Portsmouth Hospitals NHS Trust

Surge and Escalation Management Plan

April 2013

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Version Control

This document is a controlled document. It replaces all previous versions. Upon sign-off of this version, all previous versions should be removed from use and destroyed or archived. This document will be updated annually or as a result of lessons learnt following an activation or exercise of this plan. The issue date is shown in the footer.

Version History

Version Number	Title	Version Date	Status
0.1	Surge Management Plan	April 2013	Draft

1.0 Introduction

1.1 Purpose of the Plan

The purpose of this Plan is to allow Portsmouth Hospitals Trust to:

- Create additional capacity for an increase in demand created by any additional pressures
- Create emergency capacity for surge in demand
- Manage patient flow away from the admissions pathway during these events
- Define triggers for activation of escalation and surge management activity.
- To ensure escalation Triggers are noted and correct action is taken
- To ensure the Trust achieves the Operational Standards mapped out below:

INDICATOR	***OPERATIONAL STANDARD***
Four hour emergency access standard	95%
Ambulance turnaround time	Maximum 15 minutes
Total discharges by 1600	80% of total discharges
Daily In patient Discharges	Equal to or greater than admissions
Cancelled Electives	<1% Trust wide
No. of High care / Resus beds available in Emergency Dept.	1 or more
Patient Flow Standards	Correct patient to correct bed first time Limit maximum number of patient ward moves to 4
Delayed Discharges	50 clinically stable

1.2 Definition

For the purposes of this plan, escalation is an anticipated increase in the number of patients or a delay in the availability of beds requiring additional capacity to be created in the hospital. This may be caused by a number of factors as detailed in section 1.4.

External trigger points for activation of the escalation arrangements are:

- Increased demand
  - Calls to SCAS increase as such that attendances to the Emergency Department rise
  - Patient attendances above the seasonal norm
  - Increase in demand for community and primary care services
  - Issuing of a weather alert likely to increase attendances
- Decreased supply
  - Critical Care capacity drops below 1 available space in ITU with no patients ready for transfer to wards or high care areas, Resus is full
  - DTOCs reach 5% more than normally accepted
  - Discharge volumes are below those required to meet admissions
  - Beds/wards closed due to outbreak of D&V and community illness
- Waiting Times
  - Performance against four hour operational standards falls below 95% for 2 days
  - Significant risk of patients waiting more than 6 hours in Emergency Department
- Staffing
  - Actual or predicted sickness, absence or vacancy levels reach a level where patient safety will be compromised.

In turn this will trigger the Trust Escalation status to change. The triggers and subsequent actions are detailed from section 2.

Surge is an anticipated increase in the number of patients caused by a single Incident or a Major Incident which will cause extreme pressure to the system. This coupled with additional beds already being in use will trigger Surge Management.

1.3 Scope

This plan deals with the responses required to manage the expected or unexpected increase in demand caused either during a related major incident or through an increase in normal activity combined with other factors preventing discharge of patients.

1.4 Risk factors

The following factors increase the risk of there being a surge in demand for services:

- Severe winter weather
- Heatwave conditions
- A Major Incident with severe and multiple casualties
- Pandemic influenza or other infectious disease outbreaks
- Disruption to community care and/or social care services
- Extended Bank Holiday Weekends causing increased demand on both Acute Trust and OOHs services

1.5 Whole System Factors

Increased activity in the acute care setting could subsequently result in a delay in the community and social care settings as the demand for their services increase. Communication of a surge and the opening of escalation capacity with these groups will be essential for a return to normality following the surge. Failure to notify the following groups may further increase the surge in demand by creating feedback into the acute setting where patients are unsupported on discharge:

- Intermediate Care
- Community Nursing
- Social Services
- Integrated Discharge Bureau

2.0 Managing Escalation

2.1 Management arrangements

Escalation will be managed by the Clinical Service Management team within hours with the Duty Hospital Manager (DHM) supporting and the Duty Hospital Manager with the On Call Manager and Director out of hours.

Escalation will be managed locally by service leads ensuring that activity information is escalated to the daily bed meetings by the Patient Flow Managers. It will be necessary for a nominated CSC Manager and/or Chief of Service to attend the bed meeting to assist with the management of surge.

Bed meetings occur at 09:45, 12:30, 15:00, 17:00 and 19:00 daily with further meetings held at request of the Duty Hospital Manager if required.

The Trust will also participate in conference calls which will be joined by all leads within the LHE. The frequency of which will be determined by the Escalation Level.

Command and Control Arrangements

In the event of command and control arrangements being required it is expected that the Trust reports its status to the Clinical Commissioning Group (CCGs) who in turn will escalate to the NHS Commissioning Board area team for Wessex (NHS CB). This means the CCGs will be the first point of contact.

2.2 Assessment, monitoring and information cascade

Assessment will be carried out on a daily basis at the bed meetings by reviewing the Emergency Department attendances, GP calls and admissions and the admission numbers to each specialty. The Escalation Status may need to adjust depending on the current position of the hospital. This will be monitored by the DHM through each day and the information surrounding this will be

delivered within the Operations reports. If the demand on services affects particular CSCs significantly the DHM may contact the relevant Managing Director directly to inform them.

2.3 Situation reporting

The escalation status will be communicated internally three times a day and externally once a day unless the status changes, in which case a further escalation status will be issued externally.

2.4 Alerting other organisations

The Trust will escalate to the CCGs if required. If the Hospital Status moves to Red then the Trust will need to assess the need for organising and chairing a whole system teleconference. If the Hospital Status moves to Black then the Trust will contact the CCG Director on Call.

2.5 Role of Community Partners

The following roles and responsibilities will be carried out by the CCGs during the winter period, and other surge events:

- To lead the Cluster response to pressure surges on a daily basis in and out of hours
- Monitor the daily situation across the Cluster
- Be aware of measures taken by trusts to manage pressures and ensure timely implementation
- Broker cross Cluster agreements for the management of pressures
- Liaise with SCAS over pressure levels, including the authorisation of redirections from Emergency Departments where necessary
- Ensure Trusts investigate at a senior level the reasons for redirections
- Advise key leads within the LHE if there are actions that need to be undertaken or require approval or brokerage
- During implementation of central command and control monitor the implementation of centrally requested actions on the ground and escalate issues to

- Keep informed through additional briefings required to manage the situation
- Ensure partners are working in an effective way together to manage demand and create capacity
- To overcome barriers to effective partner working and escalate to where this is not possible
- Brief boarding Clusters on any issues which may impact on their management of pressure surges and patient re-directions beyond the Cluster border.

2.6 Contingency/Flex Capacity Options/Queue Management

The Flex Capacity options below should be considered after all appropriate discharge measures have been carried out as per the action cards contained in this plan. Each area has been RAG rated and risk assessed for use.

The aim must always be not to queue however at such times of a large surge this may occur. Staffing within the Emergency Department must be assessed as to whether they can support caring for patients in the queue. The patient to nurse ratio must be 4:1. If this cannot be supported by the Emergency Department plans to seek support must be made via the ED Matron and Head of Nursing and/or the Duty Hospital Manager. Staff from other areas across the Trust may be called upon to assist.

A discussion also needs to take place with the MAU Consultant or other Specialty Teams with regard to assisting the assessing of patients in ED and the Queue.

2.7 Escalation/Declaring Black Status

The Care Commissioning Groups (CCGs) provide the route by which issues are escalated to. However an external Trust status report must be issued daily and again if the status changes. The COO, On Call Director or DHM must also remain in contact with the relevant CCG to escalate any internal changes that they may be able to assist with.

In the event of declaring Black Status a telephone call between the Trust COO or Duty Director and the Chief Commissioning Officer or CCG Director On Call must take place to confirm the status. Out of Hours this call must be between the Directors on call for the Trust and for the Wessex area Commissioning Board.

2.8 Stand down/De escalation procedure

The decision to stand-down from any of the alerting levels, or close additional capacity will be made by the DHM in conjunction with the Director on Call or Chief Operating Officer, based upon demands, capacity and expected pressures. A discussion with the CCGs must take place before de escalating from Black.

When deciding which additional capacity should close those areas which opened with a higher risk score attached to it should take priority.

Upon agreeing to stand-down, all managers activated or placed on stand by should be contacted and stood down, other staff should be informed as necessary, and the Trust's alert status will be updated on the intranet.

Other responding agencies, will be informed as necessary.

2.9 Recovery management

Return to normal business operations following the activation of the Surge Management arrangements should consider the key aspects below. In addition to this the recovery of ward space used for escalation should be returned to normal operations at the earliest opportunity especially where this impacts on performance. A full debrief should be under taken to identify improvements to the plan and procedures.

Key aspects & Considerations

- Cause of the Surge
- Escalation process and order of opening
- Actions taken internally to the Trust
- Actions taken externally in support

3.0 Escalation Status

3.1 Summary

Activity/capacity imbalance undermines the Trust's ability to deliver to its operational standards, and to care safely for individual patients.
The escalation process is the mechanism for sharing capacity pressures at times of difficulty. The triggers for escalation mechanisms to these emergency pressures are outlined below.

It is to be assumed that the hospital does not close to emergency admissions and will not be able to divert acute workload to another acute provider unless in an event of an internal or external major incident.
It is important that Trust is able to assure healthcare partners that all internal measures have been taken before escalating to the highest escalation status.

There are four categories of escalation: Green, Amber, Red and Black. Specific trigger points for these are defined in the tables below. Quick use Action Cards will be made accessible.

Green and Amber are used to define 'normal' levels of activity. Communication of internal capacity pressures will be in the form of the Escalation report issued internally and the daily capacity meetings. Actions taken in amber will be as above, with specific attention to individual areas of pressure, but it is not intended that amber status should result in any action likely to be disruptive to normal patterns of activity. Amber status represents 'busy, but within normal boundaries'.

Red is to be used as the next escalation status and senior managers within CSCs will agree an internal action plan. This will include reviewing all admission and discharge decisions, to review current bed base and unfunded capacity. In line with this the Duty Hospital Manager will be expected to alert relevant partners and escalate to the relevant Management Teams.

To declare black escalation within the Trust all triggers must be checklisted. A telephone call to confirm will take place between the COO of the Trust and the Chief Commissioning Officer in hours and the Duty Director for the Trust and CCGs out of hours. Agreed Conference call times will be activated and all measures to prevent escalation this far will have been taken. In addition to these internal meetings between the Chief Operating Officer, On Call Manager and Director with all Senior Managers from CSCs will discuss whether there is a requirement to declare internal Major Incident, cancel Elective cases and adjust threshold for discharge further. Regular Conference Calls with partners must be maintained.

4.0 Level 1 - Green

Escalation Level	Actions
Level 1 Green: Normal **Triggers:** **At least 3 of the following apply :-** • **No risk of breaching - patients discharged, transferred or moved to ward within 3 hours of arrival** • **No ambulance queues - ambulances able to unload and turn around within 15 minutes +** • **Day starts with predicted balance of no more than: Minus 15 (Medicine/DMOP) Minus 10 (Surgical Div) and minimum of 6 Mau and 2 SAU beds and capacity will meet expected demand** • **Flow is progressing smoothly in ED with capacity at all times for resus and majors** • **Staffing levels manageable including flexing staff to fill gaps** • **Anticipate discharge targets**	PHT – HOSPITAL WIDE • **Operations Centre:-** ○ To maintain an accurate Trust wide bed state and Hospital Ops meetings to assess the hospital position and to determine action required of CSCs and departments: Meetings at: 0945, 1230, 15:00, 17:00, 19:00 ○ Hospital Status will set escalation level, 2 status reports @ 1000 and 19:00 will update the position. • **Patient Flow Co-ordinators:-** ○ to work with wards to ensure that flow is maintained, discharge targets are met, discharge lounge is maximised, diagnostics are progressed and patients are transferred from ED and assessment areas in timely manner ○ to ensure that available beds are filled within a maximum of 30 minutes of notification and escalate if not • **Duty Hospital Manager**:- ○ to oversee whole hospital and local health economy position and communicate with wards, department and divisional teams the action that are required to keep flow going/tackle any slow down in flow. This will include potential to escalate internal delays (e.g. TTOs, CT, endoscopy, transport, whiteboard patients) to maintain flow and or external delays (repatriations, cardiac to SUHT etc) ○ to communicate with On Call Manager and/or On Call Director if there is any risk that the escalation level will not be maintained and it is necessary to move to the next level **Specialty Wards** **NiC or Ward Manager:-** ○ to ensure that patients are admitted in time for space to be created in assessment areas so that patients can be transferred from ED ○ all patients to have an EDD within 12 hours of arrival on ward and a confirmed treatment plan. ○ Ensure updates of patient planning status boards and visual hospital ○ review EDD for current and next day and ensure that they take the necessary action to achieve their target for

will be met and no more than 10 outliers • **Less than 10 additional care spaces in use**	beds for the day and enabling actions for the following day's discharges, this is to include beds for elective patients ○ ensure all next day discharges are reported to the Operations Centre by 17:00 the previous day ○ to ensure that all actions reviewed for all patients and chased up including tests, test results/reports, doctor reviews, therapy treatment ○ if risk that discharge target will not be met for day communicate with medical and management teams to correct this ○ to ensure that potential discharges are flagged up to the medical teams and reviewed first on the ward round and that actions to discharge are carried out promptly ○ to ensure full use of the discharge lounge in the discharge of their patients and provisional transport bookings are made ○ to ensure that available beds are declared to Patient Flow Co-ordinators in a timely manner and filled within 30 minutes ○ to identify minimum of 1 patient for discharge/transfer to discharge lounge by 1000 and to achieve all morning discharges by 1300 hrs ○ by 1300 hrs to have the capacity either available or imminent to meet the expected admissions for the day and to have made all moves to create the capacity completed by 2200 hrs ○ Ensure all Green Cross forms are submitted daily to the IDB **Medical staff:-** ○ to review all patients, update estimated discharge dates and take actions to progress care or achieve discharge for current and next day – spell summaries, TTOs to be written up for any patient and transport requested if required with a potential discharge with 48 hours. ○ to identify patients who could outlie if further capacity is required **Discharge Planning team/Integrated Discharge Bureau:-** ○ to ensure that all wards are carrying out necessary tasks for the discharge of patients with complex needs i.e. making sure the need or referrals are identified and that referral are made ○ to ensure that all actions are taken to achieve predicted discharges for patients with complex needs for the current and next day and later in the week ○ to ensure that community beds are considered as an option for patient transfer and reported daily in the Operations Centre meeting; wards to liaise with Community Hospitals/Community Intermediate Care Schemes to transfer patients and support this process if required ○ To ensure all Medically Fit for Discharge and Discharge ready patients are identified and actions to progress are

underway

Assessment Areas Co-ordinators:-

- to ensure that GP referrals can be admitted directly to the unit to ensuring smooth flow of admission from home,
- to maintain space at all times to receive GP direct admission and patients from ED
- to ensure that actions are being followed up in all areas to progress care and achieve discharges and transfers to wards
- to ensure all patients have a PDD within 12 hours of arrival on ward and a confirmed treatment plan.
- to ensure patients are allocated to appropriate empty staffed beds, liaising with specialties
- to prioritise work of the transfer team and ensure available beds can be filled within a maximum of 30 minutes from notification re patient discharge
- to ensure that all patients confirmed as requiring an inpatient bed are transferred from the assessment areas to the appropriate inpatient ward by 2200

Emergency Department ED Coordinator:-

- Ensure that first assessment times are met and patient pathways are managed within agreed standards
- Ensure that specialty referrals are made in a timely manner and within agreed standards
- Deploy nursing and medical staffing across the department to ensure that patients can be dealt with within agreed standards, taking proactive action based on known arrival pattern, as well as current day's information from the ambulance service
- Escalate as per trigger plans if space in the department becomes compromised and if there is any threat to the department's ability to be able to take handover of patients from SCAS in 15 minutes. Monitor requirement for Queue Nurse.

Diagnostics:-

- **Imaging**
  - call for patients based on clinical priority and the requirement for reports to allow patient discharge and/or progress in the treatment pathway. Requesting specialties liaise with DI to identify suspended admission patients to return for imaging at an outpatient appointment booked for a later date.
- **Pathology**
  - report blood test etc., results within target turnaround times as determined by category of clinical requestor.
- **Pharmacy**

- Pharmacists to cover all wards ensuring that drug histories are taken on all patients and that all prescriptions are clinically safe.
- Pharmacists or technicians to highlight those patients requiring counseling or special help with their medications on discharge.
- Liaising with discharge planners and wards so that any potential problems relating to drugs on discharge are sorted in advance of the discharge, particularly NOMADs.
- Balance priorities to ensure that dispensing TTOs is balanced with routine working and training.
- Liaising with the Discharge Lounge to ensure that any TTOs not processed in advance are sent to the correct place.
- Inform the Duty Hospital Manager of any staffing/IT/portering issues that could affect the turn around times for TTOs.
- Ensure that “drug trolleys” used on overflow areas are replenished.

- **Transport Desk/Discharge Lounge**
  - Transport Co-ordinator assigns patients to available vehicles so as to maximise capacity and prompt transport of the patient.
  - Ensure additional transport requested if necessary following authorisation

South Central Ambulance Service (SCAS)

- Control Duty Manager - can be reached on 01962 898239 24 hours a day.
  - Ensure drop off of patients and clearance of ED department unloading bay as soon as possible and or within 15 minutes of arrival
  - Ensure prompt pick up of patients from ED for transfer and or discharge – if possible within 15 minutes of arrival to collect
  - PHT escalation report to be circulated daily to all teams and actions taken according to the status
  - Concerns/Issues to be fed back to PHT

Whole System Partners

To maintain Patient Flow and capacity

5.0 Level 2 - Amber

Level 2: Heightened (Internal Alert) **At least 3 of the following apply :-** • **Risk of 3 hour breaches with patients waiting 90mins to 1st assessment or 180 mins with no decision to discharge, treat or transfer** • **Ambulances turn around >15 minutes but < 30 mins** • **Flow is manageable but ED is busy at times with build up of patients** • **Day starts with predicted balance of no more than:** **Minus 25 (Medicine/DMOP)** **Minus 20 (Surgical)** • **Staffing levels of concern – some redeployment required** • **Predictions indicate that discharge targets are in doubt and or 15 - 20 outliers** • **Less than 20 additional care space in use**	PHT HOSPITAL WIDE - All actions in Level 1 plus • **Patient Flow Co-ordinator**:- ○ to communicate position across all CSCs to the Management team and agree actions with them and at the Hospital Operations meetings. ○ to receive escalation of any delays in patients treatment plans and take actions to address ○ to liaise with specialties to target patients whose discharge could be expedited ○ to agree and facilitate the outlying of patients to create space on wards ○ In all specialties divisional teams and on call managers to be alerted and actions to improve flow agreed and enacted • **Duty Hospital Manager**:- ○ to communicate the position hospital wide and to primary and secondary care ○ Duty Hospital Manager to contact PTS provider and assess certainty of transport arrangements and to arrange additional capacity if required including use of taxis ○ to liaise with Patient Flow Co-ordinators to assess potential to utilise community beds ○ to liaise with Discharge Planning team to explore expediting actions for complex patients ○ to ask facilities to expedite cleaning and transfers, including additional portering support ○ to alert SCAS to potential issue and agree ambulance liaison cover ○ to contact GPs/OOH and ask to consider alternative pathways • **Duty Hospital Manager and Patient Flow Co-ordinators** to ensure beds are filled within 30 minutes **Specialty Wards** **Senior Management Teams or Matrons:-** ○ to inform senior Medical staff of the situation ask them to consider additional discharge decisions, agree these with them and expedite eg patients suitable for discharge lounge, discharge pending diagnostics and outliers.

- to communicate to all teams if discharge target are in doubt and review further actions to expedite

Medical staff:-

- to split for early review of existing outliers and patients on specialty wards
- to review all patients on every ward and agree discharge plan
- to identify suitable outliers with the NiC

NiC or Ward Manager to follow up on actions from patient review to increase discharges, progress care and where possible to move patients to discharge lounge pending discharge.

Discharge Planning Team/Integrated Discharge Bureau to review all patients on complex discharge list with Social Services to see if plans can be brought forward

Assessment Areas Coordinators:-

- **MAU NiC/ Coordinator :-**
  - To ensure GP call centre to work with GPs to agree patient admission times based on clinical need
  - To ensure medical teams review referrals and agree admission criteria based on clinical need
  - To ensure medical and nursing teams to expedite actions to create space in respect to (i) discharges (ii) transfers to wards – this will include a review of the triage categories of patients

- **ED Co-ordinator and ED Consultant in majors:-**
  - to assess the situation and expedite actions to ensure first assessment times and referrals times are adhered to and patients are seen rapidly
  - review need for 'See and Treat' pathway if not already in place
  - to ensure that patients suitable for discharge from the department have all actions expedited to achieve this and early referrals to specialties are made
  - to identify queue staff to look after patients if at any time they cannot be handed over within 15 minutes
  - to conduct 'Board' round to ensure that referrals are made promptly to specialties
  - inform Minors patients of alternative care pathways ie Treatment Centre

Diagnostics:
As for green status

- **Diagnostic Imaging, Clinical Nutrition Nurses, and Patient Transport Desk** as for green status.
- **Pharmacy** - to speed up turnaround times for on the day discharge decisions

Support Services:

- Facilities and porters to prioritise cleaning and transfers

South Central Ambulance Service (SCAS)

Control Duty Manager - can be reached on 01962 898239 24 hours a day.

- SCAS to attend PHT Emergency Department and liaise with ED coordinator / Duty Hospital Manager re situation and agreed actions to support.

Community Care Providers

- Maximise use of re-ablement beds
- Task community hospitals to bring forward discharges to allow transfers as appropriate
- Additional ward rounds within community providers to expedite discharge and create capacity
- Community providers to lower admission/treatment thresholds wherever possible through implementation of previously agreed flexible working arrangements to alleviate pressure
- Apply flexibility regarding beds and staffing to increase capacity where possible
- Expedite rapid assessment by multidisciplinary team (MDT) including Social Services assessment
- Undertake additional ward rounds

Social Care

- Expedite care packages and nursing / EMI / care home placements Ensure all patients waiting within another service are provided with appropriate service
- Where possible, increase support and/or communication to patients at home to prevent admission. Maximise use of re-ablement beds

6.0 – Level 3 Red

Level 3 Heightened (LHE Alert) **At least 3 of the following apply :-** • **ED full and ambulances cannot offload within 30 minutes with ambulance queues** • **Total occupancy 100% with no spaces on MAU or SAU** • **20 - 30 outlying patients (of any specialty)** • **Trolley waits at 4 + hours** • **A&E majors cubicles full Resuscitation area available Minors busy with 1.5 hr wait** • **More than 3 patients kept at home overnight unplanned** • **Staffing shortages in key areas** • **More than 30 additional care spaces in use**	PHT – HOSPITAL WIDE – All actions in 1 & 2 plus: • **Duty Hospital Manager / On Call Manager (out of hours)**:- to discuss move to 'Red' status with on call Exec ○ to lead additional Hospital Site status checks to agree expedited actions with all teams at agreed times ○ to notify consultant on call and on call manager of escalation level ○ to communicate hospital position to all departments and request prompt action on all matters to do with flow ○ to ensure that referrals for diagnostics are prioritised ○ to liaise with ED and MAU on use of bank pool of staff and or additional staff needed in pharmacy, imaging and or pathology. ○ to make decisions in collaboration with CSCs and On Call Director about opening of extra care spaces / additional capacity for a limited time (aim should be to close within 48 hours) ○ to contact CCGs and SCAS and ensure new escalation report distributed to alert them to situation and escalation to 'red' status and steps taken to address'. ○ to assess possible divert options • **Exec on call** ○ to attend next Hospital Operations meeting and or call extraordinary Hospital Ops meeting (s) throughout the day ○ to complete duty director report and circulate ○ to notify partner organisation On Call Director reference 'red' status. ○ to ensure all CSCs have communicated escalation level to their teams and associated services and release staff from 'normal 'duties to resolve patient flow • **Patient Flow Co-ordinator / Duty Hospital Manager (out of hours)** ○ to ensure that beds are filled within fifteen minutes ○ to review elective admissions and if appropriate postpone in discussion with CSC Management Teams ○ All CSCs to communicate escalation level to their teams and associated services and release staff from 'normal

	‘duties to resolve patient flow **Specialty Wards** • **HoN or if not present Matron** o to review deployment of nursing staff across each CSC to target priority areas o to review patients admitted today for procedures tomorrow to find alternative accommodation or sent home o to identify staff / arrange for staff to be available to open extra care spaces o review the need for Queue nurses and need to deploy additional staff to ED to assist – determine skill mix based on situation • **Consultant medical staff** o will identify further actions that could be taken to expedite individual patient discharge and improve flow – this includes lowering the threshold on patients to be discharged o to review deployment of medical teams to best affect patient flow and discharge, including ensuring that specific responsibility for reviewing outlying patients has been allocated. **All CSCs** o to review potential for any other form of treatment for electives (i.e. day case) **Assessment Areas** • **MAU coordinator** ask GP call centre to ensure :- o GP expected patients go to assessment areas o GP call centre to work with SPA to increase utilisation of community patients to care for patients • **Medical and nursing teams** to expedite further actions to increase discharges and/or transfers to wards. • **DMOP/ MAU Team**:- o to increase scrutiny of admissions and utilise SPA to divert admissions where clinically appropriate o contact all community hospitals and feed information back to Ops Centre o Consultants in MAU to work together to progress patient flow o to communicate with community services as above and report any problems/ opportunities to the Integrated Discharge Bureau Matron • **MAU / Acute Team** to scrutinise patient and send them home if possible thinking of alternatives to admission **Emergency Department** • **ED coordinator** o To assess the queue situation and deploy staff/assess need for outside agencies to assist in the care of patients who cannot be formally handed over including triage of patients in ambulances so treatment can commence

- to work with ambulance liaison officer on management of ambulance queue, acuity, deployment of resource
- **SCAS**
  - provide continued liaison support splitting crews where appropriate
  - to remain aware of situation and non conveyance of the patient to hospital if appropriate
- **Consultant/Registrar**
  - to scrutinise admission decisions and ensure all appropriate actions are being taken to progress care

Diagnostics

- **Imaging** as for amber plus:-
  - potential capacity for extra three dimensional imaging checked and scheduled for later deployment as available. Requesting specialties/discharge planners liaise with Diagnostic departments re result - dependent discharges.
- **Pharmacy**
  - Ensure extra drug trolleys are moved to appropriate areas in a timely way
    - Re-allocate staff as required to maintain the flow of TTOs to allow discharges
- **Patient Transport Desk**
  - Assess the likelihood of later discharges, verify that transport capacity is available and consider ordering extra if appropriate.

South Central Ambulance Service (SCAS)

Control Duty Manager – to be notified on 01962 898239 24 hours a day and once an ambulance officer onsite they become the first point of contact for liaison and action with SCAS :-

- Ensure deployment of SCAS PHT Emergency Liaison Officer to PHT ED department to assess and help with patient flow
- Review and reallocate resources to meet current emergency workload
- Ensure usage of managers / officers, staff and community responders is maximised
- Maintain communication with GP and OOH services to review potential delays to patient admissions
- Ensure all duty officers and directors are aware of current status level
- Reinforce with ECPs and other ED staff the need to use alternative care pathways whenever possible

Community Care Providers

- Review all patients awaiting assessments in order to expedite discharge or transfer – this to include in reach teams, deliberate self-harm, community hospitals

	○ Undertake additional ward rounds and capacity where possible ○ expand capacity wherever possible through additional staffing and services ○ Consider the use of wider group of agencies to increase staffing capacity ○ Refer patients waiting at home for admission to Community Teams (by in reach nurses) **OOHs** ○ 111 to confirm staffing levels and possible challenges ○ OOHs to review staffing level of GP Out of Hours service and communicate any possible challenges **Social Care** ○ On-call Managers to expedite care packages ○ Review all assessments in pipeline to expedite discharge ○ Increase domiciliary support to service users at home in order to prevent admission

7.0 Level 4 - Black

7.1 Summary

This section details the necessary arrangements for the re-direction of patients out of care pathways into more suitable arrangements during times of extreme pressure.
A checklist to confirm status must be completed and filed and the COO or Duty Director must confirm Black status with Chief Commissioning Officer or equivalent.

Level 4 Internal Incident (SHA level) alert
 	
At least 3 of the following apply :-
 	
• **Total occupancy 100% with no spaces on MAU and SAU and**
• **More than 40 outlying patients or**
• **Cumulative trolley waits indicating potential to breach 70 for the week**
• **10 or more ambulances being held for over 30 minutes (at any one time)**
• **No space in resuscitation area or Majors cubicles in ED**
• **Over 5 patients left at home unplanned overnight or accumulation of patients**
	PHT HOSPITAL WIDE - All actions in 1, 2 & 3 plus
	
	• **Duty Hospital Manager / On Call Manager (out of hours)** :-
	  ○ To ensure that priority is given to clearing resuscitation area in ED and ensure further risk assessment of patients at home, expediting admission to hospital if required
	  ○ Specialty patients to be transferred from Observation area to specialty area
	  ○ To liaise with South Central Ambulance Liaison Officer and Chief Operating Officer / On Call Director to keep them informed of the situation
	  ○ Duty Hospital Manager / On Call Director (out of hours) to contact CCGs Chief Executives to review any other options and to keep them appraised of the situation.
	  ○ Non frontline clinical staff (eg Corporate clinical staff))to be focused on all aspects of clinical work that will help to improve patient flow – to be agreed with Duty Hospital Manager
	  ○ All remaining electives to be further reviewed by CSC Managers and or relevant surgeons and consideration given to cancellation.
	  ○ to make decisions about opening of extra care spaces / additional capacity for a limited time aim should be to close within 48 hours)
	• **Heads of Nursing**
	  ○ to undertake risk assessment of areas of increased capacity and ensure all steps up to Escalation Red have been taken
	  ○ in particular to ensure the thresholds for discharge have been lowered and for admission have been raised
	• **Clinical Directors** :-
	  ○ to ensure that Consultant Medical staff review all patients and identify blocks as above. Consultant staff to be arranged to take GP referrals
	• **COO**:-

waiting at home during the day • **Staffing shortages in all areas** • **More than 40 additional care spaces in use**	○ will request an urgent meeting/conference call (within 2 hours) of the Local Health Economy with representatives from each area, SCAS and SS **Diagnostics** • Imaging and Pathology: ○ requesting specialties liaise with diagnostic departments regarding appropriate prioritisation of patients, and provision of discharge - critical reports. • Pharmacy ○ Senior staff ensure that workflow through the dispensary is maintained and provision of TTOs prioritised appropriately. • Patient Transport ○ liaise closely with suppliers to maximise capacity and move patients promptly. **South Central Ambulance Service (SCAS)** • **Control Duty Manager – to be notified on 01962 898239 24 hours a day and once an ambulance officer onsite they become the first point of contact for liaison and action with SCAS :-** ○ Review current GP admissions with GP's to ensure safe standards of care to patients ○ Call in additional operational and communications centre staff and additional resources eg St Johns, private ambulance services etc ○ Review all long distance inter hospital referrals ○ Direct communications between SCAS and PHT NHS Trust Duty Director ○ If emergency response is severely compromised consider use of Major Incident procedures **111** 1. What is the current demand and capacity? **2.** Can 111 redirect to alternative providers other than ED? What is the capacity **OOH** 1. within service / any gaps in service provision? **ISTC** 2. What is the current demand and capacity? 3. Can ED redirect to ISTC?

[redacted]	**Community (SHFT and Solent – HCC and PCC)** 1. How many community beds are available? 2. Where are community beds available? 3. What is the staffing status? 4. How many extra ward rounds are taking place? 5. Are there any package of care issues – if so what actions have taken place? 6. Consider relaxation of community bed admission criteria where appropriate
MAJOR INCIDENT	• As per Major Incident Policy

7.2 Further Trust Actions

Actions
Establish permanent command and control in Operations Centre
Identify suitable lead for situation (Director on Call), if not being led by Chief Operating Officer
Follow process for requesting Ambulance Redirection if deemed appropriate
Pull staff from other services to support Emergency Department and Discharge processes and ensure all clinical staff have clear diaries to allow them to support
Ensure frequent clinical safety assessments are conducted
Open and Staff additional contingency beds
Request the spot purchasing of beds within Nursing Homes to support discharge
Consider scale back of non essential functions across all services to create capacity and staffing
Use of corporate (staff not normally in clinical roles) nursing staff to support care where necessary
Ensure all staff are made aware of pressures, and need to prioritise discharge
Re review of all Elective activity

7.3 Internal Control

Upon reaching a bed crisis level, there should be a move to centralised control or escalation of bed meetings to identify business continuity measures to be used to support ongoing pressure management.

Internal control arrangements should take the form of additional bed meetings, which focus on the issue of capacity. Or the use of the Operations Centre to centrally collate information, reflecting the structures used to respond to a Major Incident as detailed in the Emergency & Major Incident Plan or those of the Overarching Business Continuity Plan. **A bed crisis is to be considered an Emergency under these arrangements and will not be declared a "Major Incident"**. All staff should be made aware of the arrangements and may need to support pressures management by moving away from their usual daily routine.

7.4 Re-direction Options

Ambulance Redirection

An ambulance redirection may be requested. This should be agreed with SCAS and with the receiving hospital/s. The request for a hospital re-direction will be balanced against the impact this will have on the surrounding hospitals and overall pressures in the cluster. Any re-direction will be time limited and provide a pressure ease on the Accident and Emergency Department, it will not though prevent self presenters attending the hospital.

Primary Care

It is also possible to request primary care support, with the stepping up and redirection of patients where their clinical need allows into primary care services, either in to primary care walk-in centres and general practices.

7.5 Re-direction Actions

The following actions should be taken when arranging a hospital re-direction.

Actions
Ensure SCAS is aware of situation and visits site
On-Call Director to contact On-Call Directors for SCAS and neighbouring Trusts and request redirection
SCAS On-Call requests redirection from alternative site with agreement of receiving site and the Ambulance Service.
SCAS confirms the request to On-Call Director
The On-Call Director confirms with the Duty Hospital Manager

8.0 Emergency Surge

8.1 Summary

Surge caused as a result of a single incident that overwhelms normal surge management processes or occurs during a time when all additional bed capacity has been activated. This will usually be opened only in the event of a Major Incident and as a temporary solution.

8.2 Declaration of an emergency

In the event that an Emergency or Major incident needs to be declared due to the impact of an incident on the trust services the Chief Executive, or deputy, will declare an “emergency” or “major incident” with guidance from the Emergency Planning Manager. In such an event the actions of this plan maybe superseded by those of the Emergency & Major Incident Plan.

8.3 Hospital Control Room (HCR)

During an emergency response the Incident Controller will decide if the HCR is to be established or if the incident will be handled using existing working methods, should the Hospital Control Room be required details can be found in the Emergency and Major Incident Plan.

The main role of the HCR during an emergency will be to co-ordinate the response of all services and issue communications relating to the current status of the hospital including capacity. The Incident Controller will decide if Bed Meetings will become part of the control room functions or remain separate. In either case beds will be managed by the bed coordinator.

8.4 Emergency Surge Capacity Options

The following outline the options for managing emergency surge in the hospital, constraining factors will include staffing availability, length of surge and type of surge:

- Suspension of Day Cases to create capacity
- Suspension of Elective Programme
- Redirection of more patients
- Expansion of discharge lounge eligibility criteria, and formation of patient observation area
- Opening additional capacity, or creating capacity outside of normal areas (may exceed time of surge to establish)

8.5 Emergency Surge Capacity Actions

Upon declaration of a “Major Incident”.
Initiate actions for Amber and Red, and actions for Black
Identify services to be suspended/capacity to be opened
Identify and call in support staff
All areas to initiate Major Incident Cards
Ensure clinical safety assessment is conducted on all areas opened
All clinical and non clinical teams to focus on discharge and creating capacity

9.0 Communications

9.1 Summary

Below are communication actions that need to be considered or taken in the event of a Surge, outside of the standard messages that would be issued as part of a response to an incident as outlined in the Emergency & Major Incident Plan.

- Duty Hospital Manager to inform key staff, including Carillion, of immediate ward changes e.g. opening and closing of wards, restricted access to wards and any other relevant information.
- Going into weekends and evenings, ensure that reactive press lines have been agreed and the Communications Officer has circulated. An On Call Communications Officer is available OOHs.
- Use of communication channels that reflect the urgency and frequency of messages especially where changes will impact on support services.
- General Managers to ensure that they take responsibility for communicating key messages to their departments and services face to face if at all possible –do not rely on email to communicate urgent and important information - refer to action lists. Hospital Twitter Account now also available.
- Patient information will be communicated using the website, switchboard message, and outpatient call centre system as required. This is only likely to be needed in extreme circumstances/sudden onset surge.
- Joint communications messages, and longer term communications planning and strategies, are developed and practiced with partners.
- The communications team can be contacted via the information in the contacts section of the emergency management manual or switchboard.

10.0 Advice to managers and staff

10.1 General guidance

Staff should where possible make themselves aware of the actions and alert levels contained in this plan, and know the Trust alert level throughout the day. This will enable individual staff and managers to take action to relieve pressure on the Trust during surge effectively. In addition to these actions additional tasks to alleviate pressure on specific services may be undertaken at the direction of the appropriate lead or on-call.

10.2 Redeployment

During any surge event it may be necessary to redeploy staff from their usual routine duties into other services. In doing so the Trust will ensure that staff are redeployed based upon their clinical skill set, and adequately supervised within the role they are given.

Managers and senior staff in the receiving area must ensure that any staff deployed to them are made aware of any risks, given a complete health and safety briefing and are aware of whom to escalate problems to. No member of staff that is redeployed should be asked to complete tasks they are not competent in, or without supervision.

Appendix 1

Flex Capacity

Escalation Beds opened as a change of designated function from day areas or unfunded inpatient bed spaces which are already based within funded ward areas. Those spaces available clinically have been risk assessed, RAG rated and detailed below.

Escalation Beds are a change of designated function and conform to Trust standard on risk assessment. To review utilisation when all funded capacity is in use and cannot meet the forecasted demand.

Escalation Beds are a change of designated function and conform to Trust standard on risk assessment. Some specified staffing levels may apply and/or equipment may need to be moved or sought. To review use of these when all Green Escalation Beds are in use.

Escalation Beds are a change of designated function and conform to Trust standard on risk assessment. Specified staffing levels may apply and opening will impact on normal service delivery. Equipment will need to be sought and other equipment moved. These beds are agreed via consultation with the General Manager for the Service and/or Director on call. To review use of these when all Green and Amber beds are in use.

Black Escalation. Only to be considered when in Black or Major Incident. The opening of these will impact on service delivery and will require cancellation of activity. Specified staffing levels will apply and equipment will need to be acquired. Commissioning of areas may need to take place and discussion with Director of Estates must take place if this is the case. These beds are agreed via consultation with the General Manager for the Service and/or Director on call. To review use when all of the above are open and all other measures have been taken to release capacity and failed.

Escalation Areas	Risk Score
D8 weekend beds (8) **D level Orthopaedics Beds** E1 – 5th Bed space ED Obs Ward ED Majors Cubicles G5 **Renal – flex in all wards** G2 cubicles	Low - 4

E6 Respiratory High Care – Level 2 Patients only	
E1 – Ambulatory cubicles	Low / Medium - 6
D3 – Room 18	Medium - 9
Renal Day Unit Cardiac Day Unit D5 - DOSA	Medium / High - 15
Treatment Rooms – *NO CALL BELLS* CHOC E1 – Needs equipment **E1 – Treatment Room** E8 – Would need to relocate Pharmacy Dispensary E7 – Storage area D5 – Would need to relocate Pharmacy Dispensary D8 Treatment Room – *No Call Bell* C7 Coronary Care – Pacing Room C6 – Would need to relocate Cardiology Research team and equipment C5 – Would need to relocate the Gastro day case / treatments including the nurse led venesection Service(Mon - Fri)	High - 20

E3 - Physio room F3 – Gym D6 – Joint School MAU Ambulatory Would require some works to alter function/recommissioning works, but possible Day services would require relocation prior to use	Very High - 25
Major Incident Spaces:- **G1** Waiting areas Recovery Areas Day Case Units Endoscopy Theatres Old ED Majors **Areas used for Offices or Training Rooms**	Major Incident spaces

Floor	Ward /	Room	Additional	• Impact Assessment

Level	Dept		Care Space(s)				
				• Quality	• Cost	• Delivery	• Risk Score
G	Renal	Flex in all wards	4	•Fully serviced •Not available until August 2013	• Staff review needed	•	
	Renal	Day Unit	5	• Fully serviced • Single Sex only • Not available until August 2013	• Staff required out of hours 2x RNs • If activity cancelled – income implications	• Impact on day cases following day	15
		Training area	3	• Removal of kit and testing of gases/ cleaning/ beds etc • Single sex only • Fully serviced	• Staff required	• Changed function of room requiring relocation of equipment	25+
	G5	PP unit	Variable. +/- clinic	• Fully serviced	• Financial Recharge for	• Impact on next day admissions	3x2=6

			room	and staffed • Must inform Hospital at night to ensure adequate Medical cover in place • NHS Patient admission criteria – Surgical patients only with next day PDD • No pre-op NHS patients should be admitted • No Paediatric patients • Equipment will need to be removed from clinic	NHS patients using the PPU (£300 per night per patient)	– exact number of beds available must be agreed with Medicine CSC as PP must have beds available • Impact on Emergency PP admissions potential to need to repatriate outliers to accommodate	

				room **Patients must not pose an infection risk**			
	G5	Endoscopy		• No beds • Small spaces • Privacy and dignity issue • Single sex only • Isolated Unit	• Staff required • If activity cancelled – income implication **Beds required**	• Impact on day cases following day	**25+**
	G2	X 3 Cubicle Nos 3, 4, 5	3	• Services are still in place • Cubicles are based behind doors, sits within G1 ward and are isolated	• Staffing levels would need to be reviewed	•	**2x2 = 4**
	G1	Inpatient Ward facility	15	• Areas currently used for TIA clinic and broken	• Staff required • Would require new space for existing services	• Would need to relocate broken beds and negotiate clinic space	**25+**

				beds • Fully serviced	**Would need re commissioning as a ward**	elsewhere for TIA	
F	F7	Acute Oncology Service	6 (4 bedder and x2 cubicles)	•Fully serviced	• Staff required •Equipment required	• Would impact on delivering the Acute Oncology Service the following day (in operation Mon – Sat) **Patients would need to be admitted via the Emergency Corridor if utilised** • Risk to patients requiring emergency admission with neutropenia following a differing admission pathway	**16**
		F6	1	• Fully serviced	•	• Behind two sets of doors, patient would need to be independant	**2**

	F3 Gym	Room 18 - Gym facility	4	• Fully serviced **Privacy and Dignity considerations due to link corridor sightline**	• Staff required **Equipment required including curtains – only 2 rails** • No call bells, arrangements would need to be made for a nurse to remain in room	• Would need to use Gym facilities in D Level Physio Offices	**4x5 = 20**
E	E1	Waiting room	2	• Fully serviced	• Staff required	• Would need to re-provide waiting area, need beds, lockers etc	**25**
		Treatment room	1	• Fully Serviced	• Staffing levels would need to be reviewed	• Need bed, locker	**5x4=20**
		Ambulatory Beds	2	• Fully serviced • Used between 8am and 2000	• Staffing levels would need to be reviewed	• Need bed, locker • Impact on next day Ambulatory activity	
	E3	Room 18	2	• Fully serviced • 2 bed spaces already in use, 2 bed	• Staff required	• Removal of physio bars and repair to floor, need beds, lockers etc but all services are	**25**

				spaces not ready to use		still in place	
	E6	RHCU	2	• Fully serviced • Level 2 patients only though cubicle with en suite can be assessed and used for Level 3 if required	•Staff required (2:1 ratio) • 10 patients 4+1		**2x2 = 4**
	E8	Treatment Room	1	• Oxygen and suction in place • Patient in this room would require specialling, as NO call bells • Storage area • This room should not	• Staffing levels would need to be reviewed •Patient in this room would require specialling, as NO call bells	• Pharmacy dispensary would require re-locating	**5 x 5 = 25**

				be used as an admission area over a maximum time of 1 hour			
E7	Treatment Room	1		• Oxygen and suction in place • Patient in this room would require specialling, as NO call bells • Storage area • This room should not be used as an admission area over a maximum time of 1 hour	• Staffing levels would need to be reviewed • Patient in this room would require specialling, as NO call bells	• Pharmacy dispensary would require re-locating	**5 x 5 = 25**

	ITU		24 physical bed spaces Funded for – 17 x Level 3 equivalent often therefore use 20-21 spaces (have been known to use 22-23 in severe winter acuity periods)	• *Fully serviced* • *Only 1 disabled toilet and shower for the entire department* *Would trigger a single sex breach as cannot be single sexed due to acuity needs of acutely unwell patients*	•*Staff required* • *Nursing Staff required* **Lack of provision for patients requiring level 2 and level 3 care in cases of outlying**		**5x5=25**
	Theatre	Recovery		•No beds • Small spaces • Privacy and dignity issue • Single sex only • Isolated Unit **Only one toilet, no wash facilities**	•Nursing and Medical staff required **If activity cancelled – income implications and cost expenditure with unused theatre slots. High cost if need to provide further staff.**	•Would need all equipment **Would need to consider this area will still be used to recover patients**	**5x5 = 25**

D	DSU	Recovery area		• No beds • No meal provision • Small spaces • Privacy and dignity issue • Single sex only • Isolated Unit • Unable to accommodate visitors due to areas still being used as recovery also • No call bells • No medical cover	• Staff required • If activity cancelled – income implications	• Would need all equipment • Would need to consider this area will still be used to recover patients	**5x5 = 25**
	D level Orthopaedic beds	17	4	• *Fully serviced*	• *Staff required*	•	**Tba**
	D5	DOSA	8	• Fully serviced	• Staff required 24/7 with expertise of	• Impact on next day Theatre Cases and	**5x4 =20**

					patients within area – staff in area only used to nursing elective patients **Cost implications if causes activity cancellations**	admission pathway (Monday – Friday) could lead to cancellation of surgery	
	D6	Joint School	4	•Fully serviced bay	•Staff required – 1 RN	•Joint school would need relocation **Significant kit removal and relocation**	**5x5 = 25**
	D8		8 (unfunded at weekends)	•Fully serviced bays	•Staff required **Potential to cancel activity if full on Monday**	•Impact on Monday elective admissions	
	D8	Treatment Room	1	• Fully serviced	• Staff review may need to take place	• Unable to see all emergency admissions and therefore will impact on ED	
	Endoscopy recovery			•No beds • Small spaces • Privacy and dignity issue • Single sex only • Isolated	•Staff required overnight and daytime weekends •If activity cancelled – income implications	•Impact on day cases following day	**5x5 =25**

				Unit •Fully serviced			
C	CDU	Day ward trollies	7 (variable depending on next day activity and staffing for the night)	•No beds • Small spaces • Privacy and dignity issue • Single sex only • Isolated Unit •Fully serviced	•Staff required overnight and daytime weekends •If activity cancelled – income implications	•Impact on day cases following day	**4x3 =12**
	MAU	Ambulatory	5	•No beds, •small spaces • privacy and dignity issue •single sex only •Fully serviced	•Staff required overnight **Equipment required**	• Impact on next day ambulatory service	**5x5=25**
	ED	Obs ward	9	• Fully serviced and staffed	• Staffing levels would need to be reviewed	• Impact on short stay provision	**2 x 2 = 4**

	C7 Coronary Care Unit	Pacing Room	1	• Fully Serviced • Storage area • Pacing Room • This room should not be used as an admission area over a maximum time of 1 hour	• Staffing levels would need to be reviewed	• Clinical room used for weekly Tilt testing service diagnostics and emergency external pacing	**5 x 3 = 15**
	C6	Treatment Room	1	• Oxygen and suction in place • Patient in this room would require specialling, as NO call bells • This room should not be used as an admission area over a	• Staffing levels would need to be reviewed • Patient in this room would require specialling, as NO call bells	• Research Room – would require relocation of research equipment prior to use	**5 x 5 = 25**

				maximum time of 1 hour			
	C5	Treatment Room	1	• Oxygen and suction in place • Patient in this room would require specialling, as *NO call bells* • Storage area • This room should not be used as an admission area over a maximum time of 1 hour	• Staffing levels would need to be reviewed • Patient in this room would require specialling, as NO call bells	• Impact on Venesection service which runs daily from this area. Would require alternative space to provide this	**5 x 5 = 25**
	Respiratory Day	Day ward trollies	4	•No beds, •small spaces, •privacy and	•Staff required overnight and daytime weekends	•Impact on day cases following day	**25**

				dignity issue, •single sex only •Isolated •Fully serviced	• If activity cancelled – income implications		
Maternity	B5		12	•Females only •Fully serviced **Psychological impact if utilised for Gynae** • Nurses will be required as midwives cannot staff this area	•Staff required – Registered Nurses	•	**3x2 = 6**
Paeds			4	•Fully serviced **Only available to Gynae to use**	•*Staff required- Registered Nurses*	•	**Tba**
Gynae	A6	unfunded	2	•Fully serviced	•Staff required	•	

Appendix 2

SOP for the Minor Injuries Unit
When there is a delay in first assessment of patients or when capacity exceeds staffing

Background
The MIU in Gosport is staffed by 2 ENPs on duty per shift. Currently two ENPs work from 07:30 to 15:30 and two work 13:45 to 21:45. In addition, an HCSW is on shift between the hours of 13:45 and 21:45 to assist with treatments etc. At times the department experiences extended waits to be seen for a variety of reasons. This includes large numbers attending, complex treatments (ie extensive suturing), and complex patients that require extended time to assess and manage (ie elderly fallers). This SOP outlines the action to take at the MIU when the waiting times begin to increase and reach a 2 hour+ wait.

2 hours from time of arrival
When a patient has been in the MIU for two hours the ENPs must escalate this to the nurse in charge at the ED (bleep 1170). Details that need to be communicated to the NIC at the time of escalation are:

- Total number of patients in the MIU
- Number of patients waiting to be seen
- Longest wait for patients waiting to be seen
- The plan for a patient who has been seen but still in the dept. (ie what is the plan to discharge the patient before 4 hours from time of arrival)
- Reason for the delay if patients have waiting two hours for their initial assessment
- Action taken to remedy situation (see and treat implemented; late staff due in shortly; ambulance control contacted etc)

The NIC must escalate this to the DHM. If the delay is due to large numbers of patients attending or there are more than six patients in the department who have waited two hour to be assessed a review of staffing must take place to see if ENPs can be diverted from the ED if the situation does not resolve (ie prepare to divert the late / twilight at QA to the MIU; identify staff who live in the Gosport area who may be able to assist for a few hours)

3 hours from time of arrival
When a patient has been in the MIU for three hours (whether assessed or not) the ENPs must again escalate to the nurse in charge at the ED (bleep 1170). Details that need to be communicated to the NIC are as above. See and treat must already have

been implemented. The NIC is then to escalate to the DHM accordingly. A decision to divert or call in additional staff to the MIU must be taken.

Action to take in the evening when there is a delay

The MIU is open to the public until 21:00 hours. The late shift does not finish until 21:45. Escalations should be made as outlined previously throughout the shift so that by the time the evening arrives the situation should have been rectified.

However, on occasions when the number of patients arriving at the MIU in the evening are such that a delay in first assessment develops and there is a risk that those waiting to be seen will not be seen before the unit is scheduled to close at 21:45.

Escalation should be made promptly to the NIC of ED, identifying the number of patients waiting and the presenting complaints of those in department at the time.

See and treat must be implemented to ensure rapid turnaround of patients where possible.

Action must be taken as to whether additional staff can be called to the MIU to assist.

If after implementing all actions the patients continue to arrive in large numbers and the wait continues to increase the ENP must inform the NIC promptly.

The NIC must then discuss with the on-call consultant and the DHM and a decision taken as to whether the on-call exec needs to be contacted. If the decision is taken to close the unit **the front doors must be left open and not locked.** If patients arrive after the unit has been closed to new attendances reception must inform the patients that due to high demand the unit has closed and that they should return the following day, or attend the ISTC or the ED. If the a patient looks unwell or is complaining of chest pain / SOB etc they must be booked in, and assessed for suitability to be diverted to the OOHs GP or whether a 999 ambulance needs to be called rather than the patient being turned away from the MIU. The receptionist must keep a log of the number of patients that arrive after the unit has closed to new attendances for audit purposes.