

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Bed Management Policy

Effective: December 2011

Review: December 2014

### 1. Introduction

This Policy has been developed in conjunction with Clinical Directorates. The aim of the policy is to:

- Standardise the documentation of Directorates' approach to bed management
- Provide clarity regarding the management of daily bed pressures and be explicit about escalation
- Link escalation policies to individual Directorate plans and the Trusts NEEP plan
- Provide clear guidelines for the Patient Services Coordinators Team to work within
- To identify useful contacts in and out with the Trust

**DIRECTORATE  
PATIENT SERVICES-PATIENT SERVICES CO ORDINATORS**

Daily bed management of both RVI and FH (green)	Increased Pressure (amber)	Escalation plan (Red)	Useful numbers and Contacts
<p>Acute general medical admissions will be centralised at the Royal Victoria Infirmary (RVI). All acute medical and surgical referrals will be routed through the Assessment Suite (AS) at the RVI.</p> <p>Freeman Hospital (FH) will accept sub-acute medical patients requiring a more extended hospital stay, transferred from AS.</p> <p>There will be no direct GP referred patients received at FH for emergency medical assessment/admission.</p> <p>GP referrals requiring emergency surgical review will continue via the bed bureau who will follow a protocol to determine destination.</p> <p>Emergency admissions for</p>	<p>Decreased capacity and flow through AS will trigger the following.</p> <p>PSC to instigate the process for 'GP's on Hold' via the Bed Bureau</p> <p>Capacity (max 2 beds) should be preserved on AS to accept patients who cannot wait at home and require urgent admission .</p> <p>Additional transfer arrangements from RVI to FH should be considered. Capacity on AS should be sufficient to accommodate an increased flow of patients.</p> <p>The PSC will contact the "on call" clinician and Discharge Liaison Facilitator who will be asked to action the safe discharge/transfer</p>	<p>A daily or twice daily bed meeting will take place, as part of the escalation plan. Representatives of Patient Services AS, ED and Medicine are compulsory. Any other relevant Directorate speciality representation may attend.</p> <p>Elective and expected emergency throughput will be prioritised and any necessary cancellations of elective admissions will be decided.</p> <p>See Escalation Plan for details</p>	<p><b><u>PSC RVI 24300</u></b> Instigate and manage any bed meetings that are held. Accurate Trust wide bed availability Accurate recording of Trust wide boarders. Ensure Prioritisation of surgical admissions Supply accurate advanced surgical waiting lists from E record system to enable decisions to be made re waiting list prioritisation/cancellation for the following day</p> <p><b><u>PSC FH 26623</u></b> Accurate FH bed state and recording of boarded patients</p> <p><b><u>Matron Patient Services 29460</u></b> Ensure that all steps identified in "Escalation Plan" are instigated. Lead bed meeting ensure relevant areas attend.</p>

Daily bed management of both RVI and FH (green)	Increased Pressure (amber)	Escalation plan (Red)	Useful numbers and Contacts
<p>all other specialties will continue to be referred and reviewed at other designated emergency areas throughout the Trust</p> <p>Tertiary referrals to general medicine and general and vascular surgery will be made via the registrar for that speciality. The Patient Services Coordinators. will accept referred patients into the Trust according to clinical need and bed availability.</p> <p>Detailed pathways for patients with suspected cardiac chest pain, acute stroke (see appendix 2) or patients having sustained an overdose is available in</p> <p>The transfer of patients out of the Trust and between wards within the trust. (See Transfer of Patient Policy and the Repatriation Policy Exhibit 2 on intranet)</p>	<p>of appropriate patients.</p> <p>The capacity available in the Trust will be monitored by increasing the frequency –up to 2hrly- of the bed states carried by the bed bureau.</p> <p>The PSC will instruct switchboard to use the call out to Consultants/Registrars briefly explaining the bed pressures the Trust is experiencing and to encourage review/discharge of patients using the Discharge Lounge where appropriate.</p> <p>Management of Acute Chest Pain – When the Chest Pain Assessment Unit and Coronary Care Units across both sites are full, patients should be referred to ED. RVI, HDU should be advised that spare capacity should be cleared and could be used</p>		<p>Inform Patient Services Manager, on call manager and if necessary Medical Director re Trust position Highlight any outstanding immediate problems. Ensure decisions made are carried out by appointed staff.</p> <p><b><u>Discharge Liaison 48900</u></b> Instigate discharge/transfer of patients out of the Trust.</p> <p><b><u>USEFUL NUMBERS</u></b> ED Matron 29927</p> <p>Medical Matron 29917</p> <p>AS Co Ordinator 29327</p> <p>ED Co Ordinator 23705</p> <p>Matron Surgery 29362</p> <p>Bed Bureau 31404</p> <p>CPAU 29058</p> <p>Stroke Nurse 21616/29313</p>

Daily bed management of both RVI and FH (green)	Increased Pressure (amber)	Escalation plan (Red)	Useful numbers and Contacts
Wards at the RVI should use the Discharge Lounge for patients waiting to go home or be transferred to other facilities. This will release capacity on base wards earlier.	to accommodate patients with acute chest pain. The use of resuscitation beds or decommissioned monitoring beds in ED should be considered.		Patient Services Manager 48963

**DIRECTORATE  
PATIENT SERVICES-DISCHARGE LIAISON FACILITATOR**

Daily Function Role of DLF (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>To assist wards to discharge patients who have complex needs either in person or via phone.</p> <p>Promote discharge planning and documentation to ward staff by attendance at MDT meetings and being visible across the Trust.</p> <p>Representation of the Trust in meetings with external agencies.</p> <p>Attend safeguarding and planning meetings concerned with discharge planning aiming to create smoother working practices.</p> <p>Support the Patient services manager and Matron in production of policy and protocol to support the discharge process.</p> <p>Validation of the reported</p>	<p>Liaise with Care of the Elderly and PCT bed Managers at SPA to ensure ward beds and community beds are fully utilized.</p> <p>Alert the social workers to the pressures with a view to discharging patients either home, care home or to delay beds.</p> <p>Review boarder's lists daily with a view to promoting the discharge of those patients who are MDFit and whose discharge would be safe.</p> <p>Expedite delays if possible by liaising with outside agencies e.g. Social Services/PCT support services/housing and requesting that care homes accept patients on that day rather than later in the week. Numbers available in patient records</p>	<p>PCT team requested to transfer patients as soon as possible</p> <p>Move patients waiting consultant led continuing care beds</p> <p>Prioritize hospital transfers to community rehab beds rather than admit from the community to those beds</p>	<p>Discharge Liaison Facilitator 48900</p> <p>Matron 29460</p> <p>SPA 23869</p> <p>SW 31025 FH</p> <p>SW 25334 RVI</p>

Daily Function Role of DLF (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Delays in Discharge on a weekly basis and follow up specific patients to ensure discharge plans progress</p> <p>Support the ward staff in pursuing the Patient Choice Directive policy which is available on the Trust intranet</p> <p>Lead in writing and reviewing the Trusts Discharge Policy. Responsible for its dissemination.</p>			

**DIRECTORATE  
PATIENT SERVICES-BED BUREAU**

Daily Function of Bed Bureau (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Facilitates the admission process for GP's to ensure timely admission of their emergency cases to the Trust 24/7.</p> <p>PSC's and clinical staff are informed of admissions and transport organised if necessary. Relevant medical and GP details are recorded via the Bed Bureau system and information is sent to the relevant receiving area.</p> <p>Current bed availability and expected admission information is made available to the PSC team to enable timely decisions to be made regarding bed management.</p> <p>Collects and produces reports to enable pro active decisions on bed management to be made.</p> <p>Ensures correct Bed availability information (current and expected) is available at 12.00 16.00 20.00</p>	<p>Co ordination of the GP "on hold" Mechanism following instructions from the PSC.</p> <p>The PSC identifies that limited capacity has been reached within the Trust. He/She will instruct the BB to ask the GP if the patient he is referring can be kept "on-hold" at home. This may reduce the incidence of patients being sent to ED and increasing the pressure in that area.</p> <p>The GP is responsible for the decision to hold at home. Urgent cases will be accommodated in AS if capacity available, or ED.</p> <p>A time limit for holding the patient at home is decided by the GP and the patient or carers advised that should there be any change in the patients condition they should contact their GP again. And this may result in an earlier admission.</p> <p>The BB will make the necessary</p>	<p>Information from BB may be used to instigate the Trust Escalation Policy.</p> <p>The BB will carry out Trust wide bed states for all areas including Paeds and Critical Care, Cardio etc.</p> <p>To enable informed decisions to be made regarding capacity or escalation</p>	<p><u>Bed Bureau</u> 27512 27519 31404 <u>PSC</u> RVI 24300 FH 26623</p>

Daily Function of Bed Bureau (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>This enables timely decisions to be made regarding Bed Management. Some information may be taken from E record Investigations may take place should any member of staff provide deliberately misleading information as to bed availability. The PSC will speak to the relevant ward sister or Matron in this case.</p>	<p>transport arrangements and they will contact the patient to advise them of the ambulance arrival time and the allocated receiving site.</p> <p>The time the patient is expected and the time the ambulance was booked is recorded in the bed bureau. They will also send referral details to the receiving department including the patients expected arrival time.</p> <p>The PSC may ask for more frequent or more specific information on bed availability.</p> <p>Check accuracy of E record information with ward</p>		

**DIRECTORATE  
PATIENT SERVICES-BOARDERS**

Daily Function Management of boarders (green)	Increased Pressure  (amber)	Escalation Plan (Red)	Useful Contacts
<p>Patients are classed as boarders when they are residing in a ward outside their admitting specialty.</p> <p>Each ward should identify, daily, patients who are suitable to board into other specialties clinical areas. Identification of boarders should be the responsibility of the medical staff. Patients should not be boarded without approval by the medical staff to ensure that they are fit to board.</p> <p>Ideally patients should be from base wards awaiting discharge within 48hrs, this may not always be possible but other factors such as bed pressures and the lack of identification of other boarders should be taken into account. Other patients suitable for boarding include those who are Medically/surgically stable and mainly self caring.</p> <p>Infected patients or those with disability or cognitive impairment must not be boarded.</p> <p>When placing patients as boarders the following must be considered</p>	<p>Boarding capacity at FH will be up to 12 medical patients. NEEP Level 2 (See exhibit 8 for NEEP level triggers).</p> <p>Emergency admissions should be boarded only after Consultant review as to the suitability of the patient to board. They should have minimal medical or chronic problems.</p> <p>During increased bed pressures the boarding of patients after 22.00hrs may occur. Receiving wards must be made aware of late transfers and if boarding is cross site then the approval of the medical director must be sought.</p>	<p>Increased pressure on beds/capacity may result in an Increase in boarding capacity at FH. This should happen following a discussion with the Medical Director and matron Patient Services. Identification of wards to be used for boarding will be done by PSC FH and Matron Patient Services. NEEP Level 3&amp;4</p> <p>Infected patients may have to be boarded after liaising with the Medical registrar and Infection Control. Patients who are suitable to board may be placed in areas</p>	<p>Matron Patient Services 29460</p> <p>PSC RVI 24300</p> <p>PSC FH 26623</p> <p>Discharge Liaison Facilitator 48900</p> <p>Patient Services Manager 27475</p>

<p style="text-align: center;">Daily Function Management of boarders (green)</p>	<p style="text-align: center;">Increased Pressure  (amber)</p>	<p style="text-align: center;">Escalation Plan (Red)</p>	<p style="text-align: center;">Useful Contacts</p>
<p>The receiving ward must have the relevant nursing and clinical skills to care for the patient.</p> <p>Location and normal activity of the ward where boarders may be placed.</p> <p>Preserving special care areas CCU etc.</p> <p>Waiting list admissions and the preserving of elective activity.</p> <p>Returning of boarders to their base wards may be needed to accommodate elective activity.</p> <p>Daily senior review by the patients consultant or allocated team must be undertaken to ensure a clinical care plan is in place to progress the care of the patient. See exhibit (1) for base ward allocation for boarders</p> <p>Only by exception will a patient be moved more than once for a non specialty clinical need. The patients consultant/allocate team must be involved in the decision making process.</p> <p>Boarding should take place between 09.00-22.00</p> <p>PSC's will update lists of boarders daily and distribute to all relevant Directorates,</p>	<p>PSC's to ensure that boarders are reviewed daily and plans made for their ongoing care.</p> <p>Contacting individual directorates if their boarders remain high.</p>	<p>such as the Cardio block at FH if clinically safe to do so.</p> <p>Elective activity of base wards may be cancelled due to high levels of boarded patients.</p> <p>PSC's to ensure that boarders are reviewed daily and plans made for their ongoing care.</p> <p>Involving Discharge Liaison if necessary</p>	

<p style="text-align: center;">Daily Function Management of boarders (green)</p>	<p style="text-align: center;">Increased Pressure  (amber)</p>	<p style="text-align: center;">Escalation Plan (Red)</p>	<p style="text-align: center;">Useful Contacts</p>
<p>Consultants Heads of Nursing, Medical Directors, Matron for Patient Services and Patient Services Manager</p>			

**DIRECTORATE  
PATIENT SERVICES-BED CLOSURES  
Including INFECTION CONTROL**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
Closures may be necessary due to vacancies, sickness, infection control or Patient dependency.	<p>Inform Directorate manager or PSC OOH Staff on ward or in Directorate to work extra shifts or Bank cover.</p> <p>Review dependency of patients against expected admissions and staffing.</p>	<p>Submit a bed closure form (available on intranet) to Matron Patient Services or Patient Services Manager. OOH via PSC and manager on call. Closures will be for a specified length of time and reviewed on a daily basis by Directorate. NB For Critical Care or Paediatrics the on-call consultant must be part of the decision making process.</p>	<p>PSC RVI 24300</p> <p>PSC FH 26623</p> <p>Patient Services Manager 27475</p> <p>Matron Patient Services 29460</p>
<p><b>Infection Control</b> Patients isolated in cubicles on wards if known to have MRSA CDiff or any other infection that requires isolation following guidance by the Infection Control team.</p>	<p><b>Infection Control</b> Not possible to isolate all infected patients.</p> <p>Restrict admissions to the ward and use of bank staff</p> <p>Following instruction from ICT the ward is closed to admissions.</p>	<p><b>Infection Control</b> For major outbreaks please follow "The Infection Control Policy for the investigation and control of major outbreaks of infection"</p>	<p><b>Infection Control</b> Matron Infection Control 20584</p>

<p>PSC to assist in locating cubicles.</p>	<p>PSC attends daily meetings to discuss outbreak and impact on service of bed closures. Issues communicated post meeting to the hospital management team which includes All IPCN's Heads of Nursing, Nurse Bank, Hotel Services, Occupational Health, PSC's Matron Patient Services Clinical Director and relevant Directorate Management Team.</p> <p>Terminal cleaning to be carried out by Hotel Services directed by ICT (See Trusts Terminal Cleaning Policy)</p> <p>OOH wall washers booked via PSC.</p>		
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**DIRECTORATE PATIENT SERVICES  
ESCALATION ACTION AND COMMUNICATION PROCESS  
Excluding ED**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts												
<p>This section identifies the process for the management of emergency pressures within the Trust when demand exceeds capacity. It provides guidance for the operation of facilities during periods of extreme pressure. A communication process is set out to support an escalation situation with responsibilities of all key individuals identified.</p>	<p>Indicators to evoke the process are all currently available and appropriate bed capacity is occupied and NEEP level 3 has been reached and possibly sustained over a period of days. i.e. The number of medical boarders at the RVI is 20 and the number at FH is 30.</p> <p><b>Contingency Plans to manage increased pressure</b></p> <p>The PSC will advise the AS Coordinator, A&amp;E Coordinator and the On-Call Manager of escalating bed pressures.</p> <p>Matron for Patient Services/On-Call Manager (OOH) will assess the situation and inform the Nursing and Patient Services Director and the Medical</p>	<p><b>Accommodating Emergencies</b></p> <p>Escalation plans to increase medical base ward capacity will be implemented. This will be instigated by the Nursing and Patient Services Director, Emergency Care Lead, Medical Director, and/or 'On-call' manager.</p> <p><b><u>Capacity will be increased in the following areas:</u></b></p> <ul style="list-style-type: none"> <li>• <b><u>Open weekend capacity</u></b> taking into consideration the following options and order:</li> </ul> <table style="margin-left: 20px;"> <tr> <td>RVI Ward 51 (PIU)</td> <td>6 beds</td> </tr> <tr> <td>FH Ward 29</td> <td>6 beds</td> </tr> <tr> <td>RVI Ward 44</td> <td>6 beds</td> </tr> <tr> <td>RVI Ward 46</td> <td>1+7bds</td> </tr> <tr> <td>RVI Ward 20</td> <td>6 beds</td> </tr> <tr> <td>FH Ward 6</td> <td>4 beds</td> </tr> </table>	RVI Ward 51 (PIU)	6 beds	FH Ward 29	6 beds	RVI Ward 44	6 beds	RVI Ward 46	1+7bds	RVI Ward 20	6 beds	FH Ward 6	4 beds	<p>RVI PSC 24300</p> <p>FH PSC 26623</p> <p>Matron Patient Services 29460</p> <p>Patient Services Manager 48963</p> <p>Matron Surgery 29362</p> <p>Matron Medicine 29917</p> <p>Manager on-call via switch</p> <p>Medical Director on call via switch</p>
RVI Ward 51 (PIU)	6 beds														
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FH Ward 6	4 beds														

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
	<p>Director.</p> <p>Elective work will continue to operate as normal, but specific pressure points may result, and the cancellation of planned elective admissions will be considered. Clinical prioritization of patients will be undertaken by the relevant Consultant surgeon on-call and priority will be given to urgent surgical cases and patients who may breach waiting times targets. PSC will obtain accurate information regarding elective patients admitted that day i.e. patients condition, surgery schedule and investigation being undertaken in order to ascertain whether overnight discharge is a possibility; this may release some capacity</p>	<p style="text-align: center;"><b><u>Open additional weekday capacity:</u></b></p> <p><b><u>Option 1</u></b>  <b>Convert Day-case capacity to Inpatient capacity</b></p> <p>RVI Wd 45 – Create up to 10 beds Monday – Friday utilising the first 2 bays which have full bed-head services.</p> <p>Planned Day-cases to be accommodated on RVI39; vacant Special care capacity on RVI 36 and RVI 47 and Park Suite. The on-call surgeon will prioritise cases for cancellation/admission if all patients cannot be accommodated.</p> <p>The responsibility for identifying Nurse staffing resource will be as follows:</p> <ul style="list-style-type: none"> <li>▪ 07:30hrs – 21:00hrs; Matron for General Surgery</li> <li>▪ 21:00hrs – 07:30hrs; Matron for General Medicine</li> </ul> <p>Use physical beds may be located on the Winter Ward when closed or the “void” on level 4 New Victoria Wing, RVI. Only the Matron, Patient Services can authorise the use of these beds.  Matron, Patient Services and Matron,</p>	

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
		<p>General Medicine will identify patients to be managed/accommodated in the 10 bedded area.</p> <p>The clinical care of the patients will remain the responsibility of the original base ward Consultant. <b>In the event of patients having no RVI consultant ie those directly admitted from AS the PSC will allocate appropriately.</b></p> <p>The maximum duration of opening this capacity will be up to 5 working days in any Monday – Friday period.</p> <p>The RVI PSC will assist with closure management.</p>	

**DIRECTORATE INTERNAL MEDICINE  
ED Management of Increased Pressure**

Introduction and purpose of policy	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>This section identifies the process for the management of emergency pressures within the Trust when demand exceeds capacity. It provides guidance for the operation of facilities during periods of extreme pressure. The communication process is set out to support an escalation situation with responsibilities of all key individuals identified.</p>	<p><b>Phase One</b> The ED doctor and Nurse in charge should be informed of and confirm that there is ED capacity problems. The only remaining beds available are 2 resus bays</p> <p>The PSC informed of capacity problems and will endeavor to relieve ED pressure by facilitating the transfer of patients to AS or base wards.</p> <p>PSC will liaise with ED nurse in charge and AS nurse in charge regarding outflow from each area and endeavor to increase transport capacity for those patients awaiting discharge or transfer to FH. The PSC should seek additional transport resource from NEAS and Lifeline services. Consideration should be given to opening additional A&amp;E capacity (for up to 8</p>	<p><b>Phase Two</b> When all 18 bays are full and only two resuscitation bays remain free, the A&amp;E Consultant confirms capacity problem is sustained and not rectifiable; contacts Clinical Director, Nursing and Patient Services Director / Medical Director, and out of hours informs the On-Call Assistant Medical Director and Manager;</p> <p>The following actions will be considered and implemented <b>only</b> following authorization from an Executive Director :</p> <p>Closure of A&amp;E to all further medical / surgical emergencies with the exception of multiple trauma. Ambulance Service to be advised to redirect patient to alternative A&amp;E. Inform other local A&amp;E departments. Chief Executive, Local Primary Care Trust and Strategic Health</p>	<p>RVI PSC 24300 FH PSC 26623 ED Nurse 23705 AS Nurse29327 Matron Patient Services 29460 Patient Services Manager 48963 Medical Director via switch Manager on call via switch</p>

Introduction and purpose of policy	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
	<p>hours) in order to alleviate immediate pressures. 3 additional bays should be opened in monitoring; the Nurse in charge of ED should seek to provide an additional qualified nurse to support this. See Table of Directorate Lead Contacts to identify Nursing Resource.</p> <p>Once capacity problem has been confirmed and there is no immediate solution, the PSC will advise the Nursing and Patient Services Director / On-call Manager.</p> <p>At this stage consideration should be given to opening additional Emergency Capacity as outlined in <b>Escalation and Communication Process</b></p>	<p>Authority to be advised.</p> <p>While phase two is being put into action, patients en-route will arrive in A&amp;E and they will have to be accommodated in the monitoring or corridor area on trolleys. The maximum number of patients that can safely be accommodated in this way is three.</p> <p><b>Phase Three</b> On-call Manager or Assistant Medical Director advises the Nursing and Patient Services Director who discusses with the Chief Executive and Medical Director the movement to 'Red Alert' Status.</p> <p>The Strategic Health Authority and PCT will be informed by the Nursing and Patient Services Director / Chief Executive that the Trust is in a 'Red Alert' situation.</p>	

**DIRECTORATE  
MEDICINE CARE OF THE ELDERLY**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and Contacts
<p>Daily referral to Care of the Elderly following protocol flow chart (exhibit 6)</p> <p>Complete the “Referral to Care of the Elderly” consultant request available on the Care of the Elderly intranet site.</p> <p>Referred patient details (those awaiting “in house” rehabilitation or transfer to a CofE ward held by Secretary 31683)</p> <p>Refer out of area patients to their local hospital rehab services (exhibit 2)</p>	<p>Matron for Cof E contacted to ensure all transfers have taken place and to check progress of referral with a view to transfer/discharge.</p> <p>Communicate with the Discharge Liaison Facilitator to check availability and facilitate transfer to Continuing Care Beds</p>	<p>Initiate bed management meeting to include Discharge Liaison Facilitator and Matron for Patient Services</p>	<p>Matron Care of the Elderly 48613</p> <p>Directorate Manager 29580</p> <p>Discharge Liaison Facilitator 28900</p> <p>Matron Patient Services 29460</p> <p>PSC RVI 24300</p> <p>PSC FH 26623</p>

## DIRECTORATE SURGERY

Daily Function  (green)	Increased Pressure  (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Cross site daily accommodation of elective and emergency admissions.</p> <p>Respective PSC's will assess capacity and place patients both elective and emergency, according to their diagnosis.</p> <p>Decanting of patients from HDU and ITU will also be accounted for by the PSC to allow theatre lists to begin.</p> <p>Ward 12FH holds 1 protected bed for liver transplant patients.</p> <p>RVI accepts all emergency referrals except for vascular and HPB patients whose specialist clinicians are based at FH.</p> <p>A direct HPB admission to FH has to have an amylase of &gt;500. All other patients suspected of having HPB</p>	<p>PSC alerts Directorate team to capacity problems.</p> <p>If possible move boarders back to their base wards or discharge.</p> <p>Instigate extra consultant ward rounds</p> <p>Board appropriate surgical patients to accommodate surgical emergencies.</p> <p>Consider boarding appropriate pre-op patients taking into consideration their post op requirements.</p> <p>RVI. Clinically appropriate surgical emergencies to stay on AS till bed available.</p> <p>Weekend only-consider opening closed surgical capacity.</p> <p>Use any protected beds.</p>	<p><u>Both RVI and FH.</u> If bed pressures continue increasing the surgical consultant on call will prioritize ITU/HDU, elective and emergency patients. This may result in the cancellation of elective cases.</p> <p>Waiting lists for the following days to be prioritized and cancellation of admissions considered if predicted future capacity not enough to accommodate waiting lists</p> <p>FH to take surgical emergencies to alleviate pressure on RVI. Only to take place after consultant to consultant discussion.</p> <p>Open close capacity on non-surgical wards eg Ward 20 RVI</p>	<p>RVI PSC 24300</p> <p>FH PSC 26623</p> <p>Surgical Matron 29362</p> <p>Directorate Manager 48902</p>

<p style="text-align: center;">Daily Function (green)</p>	<p style="text-align: center;">Increased Pressure (amber)</p>	<p style="text-align: center;">Escalation Plan (Red)</p>	<p style="text-align: center;">Useful numbers and contacts</p>
<p>problems will go to EAU RVI to be assessed. Patients referred with ?pancreatitis will go to ES RVI. Patients who present regularly with chronic pancreatitis, and have extensive histories at FH will continue to be admitted to FH. Patients presenting with “new” jaundice will be sent to RVI ES. (Eventually these patient will be accommodated on ward 16 FH but this service is not available yet)</p> <p>Definition of a “return” (for all surgical specialities) is as follows. A patient will be classed as a return when they have “an outstanding Clinic appointment or are on a waiting list for treatment”</p>			

**DIRECTORATE  
OPHTHALMOLOGY WARD 20**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful Contact Numbers
<p>Ward accepts waiting list and emergency ophthalmology and Max Fax patients. Also Day case orthopaedic cases</p> <p>Mon-Fri (12md) 22 beds Fri(12md) - Sat(12md) 16 beds Sat(12md)–Sun(12md)12 beds Sun(12md)-Mon(am) 16 beds Beds allocated as follows 12 Max Fax 10 Ophthalmology</p> <p>Patients may be boarded onto ward 20-with the exclusion of Head injury Chest Pain Acute heart problems Infective diarrhea Unstable Diabetics Confused patients</p>	<p>Contact PSC to move any boarded patients</p> <p>Open extra capacity if beds are closed. Review daily</p> <p>Suitable ophthalmology/max fax patients identified for boarding by ward staff. Wards identified to accept boarders should be competent in the patients management and at no time should patient care be compromised.</p>	<p>Open to full capacity at weekends review daily.</p> <p>Consider the cancellation of elective activity both ophthalmology and max fax. Consultants and Matron to discuss which patients to cancel.</p> <p>Directorate responsible for informing the patient and re booking admission.</p>	<p>Ward Coordinator 29025</p> <p>Matron 29192</p> <p>Directorate Manager 29124</p> <p>RVI PSC 24300</p>

**DIRECTORATE  
DERMATOLOGY**

<p align="center">Daily Function (green)</p>	<p align="center">Increased Pressure (amber)</p>	<p align="center">Escalation Plan (Red)</p>	<p align="center">Useful numbers and contacts</p>
<p>8 in patient beds 8 day case areas Accept emergency, waiting list and day treatment patients.</p> <p>Monday – Friday Dermatology OP staff will see and treat and paediatric patients. Sat-Sun Ward 5 will be responsible for Paediatric patients.</p> <p>Criteria for accepting boarders Staffing levels Medical cover Dependency</p> <p>Emergency medical/surgical patients should not be sent directly to ward 5</p> <p>Dermatology patients with the following diagnosis should not be boarded from ward 5 Eczema Psoriasis Erythroderma Vasculitis Bullous Pemphigoid</p>	<p>Move any boarders back to base wards.</p> <p>Consider using day case space as in patient capacity. This may not be required immediately but may be over the next few days.</p> <p>Review patients with a view to discharge</p> <p>Board Dermatology patients into appropriate specialty. PSC to liaise with the Dermatology Consultant/Reg and discussed bed availability and needs of the patient.</p>	<p>Cancel elective activity.</p> <p>Open extra capacity in day case areas as planned. To be reviewed on a daily basis taking into account.</p> <p>Demand Patient needs Staffing levels</p>	<p>Matron 29192</p> <p>Directorate Manager 29124</p> <p>PSC 24300</p>

**DIRECTORATE  
MUSCULO SKELETAL**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Accept waiting list and emergency admission on a daily basis to RVI and FH. <u>RVI</u> Ward 23 Trauma     Neck of Femur Ward 22 Planned spinal     Surgery</p> <p><u>FH (waiting list only)</u> Ward 19 Planned joint surgery Ward 20 (inc13 Rheumatology D/C beds open Mon-Fri 08.30-18.30) Rheumatology elective admissions Planned joint surgery Cancer surgery</p> <p>Senior Nurse to ensure no less than 3 trauma beds are available at all times. This may necessitate the moving of patients to FH from the RVI. (see increased pressure)</p>	<p>Directorate team-Matron/ Directorate Manager-informed of capacity problems which may impact on elective activity. They should then initiate</p> <p>1) Identification of boardable patients by a senior member of the clinical team will take place. The PSC will then coordinate their move. If there is capacity within the Directorate at FH then the boarding of patients from the RVI to FH should take place, before boarding to wards within the RVI. Only patients belonging to the following Consultants should be boarded: Mr.Deehan Mr.Holland and Mr. Grey.</p> <p>2) If there is no capacity at FH identified patients should be boarded to neuro wards first due to expertise and proximity. PSC to liaise and document details of boarded patients in the usual way.</p> <p>3) Orthopaedic wards who have boarded patients should also keep a record of boarded patients name, diagnosis and Consultant.</p> <p>NB All consultants must be informed if their patients are to be boarded</p> <p>Inform on call consultant of bed situation.</p>	<p>Inform Directorate management team of ongoing problem.</p> <p>Hourly bed states while situation remains critical.</p> <p>Re assess bed availability of orthopaedic beds at FH and identify more boarders if possible</p> <p>In order to provide capacity the cancellation of elective activity should be considered. This should be carried out by Directorate management team and Orthopaedic consultants.</p>	<p>Directorate Manager 48062</p> <p>Matron 48618</p> <p>Senior Sister 21751</p> <p>PSC RVI 24300</p> <p>PSC FH 26623</p>

**DIRECTORATE  
PAEDIATRICS**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Emergency and waiting list admissions accepted into the Directorate via ward 6 (no blue light emergencies) and ED After 10pm all admissions via ED</p> <p>Bed management 9-5 Childrens Coordinator 29261 OOH Senior Nurse 29261 OOH Senior nurse/manager on-call via switch</p> <p>1bed on 1a(renal) 1b (neuro) ward 11(burns) should ring fenced for specific emergencies.</p> <p><u>Age Range</u> Patients under 16 admitted to Childrens areas. Admission to adult areas may be indicated if specialist opinion required. 16yrs-18yrs Assessed on an individual basis consideration given to Clinical need, maturity, family support and safeguarding issues Child and Adolescent Mental Health-S/A</p> <p>Regional bed states are completed twice a day by the Paediatric Bed Bureau (external to the Trust) available via ward 6 or Childrens Coordinator</p> <p>Bed closures via Directorate team PSC OOH on-call</p>	<p>Extra ward rounds to review and discharge</p> <p>Childrens coordinator communicates bed pressures to on call consultant and ward 6</p> <p>Identification and medical approval of boarders to move to other wards (consider ward specific acceptable criteria when identifying boarders) move before 20.00 Use ring fenced beds to create capacity</p> <p>Review any bed closures and open as soon as possible. Consider using weekend leave and PICU beds (approval via Childrens coordinator)</p>	<p>Regional bed state from Paediatric Bed Information Service (PBIS) 0191 4302210</p> <p>Review elective admissions and consider cancelling the day before</p> <p><b>Deflection to other Trusts Can only be actioned by Clinical Director or nominated deputy. Each referral is via RVI registrar to receiving Trust</b></p> <p>Boarding after 20.00 to facilitate capacity</p> <p>Review any bed closures and open if possible</p>	<p>Directorate Management Team</p> <p>Matron 29720</p> <p>Directorate Manager 29800</p> <p>Childrens Coordinator 29261</p> <p>OOH Senior Nurse 29261</p> <p>On call manager via switch</p>

**DIRECTORATE  
NEUROSURGERY AND NEUROLOGY**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Normal daily activity is the acceptance of waiting list and emergency admissions to the Directorate. Admitting if possible to the accepting Consultants ward. The Trust is a Regional Neurosciences Centre and as such is required to accept referrals from a wide area.</p> <p>Prioritisation of admissions should be in the following order Emergency HDU Transfer Elective Day of Surgery Arrival Elective Not Day of Surgery Arrival</p> <p>ITU/HDU (ward 18) On a daily basis patients from neuro ITU/HDU will be moved to base wards after Consultant review. The nurse practitioner will liaise with ward staff and organize patient transfer. If demand for HDU beds exceed predicted capacity the on-call consultant must be informed.</p>	<p>Directorate management team will inform PSC of capacity problems. The PSC may inform Management team first if he/she is aware of ED neuro patients who require admission.</p> <p>Board patients from base wards preferably to Orthopaedics due to proximity and expertise of staff.</p> <p>If not enough beds available consultant and Matron to liaise and prioritize patients and cancel if necessary. <u>Elective admission</u> Consider sending home to return the following day patients who are not day of surgery arrival.</p> <p><u>Emergency Admission</u> Can only be accepted by Neuro registrar. If no bed available in Neuro directorate, identify suitable boarder(s) contact PSC to arrange transfer. Consider “swapping” patients on repatriation list with emergency admission</p> <p>Inform consultant on call if less than 2</p>	<p>Involve Directorate Management team if outlying hospitals reluctant to take patients from repatriation list</p> <p>Admit patients who were sent home If no beds available on following day the Admissions coordinator will arrange re-admission within 28days</p> <p>Board to accommodate emergencies (may be outside suitable time recommended in Boarding policy)</p>	<p>Matron 21780</p> <p>Directorate Manager 21757</p> <p>RVI PSC 24300</p> <p>On call Neuro Specialist Registrar 23720</p>

<p>All neuro wards liaise with each other to accommodate daily emergency and waiting list admissions.</p> <p>Repatriation –(see Repatriation policy exhibit 2)</p> <p>Patients who require repatriation, after appropriate referral, to other facilities will be transferred when an appropriate bed is available . A list of these patients will be updated by ward staff or PSC on a daily basis. Plans to transfer will be actioned by ward moving the patients. Updated list will be E mailed to Matron in Neuro.</p>	<p>emergency beds available at 5pm. And ensure wards have suitable boarders identified. Contact PSC to move if necessary</p>		
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**DIRECTORATE  
WOMENS SERVICES (WARD 40 & WARD 40 DAY UNIT)**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Ward 40 Accepts elective and emergency Gynecological admissions 24/7</p> <p>Ward 40 Day Unit 8am-8pm Mon-Fri 7beds Pregnancy Loss</p> <p>2 emergency beds for Gynecology patients.</p> <p>OOH Nurse in charge liaises with PSC if beds required</p>	<p>Contact Matron (OOH nurse in charge )who will inform medical staff Bed Bureau obtain regional bed state</p> <p>Contact PSC to move any boarders/board Gynae patients to other wards</p> <p>Admissions prioritized by Nurse in charge /Matron</p> <p>Consider using 2 emergency beds</p>	<p>Consultant on call to decide if deflection to other hospitals to take place</p> <p>Consider cancellation of admissions and Inform Directorate manager and Consultant if any occur.</p>	<p>Matron 20527</p> <p>Directorate Manager 25669</p> <p>PSC RVI 24300</p>

**DIRECTORATE  
UROLOGY AND RENAL SERVICES**

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p>Accommodation of elective and emergency admissions on wards 1,2 and 3 Ward 1-Mon-Fri short stay Wards 2&amp;3 waiting list and emergency patients.</p> <p>Matron (Urology) responsible for allocation of beds for urology elective/emergency admissions to Urology wards.</p> <p>4 beds to be available for emergency admissions.</p> <p>PSC FH informed of bed shortages. Any boarders moved back to base wards or discharged if possible.</p>	<p>Inform Directorate management team of problems.</p> <p>Accommodate longer stay patients on ward 1 until bed is available on 2 or 3</p> <p>Board elective or emergency activity with a view to return to Urology the next day.</p>	<p>Keep open planned weekend bed closures.</p> <p>Consultant on call identifies possible discharges</p> <p>Prioritisation of by Registrar/Consultant if unavailable the on-call consultant should be contacted. Admissions should be considered in the following order</p> <ul style="list-style-type: none"> <li>Cancer</li> <li>Previous cancellation</li> <li>Long Waiter</li> <li>Ease with regard to rescheduling</li> <li>Urgent cases</li> </ul> <p>As a last resort low priority admissions will be sent home to accommodate emergency admissions. Consultant or on-call Consultant to decide which patients fit this category. PSC and Manager on call will be informed before this step is taken</p>	<p>Matron (Urology) 48822</p> <p>Matron (Renal) 48960</p> <p>Directorate Manager 48298</p> <p>PSC FH 26623</p> <p>EAS 26419</p>

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (Red)	Useful numbers and contacts
<p><b><u>RENAL</u></b>            Patients access admission            direct to ward 32 or RCIU            If patient too ill or no bed            available admit to EAS</p>	<p>Patients boarded to            accommodate            emergencies to Urology            wards if possible            Repatriate patients            where possible.</p>	<p>Consider opening closed            capacity</p>	<p>RCIU 37562            Ward 31 37031            Ward 32 37032</p>

**DIRECTORATE  
Cancer Services and Clinical Haematology  
WARDS 33, 34 and 35 FH**

Daily Function  (green)	Increased Pressure  (amber)	Escalation Plan (red)	Useful Contacts
<p>Admit patients for Elective Chemotherapy, Radiotherapy, Stem Cell Transplantation and non urgent symptom control.</p> <p>Accept appropriate haematology and oncology emergency admissions Monday-Friday via Supportive Therapies Unit. Out of hours/weekends review appropriate direct access patients on ward and arrange admission if needed.</p> <p>Daily bed meetings to identify 2 suitable patients for potential boarding from each ward if bed pressures increase (boarding decisions according to Directorate policy)</p> <p>Bed Management</p>	<p>Attending Consultants (with input from Clinical Director/ deputy, Matron and Senior Nursing Team) will prioritise elective admissions and defer if clinically acceptable</p> <p>Contact FH PSC to arrange boarding of patients. Boarded patients will remain under the care of their the haematology or oncology Consultant who should be informed of patient movement. (See exhibits 3 and 4).</p> <p>Boarders will be reviewed daily by haematology or oncology registrar or Consultant supported by junior staff.</p> <p>If a patient is admitted as a Haematology or Oncology boarder the patients Consultant, team SPR and the Directorate bed manager</p>	<p>Open any closed capacity</p> <p>Increase boarding of haematology and oncology patients.</p> <p>Attending Haematology and Oncology Consultants to review all current inpatients to facilitate early discharge.</p> <p>Where possible transfer patients to “base hospital”.</p>	<p>Directorate Bed Manager 39369</p> <p>Matron 39280</p> <p>Patient Services Coordinator (FH) 26623</p> <p>Directorate Manager 48723</p> <p>Clinical Director 29730</p> <p>Attending Consultant Haematologist or Oncologist available via switchboard.</p>

Daily Function (green)	Increased Pressure (amber)	Escalation Plan (red)	Useful Contacts
<p>coordinator (in hours) to allocate elective patients.</p> <p>Urgent admissions allocated beds as needed. If bed pressures prioritise according to clinical circumstances after discussion with Matron/Senior Nurse and Attending Consultant haematologist /oncologist.</p> <p>See Directorate Bed Management Guidelines for the prioritisation of emergency admissions for haemato-oncology, oncology, stem cell transplantation and non-malignant haematology and emergency admissions via ED and AS</p> <p>See Exhibit 5 for Teenage and Young Adult Unit (TYAU) information.</p>	<p>must be informed. The patient will be listed on the daily boarders list provided by the FH PSC.</p>		

## 2. Monitoring

The policy will be monitored on an annual basis by the Matron for Patient Services.

Ward	Responsible for	Windle, Matron.
52 Resp	PIU, CF Unit, Park Suite and Neurosurgery Burns Unit	
48 Gastro	36, 45, 46,	Windle, Matron.
31 Diabetic&Endo	20, 22, 23 and 47	
30 Short Stay	44 and 47.	<b>Ward</b>
19 ID	5	
41 ASU	Non-stroke patients on 41 and ward 43	
Ward 49	Non-cardiac patients on 49	

**Author:** Valerie  
Patient Services  
**Exhibit 1**

**Boarders at RVI  
Responsibilities**

If possible “short stay” patients in AS should not be sent to outlying wards they should preferably go to ward 30. If a short stay patient has to be boarded then the AS team may review in 24hrs with a view to discharge.

All boarders who have been seen by the AS physicians, and then boarded from AS, must be handed forward to the base ward team covering that ward.

All boarders boarded out overnight should be handed forward to the base ward team by the out of hours/day time team on the post take ward round.

The base ward teams should contact their respective boarder wards daily, to find out if they have any boarders to review. This information is also available from the boarders list that the PSC compiles on a daily basis and is available via E mail.

When the base ward team first see a boarded patient they will allocate an appropriate base ward consultant. This must be communicated to the ward clerk in order for the patients records to be updated.

### Boarders at FH Ward Responsibility

Before boarding patients at FH the Clinical Director for Medicine should be informed

Boarders should be limited to 12 but if it is necessary to increase the number then the Clinical Director should be advised.

Post take patients from AS should be considered for boarding first.

If it is necessary to board from base wards at FH the patients should stay under their consultant from the base ward and allocation of junior doctors responsibility must be clarified.

The first **8 boarders** at FH should be shared equally between

Consultant	Team Responsible
Dr. Thompson	Ward 16
Dr. Louw	Ward 13
Dr. H. Wynn	Ward 18
Dr. Frearson	Ward 15

The next **4 boarders** should be shared equally between

Consultant	Team Responsible
Dr. Jay	Ward 15
Dr. Davison	Ward 15
Dr Gani	Ward 13

Should boarders at FH site have to be increased beyond 12 then the Directorate Medical Director should be contacted for approval.

The boarders over and above 12 should be allocated to consultants in the following order Thompson, Louw, Wynn, Frearson, Jay, Davison, and Gani until all boarders have an allocated consultant.

## Repatriation Process for Patients Transferring out of the Trust

Patients requiring repatriation are defined as those who are medically fit for transfer to their destination centres, which may be local hospitals or social services establishments. The following guidelines outline a structured approach which should maximise the repatriation of patients within a one week period. Consideration must be given to the prior booking of ambulances to facilitate transfers.

It should be noted that planned transfers with an agreed date are not part of the repatriation process. For Example Neurosurgery patients being transferred to Walkergate Park.

The following process begins AFTER a referral to the receiving hospital has been made by the Trust.

### Days 1&2

Nurse in charge initiates contact with receiving centre

### Day 3

Nurse contacts receiving centre. If bed not available she/he to contact PSC who will speak to receiving centres bed manager. Trusts specific Directorate Manager informed

### Day 4

If no bed available after 3 days PSC to inform the Consultant who will liaise directly with the receiving Consultant. DM will inform Clinical Director/Head of Department.

### Day 5

Matron Patient Services speaks to head of Services at the receiving centre to discuss options for repatriation. This should include the option of sending the patient to the receiving centres emergency area. If repatriation is not resolved Medical Director to be advised to take appropriate action.

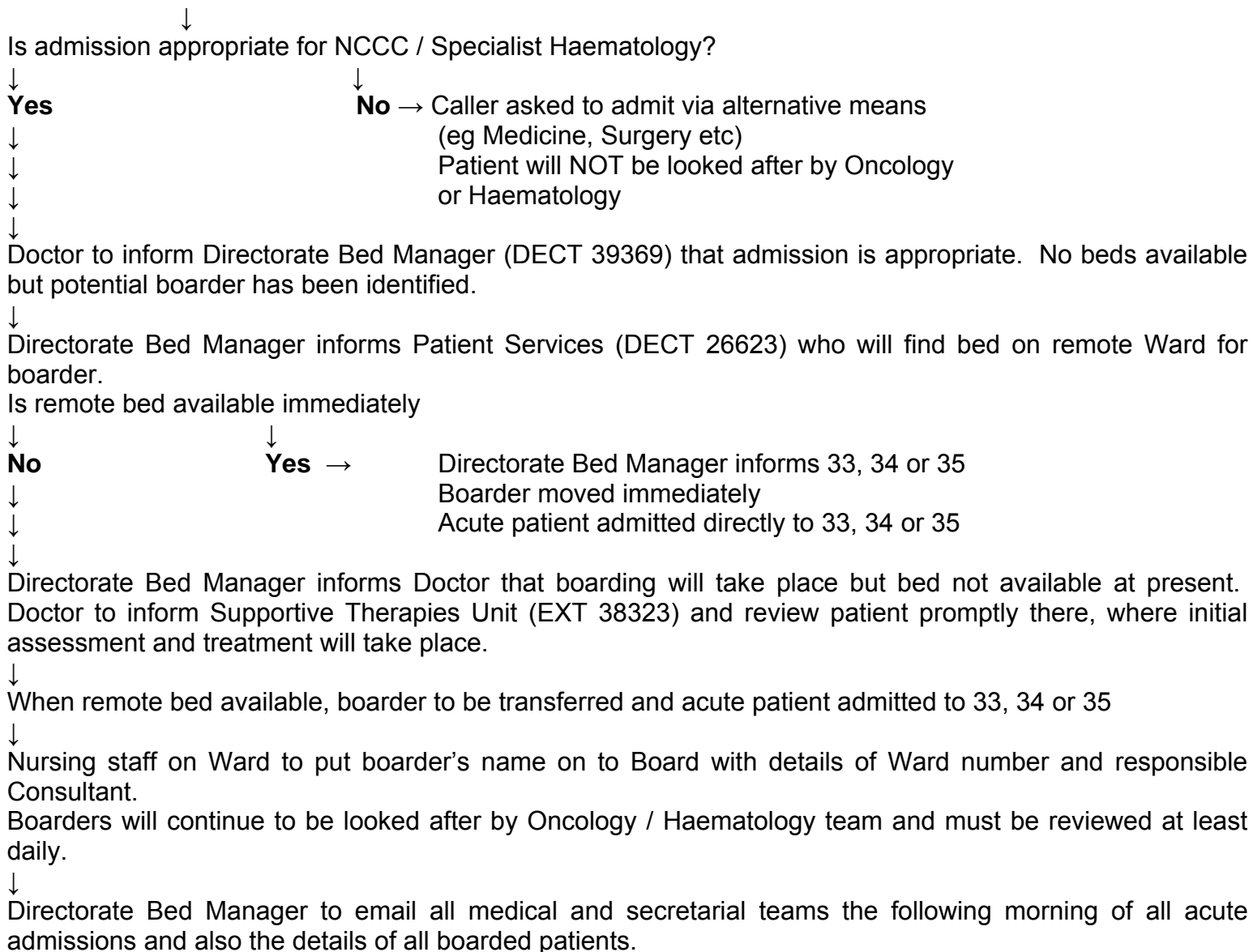
### Hospital Telephone numbers

Hospital	# code	Bed manager bleep
North Tyneside	#61148	5246
Wansbeck	#61148	167/156 ext 3232
Hexham	#61148	1065/1167
University Hospital Durham	#61114	2080 ext 2062
Cumberland Infirmary	#61111	"Gate 156"
South Tyneside District Hospital	#61171	201(surgery) or Medical Admissions Unit
Queen Elizabeth Hospital	#61103	2219(med) 2252(surg)
Sunderland Royal	#61139	51044

## FLOW SHEET 1

ADMISSION OF PATIENT TO NCCC / HAEMATOLOGY WHEN APPROPRIATE BOARDER IDENTIFIED

Acute admission rung via SpR / Consultant



Other contact numbers:

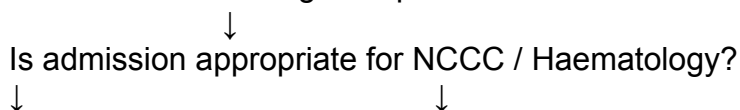
Ward 33	37033
Ward 34	37034
Ward 35	37035
Matron	39280

**Exhibit 4**

**FLOW SHEET 2**

**ADMISSION OF PATIENT TO NCCC / SPECIALIST HAEMATOLOGY WHEN THERE ARE NO APPROPRIATE BOARDERS**

Acute admission rung via SpR / Consultant



**Yes**  
↓  
↓  
↓  
↓

**No** → Caller asked to admit via alternative means  
(eg Medicine, Surgery etc)  
Patient will NOT be looked after by Oncology  
or Haematology

Doctor to inform Directorate Bed Manager (DECT 39369) that admission is appropriate. No beds available and patients suitable to board out.

↓  
Directorate Bed Manager informs Patient Services (DECT 26623) who will find bed on remote Ward for acute Oncology / Haematology admission.

Doctor to inform Supportive Therapies Unit (EXT 38323) of situation and arrange to promptly review patient here where initial assessment and management can be undertaken.

After medical assessment, Doctor to contact Patient services (DECT 26623) with details of assessment to ensure patient boarded to appropriate Ward.

When remote bed available, patient is transferred from Supportive Therapies Unit.

Doctor to put boarder's name on to Board with details of Ward number and responsible Consultant.  
Boarders will continue to be looked after by Oncology / Haematology team and must be reviewed at least daily.

↓  
Directorate Bed Manager to email all medical and secretarial teams the following morning of all acute admissions and also the details of all boarded patients.

Other contact numbers:

Ward 33	37033
Ward 34	37034
Ward 35	37035
Matron	39260

**Teenage and Young Adult Unit (TYAU)**

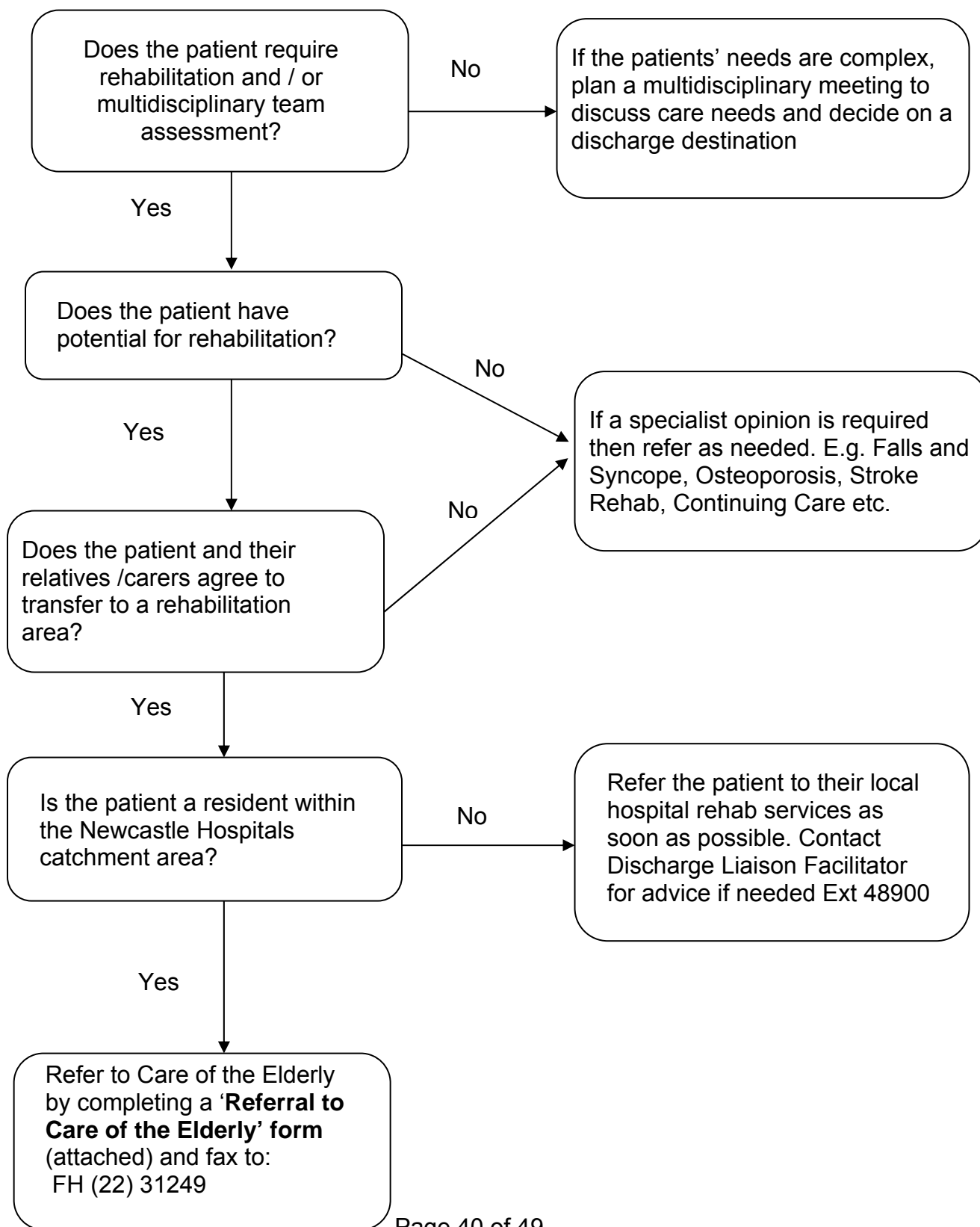
The TYAU is due to be operational from January 2012 onwards.

There are 7 designated beds (3 Cubicles and a 4-bedded bay) on ward 34 which comprise the TYAU. This is an age-appropriate facility for patients aged 19-24 years. In addition there is a single age-appropriate cubicle on ward 33 which is available for stem cell transplantation in the 19-24 age group.

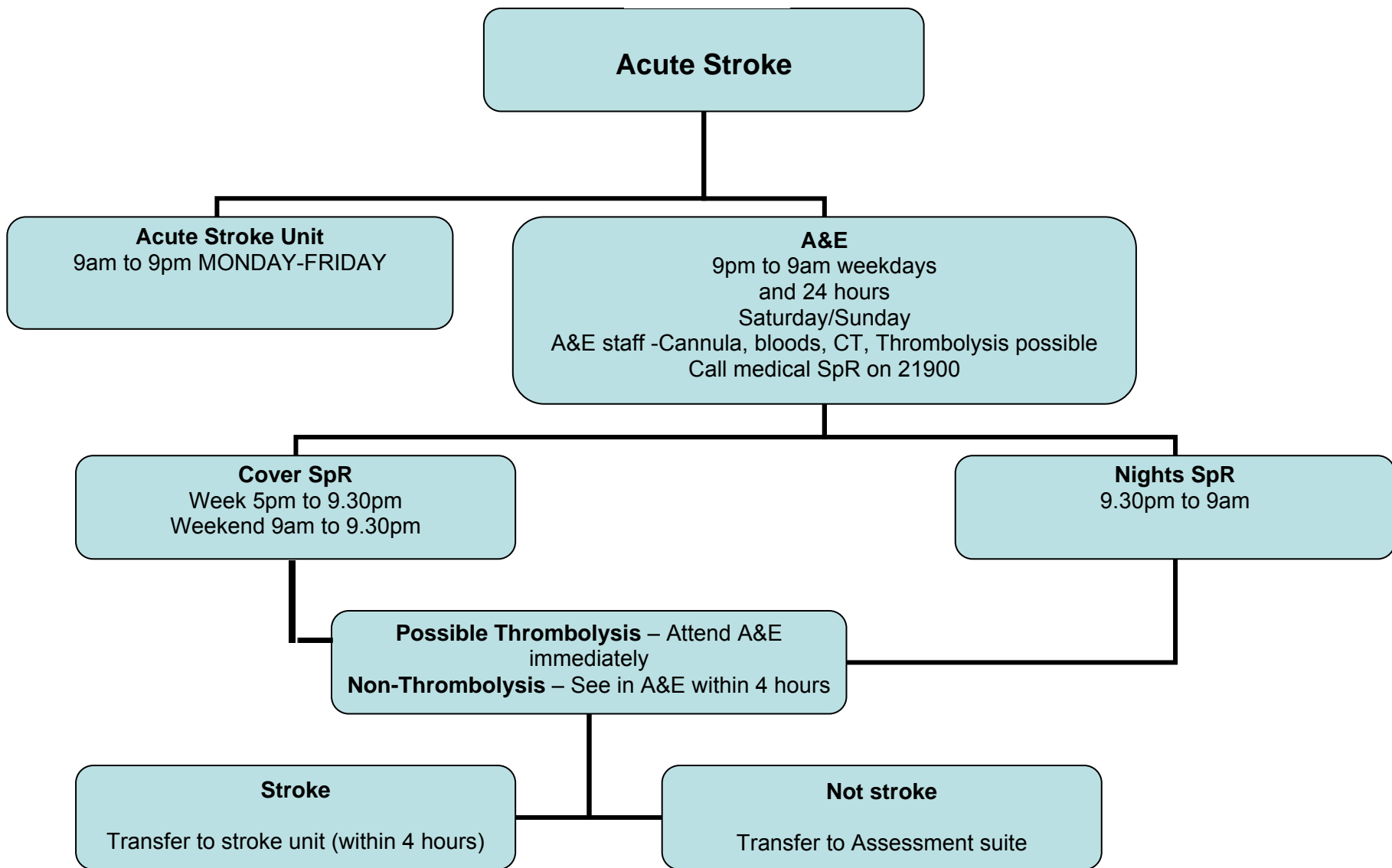
- Whenever clinically feasible patients in the 19-24 year age group should be accommodated in the TYAU.
- When there are beds available in the TYAU, and no patients in the 19-24 age group, the beds should be managed according to the Directorate bed management policy and may be used for patients of any age.
- At the earliest appropriate opportunity patients in the 19-24 age group, initially admitted elsewhere, should be moved into a TYAU bed.
- Conversely, if a patient aged >24 is initially admitted to a TYAU bed, the patient should be moved to an alternative bed at the earliest feasible opportunity.
- All patients in the TYAU should be under the care of a designated Adult Consultant Oncologist or Haematologist.
- Any patients outwith the above criteria need to be discussed on an individual basis with both the TYA clinical lead and the Directorate Matron.

*The TYAU is due to be operational from January 2012 onwards. As this is a developing service the Bed Management policy will be reviewed in 12 months (January 2013)*

Protocol for Referral to Care of the Elderly



**Exhibit 7**



Patient within 4 hours of stroke onset

Stroke assessment bay  
09:00-17:00  
Prehospital notification to ASU  
ASU Coordinator- nurse specialist-  
informs consultant and stroke SPR  
CT, venous access and bloods sent by  
specialist nurses  
Initial assessment and clerking by SPR or  
stroke unit doctor  
Stroke consultant review and  
thrombolysis if suitable

Stroke assessment bay  
17:00-21:00  
Prehospital notification to ASU  
ASU coordinator contacts cover SPR and  
stroke consultant  
SPR led assessment  
CT arranged by stroke specialist nurses  
Venous access/Bloods by stroke  
specialist nurses  
Clerking and initial assessment by  
registrar  
Suitable patients will be reviewed by on  
call stroke consultant

21:00-09:00  
Prehospital notification to ASU  
ASU coordinator informs medical SPR  
and A/E and on call stroke consultant  
CT/venous access/bloods and initial  
assessment by A/E doctors (middle  
grade)

## Exhibit 8

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
<ul style="list-style-type: none"> <li>• What needs to have happened (actual), or be about to happen (prospective trigger)?</li> <li>• Are these internal organisational triggers, or external ones i.e. across the PCT cluster or SHA?</li> </ul>	<ul style="list-style-type: none"> <li>• NHS North East Escalation Plan (NEEP) level</li> <li>• Description of what is happening in the organisation or service at this level</li> </ul>	<ul style="list-style-type: none"> <li>• What will be done to mitigate the raised level of pressure as a result of moving to this level?</li> <li>• Who by? When? Where?</li> </ul>	<ul style="list-style-type: none"> <li>• What will be communicated intra and/or inter organisationally?</li> <li>• Who by? When?</li> </ul>	<ul style="list-style-type: none"> <li>• What command and control arrangements will be in place?</li> <li>• Who has the authority and responsibility to trigger?</li> <li>• When and where will it be triggered?</li> <li>• Are these different in hours and out of hours?</li> </ul>	<ul style="list-style-type: none"> <li>• Expected impact of these actions</li> </ul>	<ul style="list-style-type: none"> <li>• Any implications of these actions on other organisations</li> </ul>
<p>Normal level of Trust activity and functioning</p>	<p><b>NEEP 1 Normal</b> (white)</p>	<ul style="list-style-type: none"> <li>• Planning for escalation in line with Business Continuity Plans</li> <li>• Executive agreement of Trust Winter Plan including plans for acute and community based services</li> <li>• Winter &amp; Operational leads identified</li> <li>• Responsibilities of key leads identified</li> <li>• Maintain daily, weekly and monthly Sitrep reporting</li> <li>• Relevant PPE testing in place</li> <li>• Vaccination programme for front line clinical staff actively promoted through Peer vaccination and clinic sessions</li> <li>• Planning to maintain supply chain within BC plans.</li> <li>• Critical care skills maintained at Directorate level.</li> <li>• Critical care skills training package in place and tested on non critical care staff.</li> <li>• Clinical skills training in place.</li> <li>• Capacity mapping undertaken</li> <li>• Planned Winter capacity will become operational</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Winter Contingency plan to ensure actions are both timely and accurate</li> <li>• Directorate and Department Managers aware of the plan and the implications for service delivery</li> <li>• Daily sitrep reporting commenced as per DH instruction (November)</li> </ul>	<ul style="list-style-type: none"> <li>• Command and control structures detailed in plan but not implemented</li> <li>• The Director and operational Winter Leads will be accountable through the NoT Winter Leads to the SHA.</li> </ul>	<ul style="list-style-type: none"> <li>• Nil</li> </ul>	<ul style="list-style-type: none"> <li>• Trust, SHA and PCT (NoT) Winter Contingency Plans should be checked for consistency and compatibility</li> </ul>

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
<ul style="list-style-type: none"> <li>● In excess of 12 medical boarders at FH</li> <li>● In excess of 20 medical boarders at RVI site</li> <li>● Paediatric inpatient reaching capacity</li> <li>● Other pressures ie infection control outbreak impacting on above</li> <li>● NE PICU or Adult Critical Care escalated to level 2</li> <li>● Staff absence 5% above normal baseline; or level of absence resulting in difficulties in delivering services.</li> <li>● Inclement weather affecting the ability of community staff to deliver care to patients</li> <li>● SHA may have asked for mutual aid</li> </ul>	<b>NEEP 2 Concern (green)</b>	<ul style="list-style-type: none"> <li>● A review of all planned elective activity will take place on a daily basis at Directorate level</li> <li>● The need to open additional paediatric capacity will be assessed (See paediatric plan for specific detail)</li> <li>● Consultant led daily review of all in patients made with aim to facilitate prompt discharge of patients</li> <li>● Review of bed state and staffing levels across the Trust will be made on a daily basis, this will be coordinated by the Bed Bureau under the direction of the Patient Services Matron.</li> <li>● Initiation of twice daily bed meetings led by Patient Services Matron.</li> <li>● Matrons to monitor staffing levels on a daily basis and to implement local actions to ensure safe staffing levels are maintained</li> <li>● All bed closures will be authorised by the Nursing and Patient Services Director or Senior Manager on call</li> <li>● Active management of any Infection outbreaks to minimise the need for bed closures.</li> <li>● Community service operational lead to: <ul style="list-style-type: none"> <li>&gt;Consider deployment of 4x4 vehicles</li> <li>&gt;each community clinical lead to prioritise community services caseload,</li> <li>&gt; coordinate pathways of communication between services and general practice,</li> <li>&gt; consider staff re-deployment depending on service affected (may require geographical relocation).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Regular internal communication between Winter operational leads, Patient Services Matron and relevant clinical directorates. Internal communications briefings as required</li> <li>● Daily conference call between NoT and SHA,</li> <li>● Trust operational lead to provide daily update of areas of concern to PCT Winter Lead</li> <li>● SHA informed by email via the PCT Winter Lead of the need to escalate NEEP.</li> <li>● Winter leads operational groups will meet monthly as a minimum requirement (NoT)</li> <li>● Daily SitRep reporting to the SHA &amp; NoT following agreed protocols</li> <li>● Winter Contingency Planning a standing Agenda item on all senior team meetings</li> </ul>	<ul style="list-style-type: none"> <li>● The Winter Lead will oversee the implementation of all actions detailed in the escalation plan</li> <li>● The Winter Lead will be accountable through the PCT Winter Lead to the SHA</li> <li>● The SHA Winter Lead will be in command and control of all Winter escalation activities across the North East NHS and will be accountable to the SHA and DH</li> </ul>	<ul style="list-style-type: none"> <li>● Daily operational activity will continue without disruption</li> <li>● Key members of the organisation will be aware of planned responses to enable us to deal with an escalation in activity</li> </ul>	

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
<ul style="list-style-type: none"> <li>• FH medical boarders up to 16-20</li> <li>• Medical boarders at RVI site remain in excess of 20</li> <li>• ACEP level increased to 2-3</li> <li>• Boarding threshold breached for more than 3-4 days</li> <li>• Paediatric inpatient at capacity and additional capacity opened</li> <li>• Sustained increase in A&amp;E attendance, sustained for &gt; 24hrs</li> <li>• Sustained increase in EAU attendance, sustained for &gt; 24hrs</li> <li>• Other pressures ie infection control outbreak impacting on above</li> <li>• NE PICU or Adult Critical Care escalated to level 3</li> <li>• SHA may have asked for mutual aid</li> <li>• Staff absence 5- 10% above normal</li> </ul>	<p align="center"><b>NEEP 3 Pressure (amber)</b></p>	<ul style="list-style-type: none"> <li>• Review of bed state and staffing levels across the Trust will be made on a twice daily basis, this will be coordinated by the Bed Bureau under the direction of the Patient Services Matron. Regular bed meetings continue.</li> <li>• A review of all planned elective activity will take place on a daily basis. This may affect theatre activity &amp; scheduling which will require liaison with Perioperative Services.</li> <li>• Elective activity prioritised</li> <li>• Possible training of non clinical staff to work in clinical areas will begin under the direction of the training department</li> <li>• Contingency bed capacity in operation as detailed in Winter Contingency Plan 2011/12</li> <li>• The need to open additional bed capacity will be assessed, aim to utilise RVI Ward 45.</li> <li>• Further additional paediatric capacity will be opened (See paediatric plan for specific detail)</li> <li>• Consultant led daily review of all in patients made with aim to facilitate prompt discharge of patients</li> <li>• Consideration of the need to request mutual aid from other local providers through NoT &amp; SHA Winter leads.</li> <li>• All managers to review specialist nurse activity and redeploy staff to support ward areas</li> <li>• Review of clinical threshold in relation to admission and discharge criteria will be made by the clinical lead at the RVI in consultation with the medical director's team.</li> <li>• <i>Consider the need to establish Silver control team as per Business Continuity Plan; Silver command will:</i> <ul style="list-style-type: none"> <li>➢ instruct managers to review all annual leave. Staff to be asked to cancel annual</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Regular internal communication between Winter operational leads, Patient Services Matron and relevant clinical directorates. Internal communications briefings as required</li> <li>• Daily conference call between PCT and SHA,</li> <li>• SHA informed by email via the PCT Winter Lead of the need to escalate NEEP</li> <li>• Daily sitrep reporting ongoing</li> <li>• Winter Lead operational groups will meet as required by NoT</li> <li>• Directorate managers/leads will be responsible for informing the patient services coordinators of the daily admission priorities.</li> <li>• Clinical service managers responsible for identifying and communicating priority services.</li> </ul>	<ul style="list-style-type: none"> <li>• The <i>Silver control team</i> will oversee the implementation of the escalation plan.</li> <li>• The Winter Lead will be accountable through the NoT Winter Lead to the SHA</li> <li>• Command and control structure will be fully operational</li> <li>• The Director &amp; Manager on call and the Assistant Medical Director on call will be informed of the decision to escalate the plan</li> <li>• The patient services coordinator will be informed by the silver control team of all decisions that affect the flow of patients in and out of the Trust</li> </ul>	<ul style="list-style-type: none"> <li>• Winter Contingency Plan implemented and the escalation framework will be in place to support actions</li> <li>• Disruption of services; planned non-priority inpatient admissions &amp; low priority community services.</li> </ul>	<ul style="list-style-type: none"> <li>• Impact on other organisations due to our need to prioritise transfers into Trust</li> <li>• Impact on activity in other organisations as we request mutual aid</li> </ul>

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
<p>baseline</p> <ul style="list-style-type: none"> <li>Community services experiencing a sustained level of pressure arising out of persistent inclement weather;</li> <li>Inability to deliver all services &amp; services finding it difficult to prioritise resulting in some clinical risk</li> </ul>		<ul style="list-style-type: none"> <li>leave wherever possible</li> <li>instruct managers to review all study leave and cancel all but essential leave,</li> <li>assess the impact on the organisation and communicate this to the SHA via the command and control structure.</li> <li>Community services experiencing a sustained level of pressure arising out of persistent inclement weather; <ul style="list-style-type: none"> <li>Use of escorted 4x4 vehicles</li> <li>Restriction of movement of community workers with staff reporting to nearest bases,</li> <li>Consider restrictions to low priority services &amp; redeploy staff</li> </ul> </li> </ul>				
<ul style="list-style-type: none"> <li>40% increase in A&amp;E attendance, sustained for &gt; 24hrs</li> <li>45% increase in Assessment Suite (emergency) activity, sustained for &gt; 24hrs</li> <li>Previously expanded critical care resource now at maximum capacity</li> <li>Previously expanded paediatric beds now at maximum capacity. Additional paediatric beds opened</li> <li>Other</li> </ul>	<b>NEEP 4 Severe Pressure (red)</b>	<ul style="list-style-type: none"> <li>Silver control team will remain operational</li> <li>All non urgent meetings cancelled to ensure priority focus on managing escalating pressures</li> <li>Review of bed state and staffing levels across the Trust will be made three times a day this will be coordinated by the Bed Bureau under the direction of the Senior patient services coordinator</li> <li>A review of all planned elective activity will take place on a daily basis</li> <li>Non urgent elective activity cancelled. This will affect theatre activity &amp; scheduling which will require liaison with Perioperative Services.</li> <li>Potential reduction in elective activity will lead to site specific cohorting of surgical patients.</li> <li>Additional Contingency bed capacity identified and activated</li> <li>The senior patient services coordinator will oversee the</li> </ul>	<ul style="list-style-type: none"> <li>Daily conference call between PCT and SHA,</li> <li>Trust Winter Lead to provide daily update of areas of concern to PCT Winter Lead</li> <li>SHA informed by email via the Winter Lead of the need to escalate NEEP</li> <li>Directorate managers/leads will be responsible for informing the patient services coordinators of the daily admission priorities.</li> <li>All actions and impacts will be communicated to the SHA including the impact on performance targets with a request to relax targets</li> </ul>	<ul style="list-style-type: none"> <li>SHA gold command control of NE NHS</li> <li>Trust Silver control team will be operational</li> </ul>	<ul style="list-style-type: none"> <li>Resources will be deployed in such a way as to ensure care remains safe and of a high quality.</li> <li>Reduction in elective and outpatient activity will result in inability to meet performance targets</li> <li>Outpatient activity will be significantly compromised</li> <li>Non clinical activity within the Trust is disrupted as staff are</li> </ul>	<ul style="list-style-type: none"> <li>Impact on other organisations due to our inability to accept transfers into Trust</li> <li>Recovery period likely to be several weeks</li> </ul>

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
<p>pressures ie infection control outbreak impacting on above</p> <ul style="list-style-type: none"> <li>• NE PICU or Adult Critical Care escalated to level 3</li> <li>• SHA have asked for mutual aid</li> <li>• Difficulties in scheduling some or all of key elective activity</li> <li>• Staff absence 10 – 20% above normal baseline</li> <li>• Unable to deliver priority 1 &amp; 2 community services</li> </ul>		<p>deployment of acute service staff across the Trust. The deployment of community staff will be undertaken by service managers.</p> <ul style="list-style-type: none"> <li>• A review of the need to reduce outpatient activity will be undertaken under the direction of the silver control team.</li> <li>• Aim to continue outpatient work where there is the potential to reduce hospitalisation. There will be a site specific cohorting of clinically urgent clinics</li> <li>• Staff will be redeployed from non clinical to clinical roles. Staff will be moved from areas where their absence will cause least impact</li> <li>• All annual leave will potentially be cancelled</li> <li>• Consideration of Agency staff to support critical services</li> <li>• Close Community priority 3 services and divert staff to support higher priority services</li> </ul>			<p>moved to clinical areas</p> <ul style="list-style-type: none"> <li>• Mutual aid will ensure the provision of equitable care across the region.</li> </ul>	
<ul style="list-style-type: none"> <li>• Staff absence 20% - 30% above normal baseline</li> <li>• 60% increase in A&amp;E attendance, sustained for &gt; 24hrs</li> <li>• 55% increase in Assessment Suite activity, sustained for &gt; 24hrs</li> <li>• Other pressures ie infection control outbreak impacting on above</li> <li>• NE PICU or Adult Critical</li> </ul>	<p><b>NEEP 5 Critical (purple)</b></p>	<ul style="list-style-type: none"> <li>• Silver control team will remain operational</li> <li>• A review of all planned elective activity will take place on a daily basis</li> <li>• Cancellation of all elective work that is not life threatening. This will affect theatre activity &amp; scheduling which will require liaison with Perioperative Services.</li> <li>• The need to move ward based staff into critical care will be assessed</li> <li>• Further movement of staff from non clinical to clinical roles</li> <li>• Loggists to commence recording of all decisions made</li> <li>• SHA will oversee decisions taken by clinicians and managers in Trusts to manage patient demand whilst meeting acceptable standards of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Daily conference call between NoT and SHA,</li> <li>• Trust Winter Lead to provide daily update of areas of concern to NoT Winter Lead</li> <li>• SHA informed by email via the Winter Lead of the need to escalate NEEP</li> <li>• Directorate managers/leads will be responsible for informing the patient services coordinators of the daily admission priorities</li> <li>• The impact on all performance targets will be communicated to SHA</li> </ul>	<ul style="list-style-type: none"> <li>• SHA gold commander assumes command and control of NE NHS</li> <li>• Trust Silver control team will be operational</li> </ul>	<ul style="list-style-type: none"> <li>• Only clinically vital care can take place</li> <li>• There will be rationalisation of services</li> <li>• Mutual aid will ensure the provision of equitable care across the Region</li> <li>• Major impact on clinical activity</li> <li>• Failure to meet any activity based performance targets</li> <li>• Almost total</li> </ul>	<ul style="list-style-type: none"> <li>• Recovery period likely to be months</li> <li>• Significantly reduced planned activity</li> </ul>

Trigger	Level	Action	Communication	Command and control	Impact	Implications?
<p>Care escalated to level 4</p> <ul style="list-style-type: none"> <li>• SHA have asked for mutual aid</li> <li>• Only able to schedule essential/life threatening elective activity</li> <li>• Unable to deliver priority 2 and possibly priority 1 community services</li> </ul>		<ul style="list-style-type: none"> <li>• Possible cessation of non-essential Outpatient activity</li> <li>• Restriction of priority 2 community services with resources diverted to provide priority 1 services</li> </ul>			<p>cessation of outpatient activity</p>	
<ul style="list-style-type: none"> <li>• Staff absence &gt; 30% above normal baseline</li> <li>• Extreme pressure from increasing activity</li> <li>• Unable to carry out any elective activity</li> <li>• Other pressures ie infection control outbreak impacting on above</li> <li>• NE PICU or Adult Critical Care escalated to level 4</li> <li>• SHA have asked for mutual aid</li> <li>• Unable to deliver priority 1 &amp; 2 and community services</li> </ul>	<p><b>NEEP 6 Potential Service Failure (black)</b></p>	<ul style="list-style-type: none"> <li>• Silver control team will remain operational</li> <li>• SHA to advise on service postponement/mutual aid</li> <li>• All available resource to be deployed to front line care</li> </ul>	<ul style="list-style-type: none"> <li>• Daily conference call between NoT and SHA,</li> <li>• Winter Lead to provide daily update of areas of concern to NoT Winter Lead</li> <li>• SHA informed by email via the NoT Winter Lead of the need to escalate NEEP</li> </ul>	<ul style="list-style-type: none"> <li>• SHA gold commander assumes command and control of NE NHS</li> <li>• Trust Silver control team will be operational</li> </ul>	<ul style="list-style-type: none"> <li>• Mutual aid will ensure the provision of equitable care across the region .</li> </ul>	<ul style="list-style-type: none"> <li>• Recovery period likely to be several months</li> </ul>

## Community Services Priority Levels

Priority 1	Priority 2	Priority 3
District Nursing	Community Resource Team	Funded Nursing Care Assessors
Rapid Response and supported Discharge team	Domicilliary Physiotherapy	TB service
Single Point of Access	Community Stroke Services	Community matrons
Phlebotomy		Community Podiatry
Loan Equipment		SALTS

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**  
**IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Bed Management Policy	Policy Author:	Valerie Windle
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)	No	
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	n/a	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?	n/a	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	n/a	
4(d).	Can we reduce the impact by taking different action?	n/a	

<b>Comments:</b>	<b>Action Plan due (or Not Applicable):</b>
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Name and Designation of Person responsible for completion of this form: .....Susie Hall, Patient Services..... Date: .....29/11/2011.....

Names & Designations of those involved in the impact assessment screening process:.....Valerie Windle, Patient Services Matron.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

*For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) [steven.stoker@nuth.nhs.uk](mailto:steven.stoker@nuth.nhs.uk) together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.*