Health and Social Care Board

HSC

HSC Regional Unscheduled Care Escalation Guidance

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1. Background

This document provides HSC Trusts with guidance specific to mechanisms of unscheduled care pressure escalation.

HSC Regional Unscheduled Care Escalation Guidance was first issued in February 2016 following regional agreement to provide support for HSC Trusts implementing escalation procedures. This document (DRAFT v2.3) supersedes all previous guidance updates.

2. Scope

This escalation guidance applies to HSC adult services only.

The guidance provides commentary on internal Trust escalation processes where the expectation is that Trusts will seek to primarily manage heightening pressures autonomously.

The guidance does not dictate internal Trust escalation measures, triggers or plans; this remains the responsibility of individual Trusts who will determine appropriate steps based upon context and resource.

The guidance does however set out the regional escalation processes extending from the point at which 'extreme' site pressure is identified using the *Hospital Early Warning Score (HEWS)* to the point where an Early Alert is potentially issued to the Department of Health.

Although it is acknowledged that HSC-wide calibration of the Hospital Early Warning Score is required to provide consistency across the region; this work is ongoing and in the interim period Trusts should continue to determine HEWS pressure status in accordance with existing tools.

3. Underlying Principles

The following principles underpin the mechanics of regional unscheduled care escalation:

- Trusts should monitor their activity and determine anticipated peaks and surges based on trend analysis with robust plans in place detailing mitigations and expected outcomes.
- Planning unscheduled care delivery needs to take account of a whole system approach to deliver both emergency and planned elective activity.
- Control room / hub meetings should be conducted to identify building pressures, with focused actions agreed at an early stage.

- Trusts should make data-informed escalation decisions.
- The *Hospital Early Warning Score* (HEWS) must determine the required levels of escalation and should be widely shared with clinical and managerial teams.
- Escalation plans are essential, structured operational documents which have input from all relevant stakeholders.
- Escalation decision-making and actions should be consistent and within agreed timescales; prompt de-escalation will minimise disruption to patient care.
- NIAS should be continually updated during of periods of heightened pressure and of any consequent change in escalation status.
- All staff disciplines should be made aware of their site status and those in the wider Trust area during times of heightened pressure.
- Trust Escalation Plans should explicitly detail staff roles and responsibilities.

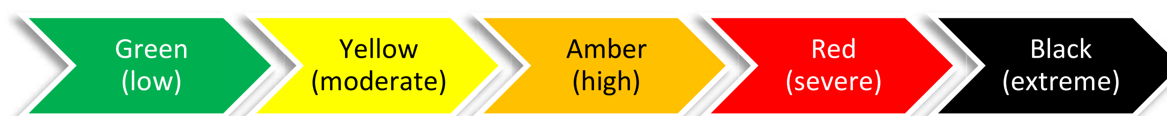
4. Levels of Escalation

Provider Trusts have escalation plans based on the 5 levels of escalation within the *Hospital Early Warning Score* (HEWS) (Appendix One). The Northern Ireland Ambulance Service (NIAS) employs a *Resource Escalation Action Plan* (REAP) which has 4 levels of escalation (Appendix Two). Whilst specific to the ambulance service, REAP provides alignment as far as possible with the Regional Unscheduled Care Escalation Guidance.

5. Provider Trusts

Escalation required may be site specific or Trust-wide. Whilst there may be occasions when inter-Trust co-operation is required to resolve specific issues, during times of heightened pressure Trusts will primarily work as far as possible within their own boundaries.

The use of indicators to highlight when and what action is required is outlined using the HEWS colour-coded warning system (Appendix One).



6. Escalation Status

Individual Trusts are responsible for the identification, management and ongoing monitoring of pressure within their own Trust boundaries.

When assessing pressures at a particular site Trusts must ensure they have consistent triggers which are understood by all relevant staff to inform levels of escalation.

Each site will need to have agreed calibrated numbers supported by reliable data to inform calculation of the HEWS score.

Trusts are supported with data-informed decision-making by (e.g.) Trust site pressure dashboards and predictive analysis statistics; and also by HSCB-PMSI who circulate a rolling 7-day report of associated activity, based upon information extracted from the twice-daily *Unscheduled Care Sit-reps* (circulated Monday-Friday).

At times of heightened pressure regional daily tele-calls/control room huddles are held to share information relating to specific pressures (including the submission of completed HEWS templates). This provides opportunities for the early identification of mounting pressures/escalated positions and will enable inter-Trust discussions, collaborative solutions and will also assist with NIAS smoothing decisions.

NIAS will be made aware of any change in site escalation/de-escalation status as part of the regional control room calls.

7. Ambulance Smoothing

NIAS has **sole** responsibility for smoothing across the region. NIAS smoothing is a process which seeks to address rising pressures and associated ambulance availability issues. The decision to smooth ambulances away from one site to another under less pressure is currently informed by three sources of information: the NIAS arrivals board; Trust ED pressures dashboards; and the current ‘stack’ on the C3 ambulance control system. The metrics that are used to inform smoothing are subject to ongoing review.

Whereas NIAS retain autonomy to redirect ambulances appropriately across the region, in **exceptional circumstances** there must be provision for Trusts to ask for smoothing consideration. If a Trust has not yet reached the highest level of escalation (Extreme HEWS) but harbours concerns that a site may be trending imminently in that direction, then a request made at Director-level to NIAS may be appropriate.

8. Extreme HEWS

There are a range of actions at lower levels of escalation that are considered 'daily routine' with embedded local action cards/plans to ensure normal working. However, at times of 'Extreme 'pressure (HEWS - black); Trusts ***must*** implement their associated escalation measures before seeking a regional resolution. There are a number of commonalities in the measures to be considered at times of Extreme HEWS. This is particularly true in relation to those actions linked to the Emergency Department and NIAS.

Common actions include:

- Consultant at triage / front door decision making.
- Senior management on the hospital floor (Director-level).
- Implementation of full capacity protocol.
- Secure additional nursing/HCA/support staff.
- Out of hours on-call consultant evaluates the situation, returns to / remains in ED if necessary.
- Deferral of clinical duties.
- Continuous liaison with HALO / NIAS.
- Discuss options to ease pressure with other Trusts and NIAS.

(This is not an exhaustive list and may differ dependent on site)

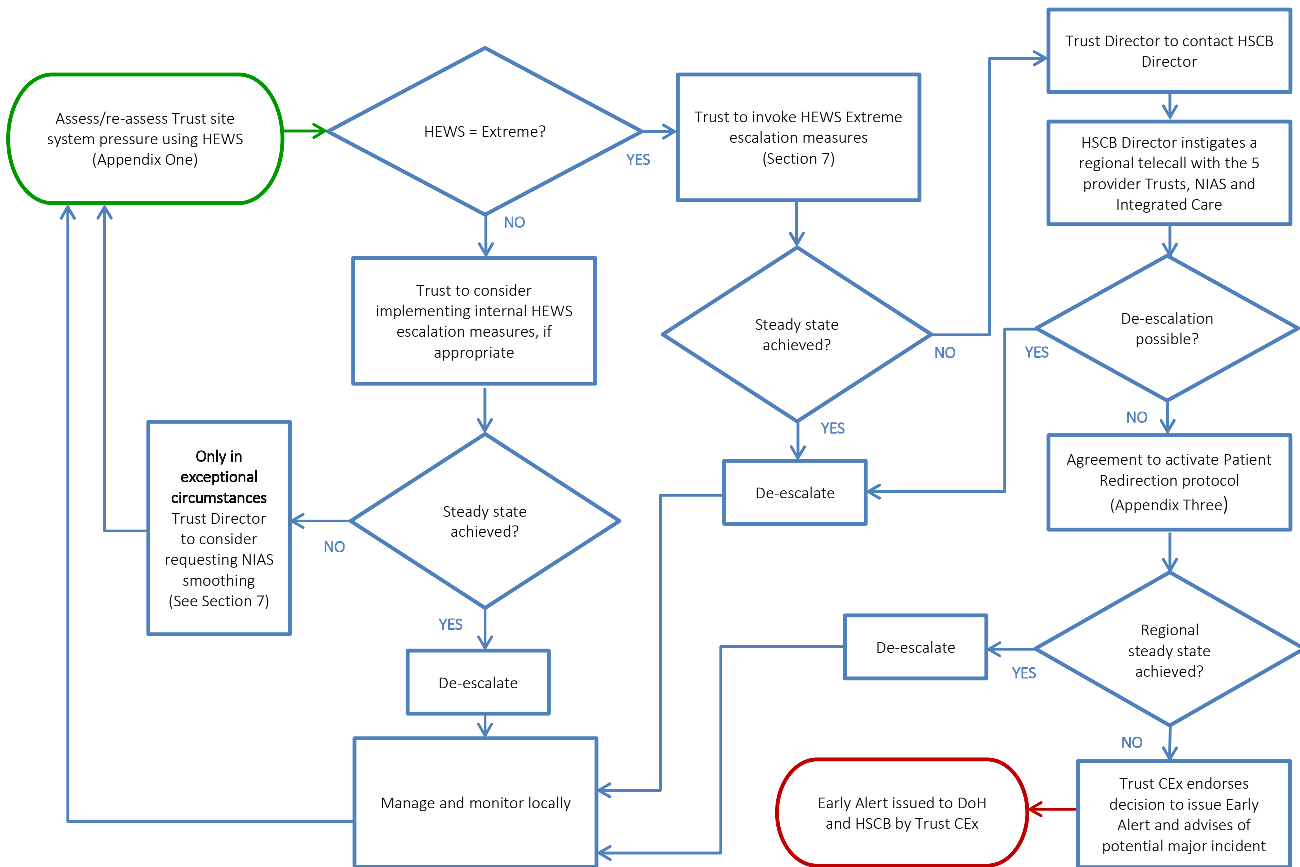
If following these actions, the Trust remains in Extreme HEWS then discussion will take place at Director-level with HSCB.

The HSCB Director will instigate a regional telecall involving the 5 provider Trusts, NIAS and Integrated Care in an attempt to de-escalate the situation. If de-escalation is not feasible then the *Patient Redirection Protocol* (Appendix Three) should be activated.

If the situation still remains unresolved and there is Director-level agreement for consideration of an 'Early Alert', the Chief Executive of the provider Trust must endorse the appropriateness of Early Alert Action before steps are taken to notify the Department of Health and the HSCB.

This process is summarised in the *Regional Escalation Process* flowchart in Section 8.

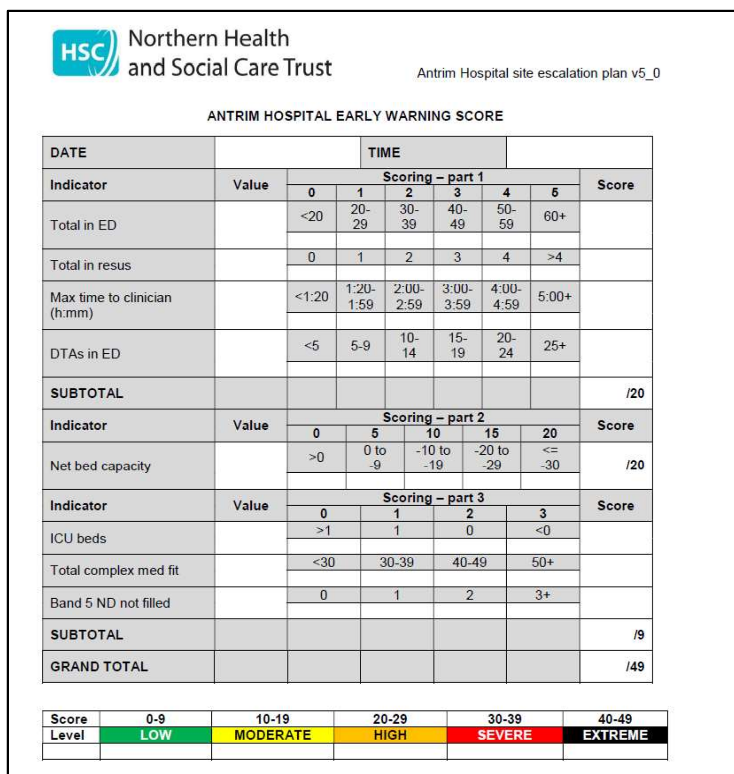
Regional Escalation Process



Appendix One: Hospital Early Warning Score (HEWS)

Escalation status will be determined based on predicted demand and capacity disparities as well as for short term escalation in response to identified trigger points
Green (Low HEWS) Normal Working
Yellow – (Moderate HEWS) Principles of normal working apply with additional yellow escalation measures actioned
Amber – (High HEWS) Principles of normal working with yellow escalation measures in place with additional amber actions
Red – (Severe HEWS) Principles of normal working, yellow & amber measures in place and red escalation actions applied
Black (Extreme HEWS) Principles of normal working, yellow, amber, red and black escalation actions applied

Each Trust site will need to have agreed calibrated numbers supported by reliable data to inform calculation of the HEWS score. An example of how HEWS is calculated is illustrated in the template shown:



Northern Health and Social Care Trust

Antrim Hospital site escalation plan v5_0

ANTRIM HOSPITAL EARLY WARNING SCORE

DATE		TIME	

Indicator	Value	Scoring – part 1						Score
		0	1	2	3	4	5	
Total in ED		<20	20-29	30-39	40-49	50-59	60+	
Total in resus		0	1	2	3	4	>4	
Max time to clinician (h:mm)		<1:20	1:20-1:59	2:00-2:59	3:00-3:59	4:00-4:59	5:00+	
DTAs in ED		<5	5-9	10-14	15-19	20-24	25+	
SUBTOTAL								/20

Indicator	Value	Scoring – part 2					Score
		0	5	10	15	20	
Net bed capacity		>0	0 to -9	-10 to -19	-20 to -29	<= -30	/20

Indicator	Value	Scoring – part 3				Score
		0	1	2	3	
ICU beds		>1	1	0	<0	
Total complex med fit		<30	30-39	40-49	50+	
Band 5 ND not filled		0	1	2	3+	
SUBTOTAL						/9
GRAND TOTAL						/49

Score	0-9	10-19	20-29	30-39	40-49
Level	LOW	MODERATE	HIGH	SEVERE	EXTREME

(Sample template courtesy of NHSCT)

Appendix Two: NIAS REAP Escalation

REAP is a plan that is constantly under review by NIAS, with a formal weekly (Monday) decision taken dynamically, to consider the expected operating level for the next seven days, with the ability between to change this level based on changed information or intelligence. REAP is the strategic tool used to mobilise organisational action.

NIAS Resource Escalation Action Plan (REAP)	
REAP 1	Steady State
REAP 2	Moderate Pressure
REAP 3	Major Pressure
REAP 4	Extreme Pressure

REAP can operate in different modes. For example, it is used on a seven day forward basis or can be moved at any time based on dynamic situations, such as a major incident or if the circumstances change between reviews that warrant a further review.

To aid the REAP level change decisions, the Joint Decision Model shown in Figure 1 should be utilised and its component parts followed:

The principle of REAP will be that all ambulance services in England, Scotland, Northern Ireland and Wales will operate at REAP level one when the service is operating within normal parameters i.e. 'a steady state' and meeting national or commissioned standards of performance. It is also noted that for some Ambulance Trusts, REAP 1 is a common steady state. The additional three levels to this reflect an increasing pressure on the organisation all the way through to level four where there is the potential of service failure.

Appendix Three: Patient Redirection Protocol

At all times NIAS is responsible for redirecting ambulances across the region in response to the information it receives. Redirection of patients away from a particular site is only appropriate if it can be evidenced that all options to resolve issues have been exhausted.

The decision making processes on which the Redirection of patients are agreed must be open and transparent, based on timely and accurate information available from the NIAS dashboard, Hospital Ambulance Liaison Officers (HALOs) where available and any wider additional Hospital and NIAS Trust local information, providing evidence of actions taken to address pressures and resulting outcomes.

NIAS retain autonomy to redirect ambulances appropriately across the region, in terms of individual calls and on a daily operational basis, in order to preserve emergency responsiveness and supports as best possible the equalisation of system-wide pressures. The introduction of the ED dashboard has supported NIAS in this process.

However, in an escalated position, the following levels of redirection can apply:

- Level 1 - Redirection of GP urgent calls within a Trust to allow a distribution of pressure across hospital facilities within an individual Trust
- Level 2 - Full Redirection of all GP Urgent/Emergency 999 vehicles away from a particular hospital site/Trust

When considering implementing a redirection request from an acute provider Trust, NIAS Trust will take account of the following operational pressures:

- Available resources
- Current ambulance turnaround times
- Increased volume of emergency calls
- Increased GP urgent requests
- Increased requests for emergency transfers
- Increased requests for hospital discharges
- On-going significant or major incidents
- Other contingencies that may be in place

Level 1 - Redirection of GP Urgent calls across sites

NIAS will implement a Level 1 Redirection at the request of an individual Trust in response to building pressure at a particular site for an agreed period of time. The impact of the Redirect will be monitored by NIAS, and a decision regarding the need to extend the duration will be agreed between NIAS and the requesting Trust.

Level 2 - Full Redirection of all GP Urgent / Emergency 999 Ambulances across Trusts

a) A full Trust to Trust redirection can only be initiated at Director Level (or above) in the requesting and receiving Trusts. If no agreement is reached the situation must be escalated to the relevant Chief Executives for resolution.

b) When a level 2 full redirection is agreed between the two Trusts the receiving Trust should notify NIAS of the agreed arrangements.

c) Based on the Director to Director discussion it will be agreed if the redirection is to be put in place for a specific period of time, or will be negotiated for a specific number of ambulances to be diverted outside normal Trust boundaries. This must be made clear at the time of agreement, and arrangements to re-assess the situation with a follow up discussion agreed. The position must be monitored closely and kept under constant review by senior managers in both the redirecting and receiving hospitals and in conjunction with NIAS Trust. If there is a need for the redirection to stay in place after the initial agreed time period, or number of crews to be re-directed this should be discussed and agreed by the requesting and receiving Trusts (including the frequency of review), and NIAS informed accordingly.

A level 2 full redirection is a serious response to building or unexpected pressure. Every attempt should be taken at a local level to avoid this action with full implementation of local escalation plans. It will be vital that if a level2 re-direct is put in place that the requesting Trust is explicit regarding the ED's position in acceptance of standby calls for this period.

A level 2 full redirection should only be considered in extreme and exceptional circumstances, and as such proportionate and appropriate arrangements will be developed that facilitate regional sharing of learning from the circumstances that have required this action.