NHS Commissioning Board
London
Emergency Department Capacity Management, Redirect and Closure Policy (ED Policy) v6
**NHS CB London Emergency Department Capacity Management, Redirect and Closure Policy (ED Policy) v6**

<table>
<thead>
<tr>
<th>Date</th>
<th>12 February 2013</th>
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<tr>
<td>Copy</td>
<td>NHS CB EPRR leads, Assurance Managers.</td>
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<tr>
<td>Description</td>
<td>From 18 February 2013, this document replaces the NHS London Emergency Department Capacity Management, Redirect and Closure Policy (ED Policy) v5</td>
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<tr>
<td>Cross Reference and Links</td>
<td>This Policy should be read in conjunction with NHS CB London Pressure Surge Guidance</td>
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<tr>
<td>Action Required</td>
<td>Version 6 of this Policy replaces earlier versions which should be removed and destroyed</td>
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<tr>
<td>Timing</td>
<td>Effective 18 February 2013</td>
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| Contact Details | richard.mcewan1@nhs.net  
NHS Commissioning Board London, EPRR Team, Southside, 105 Victoria Street, London SW1E 6QT. |

**Document History**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date / Updated By</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>2008/9</td>
<td>Initial Policy</td>
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<tr>
<td>2</td>
<td>2009/10</td>
<td>Updated following review of use in 2008/9</td>
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<td>3</td>
<td>2010/11 Richard McEwan</td>
<td>Updated following review of winter 2009/10, incorporating Trust, sector and LAS feedback and released to the NHS in London for implementation from 16th August 2010. Go live date subsequently amended to 11 October and role of LAS Gold Doctors incorporated</td>
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<tr>
<td>3.1</td>
<td></td>
<td>Replacement of informal / formal redirect concept with immediate / planned, and clarification of requesting and notifying process</td>
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<td>4</td>
<td>2011/12 EP Team/ R McEwan</td>
<td>Updated to reflect changes to the NHS and on-going learning</td>
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<td>5</td>
<td>2012/13 Richard McEwan</td>
<td>Updated with input from PCT Clusters, LAS and London ED Consultants from the College of Emergency Medicine</td>
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<td>6</td>
<td>Feb 2013 Richard McEwan</td>
<td>Updated to reflect new NHS management structures, and including new chapter on temporary closure of EDs due to planned “engineering works”.</td>
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**Document Filing**
S:\Performance\Handover & Closure\Library of Knowledge - Performance\Topics\Planning\Winter Planning\Winter 2012 - 13\Emergency Department Capacity Management and Closure Policy v6.docx
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Appendix A – NHS CB London Coordination Arrangements for Pressure Surge related Incidents (Non Major Incident) | 22   |
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Notes to Version 6

There are three main changes from Version 5.

1) Terminology
This now reflects the changes to the NHS brought about by the Health and Social Care Act 2012, introducing the NHS Commissioning Board London and the CCGs / CSUs.

Throughout the document, the term “CCG / CSU” is used. This is to accommodate local arrangements whereby in some Local Areas, it will be the CCG that will lead the response to pressure surges, including ED redirection requests, and in others, this responsibility has been delegated to the CSU.

*Trusts should ensure they are aware of the arrangements for their locality.*

2) Cross London Border Issues
Section 7 sets out the process to be followed if a Trust in London wishes to redirect to a non London Trust and vice versa. If this situation arises, it is important that the NHS CB London is made aware (p13), so that they can discuss with neighbouring Offices if required.

3) Planned temporary Closure of an ED or Urgent Care Facility for infrastructure related works
A new section (9) includes work carried out by the LAS Commissioners as a result of a number of temporary ED closures that have been required whilst work has been carried out on ED’s, often affecting electrical supplies.

This section sets out the expectations about the planning and assurance work required to be undertaken, before such a closure can be authorised, to ensure local health economies have planned to mitigate the effects of the closure, whilst the work is completed.

This section has been produced and consulted on by the LAS Commissioning team in NW London and they are thanked for their efforts on behalf of London for completing this piece of work.
Contact Numbers/ Call Signs

LAS Control Room: 020 7921 5197
LAS Senior Clinical on-call: (Formerly LAS Gold Doc) Page via LAS control room

The following can be contacted via PageOne on 0844 822 2888 and the call sign below (leave a name and contact details):

NHS Commissioning Board London NHS01

Local Area on Call for ED Redirect / closure discussions:

North East CSU* NELCSU1
North Central CSU** NCLCSU1

NWL: NWLCP01
SEL: SEL1
SWL: SWL1

* North East:
North East CSU – Barking & Dagenham, Havering, Redbridge, Waltham Forest, Hackney, Newham, City, Tower Hamlets

** North Central:
Camden, Islington, Barnet, Enfield, Haringey
1.0 Introduction, Aims and Principles

1.1 ED capacity across London must be proactively managed to ensure that all patients are taken to the nearest Emergency Department (ED) with the appropriate clinical resources to treat that patient’s presenting condition within a clinically appropriate time frame.

1.2 Redirecting or closing a hospital ED can result in increased clinical risk to patients as well as increased pressure on other local services. The following principles apply:

1.2.1 Planned redirect or closure should be based on clinical safety considerations, lead by the ED Consultant, not performance against either the relevant ED or LAS standards.

1.2.2 Planned redirect or closure of an ED due to capacity issues should be the last escalation measure enacted in most situations.

1.2.3 Planned redirect should not be seen as a way of routinely managing Trust capacity issues. (The exception to this may be a split site Trust managing inter site capacity where protocols must have been agreed with CCG/CSUs and LAS).

1.2.4 An immediate redirect can be enacted by LAS to provide brief respite to an ED as a short term measure to reduce pressure and to try to prevent a clinical safety situation being reached. It is not designed to protect LAS response time standards.

1.2.5 At times of high pressure, consultants of relevant specialities should be available to help prevent bottlenecks around the ED from occurring.

1.2.6 Escalation measures with CCG/CSU involvement, should be taken early to reduce the likely need for a redirect.

1.2.7 If a Trust seeks a planned redirect, it must do so via the CCG/CSU in the first instance, not the LAS. This requirement has been reconfirmed by CCG/CSUs.

1.2.8 Capacity issues caused by multiple blue light arrivals within a short period of time are different from that caused by insufficient bed capacity. This is a patient flow issue, which should be solved by whole system escalation to ensure appropriate levels of resource (both clinical and managerial) are applied to providing capacity.

1.2.9 The application of this policy to local conditions may require some tailoring or interpretation. The application of a “common sense” approach to this need is expected by all NHS organisations involved.

1.3 The following definitions apply:

- **Redirect** – self presentations* and all blue lights** still accepted

- **Blue light redirect** - self presentations and non blue lights** still accepted.  
  Cardiac arrest patients and paediatric patients will still be brought to the closest appropriate unit except in cases of critical infrastructure failure

  **Note** – In the case of MTC’s and HASU, non-tertiary blue light patients will be redirected first. Major trauma and stroke patients will continue to be accepted, unless contact is made with LAS as noted under 3.2

- **Closure** – self presentations redirected* and all blue and non blue lights** not accepted

- **Clinical responsibility** – The Acute Trust (hospital) takes full clinical responsibility for the patient from the point of clinical handover or at 15 minutes from arrival of the patient with the
LAS crew at the hospital whichever occurs earlier. Close cooperation and coordination between the LAS and the Trust is essential to ensure patient safety.

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

** A “blue light” is defined as an ambulance borne patient warranting the use of the ambulance’s blue lights on the inbound journey, where the ED will have been pre-alerted (“blue call”) to the patient arrival. **Cardiac arrest and paediatric patients will still be brought to the closest appropriate unit except in cases of critical infrastructure failure.**

1.4 Three types of redirect are described in this policy:

- **Immediate** – Instigated by LAS as a short term (90 minutes) response to provide immediate relief to an ED. LAS to notify CCG/CSU and receiving Trusts (via group paging). *Extensions cannot be agreed without CCG/CSU approval.*

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

- **Blue Light** – may be required where an ED has received over a certain number of Blue lights within an hour (for example Major Trauma Centre (MTC) = 5, other ED = 3) causing capacity issues within the resus facility and may be used to redirect the next blue light away from the ED to allow time for previous conveyances to be cleared (see section 3.2 for more detail). *Other factors including site capacity will be used when deciding if this action is required. The above numbers are not an absolute trigger on their own for blue lights to be redirected.* LAS will report redirects to the CCG/CSU.

1.5 In order to lessen the impact of diversion on any one Trust, it is preferable that a redirect is made to a number of surrounding Trusts (360 degree) instead of just one Trust. In the example below Hospital 1 goes on redirect. The closest surrounding Trusts will be nominated as receiving Trusts, spreading the load so that other Trusts are not overwhelmed with additional ambulance borne patients (blue arrows).

1.6 **Action Cards**

The policy contains quite detailed descriptions of actions required, should a redirect be required. Trusts may find it helpful to create simplified action cards, appropriate to their own circumstances, to help staff making decisions during times of pressure.
1.7 LAS Immediate Redirect Flow Chart

1) LAS uses PageOne to alert receiving hospitals + CCG/CSU (using intelligence gathered from HAS & CMS)

2) Does receiving hospital(s) tell CCG/CSU of circumstances that would indicate a divert is not desirable (e.g. additional data not included in CMS)?

   Yes

   No

3a) CCG/CSU contacts LAS to discuss need for a Planned Divert

5) LAS contacts CCG/CSU to request planned divert

   Yes

   No

3b) Divert activated for up to 90 minutes

4) Further divert required?

1.8 Planned Redirect Flow Chart

1) Trust contacts CCG/CSU to request divert on grounds of safety/quality. CCG/CSU refers Trust to LAS Senior Clinical On-call

2) LAS and Trust agree divert is desirable on grounds of safety/quality and Trust re-contacts CCG/CSU DoC

3) CCG/CSU DoC contacts neighbouring Trust(s) to negotiate divert

4) Receiving Trusts agreed

7) LAS/Trust contacts DoC a minimum of 30 minutes in advance of the end of the current divert to request extension.

   Yes

   No

5) Divert activated for up to 4 hours

6) Further divert required?
2.0 **Capacity Management System (CMS)**

2.1 The Capacity Management System (CMS) provides a near-real time view across a range of indicators of the relative pressures being faced by acute Trusts.

2.2 Information update frequency:
- ED information in CMS should be updated every two hours, 24 hours a day.
- Bed state information should be updated every four hours between 06.00 and 22.00.

2.3 CCG/CSUs and acute Trusts will use this information and live Hospital Based Alert (HAS) data to inform the discussion of issues being faced and actions being taken. If organisations do not keep the information up to date, it will be assumed that they are not experiencing capacity pressures, and are in a position to offer mutual aid, including taking redirected patients.

2.4 If Trusts need to redirect, it is particularly important to ensure that information is up to date on CMS, so that they have the relevant information to discuss with the CCG/CSU.

2.5 LAS will look to use CMS and HAS information to help manage pressures at EDs across London but it is not the only consideration which will affect where ambulances are directed. A poor score on CMS will not automatically result in ambulances being redirected.

3.0 **Ambulance turnaround times, LAS initiated redirects and CCG/CSU escalation**

The Acute Trust (hospital) takes full clinical responsibility for the patient from the point of clinical handover or at 15 minutes from arrival of the patient with the LAS crew at the hospital whichever occurs earlier. Close cooperation and coordination between the LAS and the Trust is essential to ensure patient safety.

3.1 **Queuing greater than 15 minutes.** In the event that patient handover at the acute Trust exceeds 15 minutes, it is the acute Trust’s responsibility to attempt to resolve these issues as quickly as possible.

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

**Resus Capacity Issues:**

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

- Major Trauma Centres / HASUs must alert LAS via the Clinical Coordination Desk on **020 7343 6210**. LAS will try to redirect the next one to two blue lights to local trauma centres to give time for resus bays to become available to receive a further major trauma or stroke patient.

- If other EDs have immediate clinical concerns due to resus capacity they must speak to the LAS Control Room on **020 7921 5197** who will notify LAS Senior Clinical on-call, and attempt to move the next inbound blue light away from the unit to create a short term respite during which resus capacity can be managed. The ED consultant, if not in the department, should have been alerted to the situation, and should be on their way into the Trust, due to the patient safety issues involved. LAS will report blue light redirects to the CCG/CSU.
Capacity issues caused by multiple blue light arrivals within a short period of time (e.g., one hour) are different from that caused by insufficient bed capacity to move patients into once they no longer require a resus bed. This is a patient flow issue, which should be solved by whole system escalation and action, including the declaration by the Trust of an Internal Incident if required, to ensure that appropriate levels of resource (both clinical and managerial) are applied to swiftly freeing up (or creating additional) capacity. They should not be managed through redirects, unless all other escalation actions have been previously taken and have failed to resolve the situation. In these circumstances, Trusts should seek to escalate via the CCG/CSU, not the LAS.

3.3 Immediate redirect
LAS may instigate a short-term redirect considering the following points:

- The redirect will be for 90 minutes only.
- CMS and HAS data will be used to help determine which Trusts patients may be redirected too.
- Receiving Trusts will be notified by LAS through the secondary paging number. Trusts who have not signed up to this service, will still receive redirected ambulances, but will receive no prior notification of the redirect.
- When redirecting patients LAS will nominate as many EDs as possible in the surrounding area.
- The CCG/CSU will also be informed by LAS via pager – immediate redirects cannot be rolled over without the agreement of the CCG/CSU.
- 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 three patients in an hour.
- If a receiving Trust wishes to make LAS aware of other relevant circumstances, they must do so through the CCG/CSU.

3.4 Planned redirect.
If LAS decide that a planned redirect is required, the following applies:

- LAS will contact the CCG/CSU on-call director to seek authorisation of the redirect and discuss receiving Trusts.
- The CCG/CSU will notify the receiving Trusts, including those outside of London and contact the Trust on redirect to discuss the situation. Designated receiving Trusts should discuss any concerns around this with the CCG/CSU.
- The CCG/CSU will contact neighbouring CCG/CSUs if appropriate
- LAS will notify neighbouring ambulance services of the situation if they will be affected.
- Redirects should be timed to occur at least 30 minutes after the CCG/CSU has been notified, in order to allow receiving Trusts to be contacted before patients start arriving.
- The redirect will cease following agreement between the LAS, the Trust and the CCG/CSU.
- The redirected ED will continue to receive “blue lights”.
- Patients receiving active ongoing treatment from a redirected Trust (e.g. maternity care or dialysis), or who are on a pre-planned or resourced pathway (e.g. stroke patients to HASU), will not be redirected. The Trust should ensure that LAS crews have direct access to the destination departments within the site.

3.5 Queuing greater than one hour.
Patients may be at major clinical risk if ambulances are queuing for more than 60 minutes for handover. The following actions should be taken:

- Trusts should use the inbound HAS screen to monitor pressure mounting in the department and to trigger appropriate escalation actions in response to lengthening handover delays.
- 60 minute patient handover waits recorded via HAS will be tracked via NWL’s Hospital Turnaround & Patient Handover Portal 24 hours in arrears.
- Trusts are required to carry out a daily review of all 60 minute patient handover waits tracked via NWL’s Hospital Turnaround & Patient Handover Portal.
All tracked 60 minute patient handover waits must be validated in line with the 2012/13 60 Minute Patient Handover Breach Validation Process (include in appendix).

All tracked 60 minute patient handover waits under dispute must be owned and investigated by the Trust and declared as a potential Serious Incident (SI) for investigation. Where required investigation should involve LAS input.

CCG/CSUs will review evidence provided by the Trust within the timescales agreed and make a decision regarding the occurrence of an SI in line with local CCG/CSU protocols and processes.

For each validated 60 minute wait a Serious Incident (SI) will be declared.

Appendix B gives further details regarding 1 hour breaches and the agreed reporting definitions and responsibilities.

Note: Although this Policy is primarily concerned with issues affecting the ED, the arrangements also cover Trust Tertiary services if they need to redirect or close, including ITU, HASU and Cardiac Care

4.0 Emergency Department planned redirect due to Trust patient safety concerns

4.1 Situation:

- Trusts should have implemented appropriate escalation activities, including those listed in Section Eight prior to requesting a redirect.
- Following this, they may contact the CCG/CSU on-call director to negotiate a planned redirect. This request, made on clinical safety grounds should come from either the Trust Medical Director or ED Consultant (in hours) or the ED Consultant or bed manager (out of hours) following a conversation regarding the issues and actions.
- The CCG/CSU on-call Director will refer the Trust to the LAS Senior Clinical on-call, to discuss the clinical safety issues (contact via the LAS Control Room on 020 7921 5197 and ask for LAS Senior Clinical on-call to be paged, leaving mobile number).
- If the LAS Senior Clinical on-call agrees with the clinical safety concerns, the Trust must contact the CCG/CSU Director to confirm that a redirect can be initiated and the duration.

4.2 Planned redirect agreed – actions required:

- Receiving Trusts must be nominated and informed, as well as LAS Gold (via the LAS control room 020 7921 5197) of the time and duration) The CCG/CSU is responsible for informing nominated receiving Trusts.
- A redirect can be arranged for four hours maximum. A CCG/CSU-arranged conference call, will review the situation and agree any need for continuation. Conference calls should include the CCG/CSU, the LAS, the redirecting and receiving Trusts.
- Redirects will automatically lapse after their agreed duration, unless specifically authorised for extension by the CCG/CSU.
- The CCG/CSU will notify NHS London of any redirect agreed, the duration and the remedial action. In hours this will be via the Performance Directorate, and out of hours via NHS01.
- In and out of hours, LAS will notify neighbouring ambulance services of the situation.

4.3 If a redirect is agreed it is expected that the CCG/CSU would performance manage the implementation by the Trust of the designated escalation activities.
5.0 Emergency Department closure due to Trust patient safety concerns

5.1 Situation:
- Acute Trusts cannot make a unilateral decision to close EDs or tertiary services (e.g., HASU, burns etc) due to a lack of capacity.
- In and out of hours, if a Trust wishes to close its ED or tertiary service the Trust Chief Executive (or in exceptional circumstances, their nominated deputy) will need to request this personally from the CCG/CSU.

5.2 CCG/CSU agrees with Closure request – actions required:
- The CCG/CSU will contact NHS CB London Gold via NHS01 for approval. If agreed, NHS Gold will inform LAS Gold, via the LAS control room (020 7921 5197) and NHS01 who will inform comms for information only.
- NHS01 will ensure that colleagues from the Ops and Delivery directorate are aware.
- The CCG/CSU will contact Trusts who will be affected.
- LAS will notify neighbouring ambulance services of the situation.

5.3 ED closure due to capacity issues may be sufficient cause for NHS CB London to trigger command and coordination arrangements. (Appendix A).

6.0 Emergency Department closure due to Trust infrastructure failure

6.1 Closure of the ED or tertiary services to “blue lights” will only be accepted in the event that the hospital is unable to provide ED and resuscitation facilities due to infrastructure failures, for example fire, flood, major electrical failure etc.

ED or tertiary service closure should only be considered as a last resort as it may subject the most seriously ill patients to increased clinical risk as a result of travelling further to receive immediately life-saving treatment. GP calls will be expected to be sent directly to a ward or Admissions Unit rather than via A&E if practical.

6.2 In cases where an internal Major Incident is declared, Trusts are expected to follow their Major Incident Plan, which includes notifying LAS (via the LAS control room 020 7921 5197) and NHS01.

6.3 The Trust will:
- Agree the need for the closure with the CCG/CSU via the On-call Director.
- Inform NHS CB London via NHS01.

NHS CB London will:
- Inform NHS Gold and inform comms for information only (NHS01).
- In hours, ensure that relevant Ops and Delivery directorate leads are aware (NHS01).

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

LAS will:
- Notify neighbouring ambulance services of the situation if required.
7.0 Issues affecting non London Trusts

London Trust wants to redirect to a non London Trust

- London Trusts cannot redirect to non London trusts except by prior agreement, as part of pre-agreed escalation plans.
- The receiving Trust must be contacted prior to a redirect taking place to ascertain ability to take divert and gain permission to do so. As with a redirection to a London Trust, permission must be sought from the CCG/CSU before action is taken.
- If a conference call is arranged, to discuss the redirection, non London Trusts must be invited to attend if they will be affected.
- LAS should notify other out of area ambulance services if a redirect is agreed.
- If a London Trust redirects out of area, the CCG/CSU should notify the NHS CB London via richard.mcewan1@nhs.net (in hours) so that they can discuss with neighbouring NHS CB Offices. If the event takes place out of hours, they should notify as soon as possible, the next working day.
- If this occurs over a weekend, and appears to be part of a larger building pressure surge, which may require NCB London command and coordination arrangements to be invoked, NHS01 should be made aware.

Non London Trust wants to redirect to a London Trust

- The same arrangements must be followed in reverse, if a Trust outside of London wants to redirect to a London Trust – i.e., the receiving trust must agree prior to the redirection being effected.
- If a London Trust agrees, it should notify the CCG/CSU so that they are aware of any likely impact, and so that they can become involved in any discussions regarding the duration of the redirect at a later stage if required.
- The relevant Ambulance service will ensure that LAS are made aware, making contact via the control room.

Informing NHS CB Offices if an event is likely to impact outside their area:

- In Hours – The EPRR Team will notify NHS CB London Assurance Managers who will contact their counterparts in the NHS CB Offices to notify and discuss the situation, once informed by CCG/CSUs.
- Out of Hours – Notification will be via Assurance managers, once alerted, the next working day.
- Major Incident – follow major incident Policy.

Neighbouring areas informing NHS CB London – the same arrangements as above will apply if there is an issue outside the borders of London.
8.0 ED Escalation Actions Checklist
The following actions require implementation as early as possible when ED pressure starts to build in order to minimise the need for redirect or closure.

<table>
<thead>
<tr>
<th>Escalation Activity</th>
<th>Completed</th>
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<tbody>
<tr>
<td><strong>Acute Trust – managing and reducing demand</strong></td>
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<tr>
<td>• There should be senior clinical leadership (i.e., consultant level) immediately available within the A&amp;E department.</td>
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<td>• All on call consultants informed and asked for support in reviewing their areas of responsibility to free up capacity in the system where possible.</td>
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<td>• All patients in resus or majors to have initial assessment by registrar or consultant grade, to determine appropriateness of attendance or need for admission – re-direction wherever possible and not life threatening, all admissions to be reviewed and agreed by a consultant.</td>
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<td>• Waiting room to be screened for those who need care by senior nurse.</td>
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<td>• Maximisation of alternative care pathways, prior to arrival of patient at A&amp;E, through telephone triage of all GP referrals for admission, led by consultants (e.g., acute physicians, not necessarily ED consultants – see above) to ensure that admission levels are kept to a minimum, including:</td>
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<tr>
<td>o Advising on more appropriate care pathways (e.g., community based) for specific patients or conditions.</td>
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<td>o Enabling access to diagnostics not normally directly available to primary care.</td>
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<tr>
<td>o Re-assurance to GPs about continuing to manage patients on “care of the dying” pathways at home, rather than admitting to hospital.</td>
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<td>o Brokering urgent outpatient appointment in other consultant clinics, to avoid unnecessary admissions to hospital etc.</td>
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<tr>
<td>• GP patients (not calls) sent directly to a ward or Admissions Unit rather than via ED or to alternative site within same Trust if relevant</td>
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**Acute Trust - Improving supply**

• All inpatients reviewed early in the morning for discharge by consultants before 10am, followed by second ward round later in the day.

• “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, Borough’s, LAS etc in A&E bed meetings to ensure actions required are understood by the whole system.

**Acute Trust - Improving supply - Support Services**

• Pharmacies have been tasked to prioritise TTOs and ensure that medication is
dispatched to wards immediately (or discharge lounge if appropriate).

- Facilities and porters tasked to prioritise cleaning and transfers.
- Scheduled maintenance has been reviewed, and if likely to impact on capacity or patient flow, rescheduled.
- PTS providers are prioritising patient transfers (discharges) above other work.

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

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

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

**Final escalation action:**
- Request to CCG/CSU for re-direction or for closure of the ED.
9.0 **Emergency Department planned Temporary closure e.g., due to Trust infrastructure (building / electrical) works or relocation etc.**

9.1 **Purpose:**
To provide guidance on the planning and arrangements required in the event of a planned temporary ED closure (e.g., to accommodate building or electrical works), including:
- Assurance criteria
- Engagement and Communication requirements
- Organisational roles and responsibility

In the event that an **unplanned** ED closure is required, sections 5 or 6 should be followed as appropriate.

9.2 **Overview:**
In order to ensure the provision of continued high quality patient care, NHS organisations across London will occasionally need to temporarily close emergency and unscheduled care services. This may be to enhance service provision or change the location of service delivery. During these periods it is important that patients still receive high quality care delivered in the most effective and efficient manner. It is therefore critical to ensure temporary closures are well planned, well communicated and well managed across all key partners and stakeholders. This Section sets out the role of each organisation and associated key actions required at each stage of the process from initial identification to implementation.

The planned temporary closure of an Emergency Department may be required for a number of reasons such as necessary electrical work or the reconfiguration of the department. In all cases however closures should be implemented as a last resort. Given the significant impact a closure may have on patient care, an evidence based need for a closure must be identified at the earliest opportunity and be supported by a clear rationale.

9.3 **Governance and Assurance required:**
Trusts planning a temporary closure are expected to work closely with their CCG/CSUs and provide formal notification of the proposals. Commissioners will assume an assurance role throughout closure preparations to stress test plans and assess system wide impact. All planned temporary closures must be agreed and finalised by the CCG/CSU before implementation. Commissioners will then seek permission from NHS CB London to formally proceed.

The decision to temporarily close an ED should be taken as a last resort and as a result must be subject to a robust process of assurance led by the CCG/CSU. In order to agree to a planned temporary closure the following assurance is required:
- The time and duration of the closure is acceptable in relation to requirement
- Contingency plans are in place should the closure exceed agreed timeframes
- The expected volume of patients affected is known including the impact of redirecting elsewhere in the system
- The impact on performance has been assessed with mitigations implemented as far as possible
- Systems are in place to manage impact across the whole economy and that arrangements are in place to mitigate impact to other direct access services (e.g. stroke, major trauma)
- Arrangements to reinstate ED in the event of a major incident are established
- On-call arrangements are clear
- Designated contacts across each organisation involved are known and understood with clear communication lines established
- Communication with the public / service users

The CCG/CSU is responsible for recommending planned temporary closures to NHS CB London for approval, following a full planning review.
9.4 **Identification & Notification:**

Formal notification should be submitted to The NHS CB London Emergency Preparedness Resilience and Response Team (via richard.mcewan1@nhs.net) who will ensure that relevant colleagues in the Operations & Delivery Directorate are made aware.

The temporary closure of an Emergency Department should be implemented as a last resort. An evidence based need for a closure must be identified at the earliest opportunity and be supported by a clear rationale.

All partners across the health system must be informed at the earliest opportunity of the intention to temporarily close an ED, with at least 4-6 weeks advance notice dependant on the scale of the closure, and the urgency of the work needing to be carried out. This will ensure that closure plans are inclusive and take into account the requirements of other partner services that will be directly impacted, e.g., LAS. This will enable other providers to review their own internal plans for the period and implement any necessary changes with enough notice to ensure patient safety, clinical quality and staff engagement.

It is important for Trusts to provide clarity regarding the scope of the closure expected. Areas for consideration should include:

- Self presenting patients
- Ambulance conveyances
- Health Care Professional (HCP) referrals
- Resus and Critical Care
- Any specialist or tertiary services provided at the site e.g. Major Trauma, HASU or Maternity whose access routes may have been through the ED

An impact assessment should be conducted by the trust in the first instance to inform which approach is most appropriate and help discussions with the CCG/CSU.
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Role</th>
<th>Key Actions</th>
</tr>
</thead>
</table>
| Trust               | To decide whether there is need for temporary closure and provide formal written notification to CCG/CSU of temporary ED closure proposal. | • Identify and test need for closure, ensuring all other alternative options have been fully explored.  
• Liaise with key partner organisations e.g. LAS and surrounding EDs to discuss proposed approach  
• Conduct impact assessment to scope the type of closure expected  
• Provide evidence based decision making and rationale including anticipated timeframes of patient/clinical and organisational impact  
• Provide detail regarding which services will be affected and which will continue to be provided and where. Particularly providing clarity as to whether closure is for all patients or only ambulance borne patients. If all then an appropriate public communication strategy will be required.  
• Ensure medical/ clinical ownership of the closure at Trust level regarding the potential impact on patients  
• Agree with surrounding Trusts repatriation plans for appropriate patients, transport methods and timescales. |
| CCG/CSU             | Provide assurance and system management.                             | • Test rationale and decision making behind proposal and impact of proposal against whole system e.g. planned events, closures, and any local issues that may have an adverse impact  
• Ensure wider stakeholders that may be impacted by the closure have provided appropriate capacity to support increased volumes of patients during the closure to minimise impact on patient care.  
• Inform NHS CB London of discussion and intention, providing assurance of planned process. |
| LAS                 | Engage with early planning process to help inform decision making    | • Identify Strategic and Operational leads  
• Understand and inform impact assessment  
• Establish internal communication links to raise awareness at local level. |
| System Stakeholders | Engage with early planning process to help inform decision making    | • Understand and inform impact assessment  
• Review any internal process change required  
• Establish internal communication links. |
| NHS CB London       | Provides final authorisation of closure                               | • Liaise with CCG/CSU  
• Review plans as required |

- CCG/CSU = Clinical Commissioning Group/Commissioning Support Unit
- LAS = Local Authority Strategic

System Stakeholders engage with early planning process to help inform decision making.
9.5 Planning:

- Detailed planning is essential when preparing for a temporary planned closure of an ED and should be overseen by the Trust CEO. Careful consideration, effective engagement and system collaboration at this stage will help develop a robust operational plan for the period of closure and mitigate risks to patient care, key partners and the wider system economy.
- Risks and issues should be used by the Trust to inform the planning process and include necessary actions with nominated leads identified for mitigation.
- Escalation planning must be included in this process. These plans should be patient focussed whilst also taking into consideration the impact on the whole system. Escalation plans should be developed in collaboration across the local health economy affected and shared early to ensure they are stress tested and key partners understand their roles and the associated actions required at each escalated level. This approach will provide enough opportunity for individual organisations to consider the type of response (e.g. an alternative operation model for the duration) necessary as required.
- Planning should include the provision to repatriate patients including patient transport and transfer functions once the planned closure has been stood down.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Role</th>
<th>Key Actions</th>
</tr>
</thead>
</table>
| Trust        | To lead planning process and develop Operational Plan for duration of the closure | - Establish planning team and secure clinical leadership.  
- Conduct full and formal impact assessment and risk register including impact on external organisations, travel times and cost.  
- Develop engagement and communication plan both internally and externally with designated points of contact across all partners  
- Develop command and control arrangements with clear escalation plans setting out both internal and external actions expected. |
| CCG/CSU      | To agree operational plan, provide support and maintain oversight Work with LAS and local Trusts to co-ordinated nominated recipient trusts during closure | - Test operational plan and quality assure risk register and impact assessment.  
- Review ambulance activity and impact with LAS and LAS Commissioners  
- Inform NHS London of progress, providing assurance of planned process. |
| LAS          | To support development of operation plan and agree alternative destinations for ambulance conveyance | - Review ambulance activity, capacity and resourcing for affected local economy.  
- Ensure local leaders are aware of plans and are communicating to local crew |
| System       | To engage with planning process and review internal requirements necessary | - Review capacity and resource requirements need throughout closure period.  
- Confirm actions and escalatory steps. |

9.6 Communication:

- Early engagement with key partners is vital, and should be held across strategic and operational areas. Nominated leads for both the planning and implementation of a planned closure should be identified with contact details shared across the local health economy affected.
- Each affected organisation should nominate an internal delegate to take responsibility for cascading agreements and decisions internally to ensure key messages are understood.
- Out of Hours and on-call arrangements should be formalised with pre-arranged escalation arrangements, communication channels and reporting timetables set out and agreed in advance.
- Regular meetings and conference calls should be scheduled and prioritised with clear routes for communicating agreements and actions to internal and external staff identified.
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Role</th>
<th>Key Actions</th>
</tr>
</thead>
</table>
| Trust        | To take overall responsibility for engagement and communication across the system during the preparation and implementation of a planned closure | • Ensure lead nominees have been identified across the trust including clinical and managerial staff  
• Ensure lead nominees have been established with external partners including the Commissioner and LAS  
• Establish communication links and reporting arrangements  
• Agree conference call schedule to provide progress updates and written confirmation of actions following call to participants  
• Schedule daily ops meetings with internal staff  
• Provide clear communications plans as to who will be informed, how and when of closing and re-opening especially if this occurs ahead of schedule or out of hours. |
| CCG/CSU      | To facilitate conference calls and local engagement across the local health economy. | • Retain system management oversight  
• Attend necessary conference calls and meetings as required  
• Inform NHS London of progress, providing assurance of communication networks  
• Cascade agreement’s internally to key partners |
| LAS          | To attend conference calls and local ops meetings as necessary | • Attend necessary conference calls and meetings as required providing internal progress updates  
• Establish clear communication links internally between strategy and operations and ensure bulletins and communications are disseminated to all ops and clinical staff  
• Ensure local leaders are aware of plans and are communicating to local crew |
| System Stakeholders | To attend conference calls and local ops meetings as necessary | • Attend necessary conference calls and meetings as required providing internal progress updates  
• Cascade agreement’s internally to key partners |

### 9.7 Best Practice & Lessons learnt
The lessons learnt from the successful planned closure of Chelsea & Westminster’s ED in October has helped to inform the above guidance.
Fig1: Planning a temporary Closure:

NHS CB London (final authorisation)

CCG/CSU (Assurance & Review)

LAS Commissioning

System stakeholders

Local Trust (notification of planned closure)

LAS

Alternative Providers

Local Trusts
9.0 **NHS CB London Coordination Arrangements**

It may be necessary for NHS CB London to centrally implement its pre-agreed coordination arrangements, during periods of heightened pressure. CMS scores will be one of the primary means of judging whether pressures have increased to such an extent, that individual CCG / CSUs do not have sufficient capacity to cope requiring greater central co-ordination of resource.

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

9.1 **Objective of NHS CB London Coordination**

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

**Note:** Coordination arrangements, in response to seasonal pressure surges for example hot weather or winter may differ from those during a major incident, which will be governed by existing Major Incident Policies.

9.2 **CCG Input**

Prior to implementing Coordination arrangements, NHS CB London will endeavour to seek the opinions of CCGs, before a decision is made regarding their initiation. Alternatively, NHS CB London may consider it’s use, if they are requested to do so by the CCGs, the Department of Health or National CB.

9.3 **Duration**

Coordination arrangements will be maintained for as long as it is felt necessary to resolve the situation, with the intention of standing down and handing back control to the CCG / CSUs as quickly as possible.

9.4 **Role of NHS CB London Director of Ops and Delivery and NHS Gold01**

At the NHS CB London, the management of winter pressures is the responsibility of the Operations and Delivery Directorate, supported as required by other teams and Directorates, including Medical and Chief Nurse. The management of Coordination arrangements will be overseen either by the Director of Ops and Delivery, or NHS Gold01. This decision will be taken dependant upon the circumstances at the time.

9.5 **Information to support decision making**

This will be available through the CMS system, regular briefings from the CCG / CSUs and twice daily conference calls (see below for suggested attendance), chaired by SM01 (with NHS Gold01 or Director of Ops and Delivery attendance to take a strategic view). The purpose of these calls will be to support collective decision making and information sharing.

9.6 **Conference Call arrangements**

Once Coordination arrangements have been invoked, and following the initial conference call to discuss the situation and identify actions, regular conference calls will initially be scheduled daily at 10.00 and 14.00, but may be varied according to the developing situation. It is likely that calls will also take place over weekends. This will be confirmed at weekday conference calls.
<table>
<thead>
<tr>
<th>Attende</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Gold / NHS CB London Director of Ops and Delivery</td>
<td>Run the “incident” on behalf of the NHS in London providing a strategic level of oversight and direction</td>
</tr>
<tr>
<td>NHS SM01</td>
<td>To Chair the call and provide support to NHS Gold as required</td>
</tr>
<tr>
<td>NHS01</td>
<td>To be aware of capacity issues in the event of other emergency situations and advise on business continuity matters</td>
</tr>
<tr>
<td>CCG / CSU Director on Call</td>
<td>To provide updates on CCG / CSU actions, give local direction and leadership, oversee implementation of actions required by NHS CB London, and liaise with neighbouring CCG / CSUs regarding potential impacts or actions required</td>
</tr>
<tr>
<td>Trust / CCG representatives (If only 1 or 2 CCG / CSUs are affected)</td>
<td>To report on the current situation, measures taken and further measures planned. To action NCB London requirements as appropriate.</td>
</tr>
<tr>
<td>Delivery Directors or Heads of Assurance in NHS CB London</td>
<td>To liaise with CCG / CSUs outside of calls on progress, additional support required etc</td>
</tr>
<tr>
<td>NHS CB London HCAI Lead</td>
<td>If pressure HCAI linked</td>
</tr>
<tr>
<td>LAS Representative/ LAS Commissioner Rep</td>
<td>To provide an overview of LAS issues and support to EDs etc.</td>
</tr>
<tr>
<td>NHS CB London Head of Pressure Surge Management</td>
<td>To provide support, advice and brief DH etc</td>
</tr>
<tr>
<td>Others by invitation</td>
<td>To provide ad hoc specific advice as required</td>
</tr>
</tbody>
</table>

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

9.8 Circulation of notes:
- Notes of the meeting will be taken and circulated to all participants, cc’d to:
  - NHS CB London Director.
  - NHS CB London Communications.
  - NHS CB London Director of Ops and Delivery.
  - CCG / CSU Chief Officers.
  - NHS01.
  - Bordering NCB Office’s when relevant.

9.9 Briefing of Department of Health / NHS CB London Director’s Office
Following the conference calls, briefings will be communicated to DH as appropriate to keep them informed of the progressing situation. This will be particularly necessary in the event of norovirus outbreaks or the need to close A&E departments due to capacity issues.

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

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

9.1 Serious Incident Reporting
Where they do occur, trusts are expected to report them as Serious Incident’s (SI’s), and investigate their causes. Clusters are expected to ensure that both they and their Trusts have implemented robust monitoring arrangements, to ensure that one hour breach SI’s are identified, reported, investigated and the lessons learnt implemented to reduce the likelihood of recurrence in the future.

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

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

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

9.4 Reporting Responsibilities:

<table>
<thead>
<tr>
<th>HOSPITAL TURNAROUND STAGE</th>
<th>DATA CAPTURE MECHANISM</th>
<th>RESPONSIBILITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAS arrival at Hospital</td>
<td>‘Red at Hospital’ button press via the LAS MDT</td>
<td>LAS crew</td>
<td>The ‘Red at Hospital’ button press triggers time of LAS arrival on the Hospital Based Alert System (HAS)</td>
</tr>
<tr>
<td>Clinical Handover</td>
<td>Written on to the Patient Report Form (PRF)</td>
<td>LAS crew / ED clinician</td>
<td>The Patient Record Form (PRF) is scanned by LAS available to LAS IM and input into internal reporting processes. <strong>HAS should not be clicked off at this stage.</strong></td>
</tr>
<tr>
<td>Handover Stage</td>
<td>Description</td>
<td>Responsible Party</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Patient Handover (Trolley is Clear)</strong></td>
<td>‘Patient Handover’ button press on Hospital Based Alert System (HAS)</td>
<td>Acute Trust</td>
<td>The ‘Patient Handover’ button on the HAS screen is used to record when handover has occurred and LAS crew are free to leave. By using the HAS, the patient handover stage of the patient journey can be accurately captured in agreement between the LAS and Acute Staff and recorded automatically. This process allows the acute trust to take responsibility for reporting against their own performance management targets.</td>
</tr>
<tr>
<td><strong>Handover to Green</strong></td>
<td>‘Green Available’ button press via the LAS MDT</td>
<td>LAS Crew</td>
<td>This time is available to LAS IM and input into their internal reporting process.</td>
</tr>
<tr>
<td><strong>Administrative Handover</strong></td>
<td>Patient Administration System (PAS)</td>
<td>Acute Trust</td>
<td>Patient information is taken from LAS PRF.</td>
</tr>
</tbody>
</table>
Appendix C – LAS 1 hour handover breach validation protocol

60 Minute Patient Handover Breach Validation Process

Automated breaches tracked via portal 24 hours in arrears

Daily review of breaches undertaken

TRUST

Valid breaches uploaded to STEIS

TRUST

Breaches requiring challenge fed back to Cluster within 48 hours of information being available via the portal *

TRUST

Valid breaches uploaded to STEIS

TRUST

Investigation of breach detail carried out

TRUST / LAS

Valid breaches uploaded to STEIS

TRUST

Supporting evidence to confirm non-occurrence of breach provided to Cluster within 7 days

TRUST

Feedback provided to Trust regarding acceptance / non-acceptance of evidence

CLUSTER

Valid breaches uploaded to STEIS

TRUST

Review of evidence & decision made regarding breach occurrence within 7 days

CLUSTER

Notification of final breach position for all Trusts received by LAS Commissioning team

CLUSTER

Amendments to ‘Agreed Breach Report’ uploaded to portal **

LAS COMMISSIONING TEAM

Application of financial penalty to Trust

CLUSTER

Please note:

* The portal is populated 24 hours in arrears via a manual daily upload process. This means information for the previous day will be available from 12pm (noon) Monday to Friday. Weekend data will be available in full from 12pm (noon) the following Monday

** Amendments will be made on a weekly basis by noon each Friday