Emergency Department Capacity Management and Closure Policy (ED Policy) v4

Effective 3 October 2011

FINAL

This Policy Document should be read in conjunction with the NHS London Pressure Surge Planning and Management Guidance 2011/12
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Document History

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<th>Date / Updated By</th>
<th>Comments</th>
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<tr>
<td>1</td>
<td>2008/9</td>
<td>Initial Policy</td>
</tr>
<tr>
<td>2</td>
<td>2009/10</td>
<td>Updated following review of use in 2008/9</td>
</tr>
<tr>
<td>3</td>
<td>2010/11 Richard McEwan</td>
<td>Updated following review of winter 2009/10, incorporating Trust, sector and LAS feedback and released to the NHS in London for implementation from 16th August 2010. Go live date subsequently amended to 11 October and role of Section 38 Doctors incorporated Replacement of informal / formal redirection concept with immediate / planned, and clarification of requesting and notifying process</td>
</tr>
<tr>
<td>3.1</td>
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<td>3.2</td>
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<tr>
<td>4</td>
<td>2011/12 EP Team/ R McEwan</td>
<td>Updated to reflect changes to the NHS and on-going learning</td>
</tr>
</tbody>
</table>

Document Filing

S:\Performance\Performance Improvement\A&E & Winter Planning\Winter 2011 - 12\Emergency Department Capacity Management and Closure Policy v4 Final.docx
Useful Numbers

LAS Control Room: Section 38
Section 38 Doctor: Page via LAS control room

The following can be contacted via PageOne on Section 38 and the call sign below (Trusts will need to leave a name and contact details):

NHS London SECTION 38 SECTION 38 SECTION 38

Cluster Directors on Call:

ELC Cluster: Section 38
ONEL Cluster: Section 38
NWL Cluster: Section 38
SEL Cluster: Section 38
SWL Cluster: Section 38
NCL Cluster: Section 38
1.0 Introduction

1.1 The aim of this Policy is to ensure that all patients are taken to the nearest Emergency Department (ED) with the appropriate clinical resources to treat that patient’s presenting condition within a clinically appropriate time frame.

1.2 Towards this end, ED capacity across London must be proactively managed. The application of this policy to varying local conditions may require some tailoring or interpretation, and the application of a “common sense” approach to this need is expected by all NHS organisations involved.

1.3 Redirecting or closing a hospital ED can result in increased clinical risk to patients as well as increased pressure on other local services. Planned redirection or closure of an ED due to capacity issues should, in most situations, be the last escalation measure enacted, once all other identified activities have been implemented and failed to relieve the pressure. *The checklist at section 12 lists a number of escalation activities which should be implemented early on, as pressure starts to build, in order to reduce the likelihood of a redirection being required.*

1.4 For the purpose of enacting this document, the following definitions apply:

- **Redirection** – self presentations* and all blue lights** still accepted
- **Blue light redirection** – self presentations and non blue lights** still accepted
- **Closure** – self presentations redirected* and all blue and non blue lights** not accepted
- **Clinical responsibility** – The Acute Trust (hospital) takes full clinical responsibility for the patient from the point of clinical handover or at 15 minutes from arrival of the patient with the LAS crew at the hospital whichever occurs earlier.

*Ambulatory patients for co-located Walk In Centres or Minor Injury Units would continue to be accepted, except in infrastructure failure. During a closure Trusts will need to make provision for self presenting patients to be redirected or treated at alternative EDs etc.

**For the purpose of this document, a “blue light” is defined as an ambulance borne patient of sufficient criticality to warrant the use of the ambulance’s blue lights on the inbound journey to the ED, where the ED will have been pre-alerted (“blue call”) to the patient arrival. *It should be noted that cardiac arrest patients will still be brought to the closest appropriate unit, under most circumstances, except cases of critical infrastructure failure.*

1.5 Three types of redirection are described in this policy:

- **Immediate** – Instigated by LAS as a short term (90 minutes) response to a sudden operational pressure at an ED. LAS to notify Cluster and receiving Trusts (via group paging). *Extensions cannot be agreed without Cluster approval.*

- **Planned** – May be requested by either LAS or Trust. Authorised by Cluster and longer in duration (four hours maximum, unless extended). Requires conference calls to discuss ongoing situation. Notification of receiving Trusts etc via Cluster.

- **Blue Light** – may be required where an ED has received over a certain number of Blue lights within an hour (for example Major Trauma Centre (MTC) = 5, other ED = 3) and will generally be used to redirect the next blue light away from the ED to allow time for previous conveyances to be cleared (see section 4.2 for more detail) where ongoing nature of active resus has caused capacity issues within the resus facility. *It should be noted that other factors including site capacity will be used when deciding if this action is required. The above numbers are not an absolute trigger on their own for blue lights to be redirected. LAS will report redirections to the Cluster if a number of patients are affected.*
1.6 This Policy has been revised as a result of learning from hospital capacity pressures and constraints during preceding winters (2008/9 to 2010/11), Exercise Coriolis and the use of previous policies to manage the pressures generated.

1.7 Version 4 of this Policy replaces earlier versions which should be removed and destroyed. This updated version has been agreed by NHS London, the Clusters and London Ambulance Service NHS Trust (LAS).

1.8 This policy should be read in conjunction with the NHS London Pressure Surge Planning and Management Arrangements 2011/12.

How a 360 Degree Redirection Works:

Hospital 1 goes on redirection. The closest surrounding Trusts will be nominated as receiving Trusts, spreading the load and attempting to ensure that other Trusts are not overwhelmed with additional ambulance borne patients.

Note: All organisations should ensure that staff who will be affected by, or need to make decisions in regards to the execution of this policy, have familiarised themselves with its contents, ahead of the need to use it.

The policy contains quite detailed descriptions of actions required, should a redirection be required. Trusts may find it helpful to create simplified action cards, appropriate to their own individual set up, to help staff making decisions during times of pressure.

2.0 Objectives

2.1 To set out the processes by which ED capacity will be managed across London.

2.2 To provide consistency around main escalation activities and processes according to a common threshold.
3.0 Capacity Management System (CMS)

3.1 The Capacity Management System (CMS) was introduced in London in October 2010. This system has proved successful in helping manage pressures. The system provides a near-real time view across a range of indicators of the relative pressures being faced by acute Trusts.

3.2 ED information in CMS should be updated every two hours, 24 hours a day. Bed state information should be updated every four hours between 06.00 and 22.00.

3.3 Clusters and acute Trusts will use this information and live Hospital Based Alert (HAS) data to inform the discussion of issues being faced and actions being taken. It is extremely important for all Trusts to complete updates of CMS regularly including Foundation Trusts, so that a complete picture of capacity pressures across the capital can be formed and jointly acted upon. If organisations do not keep the information up to date, it will be assumed that they are not experiencing any capacity pressures, and are in a position to offer mutual aid, including taking redirected patients.

3.4 If Trusts are considering the need to request a redirection, it is particularly important to ensure that information is up to date on CMS, so that they have the relevant information to hand to discuss with the Cluster etc.

3.5 It should be noted that while LAS will look to use CMS information to help manage pressures at EDs across London, it is not the only consideration which will affect where ambulances are directed. A poor score on CMS will not automatically result in ambulances being redirected.

4.0 Ambulance turnaround times, LAS initiated redirections and Cluster escalation

4.1 Queuing greater than 15 minutes. In the event that ED capacity experiences pressure, and patient handover between LAS and the acute Trust exceeds 15 minutes, it is the acute Trust’s responsibility to attempt to resolve these issues as quickly as possible.

4.2 LAS control will monitor the number of blue lights being sent and where an ED has received over a certain number of blue lights within an hour (for example Major Trauma Centre = 5, other ED = 3) they will attempt to pro-actively move the next inbound blue light to another ED to help smooth the flow of arrivals, and prevent the ED becoming over loaded. CMS and HAS data will be used to inform this process. It is important to note that it will not always be possible to achieve this if neighbouring Trusts are under comparable pressure, and will also be affected by other considerations including site capacity etc.

It should be noted that the Acute Trust (hospital) takes full clinical responsibility for the patient from the point of clinical handover or at 15 minutes from arrival of the patient with the LAS crew at the hospital whichever occurs earlier.

If resuscitation facilities have reached full capacity, creating immediate short term patient safety concerns:

- Major Trauma Centres must alert LAS via the Clinical Coordination Desk on Section 38. LAS will try to redirect the next one to two blue lights to local trauma centres to give time for resus bays to become available.

- If other EDs have immediate clinical concerns due to resus capacity they must speak to the LAS Control Room on Section 38 who will notify Section 38 Doctor, and attempt to move the next inbound blue light away from the unit to create a short term respite during which resus capacity can be managed. The ED consultant, if not already in the department, should already have been alerted to the situation, and should be on their way into the Trust to
provide clinical leadership, due to the patient safety issues involved. LAS will report blue light redirections to the Cluster.

Capacity issues caused by multiple blue light arrivals within a given period of time (e.g., one hour) are distinct from where the capacity pressure stems from that created by resus beds being occupied by patients who no longer require active resus, but for whom the Trust does not have sufficient other bed capacity to move them into. This is a patient flow issue, which should be solved by whole system escalation and action, including the declaration by the Trust of an Internal Incident if required, to ensure that appropriate levels of resource (both clinical and managerial) are applied to swiftly freeing up (or creating additional) capacity. They should not be managed through redirections, unless all other escalation actions have been previously taken and have failed to resolve the situation. In these circumstances, Trusts should seek to escalate via the Cluster, not the LAS.

4.3 Immediate redirection – In response to sudden operational pressure at an ED, LAS may instigate a short-term redirection considering the following points:

- The redirection will be for 90 minutes only.
- CMS data will be used to help determine which Trusts patients may be redirected too.
- From November 2011, receiving Trusts will be notified by LAS paging message if they have signed up to the new Pageone provided secondary paging number. This will enable rapid communication from LAS to the ED frontline. Trusts who have not signed up to this service, will still receive redirected ambulances, but will receive no prior notification of the redirection.
- When redirecting patients LAS will nominate as many EDs as possible in the surrounding area.
- The Cluster will also be informed by LAS as part of the new paging system of the redirection and the potential for it to become a planned redirection will be discussed – immediate redirections cannot be rolled over without the agreement of the Cluster.
- The number of additional patients each nominated ED will receive will vary according to catchment area and current call volume, but is not likely to exceed two to three patients in an hour.
- If a Trust is designated as a receiving Trust, but wishes to make LAS aware of other circumstances not reflected on CMS which may cause them difficulties should they receive redirected patients, they must do so through the LAS Control Room on Section 38.

4.4 Planned redirection. If LAS decide that a planned redirection of patients away from an ED is required (four or more patients waiting over 30 minutes for patient handover), the following arrangements apply:

- LAS will contact the on-call director at the relevant Cluster (both in and out of hours), via the on-call rota, to seek authorisation of the redirection and discuss which EDs LAS has nominated to receive patients. Note – non London Trusts cannot be nominated unless they have given prior consent. Trusts should have agreed the process for this in their Pressure Surge (Winter) plans and discussed and agreed them with the Cluster, enabling established escalation processes to be followed if the assistance of non London Trusts is required.
- The Cluster will arrange for notification of the receiving Trusts, including those outside of London as a matter of priority as well as contacting the Trust on redirection to discuss the situation (contact arrangements TBA locally); designated receiving Trusts should discuss any concerns around this with the Cluster.
- The Cluster will contact neighbouring Clusters if appropriate, and will notify NHS London (senior performance managers in hours, SECTION 38 (for information) out of hours) that a redirection has been agreed.
- In hours, the NHS London Performance Directorate will alert neighbouring SHAs if their area is likely to be impacted; if an event occurs out of hours, and is not a Major Incident (MI), neighbouring SHAs will be informed at the earliest opportunity the following day. If it is an MI the NHS London Major Incident plan will be enacted.
- LAS will notify neighbouring ambulance services of the situation if they will be affected.
- Redirections should be timed to occur at least 30 minutes after the Cluster has been notified, in order to allow receiving Trusts to be contacted before patients start arriving.
The redirection will be reviewed at hourly intervals by the LAS and the redirected Trust; it will continue until a decision to cease it is made by LAS, the redirected Trust and the Cluster.

It is important to note in these circumstances that the redirected ED will continue to receive “blue lights”.

Patients receiving active ongoing treatment from a redirected Trust (e.g. maternity care or dialysis), or who are on a pre-planned or resourced pathway (e.g. stroke patients to HASU), will not be redirected. The Trust should ensure that LAS crews have direct access to the destination departments within the site.

4.5 **Queuing greater than one hour.**

Patients may be at major clinical risk, if ambulances are queueing for more than 60 minutes for handover. Patients who cannot be attended to in an appropriate time period as a result of LAS vehicles and crew being delayed at EDs may also be at major clinical risk. In these cases, the following actions should be taken:

- The clinical site manager of the relevant Trust will be made aware of any patients waiting more than 60 minutes by the duty LAS Operational Manager, in order to manage building pressure.
- The LAS will report all 60 minute patient handover waits to the relevant Cluster and NHS London within one working day of the incident.
- All LAS reported 60 minute waits must be validated using local Cluster protocol.
- For each validated 60 minute wait a potential Serious Incident (SI) will be declared for investigation.
- Each potential SI will be owned by the acute Trust. It is the Trusts responsibility to investigate and report against these SI. Investigations, where appropriate, must involve LAS input.
- LAS and acute Trusts must have robust handover and escalation processes in place, to ensure efficient clinical and patient handover, provide clarity on how handover time will be captured using HAS, and eliminate disagreements over role and responsibility.
- If two or more EDs in the same or neighbouring Clusters have delays exceeding 60 minutes, these will be reported to the Cluster by LAS. The Cluster will contact the relevant Trusts to discuss the actions being undertaken, as well as considering the need for a Cluster conference call to discuss the rising pressures.

*Appendix B gives further details regarding 1 hour breaches and the agreed reporting definitions and responsibilities.*
5.0 Emergency Department (and Tertiary services e.g., ITU, HASU, Cardiac Care) planned redirection due to Trust capacity issues

5.1 Situation:
- Prior to experiencing an extreme capacity shortage, (dependant upon cause and type – see section 3.4 and 3.5 of the NHS London Pressure Surge Planning and Management Arrangements Guidance 2011/12 for further explanation) resulting in a potential threat to patient safety, Trusts should have implemented the appropriate escalation activities listed in Section 12. These are not short term activities intended to have an immediate affect, and should be implemented early to reduce the likelihood of a redirection being required.
- If these activities have failed to address the pressure, they may contact the Cluster on-call director to negotiate a planned redirection. This request, made on clinical safety grounds should come from the Trust Medical Director (in hours) or the ED Consultant on-call (out of hours) following conversations with the bed manager.
- The Cluster on-call Director will refer the Trust to the LAS on-call Gold Doctor, to discuss the clinical safety issues (contact via the LAS Control Room on Section 38 and ask for Section 38 Doctor to be paged, leaving mobile number of requesting Medic).
- If the clinical grounds are agreed by the Section 38 Doctor, the Trust must contact the Cluster Director to confirm that a redirection can be initiated. A redirection will be agreed and implemented to reduce the clinical safety issues.

5.2 Planned redirection agreed – actions required:
- When a redirection is agreed by the Cluster, the Cluster will notify Section 38 via the LAS control room Section 38 of the time and duration, and agree the receiving Trusts (see caveat at 4.4 re non London Trusts) (informed by CMS information and LAS intelligence). The Cluster will also contact affected surrounding Trusts including those outside of London. Contact will be made by phone, using the agreed contact details, set out in local pressure surge plans.
- A redirection can be arranged for four hours maximum. A Cluster-arranged conference call after two hours of a four hour redirection, will review the situation and agree any need for continuation post four hours. Conference calls should include the Cluster, the LAS, the redirected Trust and receiving Trusts. Appropriate primary and community care participation should also be included.
- Redirections will automatically lapse after their agreed duration, unless specifically authorised for extension by the Cluster.
- The Cluster will notify NHS London of any redirection agreed, their duration and their remedial actions; in hours this will be via their usual performance contact (who will ensure that the relevant personnel at the SHA are informed e.g., SECTION 38), and out of hours via SECTION 38.
- In hours, NHS London (senior performance managers) will liaise with neighbouring SHAs if required. Out of hours, and not an MI, neighbouring SHAs will be informed at the earliest opportunity the following day. (If it is an MI, the NHS London MI Plan will be followed)
- In and out of hours, LAS will notify neighbouring ambulance services of the situation.

5.4 A redirection will not normally be granted, unless there is a potential threat to patient safety, and it is clear and agreed that the failure to redirect would result in the otherwise preventable harm of patients. If this is agreed, it is expected that the Cluster would performance manage the implementation by the Trust of the designated escalation activities, set out in section 12 (if these have not already been undertaken) in order that the length and number of redirections and the resultant impact on the surrounding organisations can be minimised in the future.

5.5 Rising pressure will be visible through the information on CMS (and conference calls if needed). Trusts under pressure will, in consultation with the Cluster, handle the consequences of pressure increases, according to their own internal escalation plans. If pressures continue to rise, the Cluster will need to coordinate and direct the availability and scope of mutual aid.
6.0 **Emergency Department (and Tertiary services e.g., ITU, HASU, Cardiac Care) closure due to Trust capacity issues**

6.1 **Situation:**
- Acute Trusts cannot make a unilateral decision to close EDs or tertiary services (e.g., HASU, burns etc) or to “blue lights” due to a lack of capacity.
- In and out of hours, if a Trust wishes to close its ED or tertiary service due to capacity issues then the Trust Chief Executive (or in exceptional circumstances, such as absence, their nominated deputy) will need to request this personally from the Cluster.
- The Cluster on-call Director may contact the Section 38 Doctor on-call (via the LAS Control Room and ask for Section 38 Doctor to be paged, leaving mobile number of requesting Director) for a clinical opinion, prior to contacting Section 38 to request closure, if they believe this is necessary.

6.2 **Cluster agrees with Closure request – actions required:**
- The Cluster will contact Section 38 via Section 38 for approval. Following agreement from Section 38 that a Trust may close their ED or tertiary service as a result of capacity issues, Section 38 will inform Section 38, via the LAS control room Section 38 and Section 38 (who will inform Section 38 (comms) for information only).
- The Cluster will contact the surrounding Trusts who will be affected, including those outside of London. Contact will be made by phone, using the agreed contact details, set out in local pressure surge plans.
- In hours, the Cluster will notify their usual NHS London performance contact
- In hours, NHS London (senior performance managers) will liaise with neighbouring SHAs if required. If an event occurs out of hours, and is not a MI, neighbouring SHAs will be informed at the earliest opportunity the following day. If it is a MI, the NHS London MI Plan will be followed.
- LAS will notify neighbouring ambulance services of the situation.

6.3 **ED closure due to capacity issues is an extremely significant event, attracting media attention and Department of Health scrutiny. It may be sufficient cause for NHS London to trigger the implementation of command and control arrangements for the Cluster. (Details of these arrangements can be found in the Pressure Surge Planning and Management Arrangements 2011/12), and reproduced in Appendix A of this Policy.**
7.0 Emergency Department (and Tertiary services e.g., ITU, HASU, Cardiac Care) closure due to Trust infrastructure failure

7.1 Closure of the ED or tertiary services to “blue lights” will only be accepted in the event that the hospital is unable to provide ED and resuscitation facilities due to infrastructure failures, for example fire, flood, major electrical failure etc. ED or tertiary service closure should only be considered as a last resort as it may subject the most seriously ill patients to increased clinical risk as a result of travelling further to receive immediately life-saving treatment. GP calls will be expected to be sent directly to a ward or Admissions Unit rather than via A&E, if practical given the nature of the infrastructure failure.

7.2 In cases where an internal Major Incident is declared, Trusts are expected to follow their Major Incident Plan, which includes notifying LAS (via the LAS control room Section 38) and Section 38.

7.3 In the event of ED or tertiary service closure due to infrastructure failure:

The Trust will:
- Agree the need for the closure with the Cluster via the On-call Director.
- Inform NHS London via Section 38.

NHS London will:
- Inform Section 38 and inform Section 38 (comms) for information only Section 38.
- In hours, ensure that relevant performance directorate leads are aware Section 38.
- In hours, NHS London will liaise with neighbouring SHAs if required and agreed with Section 38. If an event occurs out of hours, and is not a major incident, neighbouring SHAs will be informed at the earliest opportunity the following day (senior performance managers). If it is an MI, the NHS London MI Policy will be followed Section 38.

The Cluster will:
- Contact affected surrounding Trusts including those outside of London if relevant.
- Organise conference calls if required.

LAS will:
- Notify neighbouring ambulance services of the situation if required.

8.0 Redirections or closure of non London Trusts

8.1 If a Trust outside London needs to close or redirect ambulances, the relevant Ambulance service will ensure that LAS are made aware, making contact via the control room.

8.2 LAS will inform the relevant Clusters via the on call Director if it is likely that there will be an impact on their Trusts.

8.3 NHS London should be informed by the relevant neighbouring SHA, in hours via Heads of Performance. If the incident occurs out of hours, NHS London Heads of Performance will be informed as soon as possible on the next working day. If the event is a major incident, the relevant major incident alerting system for the neighbouring SHA will be followed, both in and out of hours.
9.0 Summary flowchart of the NHS London ED Policy – Trust triggered actions

Acute Trust experiences rising pressure in A&E / other Trust areas (see major triggers outlined in Pressure Surge Planning and Management Arrangements Policy, NHS London 2011/12)

- Trust discusses issues with Cluster and implements appropriate escalation actions

Acute Trust continues to experience rising pressure in A&E / other Trust areas, despite enacting escalation actions

- Trust discusses issues with Cluster and continues with all appropriate escalation actions.
- Sector scopes possibility of mutual aid arrangements

Despite enacting all possible escalation actions, Trust believes there is now a significant risk to patient safety through continuing to accept further ambulance borne patients

- Trust discusses issues with Cluster and Cluster requests Trust to obtain confirmation of clinical safety issues from Section 38 Doctor on-call.

If Section 38 Doctor agrees, Trust contacts Cluster to arrange redirection / closure.

Cluster informs LAS, receiving Trusts and NHS London.

Cluster arranges conference call to review situation two hours into the redirection

**If closure requested, Cluster contacts Section 38 via Section 38 for authorisation**
10.0 Summary flowchart of the NHS London ED Policy – LAS triggered actions

- Patient handover within the ED exceeds 15 minutes
  - Acute Trust works to resolve handover delays

- ED experiences sudden surge in pressure causing operational issues
  - LAS manager may be sent to the ED if available
  - LAS may initiate an immediate re-direction, for a period of 90 minutes. Receiving Trusts and Cluster notified by LAS (through agreed paging route)

- Patient handover within the ED exceeds 30 minutes for four patients and above
  - LAS notifies the Cluster of the issue and suggest a planned redirection, plus the Trusts they propose to receive redirected patients. The Cluster will contact the Trusts to alert them. If a four hour redirect is agreed, a conference call should be convened by the Cluster to review the arrangements after two hours.

- Patient handovers within the ED exceeds 60 minutes
  - As above, plus LAS informs acute Trust clinical site manager of patients waiting. 60 minute. These incidents will be communicated every 24 hours. Validated 60 min waits will be declared as SI’s
11.0 ED capacity issues decision tree

Emergency Department Capacity Issues decision tree

<table>
<thead>
<tr>
<th>Acute Trust</th>
<th>Cluster</th>
<th>LAS</th>
<th>NHS 01</th>
<th>Section 38</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust experience ED pressures</td>
<td>Trust contacts Cluster On-call officer</td>
<td>Section 38 Doctor discusses actions taken with Trust Medical Director or ED Clinician on-call</td>
<td>Section 38 informs Section 38 of closure decision</td>
<td>Section 38 implements Command &amp; Control</td>
</tr>
<tr>
<td>Redirection requested?</td>
<td>Trust contacts Cluster On-call officer</td>
<td>Cluster On-call officer notifies LAS Control</td>
<td>Sect advised on information only</td>
<td>Section 38 informs Section 38 of closure decision</td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Follow necessary escalation actions</td>
<td>Clinical Safety Risk?</td>
<td>LAS supports REDIRECTION</td>
<td>LAS returns to business as usual</td>
<td>Section 38 implements Command &amp; Control</td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Trust Medical Director or ED Clinician on-call contacts Section 38 Doctor</td>
<td>Section 38 discusses with Trust Medical Director or ED Clinician on-call</td>
<td>Cluster and LAS implement protocols outlined in policy</td>
<td>Section 38 implements Command &amp; Control</td>
<td>Section 38 informs Section 38 of closure decision</td>
</tr>
<tr>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Trust CEO requests Closure from Cluster On-call officer</td>
<td>Trust CEO requests contact with Section 38 via Section 38 Doctor</td>
<td>Section 38 informs Section 38 of closure decision</td>
<td>Section 38 implements Command &amp; Control</td>
<td>Section 38 informs Section 38 of closure decision</td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Trust takes action to manage pressures</td>
<td>Actions Successful?</td>
<td>Section 38 informs Section 38 of closure decision</td>
<td>Section 38 implements Command &amp; Control</td>
<td>Section 38 informs Section 38 of closure decision</td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Trust takes action to manage pressures</td>
<td>Closure Supported?</td>
<td>Cluster and LAS implement protocols outlined in policy</td>
<td>Section 38 implements Command &amp; Control</td>
<td>Section 38 informs Section 38 of closure decision</td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Trust Management Team resolve situation</td>
<td>Section 38 informs Section 38 of closure decision</td>
<td>Cluster and LAS implement protocols outlined in policy</td>
<td>Section 38 implements Command &amp; Control</td>
<td>Section 38 informs Section 38 of closure decision</td>
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<tr>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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</tbody>
</table>

If this is a Major Incident Declaration follow standard alerting procedures

* or nominated Deputy if CEO unavailable
**12.0 ED Escalation Actions Checklist**

The following actions require implementation as early as possible when ED pressure starts to build in order to minimise the need for redirection or closure.

<table>
<thead>
<tr>
<th>Escalation Activity</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Trust – managing and reducing demand</strong></td>
<td></td>
</tr>
<tr>
<td>• There should be senior clinical leadership (i.e., consultant level) immediately available within the A&amp;E department.</td>
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<tr>
<td>• All patients to have initial assessment by registrar or consultant grade, to determine appropriateness of attendance or need for admission – re-direction wherever possible and not life threatening, all admissions to be reviewed and agreed by a consultant.</td>
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<tr>
<td>• Maximisation of alternative care pathways, prior to arrival of patient at A&amp;E, through telephone triage of all GP referrals for admission, led by consultants (e.g., acute physicians, not necessarily ED consultants – see above) to ensure that admission levels are kept to a minimum, including:</td>
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<tr>
<td>o Advising on more appropriate care pathways (e.g., community based) for specific patients or conditions.</td>
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<tr>
<td>o Enabling access to diagnostics not normally directly available to primary care.</td>
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<tr>
<td>o Re-assurance to GPs about continuing to manage patients on “care of the dying” pathways at home, rather than admitting to hospital.</td>
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<tr>
<td>o Brokering urgent outpatient appointments in other consultant clinics, to avoid unnecessary admissions to hospital etc.</td>
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<tr>
<td>• GP patients (not calls) sent directly to a ward or Admissions Unit rather than via ED</td>
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<tr>
<td><strong>Acute Trust - Improving supply</strong></td>
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<tr>
<td>• All inpatients reviewed early in the morning for discharge by consultants before 10am.</td>
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<tr>
<td>• “Case conferences” between consultants, medical directors and managerial staff to review all inpatients individually and agree appropriateness of continued stay.</td>
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<tr>
<td>• Opening of all possible extra escalation capacity, private wards etc.</td>
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<tr>
<td>• 7 day working to ensure continued flow of discharges, access to therapies and diagnostics etc. Tight performance management of ward TTO requests to pharmacy to reduce delays.</td>
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<tr>
<td>• Maximisation of use of day case and laparoscopic procedures to maintain elective programme, but reduce requirement for beds.</td>
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<tr>
<td>• Cancellation of all clinically non urgent electives (including private work) / transfer of work to private sector.</td>
<td></td>
</tr>
<tr>
<td>• Consideration given to cancellation of some urgent electives / move of work to other NHS Trusts / transfer of work to private Cluster.</td>
<td></td>
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<tr>
<td>• Social Services on call managers have been notified of the situation and requested to expedite care packages. Social Services to be in contact several times a day.</td>
<td></td>
</tr>
<tr>
<td>• Inclusion of Social services, Borough’s, LAS etc in A&amp;E bed meetings to ensure actions required are understood by the whole system.</td>
<td></td>
</tr>
<tr>
<td><strong>Acute Trust - Improving supply - Support Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Pharmacies have been tasked to prioritise TTOs and ensure that medication is dispatched to wards immediately (or discharge lounge if appropriate).</td>
<td></td>
</tr>
</tbody>
</table>
- Facilities and porters tasked to prioritise cleaning and transfers.
- Scheduled maintenance has been reviewed, and if likely to impact on capacity or patient flow, rescheduled.
- PTS providers are prioritising patient transfers (discharges) above other work.

**Primary / Community Care Actions**

- Maximise discharges from community facilities to increase capacity.
- Purchase extra capacity in community to enable discharges from acute care / prevent patient admissions. Requires full discussion, clarity and agreement between Boroughs / Trusts prior to the surge to enable swift and responsive spot purchasing where appropriate, supported by locally agreed guidance.
- Use of community resource (community nursing teams etc) to pull patients from the Trusts, if appropriate, including use of intermediate care in-reach to ED and assessment units.
- Placement of patients “without prejudice” by local Borough’s for those patients out of area where external Borough’s are not expediting repatriation.
- Early domiciliary visits to assess urgent care needs
- Provide extra GP resource / more hours to WICs, UCCs etc to deal with primary care presentations, enabling A&E to focus on acute presentations.
- Provide support by contacting OOH and GPs to ensure that only the very sick are referred for admission, and that where possible, conditions are managed in other settings either at home or in community facilities, with Borough support. E.g., OOH providers to provide increased and more rapid visits to patients left at home by LAS crews.
- Where an outbreak appears to be occurring ie: D&V in a nursing home use a small nurse/Dr team to visit & treat patients in situ, thus preventing admissions – work in liaison with acute Trust if more specialised clinical experience required.
- Liaise directly with GP practices where referrals increase inappropriately.

**Staffing**

- Cancellation of staff leave, training courses and re-direction of clinical staff from managerial duties to front line care.
- Plan local accommodation for staff.
- Consider supporting staff childcare when schools are closed
- Staff to be redeployed from around the Trust to support the ED as necessary.

**LAS Escalation Actions**

- LAS to use pressure information on CMS etc to help manage vehicle flows away from Trusts under high sustained pressure where possible and consider use of ‘immediate re-direct’ to ease sudden peaks in pressure, before a situation develops which requires a ‘planned’ re-direction.
- LAS, acute Trusts / Borough’s discuss and agree additional conditions / levels of acuity that can be dealt with via WICS / UCC, to provide more options for LAS crews to convey patients to, other than just A&E.

**Final escalation action:**

- Request to Cluster for re-direction or for closure of the ED.
Appendix A – NHS London Command and Control Arrangements for Pressure Surge related incidents (non Major Incident)

10.0 Command and Control Arrangements
It may be necessary dependant upon the circumstances for NHS London to impose command and control arrangements, where it is believed that this is required to resolve a situation. CMS scores will be one of the primary means of judging whether pressures have increased to such an extent, that individual clusters do not have sufficient capacity to cope, and greater central coordination of resource is required.

In addition, there are other circumstances when it may be deemed necessary to impose command and control, including for example, when there is the potential that a Trust needs to close its ED and to new admissions, through infection outbreak or if critical care capacity reaches the predefined limits set out in the Critcon system – see section eight.

10.1 Objective of Command and Control
These arrangements have been specifically created for the management of pressure surges such as those attributable to adverse weather conditions or significant infection outbreaks which could cause the closure of a Trust to admissions. They are designed to enable pan Cluster or pan London co-ordination of NHS resources, to cope with a significant increase in pressure, through the use of mutual aid, in order to re-balance the urgent care load being placed on the NHS system, to maintain patient safety and access.

Note: Command and control arrangements, in response to pressure surges created by increased activity such as that experienced during either a heat-wave, or winter conditions, differ from those during a major incident, which will be governed by existing Major Incident Policies.

10.2 Cluster Input
Prior to enacting Command and Control, NHS London will endeavour to seek the opinions of Clusters, before a decision is made regarding their initiation. Alternatively, NHS London may consider their use, if they are requested to do so by the Clusters, or the Department of Health.

10.3 Duration
Command and control arrangements will be maintained for as long as it is felt necessary to resolve the situation, with the intention of handing back control to the Clusters as quickly as possible.

10.4 Role of NHS London Performance Directorate and Section 38
At NHS London, the management of winter pressures is the responsibility of the Performance Directorate, supported as required by other teams and Directorates, including Emergency Preparedness and the Medical / Chief Nurse’s Directorate. The imposition and management of command and control arrangements will be overseen either by the Director of Performance, or Section 38.

10.5 Information to support decision making
This will be available through the CMS system, regular briefings from the Clusters and twice daily conference calls (see below for suggested attendance), chaired by Section 38 or Director of Performance. The purpose of these calls will be to support collective decision making and information sharing.

10.6 Conference Call arrangements
Once Command and Control arrangements have been invoked, and following the initial conference call to discuss the situation and identify actions, regular conference calls will initially be scheduled daily at 10.00 and 14.00, but may be varied according to the developing situation. It is likely that calls will also take place over weekends. This will be confirmed at weekday conference calls. Call arrangements, including dial in number and participant codes, will be circulated by Clusters or NHS London (Section 38, Performance Directorate Heads of Performance or support staff) to all attendees by email.
<table>
<thead>
<tr>
<th>Attendee</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 38 / NHS London Director of Performance</td>
<td>Run the “incident” on behalf of the NHS in London</td>
</tr>
<tr>
<td>Section 38</td>
<td>To provide support to Section 38 as required</td>
</tr>
<tr>
<td>Section 38</td>
<td>To be aware of capacity issues in the event of other emergency situations</td>
</tr>
<tr>
<td>Cluster Directors of Performance</td>
<td>To provide updates on Cluster actions, give local direction and leadership, oversee implementation of actions required by NHS London, and liaise with neighbouring Clusters regarding potential impacts or actions required</td>
</tr>
<tr>
<td>Trust / Borough representatives (If only 1 or 2 Clusters are affected)</td>
<td>To report on the current situation, measures taken and further measures planned. To action SHA requirements as appropriate.</td>
</tr>
<tr>
<td>Senior Performance Managers in NHS London</td>
<td>To liaise with Clusters outside of calls on progress, additional support required etc</td>
</tr>
<tr>
<td>NHS London HCAI Lead</td>
<td>If pressure HCAI linked</td>
</tr>
<tr>
<td>LAS Representative</td>
<td>To provide an overview of LAS issues and support to EDs etc.</td>
</tr>
<tr>
<td>NHS London Winter Lead</td>
<td>To provide support, advice and brief DH etc</td>
</tr>
<tr>
<td>Others by invitation</td>
<td>To provide ad hoc specific advice as required</td>
</tr>
</tbody>
</table>

10.7 Draft Agenda

1. Welcome and introductions.
2. Updates against an agreed range of criteria for each Trust / Cluster.
3. LAS update.
4. Update against agreed actions from previous conference call.
5. Look ahead to situation over the next 12 hours and agreement of further actions.
6. Confirmation of next conference call and dial in details.

10.8 Circulation of notes:

- Notes of the meeting will be taken by the Winter Lead or an appropriate member of the Performance Directorate and circulated to all participants, cc’d to:
- NHS London Chief Executive’s Office.
- NHS London Communications.
- NHS London Director of Performance.
- Cluster Chief Executives.
- SECTION 38.
- NHS London Head of Emergency Preparedness.
- Bordering SHA’s when relevant.

10.9 Briefing of Department of Health / NHS London Chief Executive’s Office

Following the conference calls, briefings will be communicated to DH as appropriate to keep them informed of the progressing situation. This will be particularly necessary in the event of norovirus outbreaks or the need to close A&E departments due to capacity issues.

10.10 Briefing of surrounding Ambulance Services

The London Ambulance Service will liaise with their counterparts regarding re-directions / closures, on behalf of NHS London and the Clusters.
Appendix B – LAS 1 hour handover breach information

9.0 LAS Handover and One hour (Black) breaches
During the winter, it is inevitable that ED’s will experience heightened pressures, and the risk of one hour handover delays increases significantly. Trusts are expected as part of their planning process to ensure that these incidents are eliminated as far as possible.

9.1 Serious Incident Reporting
Where they do occur, Trusts are expected to report them as Serious Incident’s (SI’s), and investigate their causes. Clusters are expected to ensure that both they and their Trusts have implemented robust monitoring arrangements, to ensure that one hour breach SI’s are identified, reported, investigated and the lessons learnt implemented to reduce the likelihood of recurrence in the future. Considerable work has been undertaken on this in NWL Cluster, and all Clusters were asked in June to ensure the recommendations have been implemented.

9.2 Hospital Based Alert System (HAS)
Trusts are expected to maximise usage of the HAS to ensure accurate data collection on handover times, reducing disagreements between Trusts and the LAS about the number of 1 hour breaches taking place, enabling resource to be focused on investigating those which did occur.

9.3 The following definitions and reporting processes have been agreed and are in effect across London:

- **LAS arrival at Hospital:** The time that the LAS vehicle parks at the Emergency Department off loading bay and ‘Red at Hospital’ button pressed within the ambulance.
- **Clinical Handover:** The time at which essential clinical information about the patient has been passed from the attending LAS crew to a clinician within the Emergency Department to allow a decision about where ongoing treatment can safely be delivered.
- **Patient Handover:** The time when clinical handover has been completed and the patient has been physically transferred onto a hospital trolley bed, chair or waiting area, and the LAS equipment has been returned to crew enabling them to leave.
- **LAS Green:** The LAS Crew have notified their Emergency Operations Centre they are available for further deployment via ‘Green Available’ button press.
- **Arrival to Patient Handover:** The time from when the LAS vehicle arrives at Hospital to Patient Handover
- **Patient Handover to Green:** The time from when the patient handover has taken place to the ambulance being made available for further deployment

9.4 Reporting Responsibilities:

<table>
<thead>
<tr>
<th>HOSPITAL TURNAROUND STAGE</th>
<th>DATA CAPTURE MECHANISM</th>
<th>RESPONSIBILITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAS arrival at Hospital</td>
<td>'Red at Hospital' button press via the LAS MDT</td>
<td>LAS crew</td>
<td>The ‘Red at Hospital’ button press triggers time of LAS arrival on the Hospital Based Alert System (HAS) This time is available to the LAS Information Management Team (IM) and input into their reporting process</td>
</tr>
<tr>
<td>Clinical Handover</td>
<td>Written on to the Patient Report Form (PRF)</td>
<td>LAS crew / ED clinician</td>
<td>The Patient Record Form (PRF) is scanned by LAS and available to LAS IM and input into their reporting process</td>
</tr>
<tr>
<td>Handover Type</td>
<td>Details</td>
<td>Responsible Party</td>
<td>Description</td>
</tr>
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<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient Handover</td>
<td>‘Patient Handover’ button press on Hospital Based Alert System (HAS)</td>
<td>Acute Trust</td>
<td>By using the HAS, the patient handover stage of the patient journey can be accurately captured putting the acute Trust in control of this reporting stage. This time is available to the LAS Information Management Team (IM) and input into their reporting process.</td>
</tr>
<tr>
<td>Handover to Green</td>
<td>‘Green Available’ button press via the LAS MDT</td>
<td>LAS Crew</td>
<td>This time is available to LAS Information Management Team (IM) and input into their reporting process.</td>
</tr>
<tr>
<td>Administrative Handover</td>
<td>Patient Administration System (PAS)</td>
<td>Acute Trust</td>
<td>Patient information is taken from LAS PRF.</td>
</tr>
</tbody>
</table>