# Emergency Department Capacity Management and Closure Policy (ED Policy) v3

## Effective 16th August 2010

## Contents



**Useful Numbers:**

| | |
|---|---|
| **LAS Control Room** | **020 7921 5197** |
| **NHS London NHS01** | **0844 822 2888 – ask for NHS01, leave contact details** |

**Document History**

| Version | Date / Updated By | Comments |
|---|---|---|
| 1 | 2008/9 | Initial Policy |
| 2 | 2009/10 | Updated following review of use in 2008/9 |
| 3 | 2010/11<br>Richard McEwan | 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. |
| **Document Filing** S:\Performance\Performance Improvement\A&E & Winter Planning\Winter 2010 - 11\Final Versions\Emergency Department Capacity Management and Closure Policy v3 Final .doc | | |

# 1.0 Introduction

**1.1** The aim of this Policy is to ensure that 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** This Policy aims to ensure that ED capacity across London is proactively managed in order to ensure patients are not delayed in receiving appropriate care. Version 3 of this Policy replaces earlier versions which should be removed and destroyed. This updated version has been agreed by NHS London, the sectors and London Ambulance Service NHS Trust (LAS).

**1.3** This Policy is produced as a result of learning from hospital capacity pressures and constraints during the winters of 2008/9 and 2009/10 and the subsequent use of previous policies to manage the pressures generated.

**1.4** Re-directing or closing hospital EDs can result in increased clinical risk to the patient as well as increased pressure on other local services. Formal re-direction 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 have failed to relieve the pressure.

**1.5** For the purposes of the enacting of this document, a re-direction or closure of an ED is defined as:

- **Re-direction – self presentations* and all blue lights** still accepted.**
- **Closure – self presentations* and all blue lights** not accepted.**

*Ambulatory patients for co-located WICs or MIUs would in most circumstances continue to be accepted, except infrastructure failure.

** For the purposes 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 Department will have been pre-alerted to the patient arrival.

**1.6** **For a full understanding of the context into which this policy fits, it should be read in conjunction with the NHS London Pressure Surge Planning and Management Arrangements, issued in July 2010.**

# 2.0 Objectives

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

**2.2** To agree consistency around main escalation activities and processes according to an agreed common threshold.

# 3.0 Capacity Management System (CMS)

**3.1** In previous years, several attempts have been made to run systems designed to collect information across the capital which can be used to measure the relative levels of pressure being experienced by the system, and use this to help manage the load effectively.

**3.2** This year will see the use of the Capacity Management System (CMS) in London from October 2010. This system is already in use in a number of different parts of the country, and has proved successful in helping them to manage pressures. The system provides a near real time view across the Capital of the relative pressures being faced by acute trusts, across a range of indicators.

**3.3** Sectors and acute trusts / PCTs will use this information to inform teleconferences to discuss the current range of issues being faced and the actions being taken as a consequence. It will be extremely important for all trusts to complete the data, including Foundation Trusts, so that a complete picture of 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 pressures, and are in a position to offer mutual aid, including taking re-directed patients.

## 4. Ambulance turnaround times & LAS Initiated re-directions

**4.1** **Queuing greater than 15 minutes.** In the event that the capacity in an ED comes under pressure and patient and clinical handover between LAS and acute trust exceeds 15 minutes, it is the acute trust's responsibility to attempt to resolve these issues as quickly as possible. If resuscitation facilities have reached capacity, Major Trauma Centres must alert LAS (via clinical co-ordination desk) on **020 7343 6210**. LAS may decide to re-direct some resus cases to local trauma centres if this is the case. All other acute trusts must alert LAS control room on **020 7921 5197** and the trust must take all reasonable steps to create resuscitation capacity.

**4.2** **Queuing greater than 30 minutes**. If these capacity issues result in the patient and clinical handover exceeding 30 minutes, an LAS senior manager will alert the acute trust's on–call manager of the delays. An LAS officer will be sent to the ED to undertake a capacity assessment if three patients have been delayed for 30 minutes or over, ensure appropriate escalation is in place and work with ED staff to resolve the issues.

**4.3** If more than three patients have waited more than 30 minutes for an appropriate handover to the ED, LAS will proactively request ambulances to take patients to alternative places of treatment (i.e. alternative EDs in the vicinity) with shorter waiting times. This may result in moving patients out of area; however, the expedient handover of patients to a place of appropriate clinical care is of paramount importance.

**4.4** Should LAS decide that a full redirection of patients away from an ED that is experiencing handover delays is required (4 or more patients waiting over 30 minutes for handover), the following arrangements apply:

- The LAS will inform the on-call director at the relevant sector (both in and out of hours) which EDs the LAS have nominated to receive patients. The sector will arrange for notification of the receiving trusts as a matter of priority as well as contacting the trust on re-direction to discuss the situation. (Contact arrangements TBA locally).
- The sector will also contact neighbouring sectors, if ambulances are likely to be re-directed outside of the sector's own border and will notify NHS London (senior performance managers in hours, NHS01 out of hours) that a re-direction has been agreed.
- The SHA will alert neighbouring SHAs if their area is likely to be impacted.
- The sector will contact any out of London area trusts who may be impacted by the re-direction.
- LAS will notify external ambulance services of the situation if appropriate – e.g., East of England.
- Where possible, re-directions should be timed to occur, at least 30 minutes after the sector has been notified, in order to allow receiving trusts to be contacted before potential patients start arriving.
- The redirection will be reviewed at hourly intervals by the LAS and the re-directed trust. The redirection will continue until the LAS make the decision to cease it in conjunction with the acute trust and sector.
- It is important to note in these circumstances that the re-directed ED will continue to receive "blue lights".
- Patients that are receiving active ongoing treatment from a trust suffering ED delays, e.g. maternity or dialysis, will not be redirected to alternative locations. The Trust should ensure that LAS crews have direct access to the destination departments within the site.

**4.5** When redirecting patients LAS will nominate as many EDs as possible in the surrounding area to receive patients in order to ease the burden on all the surrounding EDs. The number of additional patients each nominated ED will receive will vary according to catchment area and current call volume, but is very unlikely to exceed 3 extra patients per hour.

**4.6** **Queuing greater than an hour.** Patients that have not received a patient and clinical handover for over 60 minutes are at major clinical risk. There is also a major clinical risk for patients waiting for ambulances that cannot be attended to in an appropriate time period because the ambulances are tied up at EDs. The on-call director of the relevant trust will be made aware of any patients waiting more than 1 hour. The LAS will also report these patients to the relevant Sector and NHS London within 1 working day of the incident. For each patient waiting more than 1 hour a Serious Untoward Incident (SUI) needs to be declared. The SUI will be owned by the acute trust and it will be their responsibility to investigate and report against. Investigations, where appropriate, should involve LAS input.

LAS and acute trusts need to ensure good administrative handover processes, including timings to provide a more accurate picture of performance, and eliminate disagreements over handovers.

## 5.0 Escalation within the sector

**5.1** If two or more neighbouring EDs have delays exceeding 60 minutes, these will be reported to the sector by the LAS.

**5.2** The sector will contact the relevant trusts and seek an explanation and discuss the actions being undertaken, as well as considering the need for a sector conference call to discuss the rising pressures.

## 6.0 Emergency Department re-direction (*all blue light emergency conveyances still accepted*) resulting from Trust Capacity Issues

**6.1** If an acute trust is experiencing an extreme capacity shortage, resulting in a potential threat to patient safety, they may contact the sector on call director to negotiate a time limited re-direction or closure. This can only be requested if the escalation activities listed at the end of this policy have been implemented and have failed to stem the growing pressure threat.

**6.2** Any trust which has not implemented the full range of escalation activities, before contacting the sector to request a re-direct, will not be granted a re-direction, unless there is a potential threat to patient safety, and that it is clear and agreed by the sector that the failure to re-direct would result in the otherwise preventable harm of patients. If this is agreed, it is expected that the sector would rigorously performance manage the full and immediate implementation by the trust of the designated escalation activities, in order that the length and number of re-directions, and the resultant impact on the surrounding organisations, can be minimised.

**6.4** Rising pressure will be visible through the information on CMS (and conference calls if needed). Trusts under pressure will, in consultation with the sector handle the consequences of pressure increases, according to their own internal escalation plans. If pressures continue to rise, the sector will need to provide co-ordination and direction on the availability and scope of mutual aid.

**6.5** **Re-direction agreed – actions required:**

- If a re-direction is agreed by the sector, the sector will notify the LAS Gold via the LAS control room **( 020 7921 5197 )** of the time and duration. The sector will also 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 the organisations pressure surge plans.

- A redirection can be arranged for four hours maximum, with a conference call, arranged by the sector, timed to convene after two hours in the case of a four hour re-direction, to review the situation and agree the need for likely continuation after the four hours has elapsed. Conference calls should include as a minimum, the sector, the LAS, the re-directed trust and receiving trusts. Appropriate PCT participation should also be included.
- Re-directions will automatically lapse after their agreed duration, unless specifically authorised for extension by the sector.
- The sector will notify NHS London in hours via their usual performance contact (who will ensure that the relevant personnel at the SHA are informed e.g., NHS01), and out of hours via NHS01 of any re-direction agreed, their duration and their remedial actions.
- NHS London (senior performance managers) will liaise with neighbouring SHAs if required and LAS will notify external ambulance services of the situation if appropriate – e.g., East of England.

## 7.0 Emergency Department closure (*includes to all blue light emergency conveyances*) resulting from capacity issues

**7.1** Acute trusts cannot make a decision themselves to close tertiary services (e.g., trauma, burns etc) or to "blue lights" as a result of lack of resuscitation, majors, ITU, HDU, CCU, general or acute bed capacity. If a trust wishes to close its ED due to capacity issues then the trust Chief Executive will need to request this personally from the sector. As with a re-direction, the same circumstances will apply, with regards to the relevant escalation actions having been fully undertaken. The sector will in turn contact NHS London Gold, contact made via NHS01* for approval. Following agreement from NHS London Gold that a trust may close their ED as a result of capacity issues then NHS Gold will inform LAS Gold, via the LAS control room **( 020 7921 5197 )**.

* NHS01 can be contacted via 0844 822 2888 and ask for NHS01 then leave your contact details**.**

**7.2** The closure of an ED department due to capacity issues is an extremely significant event, attracting media attention and Department of Health scrutiny. It will be viewed as sufficient cause for NHS London to implement command and control arrangements for the sector. (See section 11 of the Pressure Surge Planning and Management Arrangements 2010/11, issued by NHS London in July 2010 to all Sectors for immediate cascade).

## 8.0 Emergency Department closure *includes to all blue light emergency conveyances*) resulting from infrastructure failure

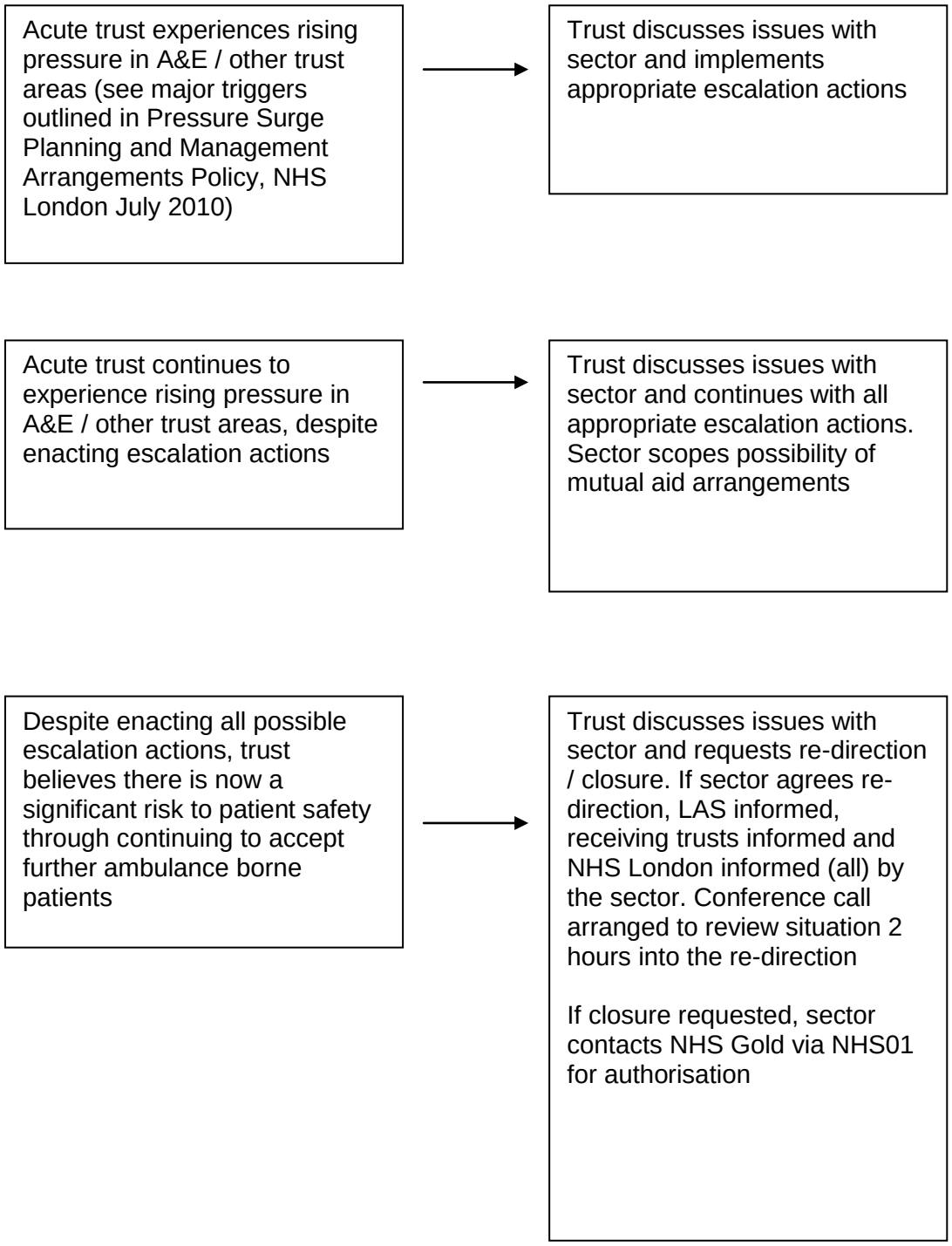
**8.1** Closure to "blue lights" will only be accepted in the event that the hospital is not able to provide ED and resuscitation facilities due to infrastructure failures, for example flood, electrical failure, fire. Closure of an ED should only be considered as a last resort as it may subject the most seriously ill of 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.

**8.2** In cases where an internal Major Incident is declared, and the hospital is unable to keep its ED open, then the hospital will need to inform the LAS via the LAS control room **( 020 7921 5197 )**. The ED will be considered as closed and no further ambulance borne patients will be brought to that ED until LAS is notified that the crisis has passed. The on-call hospital director MUST then inform the LAS of the expected timescale of the closure/next review.

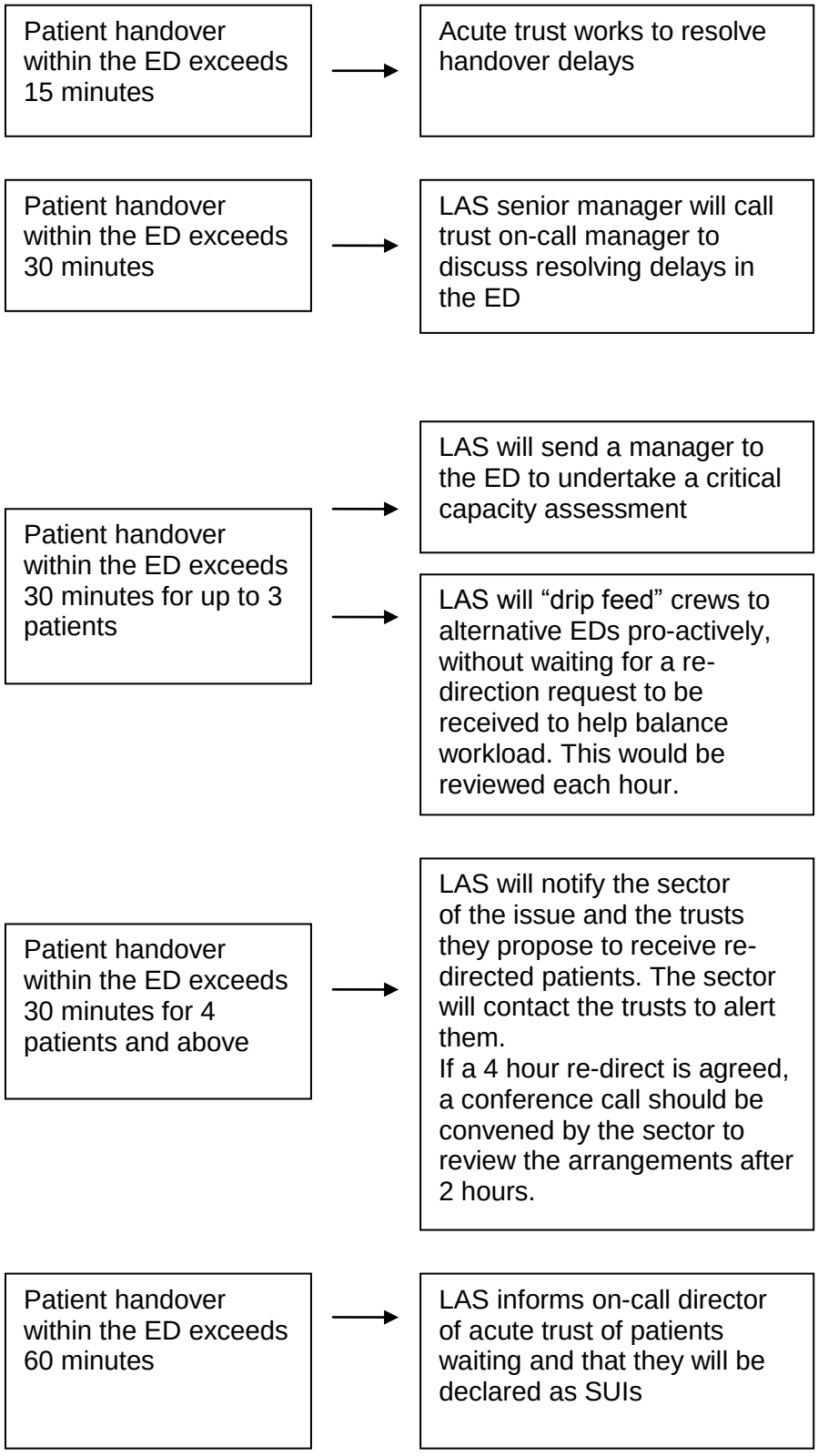
**8.3** The Chief Executive, or their nominated deputy, needs to notify the NHS London NHS01* of their intention to close as a result of an internal Major Incident, the reason for this closure, and expected duration. NHS01 will inform NHS Gold.

* Contacted via 0844 822 2888 and ask for NHS01 then leave your contact details**.**

**Summary flowchart of the NHS London Emergency Department Capacity Management and Closure Policy – Trust triggered actions**



**Summary flowchart of the NHS London Emergency Department Capacity Management and Closure Policy – LAS triggered actions**



## Escalation Actions Checklist

These actions have been agreed as requiring implementation as early as possible as pressure starts to build, in order to try to minimise the need for re-direction or closure to have to be considered and should **have been taken before contacting the sector to request a re-direction or closure of the ED due to capacity constraints.**

| Escalation Activity | Completed |
|---|---|
| **Acute trust – managing and reducing demand** | |
| • A&E consultants to be fully deployed to the A&E shop floor. | |
| • 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. | |
| • Maximisation of alternative care pathways, prior to arrival of patient at A&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:<br>o Advising on more appropriate care pathways (e.g., community based) for specific patients or conditions.<br>o Enabling access to diagnostics not normally directly available to primary care.<br>o Re-assurance to GPs about patients on "care of the dying", pathways.<br>o Brokering urgent OPD appointments in other consultant clinics, to avoid unnecessary admissions to hospital etc. | |
| • GP patients (not calls) sent directly to a ward or Admissions Unit rather than via ED | |
| **Improving supply – Acute trust** | |
| • All inpatients reviewed early in the morning for discharge by consultants before 10am. | |
| • "Case conferences" between consultants, medical directors and managerial staff to review all inpatients individually and agree appropriateness of continued stay. | |
| • Opening of all possible extra escalation capacity, private wards etc. | |
| • 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. | |
| • Maximisation of use of day case and laparoscopic procedures to maintain elective programme, but reduce requirement for beds. | |
| • Cancellation of all clinically non urgent electives (including private work) / transfer of work to private sector. | |
| • Consideration given to cancellation of some urgent electives / move of work to other NHS trusts / transfer of work to private sector. | |
| • 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. | |
| • Inclusion of Social services, PCTs, LAS etc in A&E bed meetings to ensure actions required are understood by the whole system. | |