

Capacity Management Escalation Plan

V8.3

August 2025

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

- 1.1. The Royal Cornwall Hospitals NHS Trust (RCHT) needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This plan looks at consequence management of high demand for services – surge management.
- 1.2. Under the Civil Contingencies Act 2004, NHS organisations must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health community as Emergency Preparedness, Resilience and Response (EPRR). This is supported by the Health and Social Care Act 2012.
- 1.3. NHS organisations must be able to maintain continuous levels of key or critical services when faced with disruption from high levels of demand or capacity management issues.
- 1.4. Business Continuity Management (BCM) provides organisations with a framework for identifying and managing risk that could disrupt normal service – this includes Surge Management.
- 1.5. This policy incorporates the escalation status setting, bed capacity and trigger points and action plans for the whole Trust to provide a safe emergency service whilst ensuring the maintenance of priority elective activity.
- 1.6. Emergency care activity often experiences peaks and troughs, and it is important that patients requiring admission receive that care by the right clinician in an environment conducive to their wellbeing.
- 1.7. This plan provides a consistent and co-ordinated approach to the management of pressures at RCHT and emergency care systems, where escalation points have been applied.
- 1.8. This plan is designed for managers and clinicians involved in managing capacity and patient throughput at a time of excess demand on RCHT.
- 1.9. This version supersedes any previous versions of this document.

2. Purpose of this Policy

- 2.1. The establishment of an effective escalation policy will contribute towards the following:
 - Early identification of capacity problems.
 - Proactive rather than reactive response actions.
 - Clear and concise actions.
 - Defined responsibilities.
- 2.2. The plan aims to maintain high standards of patient safety, patient experience and performance against key waiting time and quality standards of care.

- 2.3. The capacity management escalation plan enables RCHT to deal with fluctuations in demand and capacity so that it can manage associated clinical risks within acceptable limits. The plan is designed to help mitigate the risk of further escalation and ensure an appropriate response from key members of the health community to contribute to a reduction in escalation status.

3. Scope

3.1. This document applies to all RCHT staff.

3.2. The strategic aims are:

- Right care, right place.
- To maintain patient safety and minimise risk.
- To maintain ambulance handover in a timely manner.
- To deliver essential patient care.
- To maximise safe patient discharges and transfers.
- To be flexible and respond to abnormal variations.
- To monitor, manage and mitigate pressures.
- To maintain service provision.
- To enable capacity to be increased.
- To pull patients through the system, not push.

4. Definitions/Glossary

4.1. Escalation is a set of procedures set in place to deal with potential problems with a surge in demand for services.

4.2. This plan is based on identifying four statuses based on pre-determined triggers as follows:

OPEL 1 (GREEN)
Low levels of pressure. Relevant actions taken in response if deemed necessary. No support required from partners.

OPEL 2 (AMBER)
Moderate pressure with performance deterioration. Escalation actions taken in response with support required from partners.

OPEL 3 (RED)

Severe pressure with significant deterioration in performance and quality. Majority of escalation actions available are taken in response and increased support required from partners.

OPEL 4 (BLACK)

Extreme pressure with risk of service failure. All available escalation actions taken and potentially exhausted. Extensive support and intervention required.

4.3. Abbreviations

Abbreviation	Definition
AMU	Acute Medical Unit
ED	Emergency Department
EDD	Estimated Discharge Date
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
HDU	High Dependency Unit
ICB	Integrated Care Board
IT	Information Technology
MFFD	Medically Fit For Discharge
MUFFD	Medically Unfit For Discharge
NCTR	No Criteria to Reside
NIV	Non-invasive ventilation
OPEL	Operational Pressures Escalation Level
PTS	Patient Transport Service
PDD	Predicted Discharge Date
RAT	Rapid Assessment and Treatment
RfDD	Reason for Delayed Discharge
SDMA	Same Day Medical Assessment Unit
SIRI	Serious Internal Reportable Incident
SHOP model	Sick, Home Other and Plans
SOP	Standard Operating Protocol/Procedure

SWASFT	South Western Ambulance Service NHS Foundation Trust
TTO	To Take Out (prescription)
UTC	Urgent Treatment Centre

5. Ownership and Responsibilities

5.1. In each NHS organisation the Chief Executive is responsible for ensuring that there is a Business Continuity Strategy in place based on the principles of risk assessment, cooperation with partners, emergency planning, communicating with the public and sharing information. This includes management of surge conditions.

5.2. Role of the Chief Operating Officer

The Chief Operating Officer is the nominated executive director for and has overall responsibility for patient flow within the Trust and is responsible for ensuring that:

- Plans are in place to manage disruptions to services – internal or external – that require special provision to be made.
- Plans are written and published to ensure business continuity for any emergencies that may impact on Trust activity.
- Business continuity plans are kept up to date and include escalation issues.
- The Trust is compliant with all legislation relevant to EPRR.
- The plans are exercised appropriately.
- Trust staff are familiar with the plans for their particular work area and are familiar with the Trust's core plan.

5.3. Role of the General Managers

General Managers are responsible for ensuring that:

- A lead is identified for each Care Group/department to include escalation (surge) in their Business Continuity Plans with area specific action plans linked to this document. This should include non-clinical areas that can support in times of red or black status.
- During heightened escalation levels manage the escalation actions for the Care Groups (can be delegated to the Care Group Manager of the Day).
- Support patient flow within their Care Groups, focussing on future requirements, such as planning for tomorrow's discharges (can be delegated to the Care Group Manager of the Day).

5.4. Role of Clinical Site Managers

Clinical Site Managers (CSM) are responsible for:

- Day to day management of patient flow.
- Undertaking actions contained within this plan.

5.5. Role of Senior Duty Manager/Lead Clinical Site Manager

Monday – Friday, 08.00 – 17.00 hours – Lead Clinical Site Manager.

Out of hours – Senior Duty Manager as per the rota.

The Senior Duty Manager/Lead Clinical Site Manager is responsible for:

- Supporting patient flow.
- Ensuring the actions in this plan are carried out or are delegated to relevant Care Group representatives to undertake.
- Recording and documenting the current hospital status.
- Undertaking the role of Tactical Commander (if Critical Incident is declared).

5.6. Role of the Clinical Directors

The Clinical Directors are responsible for:

- Ensuring their Consultants are aware of and adhere to this plan.
- Promote next day discharge preparation (ie TTOs, discharge summary) and Criteria Led Discharge.

5.7. Role of Ward Consultant and Medical Teams

The Ward Consultant and Medical Teams are responsible for:

- Timely review of patients and ensuring the patient records are updated regularly with Estimated Discharge Date (EDD), Predicted Discharge Date (PDD) and clear medical discharge/management plans recorded.
- Establishing Criteria Led Discharge where appropriate.
- Reviewing all outliers in a timely manner.

5.8. Role of Heads of Nursing/Clinical Matrons

The Heads of Nursing/Matrons are responsible for:

- Pro-actively actioning issues identified within their area of responsibility.
- Providing support and advice to ward teams to support them in management of effective discharges.

5.9. Role of Ward/Unit Leaders

The Ward/Unit Leaders are responsible for:

- Ensuring that accurate, timely information about capacity is communicated with the Bed Managers and electronically via the appropriate IT system.
- Ensuring that their staff are working to this plan.
- Ensuring that all patients have an EDD and PDD and accurate Reason to Reside status.

5.10. Role of Named Nurses

The Named Nurses for each patient are responsible for:

- Proactive management of individual discharge arrangements and for escalating issues as appropriate.

5.11. Role of Discharge Coordinators

- Under the direction of the Ward/Unit leader support the discharge of patients from wards, this includes:
 - Transport
 - Support discharge planning
 - Attend ward/board and rapid rounds
 - Maintain electronic systems (STRATA) and NCTR and Reason for Delayed Discharge

5.12. Role of Head of Emergency Preparedness, Resilience and Response

The Head of Emergency Preparedness, Resilience and Response is responsible for:

- Undertaking a debrief when a Critical Incident is declared and ensuring that learning points are shared and included in future planning.

6. Standards and Practice – Capacity Management Escalation Plan

6.1. Escalation Criteria

The escalation criteria are now nationally set, with scores detailed below.

This can be found on the intranet - [TRT OPEL Dashboard - Power BI Report Server](#)



TRT OPEL DASHBOARD

LATEST REFRESH: TRELISKE @ 14/10/2024 13:47

Royal Cornwall Hospitals Trust

Commissioning, Performance and Intelligence



OPERATIONAL PRESSURES ESCALATION LEVELS (OPEL)

UPDATED @ 14/10/2024 13:45:54

<< BACK TO HOME PAGE

National Documentation : [NHS England » Operational Pressures Escalation Levels \(OPEL\) Framework 2023/24](#)

Metrics 1-6 & 9 are sourced from live data, metrics 7&8 are based on an 8am snapshot. Any metrics that fail will default to the most recent snapshot available

ID	METRIC <i>(The metrics below are for Treliske only)</i>	NUMERATOR	DENOMINATOR	VALUE	SCORE	OUT OF	SNAPSHOT DATE TIME
1	MEAN AMBULANCE HANDOVER TIME IN MINUTES	470	10	47.00	4	6	14/10/2024 13:46:42
2	ED 4 HOUR PERFORMANCE	77	168	45.8%	4	4	14/10/2024 13:46:42
3	ED ALL TYPE ATTENDANCES	18	14	129.8%	4	4	14/10/2024 13:46:42
4	ADULT MAJORS & RESUS OCCUPANCY	69	28	246.4%	6	6	14/10/2024 13:46:42
5	MEDIAN ED TIME TO TREATMENT	80		80	1	4	14/10/2024 13:46:42
6	ED OVER 12HRS IN DEPARTMENT	15	80	18.8%	4	4	14/10/2024 13:46:42
7	% G&A BED OCCUPANCY INCLUDING ESCALATION BEDS	536	542	98.9%	6	6	14/10/2024 08:00:00
8	% OPEN BEDS THAT ARE ESCALATION BEDS	27	542	5.0%	2	4	14/10/2024 08:00:00
9	% BEDS OCCUPIED BY PATIENTS MEETING NO CRITERIA TO RESIDE	99	535	18.5%	6	6	14/10/2024 13:46:42
AGGREGATED OPEL SCORE:					37	44	

The thresholds are defined as follows:

OPEL 1	0 - 11	OPEL 3	23 - 33
OPEL 2	12 - 22	OPEL 4	34 - 44

 OPEL METRIC DEFINITIONS	
ID	METRIC DESCRIPTION
1	AVERAGE (MEAN) HANDOVER TIME (TR ONLY) IN MINUTES OF COMPLETED AMBULANCE HANDOVERS IN THE LAST 180 MINUTES
2	% OF ALL TYPE ATTENDANCES (TR ONLY) ADMITTED, DISCHARGED OR TRANSFERRED WITHIN 4 HOURS SINCE MIDNIGHT
3	THE NUMBER OF ALL TYPE ED ATTENDANCES (TR ONLY) THAT ARRIVED IN THE LATEST FULL HOUR, AS % OF THE PREDICTED NUMBER OF ED ATTENDANCES DURING THAT PERIOD
4	% OCCUPANCY OF ADULT MAJORS & RESUS AT TIME OF ASSESSMENT
5	MEDIAN TIME FROM ARRIVAL TO BEING SEEN IN ED (TR ONLY). FOR PATIENTS SEEN SINCE MIDNIGHT
6	NUMBER OF PATIENTS SPENDING OVER 12 HOURS IN ED (TR ONLY) FROM TIME OF ARRIVAL TO TIME OF REVIEW, AS % OF TOTAL NUMBER OF PATIENTS IN ED AT TIME OF REVIEW
7	% OF ADULT G&A BED OCCUPANCY (TR ONLY, INCLUDING ESCALATION BEDS) AS PER 8AM SNAPSHOT (UEC SITREP LOGIC)
8	THE NUMBER OF ADULT ESCALATION BEDS AS A % OF THE TOTAL G&A BEDS AVAILABLE (TR ONLY), AS PER 8AM SNAPSHOT (UEC SITREP LOGIC)
9	THE NUMBER OF PATIENTS (TR ONLY) OCCUPYING A BED (UEC SITREP G&A LOGIC) WITH NCTR AT THE TIME OF REVIEW, AS % OF THE TOTAL G&A BEDS AVAILABLE (TR ONLY, UEC SITREP LOGIC)
10	AVERAGE (MEAN) HANDOVER TIME (TR ONLY) IN MINUTES OF AMBULANCE HANDOVERS SINCE MIDNIGHT

6.2. RCHT Escalation Actions / Responsibilities

NB Actions are subject to contextual check before implementing. Will that specific action help solve the problem identified at this time?

OPEL 1 (GREEN)									
Action Ref	Chief Operating Officer/Director On Call	Action Ref	All Wards	Action Ref	All Doctors	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
		W1	Declare bed availability to Clinical Site Managers and/or Bed Managers.	D1	Write up TTOs before moving on to next patient.	CSM1	Identify all patients for repatriation and ensure plans are in place for their transfer with the receiving hospital.	SDM1	Contribute to Bronze calls (if occurring).
		W2	Set EDD within one day of admission and escalate any internal delays to patient journey through the discharge hub.	D2	Book all investigations before moving on to the next patient.	CSM2	Confirm availability of transport for patient discharge.		
		W3	Ensure discharges are achieved at the earliest opportunity with transport	D3	Write and review EDD, PDD and RfDD.	CSM3	Monitor and escalate staffing issues.		

OPEL 1 (GREEN)									
Action Ref	Chief Operating Officer/Director On Call	Action Ref	All Wards	Action Ref	All Doctors	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
			booked ideally 24hrs in advance with all information required to complete the booking to prevent delays in discharge.						
		W4	Ensure staffing is reviewed at 8:30 and 15:30 hours SAFER Care meetings.	D4	Ensure that medical cover is provided for all patients outlying from speciality bed base.	CSM4	Utilise Marie Therese beds with suitable patients.		
		W5	Ensure utilisation of discharge lounge.						
		W6	Review all discharge plans for patients						

OPEL 1 (GREEN)									
Action Ref	Chief Operating Officer/Director On Call	Action Ref	All Wards	Action Ref	All Doctors	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
		W7	Work to the golden patient principles.						
		W8	Support SHOP model.						
		W9	Ensure all EDD, PDD, NCTR and RfDD information is update daily						

OPEL 2 (AMBER) (Ensure actions at previous level have been completed)

Action Ref	Chief Operating Officer/Exec On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Clinical Directors	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
		M1	Attend all bed meetings, undertake required actions, and liaise with Clinical Site Managers.	C1	Ensure that Consultants are completing e-discharge to provide parameters for nurse led discharge.	CSM1	Liaise with ED Nurse/Doctor in Charge to determine which escalation actions are required.	SDM1	Ensure speciality teams are supporting the take team and ED appropriately.
		M2	Support wards to ensure delays in diagnostics are identified and escalated, prioritising those for discharge critical patients.	C2	Reviewing inpatient lists with their Consultants to discuss and enact any alternatives to ongoing inpatient stay or ways to accelerate the inpatient pathway.	CSM2	Clinical Site Manager, in consultation with the Senior Duty Manager, to open additional capacity and out-lie patients if required.	SDM2	Escalate external actions as required.
		M3	Escalate those patients	C3	Ensure speciality teams are	CSM3	Ensure that therapies are briefed to identify	SDM3	Contribute to Bronze/Silver calls (if occurring)

OPEL 2 (AMBER) (Ensure actions at previous level have been completed)									
Action Ref	Chief Operating Officer/Exec On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Clinical Directors	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
			medically fit for discharge.		supporting the take team and ED appropriately.		patients who require packages of care or step-down beds.		
		M4	Ensure wards have identified all possible discharges and they are working on all actions to achieve them.	C4	Clinicians to prioritise discharges and accept outliers from any ward as appropriate.	CSM4	Request facility teams prioritise cleaning and patient transfer.		
		M5	Escalate diagnostic, cardiac, and other speciality delays.	C5	Contact on-take and ED on-call Consultants to offer support to staff and ensure that specialty patients in ED are assessed rapidly.	CSM5	Liaise with wards, Discharge Coordinators, Bed Managers, and Complex Hospital Discharge Team to ensure timely discharges. Reiterate use of discharge lounge to wards.		

OPEL 2 (AMBER) (Ensure actions at previous level have been completed)

Action Ref	Chief Operating Officer/Exec On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Clinical Directors	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
		M6	Identify all those patients who need repatriation and ensure Clinical Site Managers are aware. Ensure a transport request is raised once handover with hospital has been carried out but prior to bed being available so finance can be agreed with receiving ICB.	C6	Undertake additional ward rounds to maximise rapid discharge of patients.	CSM6	Liaise with pharmacy to ensure TTOs are completed without delay.		

OPEL 3 (RED) (Ensure actions at previous level have been completed)

Action Ref	Chief Operating Officer/Director On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
D1	Contribute to Silver calls and request escalation to a Gold call if believed to be beneficial.	M1	Reiterate that Patient Choice is still suspended and ensure that wards issue to patients the relevant letter on admission explaining so.	C1	On take, surgical, trauma and ED on call Consultants to ensure patients in ED are assessed rapidly.	CSM1	Liaise with wards on a patient-by-patient basis to ensure timely discharge.	SDM1	Contribute to Silver call if in place. Ensure that you join the call knowing what RCHT wants from health partners.
D2	If escalation into OPEL 4 (black) seems likely, then prepare pre-emptive communication to prevent occurring. Making sure it is clear what response is required from staff. Ensure ICB Director is aware of RCHT operational pressures and likely escalation	M2	Clinical Matrons to ensure wards declare bed availability and identify patients to be moved to the discharge lounge.	C2	Undertake extra post-take ward rounds including outliers.	CSM2	Inform Acute Physician of the Day, Medical and Surgical Take Consultants of continuing pressures and actions.	SDM2	Ensure surgical and trauma areas have liaised with St Michael's Hospital to source additional capacity subject to transfer criteria.

OPEL 3 (RED) (Ensure actions at previous level have been completed)

Action Ref	Chief Operating Officer/Director On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
	to OPEL 4 (black).								
D3	Liaise with IT and Estates to reschedule planned maintenance where work is likely to impact on capacity and flow.	M3	Contact senior medical staff and request discharge reviews for appropriate patients.	C3	Identify further patients deemed suitable for discharge given current pressures.	CSM3	Identify additional beds that could be utilised with appropriate staff.	SDM3	Review and place on standby all relevant routine elective admissions. Liaise with Clinical Director (Surgery) and Consultants to prioritise theatre lists.
D4	Request that Adult Social Care admit all package of care waiters into care homes.	M4	Visit wards and conduct board round with nurse in charge to confirm current position including: - Swiftplus boards up to date - bed availability now and later - discharges today and tomorrow including plans - Reason to	C4	Undertake daily Consultant ward rounds with every patient seen including outliers.	CSM4	Using SAFER Care, utilise staff from other areas and redeploy to relieve key pressure points.	SDM4	Request extra staffing in ED if appropriate to the problem.

OPEL 3 (RED) (Ensure actions at previous level have been completed)

Action Ref	Chief Operating Officer/Director On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
			Reside updated. - delays in assessments.						
		M5	Ensure telephone is answered to accept handovers and updates on operational position requirements.	C5	Senior Clinicians to actively scrutinise all GP requests for admission.	CSM5	Admit suitable patients directly from ED to base wards.	SDM5	Decide on which escalation areas to open (refer to Appendix 5).
		M6	Ensure wards have identified all possible discharges and are working on all actions to achieve them.	C6	Implement additional ward rounds.	CSM6	Ensure patient transport is aware of likely requirements.	SDM6	Investigate if Clinical Support Services can offer extra radiology slots and Specialist Medicine can offer extra Echo slots.
		M7	Speciality nurse to provide support to ED by assessing patients referred to relevant specialties.	C7	Focused review to convert stranded MUFFD to MFFD as appropriate.			SDM7	Bring in additional PTS crew if relevant and/or bring in HDU Ambulance Crew for transfers/ED queue management.

OPEL 3 (RED) (Ensure actions at previous level have been completed)

Action Ref	Chief Operating Officer/Director On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
		M8	Review staffing levels over next 24/48 hours and ensure suitable staffing is in place.	C8	Identify patients who are awaiting investigation and consider if they can be discharged and have the investigation as an outpatient.				
		M9	Liaise with Complex Hospital Discharge Team to identify patients whose discharges are delayed or require input to support timely discharge and support wards to enable safe and effective patient discharge.						
		M10	Patients can be						

OPEL 3 (RED) (Ensure actions at previous level have been completed)									
Action Ref	Chief Operating Officer/Director On Call	Action Ref	Matrons / Manager of the Day	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
			moved between wards during protected meal times.						

OPEL 4 (BLACK) (Ensure actions at previous level have been completed)									
Action Ref	Chief Operating Officer/Director On Call	Action Ref	Care Groups	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
D1	Declare a Critical Incident where there is a clear benefit to aiding the response. Consider after prolonged OPEL 4 (black) and when actions are not alleviating pressure.	CG1	Care Group Senior Leadership Group (including Matrons and Manager of the Day) to ensure that all inpatient areas under their jurisdiction are visited to offer support.			CSM1	Night Clinical Site Managers to support actions for discharge in the morning (i.e. bloods) and to check and challenge if patients can utilise Acute Care at Home.	SDM1	Develop a plan of action, ensuring clear responsibilities and timeframes for completion.
								SDM2	Contribute to Silver (or Gold) call - ensure before you join the call that you know what actions you would like from partners to ease pressure on RCHT.
								SDM3	Senior Duty Manager to stay on site until presence no longer deemed operationally beneficial.
								SDM4	Authorise utilisation of taxis for PTS journeys.

CRITICAL INCIDENT (Ensure actions at previous level have been completed)									
Action Ref	Chief Operating Officer/Director On Call	Action Ref	Care Groups	Action Ref	Consultants	Action Ref	Clinical Site Manager	Action Ref	Senior Duty Manager / Lead Clinical Site Manager
D1	Implement 'command and control' arrangements (including opening the ICC and having a loggist), take Strategic Commander role.	CG1	Clinical Nurse Specialists to be redeployed to support front door or discharge.	C1	Put out a request for GIM cover 5-7pm shift as a minimum but more hours if possible.			SDM1	Remain on site until presence no longer deemed operationally beneficial.
D2	Consider Senior Duty Manager shifts be split into 12-hour day and 12-hour night shifts at weekends/bank holidays or 2 Senior Duty Managers on site at weekends/bank holidays during the day time.							SDM2	Review urgent elective admissions where possible - reschedule or cancel if it will assist with the response. This may be considered through a Clinical cell review.
D3	Stay on site until presence no							SDM3	Ensure all key staff are wearing

CRITICAL INCIDENT (Ensure actions at previous level have been completed)									
	longer deemed operationally beneficial.								CRITICAL INCIDENT tabards.
D4	Cancel training and non-clinical duties where proportionate and will provide benefit. Link to SAFER Care for redeployment of staff.							SDM4	Assume the role of Tactical Commander and lead the Incident Coordination Centre response.
D5	Ensure public message are being sent out by Communications Team. Ensure internal messages are being sent out by Communications Team. Ensure internal message is sent every day that the Trust remains in Critical Incident and that it clearly states the targets and actions required to achieve them.								

CRITICAL INCIDENT (Ensure actions at previous level have been completed)									
D6	Datix incident form to be completed and SIRS reported on STEIS.								
D7	Request a Gold/Strategic call (unless already being conducted). NB: These should have CEO level representation. CEO's may seek experts in their teams to advise but these individuals will be in attendance and not members. This will maintain a strategic oversight position.								
D8	Any cancellation of annual leave requires ratification by the workforce cell.								

7. Dissemination and Implementation

All key relevant staff will need to be briefed by their managers on this plan and the relevant actions for their care group/ward.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	The plan will be monitored in it's entirely as the Trust moves between escalation levels.
Lead	Head of EPRR
Tool	Debriefs or SIRIs (if Critical Incident declared) will be held, and lessons identified incorporated into the plan.
Frequency	The plan is constantly in use.
Reporting arrangements	Reporting of escalation or capacity management issues is through Operational Leadership Group.
Acting on recommendations and Lead(s)	The Operational Leadership Group will nominate leads to undertake actions depending on their nature and the circumstances. They will monitor actions for any deficiencies and recommendations within reasonable time frames.
Change in practice and lessons to be shared	Shared learning will be via the debrief/SIRI process. Required changes to practice will be identified and actioned within an agreed timeframe. Lessons will be shared with all relevant stakeholders.

9. Updating and Review

This document will be reviewed annually by the Emergency Planning Lead.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Capacity Management Escalation Plan V8.3
This document replaces (exact title of previous version):	Capacity Management Escalation Plan V8.2
Date Issued / Approved:	July 2025
Date Valid From:	August 2025
Date Valid To:	March 2026
Author / Owner:	Louisa Forbes, Head of Unplanned Care
Contact details:	01872 255043
Brief summary of contents:	To provide guidance for dealing with escalation events leading from a surge in demand.
Suggested Keywords:	Escalation, capacity management. green status, amber status, red status, black status, OPEL
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Operating Officer
Approval route for consultation and ratification:	Operational Leadership Group, Chief Operating Officer, Chief Nursing Officer, Interim Deputy Chief Operating Officer – Clinical.
Manager confirming approval processes:	Robin Jones, Chief Operating Officer
Name of Governance Lead confirming consultation and ratification:	Louisa Forbes, Head of Unplanned Care
Links to key external standards:	None required.
Related Documents:	RCHT Business Continuity Strategic Plan v2.5. Escalation Plan – Child and Maternity.
Training Need Identified:	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
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Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
N/A	N/A	Previous version history is not known.	N/A
30 May 2018	6.13	ED actions deleted as covered under Appendix 6. Following Gold Command Mar/Apr OPEL 4 actions realigned to OPEL 3 unless 'exceptional', all 'bringing in staff' actions removed as BAU, additional actions added from lessons learned. 7 OPEL 4 triggers now needed instead of 5.	Matt Overton, Emergency Planning Lead
17 July 2018	6.14	MAA overnight use now classified as an escalation area on OPEL 4 trigger	Matt Overton, Emergency Planning Lead
2 January 2019	6.15	Infection related closures triggers aligned to IPAC outbreak policy triggers. Incorporation of OPEL4 Escalation Protocol into appendices. Appendix 3 removed; ED Escalation Framework appendix updated.	Matt Overton, Emergency Planning Lead
1 November 2019	6.16	Escalation triggers revised and actions that have become accepted BAU added. Inclusion of suggested On Call Manager to Director On Call Escalation Handover (Appendix 6). Escalation areas updated (Appendix 8).	Matt Overton, Emergency Planning Lead
1 November 2020	7.0	Escalation triggers revised. Appendix 8 - Escalation Areas updated. Addition of Appendix 9 - De-escalation Order/Exit Strategy from OPEL 4 (black)	Matt Overton, Emergency Planning Lead
29 March 2023	8.0	New table of actions/responsibilities for Critical Incident. Removed Appendix 5. Appendix 6 (now 5) revised order of priority.	Matt Overton, Emergency Planning Lead
10 July 2023	8.1	Appendix 6 updated to reflect revised practice.	Matt Overton, Emergency Planning Lead

Date	Version Number	Summary of Changes	Changes Made by
08/12/2024	8.2	Updated to include national Operational Pressures Escalation Levels (OPEL). Request to all Care Groups to update action cards. Comments received from HoN Ian Moyle-Browning and Claire Blake, CMO (Alistair Grant) and Matt Overton (EPRR lead).	Tim Mumford, Head of Unplanned Care
15/07/2025	8.3	Critical Incident actions updated to reflect January CI Debrief Report Recommendations	Matt Overton, Head of EPRR

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This document is only valid on the day of printing.

Controlled Document

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Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team
rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Capacity Management Escalation Plan V8.3
Department and Service Area:	Chief Operating Officer
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Matt Overton, Head of EPRR
Contact details:	07818 581950

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide guidance for the whole Trust to manage a capacity or escalation event.
2. Policy Objectives	To provide information and support managers in managing an escalation event.
3. Policy Intended Outcomes	• Clear actions to follow. • Clear trigger points. • Capacity and escalation managed.
4. How will you measure each outcome?	• Debriefs and SIRIs. • Audit of plan.
5. Who is intended to benefit from the policy?	Patients, staff, health partners and the public.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	- Workforce: Yes - Patients/ visitors: No - Local groups/ system partners: No - External organisations: No - Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Please record specific names of individuals/ groups: EPRR Committee, Operational Board, A and E Delivery Board (for escalation triggers only), 4hr Standards Meeting (for escalation areas only).
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys: No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Matt Overton, Emergency Planning Lead.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
[Section 2. Full Equality Analysis](#)

Appendix 3. Checklist for Opening of Additional Capacity Ward

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
Allocate responsibility to person overseeing and managing ward area.	To ensure leadership and responsibility is clearly understood.	Chief Operating Officer CFT. Chief Operating Officer RCHT.	Assign Ward Leader, Matron, Care Group or Locality Manager.		This is the person who will set up and take on the day-to-day management of the ward.
Ward Leader and Clinical matron check of intended area to carry out risk assessment for – cleaning, facilities, equipment, supplies, general state of the environment. Consider previous usage and any potential concerns that may have been raised.	To identify any anticipated patient safety issues – cross infection, single sex compliance.	Ward Leader and Matron. (Deputy Chief Operating Officer), Deputy Director of Nursing AHPs).	Ward leader and Clinical matron to visit area and with Estates and IPAC to ensure environment fit for purpose. Complete risk assessment to include IPAC and single sex compliance.		Consider anticipated work flow and health status of client group – e.g. ward to be 'well' medical female only. IPAC ex 4969 RCHT. IPAC CFT via Bodmin switchboard. Estates RCHT ex 3400, 3871. Estates CFT NHS Property Services 08000853015.
Review of ward area, nurses' station, toilets, bathrooms, treatment room, sluice.	To ensure identified area is appropriate for use as live ward area.	Ward Leader and Matron. (Deputy Chief Operating Officer, Deputy Director of	Ward leader and Clinical matron to visit area and with Estates and IPAC to ensure environment fit for purpose.		Estates ex 3400, 3871. IPAC ex 4969. Soft Facilities Management ex

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
		Nursing AHPs).	Contact Soft Facilities Management/Hotel Services and Contract Monitoring team to request daily cleaning. Ensure supply of curtains available.		2468. Hotel Services CFT ex 1315 (Bodmin). Contract Monitoring team ex 5024.
Telephone, computers, – ensure dedicated phone line and IT access is available. PAS/RIO.	Ensure effective workflow communication. Without this unable to obtain emergency assistance. Unable to have patient status at a glance to support patient flow and MDT working.	Ward leader.	Contact CITS to obtain computers, phones. Advise CITS to setup new area on PAS/RIO.		CITS 1717.
Staffing • Nursing. • Ward Clerk. • Doctors.	To maintain safe FML, service delivery and skill mix.	Head of Nursing for identified Care Group Locality Manager. General Manager identified Care Group. Therapies lead. Kernowflex. Medical staffing. Ward Leader.	Head of Nursing/Locality manager to identify correct FML for the number of beds. To liaise with other HONs/Locality managers to identify core group of substantive staff to support. To identify ward clerk cover (share with other area).		There should be a minimum of 1 RCHT substantive registered member of staff on each shift. Rostering team ex 4694. Kernowflex ex 5755 Ext: 3871.

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
		Rostering team.	Rostering team to create roster for identified area. Ward leader to create roster and liaise with Kernowflex regarding number of staff required. General manager / Locality to identify which speciality will provide senior medical oversight to cover and liaise with medical staffing to provide day to day medical cover if required or cover with Advance Nurse Practitioner. Therapies lead to identify physio and OT support.		
Call bells oxygen and suction.	Responsive safe care.	Medical physics. Estates.	Ensure each bed space has access to working call bells, oxygen, and suction.		Medical Physics ex 2491/0. Estates RCHT ex 3400, 3871. Estates CFT NHS Property Services 08000853015.
Furniture	To ensure facilities for	Relevant Care Group	Each bed space to have		Porters RCHT ex

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
	patient basic needs. To provide a quality environment to deliver safe care. Patient comfort and experience.	Porters	a bed, locker, table, patient chair. Lockable notes trolley required. Visitor chairs required.		2468. Hotel Services CFT ex 1315 (Bodmin).
CD Cupboard	To ensure facility for controlled drugs.	Pharmacy	CD Cupboard to be sited in the Treatment room. Keys to be identified.		Pharmacy RCHT/CFT. ex 2592.
Pharmacy cupboards/Treatment room	To ensure secure storage of medications.	Pharmacy	Ensure availability of keys. Drug cupboards to be stocked. Drug fridge available and working.		Pharmacy RCHT/CFT ext. 2592.
Sluice	Safe disposal of body fluids.	Ward Leader. Estates.	Check sluice facility is available as part of initial assessment. Estates to check that the macerator is working correctly.		Estates RCHT ex 3400. Estates CFT NHS Property Services 08000853015.
Kitchen	To ensure adequate nutrition and hydration.	Ward Leader. Soft Facilities Management.	Check kitchen facility is available as part of initial assessment. Soft Facilities Management/Estates to		Soft Facilities Management RCHT ex 2468. Estates RCHT ex

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
			ensure all in working order – fridge dishwasher.		3400. Hotel Services CFT ex 1315 (Bodmin). Estates CFT NHS Property Services 08000853015.
Resuscitation Equipment	To ensure access to appropriate resuscitation equipment.	Relevant Care Group/ Locality manager. Resuscitation Team.	Fully functioning resuscitation equipment required prior opening of the ward. All staff to be made aware of protocol for alerting either crash team or emergency services depending on location of the ward.		Contact resuscitation team for advice. If ward to be predominantly staffed by agency, ensure process clearly communicated to them and ensure they are up to date with BLS.
Equipment, linen, and supplies to provide basic care	To ensure safe timely care delivery.	Ward Leader. Medical physics. Soft Facilities Management/Hotel Services.	Ward leader to liaise with medical physics to determine type of equipment required and minimal numbers. Ward leader to liaise with Soft Facilities Management/Hotel Services to ensure appropriate levels of linen. Ward leader to liaise		Soft Facilities Management RCHT ex 2468. Hotel Services CFT ex 1315 (Bodmin).

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
			with Soft Facilities Management/Hotel Services to ensure appropriate levels of supplies.		
Ensure client group protocol is agreed and shared with all relevant parties.	To ensure right patient is in the correct area.	Chief Operating Officer CFT. Chief Operating Officer RCHT.	Decision required and communicated to the site co-ordination team about the suitability of transfers/admissions. Decision to be supported and sustained by the clinical site team both in and out of hours.		? Matron/Ward Lead overview of all patients selected for transfer.
Signage and communication with all services.	To ensure safe emergency response	Ward Leader. Estates. Fire and Security teams.	Ward leader to liaise with Estates and Fire and Security teams to ensure signage is amended accordingly even if only on a temporary basis to alert staff and direct patients and visitors. All user communication to be issued to all staff.		Estates RCHT ex 3400. Security RCHT ex 2147. Fire RCHT ex 3443. Estates CFT NHS Property Services 08000853015. Security CFT vis Bodmin Switchboard. Fire CFT via Bodmin

Action/works required	Risk/Assurance	Responsible	Action	RAG	Notes and Contacts
					Switchboard.
Waste (only if off RCHT site)	To ensure effective disposal of clinical waste.	Waste team	Ward Leader to liaise with the waste team to arrange waste collection from dedicated storage facility.		Waste team CFT ex 1315 (Bodmin).
Other			Ward leader to check availability of soap, paper towel dispensers, alcohol gel, waste bins, apron, and glove dispensers.		

Appendix 4. Suggested Senior Duty Manager to Director On Call Escalation Handover

Escalate using SBAR
Do you both understand the problem? Is it ED related volume of patients causing the overcrowding or a problem with flow and bed availability? Is it both?
Is anyone in the Trust inappropriately refusing to contribute to the response? Would the intervention of the Director On Call with this person assist?
Check the RCHT Capacity Management Escalation Plan actions for Director On Call /Senior Duty Manager for the relevant escalation (OPEL) level. Would any actions from the OPEL level above, if implemented, assist with de-escalation?
What is required that needs Director level approval? What are the risks of implementing and the risks if not implemented?
For ED related issues, would it assist if I liaised with my counterpart tier of command at SWASFT?
Do we collectively know what we want to raise on any system call for actioning?

Evening situational report for CSM, SOCM and OCE	
CSM	
SDMOC	
OCE	
Date	
Time	
OPEL Score	
No. in ED	
Longest Wait in ED	
No. over 4 hours	
WTBS	
No. of Ambulances being held	
Longest Ambulance Hold	
Since Midnight Departures	
Total Breaches	
Performance	

Current Bed Requirement ED	
Current Bed Requirement SDMA	
SDMA Update	
SDSA Update	
Discharge Lounge Update	
Capacity Summary: General	
Capacity Summary: Critical Care	
Concerns Discussed	1 2
Actions Agreed	
1	
2	
3	
4	
5	
6	
7	
8	

Appendix 5. Escalation Areas in priority order of opening

	Area	Criteria	Number Of Escalation Beds
1	Discharge Lounge	discharges identified for the following day.	9
2	ED Corridor		5
3	Eden Day Case	for surgical patient surge only	4
4	AMU BB and HB beds		4
5	All level 1 BB and HB		17
6	ED ADL		4
7	Planned Care Unit	for surgical patient surge only	6
The areas, above are in order of priority for escalation and and de-escalation.			
	Phoenix Stroke Beds	Stroke / EOL only	5

Any other unapproved escalation space can only be opened at RCH with the authorisation of the Director on Call or Chief Operating Officer in daytime hours.

Any other unapproved escalation space can only be opened at SMH and/or WCH with the authorisation of the Trust Board.

All areas require higher levels of staffing apart from Boarding, Holding and Phoenix Stroke beds.

Appendix 6. De-escalation Order/Exit Strategy from OPEL 4 (black)

1. Close unapproved escalation areas.
2. Close Boarding beds.
3. Cease using Holding beds outside of 08:00-20:00.
4. Cease using Holding beds 08:00-20:00.
5. Re-instate any cancelled outpatient appointments.
6. Re-instate mandatory training.
7. Re-instate non-flow/clinical related meetings/activity and non-mandatory training.
8. Redeploy corporate nursing back to their areas.
9. Reduce outliers and re-instate elective surgery.
10. Close approved escalation space.