NHS London
Emergency Department Capacity Management and Closure Policy

Effective Monday 16 November 2009

1. 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. This Policy replaces the previous London Ambulance Service Divert and Closures Policy. It has been agreed by NHS London, North West London Commissioning Partnership (host commissioner) and London Ambulance Service NHS Trust (LAS).

1.3 This Policy is produced as a result of learning from hospital capacity pressures and restraints during the winter of 2008/9 and the subsequent use of the LAS Divert and Closures Policy produced in December 2008. Diverting or closing hospital EDs can result in increased clinical risk to the patient as well as increased pressure on other local services resulting in increased waiting times in hospital and pre-hospital environment.

2. Objectives

1. **To share the agreed minimum data set, which can be proactively used to manage the demand and capacity of existing ED services served by the LAS.**

2. **To agree the processes by which ED capacity will be managed across London when patient handover in an ED is delayed.**

3. **To agree consistency around escalation policies and processes according to an agreed common threshold.**

3. Emergency Department critical capacity data collection

3.1 All London EDs have agreed to provide an agreed minimum data set which can be proactively used to manage the demand and capacity of the current EDs served by the LAS. The LAS Emergency Bed Service (EBS) will be the central collection point for this demand and capacity data. The data will be reported by each London acute trust that hosts an ED at the following times: 06:00, 10:00, 14:00, 18:00 and 22:00 hours.

3.2 The following demand and capacity data set has been agreed:

- Number of patients in ED Majors (as well as absolute capacity: static info)
- Number of patients in ED Minors (in addition to absolute capacity: static info)
- Number of patients in ED Resus (in addition to absolute capacity: static info)
- Number of patients in ED Paeds (in addition to absolute capacity: static info)
- Number of Decisions To Admit (DTAs) who remain unplaced
- Number of nurses in ED, predicted and actual
- Number of doctors in ED, predicted and actual
- Waiting time for a doctor in ED
- Whether elective surgery has been cancelled or not
- Number of cardiac beds available in the hospital
- Number of general beds available in the hospital
- General comments / free text as appropriate

3.3 EBS has provided each ED with a critical capacity assessment tool (excel spreadsheet) which they are to complete and email as an attachment to ebs.operations@lond-amb.nhs.uk.

3.4 This data will support the LAS to proactively identify areas of London that are under pressure and ensure that an LAS manager is dispatched to support the departments in resolving the issues. The data will also be used to support decision making to ensure, where possible, delays in patient handover and treatment do not occur and that if they do, they are minimised as far as is reasonable and practicable. Failure to submit returns will result in an assumption that the ED has capacity.

4. Ambulance turnaround times

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 resus facilities have reached capacity the acute trust must alert LAS and the trust must take all reasonable steps to create resus 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, 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 consider proactively requesting 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 to redirect patients away from an ED that is experiencing handover delays, the following arrangements apply:

- The LAS will inform the on-call director at the trust from whom patients will be redirected which EDs the LAS have nominated to receive their patients. It is this trust's responsibility to inform their counterparts at these hospitals.

- The LAS will also fax the receiving EDs to inform them they will be receiving additional patients as a result of a neighbouring ED experiencing handover delays. The LAS will also report the decision to redirect patients to the Sector Acute Commissioning Unit and NHS London within 1 working day.

- The redirection will be reviewed at hourly intervals. The redirection will continue until the LAS make the decision to cease it at which point the LAS will send a fax to all the affected EDs.

- It is important to note in these circumstances that the ED will continue to receive blue calls (life threatened patients).

- Patients that are receiving active ongoing treatment from a trust suffering delays, e.g. maternity or dialysis, or where a Trust provides tertiary services (e.g. cardiac, trauma, HASU) will not be redirected to alternative locations.

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 unlikely to exceed 5 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 Acute Commissioning Unit 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.

5. Escalation within the sector

5.1 If two or more neighbouring EDs have delays exceeding 60 minutes, then these will be reported to the Sector Acute Commissioning Units (in hours) and to NHS London Gold via NHS01.

5.2 During the swine flu second wave, under NHS London Command and Control arrangements, when 25% of Trusts are declared at FluCon level 2 daily teleconferences will be held to facilitate a resolution. This is described in the NHS London command and control arrangements for the management of the second wave of the pandemic influenza document.

6. Emergency Department closure resulting from infrastructure failure

6.1 Closure to blue calls (life threatened patients) will only be accepted in the event that the hospital is not able to provide 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.

6.2 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 and NHS London Gold via NHS01. The ED will be considered as closed and no further ambulance bourn 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.

6.3 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.

7. Emergency Department closure resulting from capacity issues

7.1 Acute trusts cannot make a decision themselves to close to blue calls as a result of lack of 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 NHS London Gold. 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.

Summary flowchart of the NHS London Emergency Department Capacity Management and Closure Policy