**DCC:** Divisional Capacity Manager

## 1. INTRODUCTION

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

## 2. 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
- 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. ESCALATION STATUS SETTING

### 3.1 Status Schema

The following schema will be used to help communicate the escalation status. This is based on a numbered scale that reflects the level of risk to patient safety and the extent to which patient experience may be compromised. The escalation status refers to Trust sites only.

Figure 1: Escalation Status



This status setting applies to adult acute bed capacity.

A single escalation status will be set for the both the QEHB and QEH sites.

At any one time, the site would be on an escalation status ranging from 1 to 4. This escalation status will be reviewed at periodic intervals by the Senior Clinical Site Manager.

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

Level 1	<ul style="list-style-type: none"> <li>• No Escalation required</li> </ul>
Level 2	<ul style="list-style-type: none"> <li>• Ops Centre Manager during working hours</li> <li>• On Call Manager Out of hours</li> </ul>
Level 3	<ul style="list-style-type: none"> <li>• Duty DOps during working hours</li> <li>• Exec On Call Out of hours</li> </ul>
Level 4	<ul style="list-style-type: none"> <li>• COO / Deputy COO during working hours</li> <li>• Exec on call Out of hours</li> </ul>

### 3.2 EMS system Triggers

There are 14 triggers in the EMS system that is 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

#### 3.2.1 Acute Bed Capacity Triggers

The following Acute bed capacity triggers should be considered while calculating the Escalation status of the site.

Trigger	1	2	3	4
Expected capacity Vs expected demand in the next 24 hours	Capacity > Demand	Capacity deficit of <120	Capacity deficit between 120 and 240	Capacity deficit >240
Beds in assessment areas	Less than 80% occupied	80% to 100% occupied	No assessment area for a minimum of 3 hours	No assessment area beds for minimum of 7 hours
Planned additional bed capacity	On standby	Open and less than 80% occupied	Open and more than 80% occupied	Open and full; unplanned capacity in use
Critical Care capacity	<80% occupied	80% to 100% occupied	100% occupied; planned over flow areas in use	As for (3) plus potential transfers identified-unresolved
Elective activity for the next 24 hours	Proceeding as planned	Up to 10% elective and urgent inpatient activity cancellation	Up to 90% elective and urgent inpatient activity cancellation	Greater than 90% elective and urgent inpatient activity cancellation
Medical outlier	Less than 6	6-12	12-36	>36
Infection control measures	No loss of admission capacity	Partial or whole ward closed due to Infection control measures	More than one ward closed due to Infection control measures	Whole Hospital closed due to Infection control measures

It may be necessary to use professional judgement to balance these triggers i.e. the pressures in the Emergency Department may be the result of high minors demand rather than patients waiting for admission.

The bed deficit figures are determined by comparing the current and predicted level of demand for the day versus the number of empty and potential discharges.

Funded winter pressure beds are included as part of the Trust bed base. Unfunded beds are counted as contributing to the demand side of the equation. However, discretion about whether to include or exclude these figures is held by the Senior Clinical Site Manager.

The divisional capacity coordinators will collect figures for anticipated patient discharges. Wards should update the status of their patients and their

Outstanding Length of Stay (OLOS) on PICS or other suitable tools. The Divisional Capacity Coordinators will collate the figures before the bed meetings.

The escalation status is set daily by the Senior Clinical Site Manager following the 07:30hrs bed meeting. The escalation status is reviewed at 12:00hrs and 16:30hrs bed meetings daily. This is to ensure that the need for further escalation is identified, and, where possible, to reduce the level of escalation and response.

### 3.3 Emergency Department Triggers

The following Acute bed capacity triggers should be considered while calculating the Escalation status of the site.

Trigger	1	2	3	4
4 Hour Breaches	No risk of patients breaching 4 hour ED target	Risk of 1 or 2 patients breaching 4 hour ED target	1 or more patients already breached and still in ED.	As for (3) and unlikely to be seen in the next 4 hours.
Transfer of Ambulance patient care	<15 minutes	15-30 minutes	30-60 minutes	>60 minutes
8 Hour trolley waits	No Risk of 8 hour trolley waits	Subject to risk in the next 2 hours	Patients in ED with 8 Hour trolley waits	As for (3) and with added risk of waiting for 12 hours
Cubicles in ED department	Less than 80% cubicles occupied	80% to 100% of cubicles occupied	All cubicles full. Patients waiting in planned overflow areas.	As for (3) plus patients waiting in unplanned overflow areas.
Resus bays in ED	More than 1 resus bay available for immediate use	Only 1 resus bay available for immediate use	No resus bay available for next 30 minutes	No resus bay available for the next hour

The Emergency Department also has a separate internal escalation action plan and triggers which are linked to the following timeline for safe and effective care of patients in the departments.

Figure 4: Emergency Department Timeline

Initial Assessment	Initial Clinical Review	Management Plan and treatments	Discharge Outcome	Discharge / Admission
0 - 15mins	15mins - 1 hour	1 - 3 hours	3 Hours	3 - 4 hours

The status of the department should be reviewed every hour by the Emergency Department (ED) Nurse Coordinator. The ED Nurse Coordinator and Consultant should follow the actions cards in this policy (see Appendix A).

The Emergency Department nurse coordinator will escalate to the Senior Clinical Site Manager about patients without a discharge outcome decision at 3 hours.

Professional judgment will need to be used by the ED Nurse Coordinator to weigh measures associated with the timeline above with the total number of patients in the department to determine the escalation status.

#### 4. NORMAL WORKING

All Trust members of staff are required to actively contribute to the timely and safe discharge of patients from hospital. Wherever possible discharges should be planned to take place before 13:00hrs. Ward staff should make use of the following tools to help facilitate this process:

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

Other discharge tools currently under development are the Site Management System- an extension of the EPR that will facilitate tracking of patients' progress on discharge; Discharge pathways; Criteria led discharge and the formation of the Discharge Hub. Once implemented, these initiatives will be included in this document.

Medical staff should ensure that morning ward rounds for discharge decision / planning have been completed by 10:00hrs. 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.

The Nurse in Charge must update the OLOS system seven days a week by 16.30hrs. The update will reflect:

- OLOS 0 = patient expected date of discharge that day
- OLOS +1 = patient expected date of discharge the following day
- OLOS +2 = patient expected date of discharge in 2 days
- OLOS +3 = patient expected date of discharge in 3 days etc.

No patient should ever be in a minus OLOS situation.

Discharges must be declared to the Divisional Capacity Coordinators at the earliest opportunity. Ward staff must make appropriate use of the discharge lounge to ensure that beds are freed up to accept acute admissions.

## **5. ESCALATION ACTIONS**

Key staff members have action cards which provide them with actions that they should undertake at a particular escalation status level. These cards can be found in the appendix to this procedural document.

### **5.1 Additional Capacity Areas**

The Full Capacity Protocol Appendix D, identifies additional capacity for use overnight. The decision to open these areas should be planned in advance in consultation with the Chief Operating Officer and the Associate Directors of Nursing.

The Divisional Capacity Coordinators and Senior Clinical Site Managers must coordinate the opening of these areas as per their action cards.

Currently closed areas must be risk assessed for suitability prior to be opened. The opening of any other areas on an ad hoc basis out of hours must only be undertaken with approval from the on-call executive director. The Senior Clinical Site Manager should follow the 'reopening checklist' if a ward is being opened at short notice.

### **5.2 Ambulance Diverts**

The diverting of patients because of emergency department or bed capacity pressures is governed by the Draft Trust divert protocol (see Appendix).

### **5.3 Cancellation of Training**

Students or staff who are attending courses on their annual leave are excluded from the scope of this policy.

At level 3, the Education staff should ensure that registers of all clinical staff in meetings or training sessions have been completed documenting whether the attendees are employed by the Trust; whether they are attending a training session on their annual leave, and their job title and normal place of work.

At level 4, the Education Centre should share the list of staff attending training with the Senior Clinical Site Manager and Head of Departments for potential redeployment.

If requested, the Education Centre should actively facilitate the cancellation of training sessions and meetings.



Trust staff will be required to attend training sessions in uniform. There is an escalation in place for nursing staff to get temporary uniforms authorised by Clinical Site Managers. These are held in level -1 of the QEHB site and are accessible 24hrs a day (Procedure enclosed in Appendix C).

## 6. COMMUNICATION

The escalation status is communicated to staff throughout the organisation in a number of different ways. These methods recognise that not all staff will have the opportunity to regularly access emails.

### 6.1 General Communication

These forms of communication are designed to provide general information about the escalation status of the hospital. General communications will be led and updated by the Ops Centre.

#### 6.1.1 Bed State Email

Date	Chair:	Time:	Trust Escalation Level (EMS)	2		
Exec On Call		Manager O/C		Site Manager		
Div A Coordinator		Div B Coordinator		Div C Coordinator	Div D	
Previous Day's Take	Div C Inc ED		Div B		Div D	
Predicted Day's Take for Today	Div C Inc ED		Div B		Div D	
Take so far today	Div C Inc ED		Div B		Div D	
ED Activity	Main Department			See and Treat		
	No of pts	Longest Wait		No of pts	Longest wait	
	TBS			TBS		
	Waiting for beds			Waiting for beds		
	Yesterdays ED attendances					
	ED attendances since midnight					
	Speciality pts in ED					
	Yesterdays Breaches			Breaches since Midnight		




Bed state summary would be sent to the 'Bed Meeting' circulation email at 08:00hrs, 12:30hrs, 17:00hrs, and 22:00hrs. The Bed state will contain the current Escalation Level, and will include position of the Emergency Department, assessment areas and the number of unfilled bed requests for specialty beds.


## 6.1.2 Site Management System

The Trust is working towards the creation of a Site Management System- an extension of EPR that will facilitate tracking of patient discharges; this tool will allow greater visibility and more effective capacity management. The system will be run on wall mounted touch screen computers in the clinical areas and will display the current escalation levels.

## 6.2 Escalation Communication

The following is a guide to the daily escalation process

Time	Actions	Communication
07:30hrs	Senior Clinical Site Manager to chair the bed meeting and set Escalation status. Send 'Bed meeting report' (including Escalation).	Post bed meeting update to 'Bed Meeting' distribution group.
08:30hrs	Senior Clinical Site Manager to chair additional bed meeting that may be called under exceptional circumstances. Send 'Bed meeting report' (including Escalation).  Set the EMS level before 09:30	  Key staff to follow action cards
10:30hrs	Divisional Capacity Coordinators to collate predicted demand and capacity figures.  Senior Clinical Site Manager to inform switchboard about Escalation status.  Switchboard to send out voice bleep about EMS level	  Key staff to follow action cards
12: 00hrs	Senior Clinical Site Manager reviews escalation status based on Site position.	Post bed meeting update to 'Bed Meeting' distribution group.  

		Key staff to follow action cards
16:30hrs	Senior Clinical Site Manager reviews escalation status with On Call Manager during the bed meeting.  Send 'Bed meeting report'	 Key staff to follow action cards

## 7. TRAINING

Upon launch, this procedure will be included as an agenda item in the ward meetings. The procedure will be covered at the Trust as well as the Local induction of new staff. The action cards are printed as either A4 posters or plastic credit card sized action cards for ease of reference and portability. The information included on the cards has been kept to a minimum.

Recruitment will include this policy within the 'contract pack' of new starters. Staff are required to return their action cards to their line managers when they leave employment with this organisation.


## 8. MONITORING OF COMPLIANCE


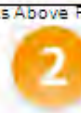

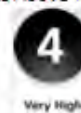
The Senior Clinical Site Manager will complete a check list at levels 3 and 4 to ensure that key staff members are undertaking the required actions. Any issues will be fed back to the Divisional Management Teams and professional leads to ensure that there is compliance with this procedure.




## APPENDIX A: ACTION CARDS

### ED Specific Action Cards





Statu s	Initial Assess ment	Time to Treat ment	Managemen t Plan	Discharge/ Admission	Actions Required by Nurse coordinator/ Senior Doctor	Patient Number s (Total)
EMS 1	15 min	Within 1 Hour	Within 3 Hours	Within 4 hours	Normal Working	<40
EMS 2	>15 min	>1 hour	>3 hours	Within 4 hours	<ol style="list-style-type: none"> <li>1. Prepare patients for rapid examination</li> <li>2. Reallocate department staff to area of demand</li> <li>3. Inform Senior Clinical Site Manager</li> <li>4. Request additional staff/On call support Move most appropriate patients to wards</li> <li>5. Escalate delays to Divisional Capacity Coordinators</li> </ol>	40-60
EMS 3	60 min	Upto 2 Hours	Upto 4 Hours	Upto 5 hours	<p>As above, and:</p> <ol style="list-style-type: none"> <li>6. All clinical staff to undertake clinical duties</li> <li>7. Request specialist teams to assist ED (E.g. Trauma, hands)</li> <li>8. Request support from ED Group manager</li> <li>9. Out of Hours- ask Senior Clinical Site Manager to escalate to On Call Manager</li> </ol>	50-70
EMS 4	90 min	Upto 4 hours	Upto 5 hours	>5 Hours	<p>As above, and:</p> <ol style="list-style-type: none"> <li>10. Contact Senior Clinical Site Manager and ensure all previous actions have been taken</li> <li>11. Ask Senior Clinical Site Manager to call Exec on call to consider calling an internal major Incident</li> </ol>	>70





Ops Centre Manager	
Escalation Actions	
	Normal Working
As Above Plus: 	Contact group managers to ensure they are aware of hotspots and to check relevant ward rounds are taking place.  Review number of patients in ED awaiting beds  Liaise with community teams
As Above Plus: 	Liaise with Community/social/ambulance services  Liaise with Duty Dops to ensure sufficient capacity during the night  Participate in conference calls  Consider cancelling non urgent elective activity via Duty Dops or COO
As Above Plus: 	Inform COO of situation  Consider declaring an internal major incident



Senior Clinical Site Manager	
Escalation Actions	
	Normal Working
As Above Plus: 	Plan for staffing of additional capacity if required.
As Above Plus: 	Open additional capacity if required.  Redeploy staff where necessary.
As Above Plus: 	Consider use of other staff to open additional capacity (Example recovery)

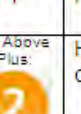
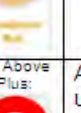
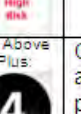
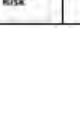
Divisional Capacity Coordinator	
Escalation Actions	
	Normal Working
As Above Plus: 	Notify any absence of ward rounds/delays to Senior Clinical Site Manager.  Escalate any gaps to the Group Manager
As Above Plus: 	Inform Ops Centre Manager to consider plan to open additional capacity in divisional areas.
As Above Plus: 	Facilitate cancellation of non urgent electives


Divisional Triumvirate (ADN, DOPs, DD)	
Escalation Actions	
	Normal Working
As Above Plus: 	Ensure all wards have Group Manager and Matron cover.  Ensure all specialties have completed ward rounds
As Above Plus: 	Consider plans to cancel non urgent elective activity.  Facilitate additional ward rounds
As Above Plus: 	Ensure divisional leads have completed actions  Medical Director to discuss the potential of cancellation of non-clinical activities of

Group Manager	
Escalation Actions	
	Normal Working (Transfers in and out) (Use of admissions lounge) (Pts in beds waiting theatre)
As Above Plus: 	Ensure all wards have rounds have been completed.  Prioritise elective cases but do not cancel.
As Above Plus: 	Consider plans to cancel non urgent elective activity.  Contact all Consultants on call by mobile phone  Discuss which other Consultants in the specialty needs to be called and actions to be taken.  Implement plans and report to ops Centre Manager/On Call Manager
As Above Plus: 	Cancel all non urgent activity  Report to Ops Centre


Matron	
Escalation Actions	
	Normal Working
As Above Plus: 	Ensure all wards have been completed and that all patients have management plans.  Discuss with consultants if required.  Review use of discharge lounge  Check that today's predicted discharges are either going or have a plan  Ensure that wards are chasing TTOs and Discharge letters for predicted discharges
As Above Plus: 	Facilitate the opening of additional capacity  Consider redeployment of staff
As Above Plus: 	Ensure all specialist nurses report to wards  Cancel non clinical activities.

Nurse In Charge	
Escalation Actions	
	Normal Working
As Above Plus: 	Escalate any delays or absence of ward rounds or reviews to Group Manager /Matron/ Senior Clinical Site Manager
As Above Plus: 	Prepare list of patients potentially be stepped down.  Discharge patients where possible.
As Above Plus: 	Cancel all non clinical activities of staff; instruct them to report to ward





Consultant	
Escalation Actions	
	Normal Working
As Above Plus: 	Help identify patients to be discharged
As Above Plus: 	All patients to be reviewed with updated management plans
As Above Plus: 	Cancel all non-clinical activities and report to wards to facilitate patient discharge



Junior Doctor	
Escalation Actions	
	Normal Working
As Above Plus: 	Ensure all medically fit patients are identified  All discharges are processed, discharge letters and TTOs completed.  Identify OLOS and further care assignments received by Therapies etc.  Escalate any delays to Nurse in Charge  Prioritise TTOs and discharge letters
As Above Plus: 	Review management plan for all patients.
As Above Plus: 	Cancel all non-clinical activities and report to ward.

Theatre coordinator	
Escalation Actions	
	Normal Working
As Above Plus: 	Review theatre capacity and planned lists  Discuss with Surgeon and Anaesthetist / Surgeon any potential problems or delays  Review available theatre space for inpatient emergencies
As Above Plus: 	Facilitate the cancellation of non urgent activity
As Above Plus: 	Hold patients in recovery where possible  Consider redeployment of theatre staff to recovery/ITU etc. to support care





<b>Nurse In Charge - Clinical Decision Unit (CDU)</b>	
Escalation Actions	
	Normal Working
As Above Plus: 	Escalate any delays or absence of ward rounds or reviews to Matron/Group Manager/ Senior Clinical Site Manager
As Above Plus: 	Prepare list of patients potentially to be stepped down.  Support the safe discharge of patients where possible.  Ensure all TTO's, transfer and discharge letters are ready.
As Above Plus: 	Cancel all non-clinical activities of staff; instruct them to report to CDU Matron.

<b>CDU Consultant - Clinical Decision Unit (CDU)</b>	
Escalation Actions	
	Normal Working
As Above Plus: 	Help identify patients to be discharged
As Above Plus: 	All patients to be reviewed and with "post take" updated management plans
As Above Plus: 	Cancel all non-clinical activities and report to CDU wards to facilitate patient discharge





<b>Matron – Clinical Decision Unit (CDU)</b>	
Escalation Actions	
	Normal Working
As Above Plus: 	Ensure all wards rounds have been completed and that all patients have management plans.  Discuss with consultants if required.  Review patients appropriate for use of discharge lounge  Check that today's predicted discharges are either going or have a plan
As Above Plus: 	Where appropriate and in discussion with ADN and DOps, facilitate the opening of additional capacity  Consider redeployment of staff
As Above Plus: 	Ensure all nurses report to the CDU ward  Cancel non clinical activities.

<b>Switchboard</b>	
Escalation Actions	
	Normal Working
As Above Plus: 	Bleep Escalation Status at 10:30
As Above Plus: 	Bleep Escalation status at 10:30 and 13:00
As Above Plus: 	Bleep Escalation status at 10:30, 13:00 and 16:00



<b>Matron – Emergency Department</b>	
Escalation Actions	
	Normal Working
As Above Plus: 	Ensure all patients have had initial 15 minute nurse assessment.  Discuss with consultants if required.  Review patients appropriate for use of discharge lounge
As Above Plus: 	Review capacity available within Resus, and cubicles to ensure “flow” of patients through ED.  Consider redeployment of staff to support flow through ED.
As Above Plus: 	Ensure all Emergency Department nurses report to the Emergency Department Matron.  Cancel non clinical activities.

<b>Consultant Co-coordinator - Emergency Department.</b>	
Escalation Actions	
	Normal Working
AS ABOVE PLUS: 	Help identify patients to be discharged to wards, home, community or other services
AS ABOVE PLUS: 	All patients to be seen by a doctor within 60 minutes Patient plans to be reviewed within 2 hours, to ensure time to implement necessary actions.  Ensure regular board rounds take place within ED.
AS ABOVE PLUS: 	Cancel all non-clinical activities and report to Emergency Department Consultant Co-coordinator to facilitate patient discharge and ensure timely flow through ED.

Emergency Department. Nurse Co-coordinator	
Escalation Actions	
 <p>1</p> <p>Low Risk</p>	<p>Normal Working</p>
<p>AS ABOVE PLUS:</p>  <p>2</p> <p>Medium Risk</p>	<p>Ensure all patients are allocated a doctor within 15 minutes</p> <p>All patients and have management plans within 2 hours. Discuss with consultants if required.</p> <p>Check that implementation of plans, are undertaken in a timely manner to prevent a four hour breach.</p> <p>Escalate potential risks to the 4 hour target to the Site Manager.</p> <p>Review patients appropriate for use of Discharge lounge</p>
<p>AS ABOVE PLUS:</p>  <p>3</p> <p>High Risk</p>	<p>Review capacity available within Resus, and cubicles to ensure "flow" of patients through ED.</p> <p>Ensure patients in ambulance queues are off loaded into cubicles within 15 minutes and monitored by a nurse and the WMAS "Halo".</p> <p>Escalate to SM if cubicles and Resus remain blocked for more than 15 minutes.</p>
<p>AS ABOVE PLUS:</p>  <p>4</p>	<p>Ensure all ED nurses report to the ED Matron.</p> <p>Cancel non clinical activities.</p>

## APPENDIX B –PERIPHERAL DIVERT PROTOCOL

The updated policy on the Peripheral Divert Protocol can found in the Ops Centre folder using the link below:

[\\uhb\userdata\Common\Ops Centre\Relevant Policies and Procedures](#)

### ACCEPTING DIVERTS (Including MTC)

1. 'In-hours' the initial conversation should be via the operational Executive to Executive (for UHB this is the COO or Deputy COO); 'out-of-hours' would be the duty director to duty director. This will provide an informed conversation about operational status including: EMS level, discharges, repatriations, elective cancellations.
2. The operational exec (in-hours) or duty director (out-of-hours) will discuss this with the relevant lead consultant/ senior decision maker to agree our position and stance;
3. Finally, if it is agreed that we are able to provide support, each patient transfer will need to be agreed **case by case** between **their** consultant/ senior decision make to **our** consultant/ senior decision.
4. A review period will be agreed between respective MTCs e.g. 12 or 24-hours as determined by the **receiving** MTC lead consultant / senior decision maker but communicated back via the operational exec (in-hours) or duty director (out-of-hours);
5. The transferring 'MTC system' will communicate the escalation plan to the Ambulance Trust, confirming that the receiving Trust has agreed and the review period. The transferring 'MTC system' will also take responsibility for updating the Ambulance Trust at the agree review points to it is absolutely clear when the arrangement finishes.

# APPENDIX C- FULL CAPACITY PROTOCOL

## Introduction

The Trust needs to be prepared to deal with variation in demand across the year and be able to flex the availability of beds based on capacity pressures.

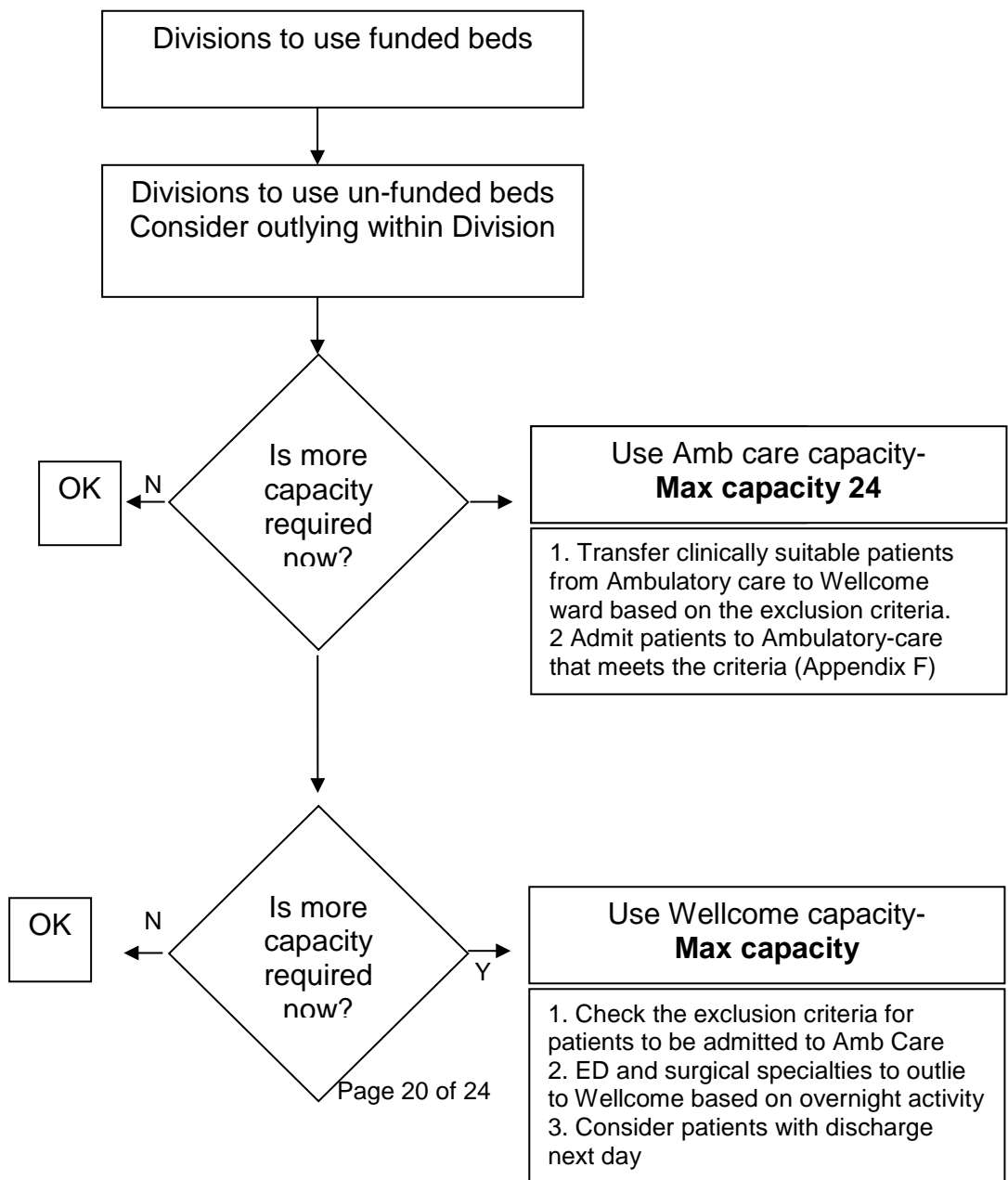
## Purpose

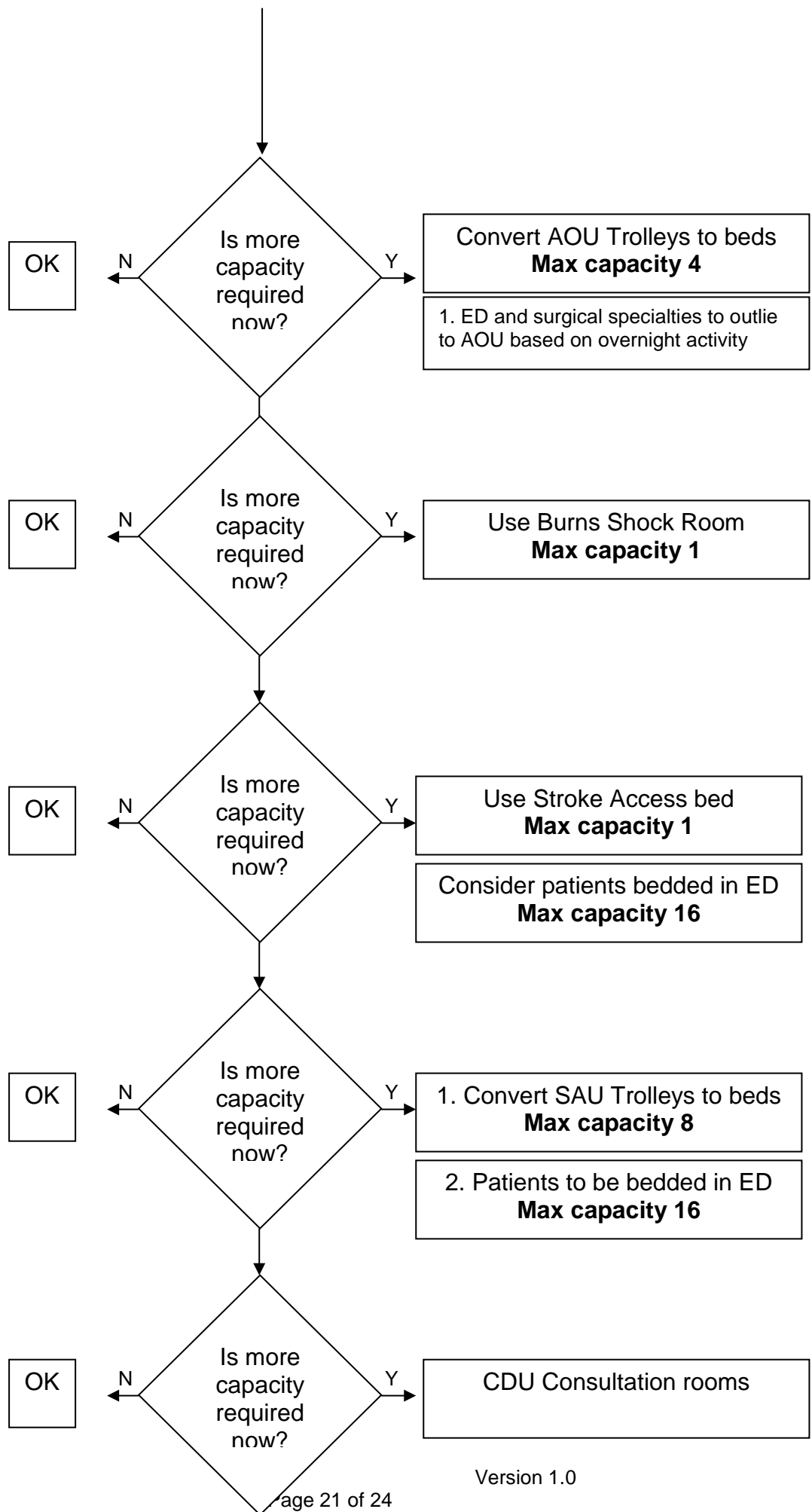
The document provides the protocol for the use of beds across the site. This document is an addendum to the Escalation Policy and be used in conjunction with the **Outlier Policy**, the **Patient Movement policy** and the **Major Incident Policy** and applicable at Escalation level 3 or 4.

## GENERAL GUIDELINES

As a general principle, beds should be allocated based on the following considerations.

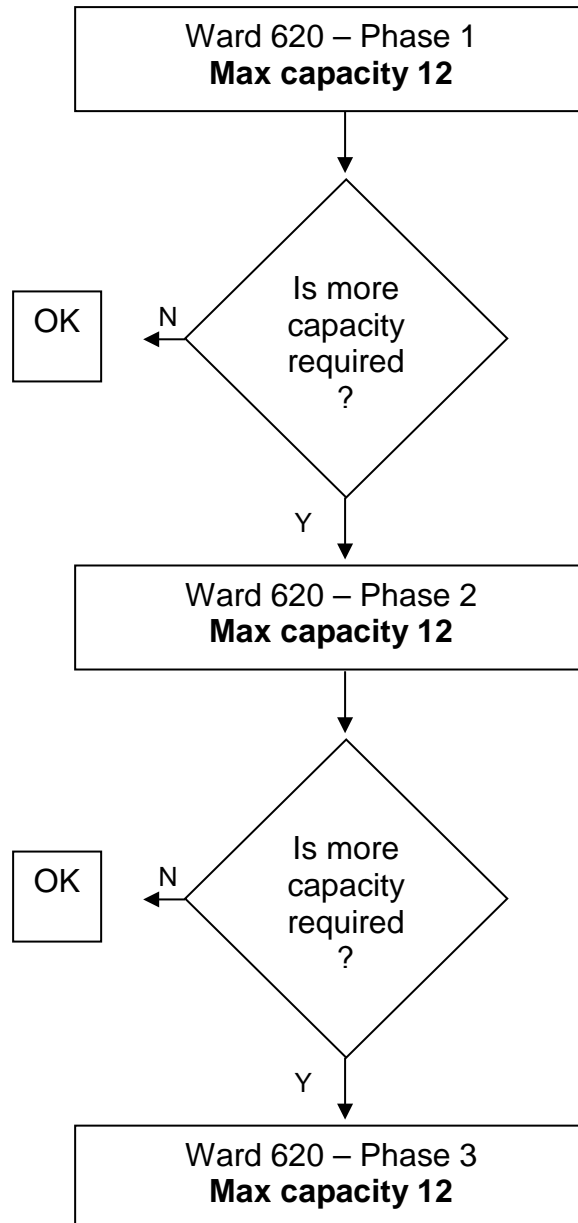
**A. Capacity required for immediate use-** Areas that have been assessed as being clinically suitable.





**B. Planned Opening of Capacity:** The planned opening of capacity would always be an Executive decision and should be planned over 48 hours and would occur typically in an EMS Level 4 position. The operational plan to support the opening of Ward 620 can found in the Ops Centre folder using the link below:

[\\uhb\userdata\Common\Ops Centre\Relevant Policies and Procedures](#)



## APPENDIX D- OUTLIER AND PATIENT MOVES PROTOCOL

### Introduction

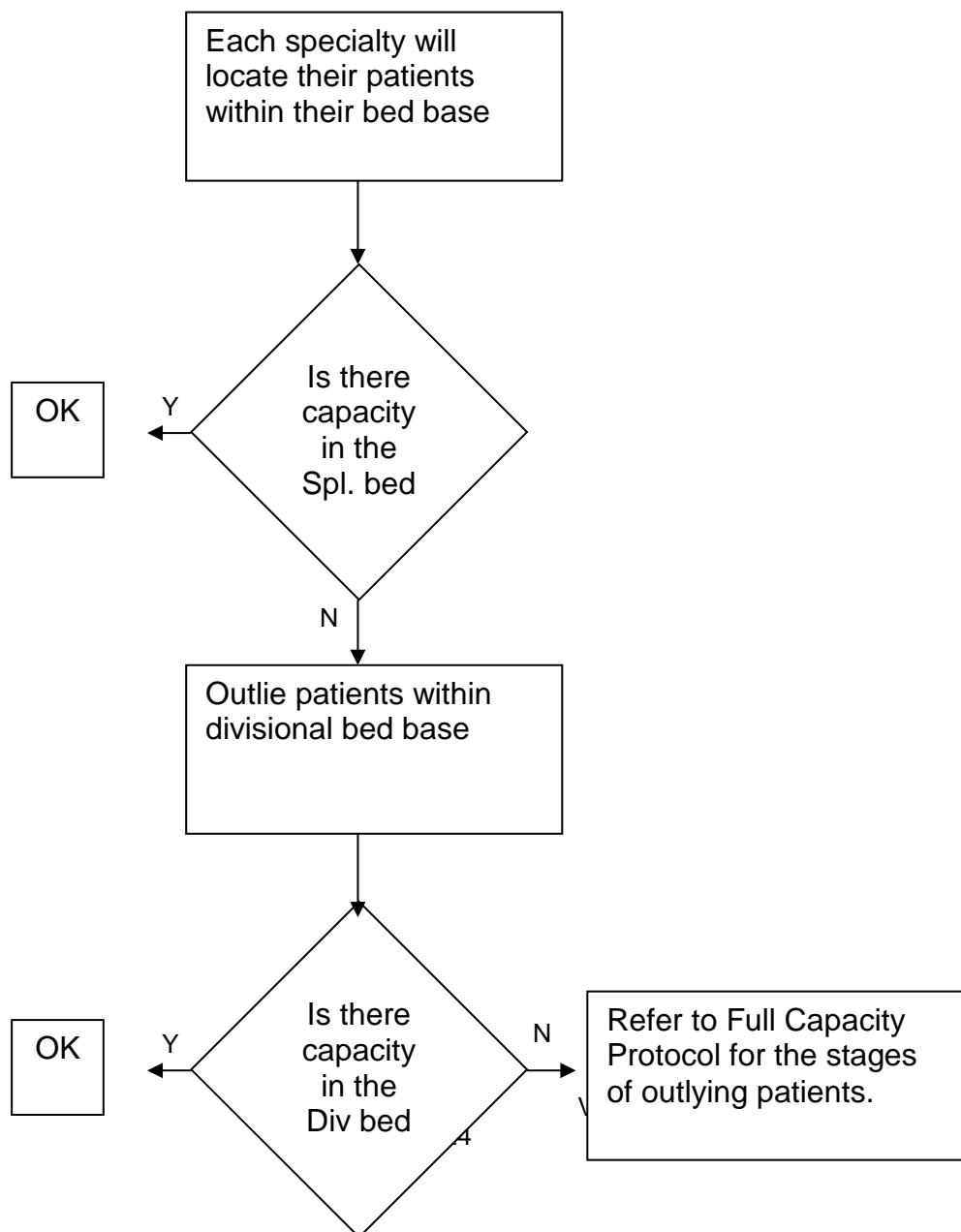
The Trust needs to be prepared to deal with variation in activity and demand. Occasionally this may mean that patients are in locations away from their specialty ward (outlier). Outlying should only happen in **exceptional circumstances** and decisions to outlie are **based on clinical assessments**. Lists of outlying patients will be **monitored daily** by cross divisional teams via the ops centre and repatriation to the base ward will be arranged if this is clinically required.

### Purpose

The document provides guidance on the stages of outlying. This document should be used in conjunction with the **Outlier Policy** and the **Patient Transfer Policy** and the Full Capacity Protocol.

### General guidelines

The following flow chart will apply for outlying patients.



## **APPENDIX E- CRITERIA FOR PATIENT SELECTION FOR AMBULATORY CARE AND WELLCOME SHORT STAY**

1. Documented senior medical staff review and a definite plan of care in place.
2. Planned discharge date to not exceed the Saturday closing time.
3. No social input or section two requirements.
4. No tracheostomy patients.
5. No confused patients.
6. Clinically stable.
7. No known infections.