NHS
Cheshire and Merseyside
Provider Collaborative

Cheshire & Merseyside

Red Lines Toolkit & System Guidance

Urgent & Emergency Care

Version 2.0, Final

Version History

Version	Date created	Brief Summary of Change	Author
V1.0	29.02.2024	Final Version of guidance produced	Julie Tunney, Elizabeth Woollam
V1.4	31/03/2026	Guidance reviewed to include sections on escalation, moral injury and MH patients	Julie Tunney, Thomas Hill, Paul Devlin,
V1.5	14/05/2026	Input from NHS England Mental Health Urgent and Emergency Care	Dr Claire Foster, Thomas Hill., Julie Tunney
V2.0	17/06/2026	Red Lines Toolkit Approved by C&M System Quality Group	Thomas Hill, Julie Tunney, Nicola Martin

Contents

1 Introduction

Delivering the best possible care for patients across Cheshire and Merseyside is the aim of all organisations. Various initiatives are ongoing across the system to reduce and ultimately eradicate the use of temporary escalation spaces (TES), including corridor care, across all providers. However, there are still instances when patients reside in temporary escalation spaces, including corridor areas in trusts across the system.

The Cheshire and Merseyside System Quality Group (SQG) has collaborated with Cheshire and Merseyside Provider Collaborative (CMPC) and providers to create the Cheshire and Merseyside Red Lines Toolkit. This toolkit is designed to ensure the safest and best possible care for any patient who does not reside within the designated clinical areas when escalation is ongoing.

The toolkit has been co-created by various healthcare professionals, including “place” senior leaders, acute providers, North-West Ambulance Service, members of the Care Quality Commission and Healthwatch. It is based around a Proactive Protection Bundle (below).

The toolkit is a guide for providers to use during times when TES are used, and corridor care is in place and should be followed when wards or emergency departments (ED) are escalated. Following these processes can ensure that the experience, safety and well-being of patients and staff are captured. Also, recording the correct evidence during episodes of TES and corridor care and processes to de-escalate are explained within the toolkit.

This toolkit may also be used in additional areas for escalation outside of wards and emergency departments.

This toolkit was launched at the NHS Cheshire & Merseyside Directors of Nursing Meeting on 5th March 2024 and reviewed in March 2026, this version was officially released in June 2026.

Acknowledgements

Cheshire and Merseyside Provider Collaborative would like to express our gratitude to all the staff who have contributed to the development of this toolkit.

2 User Completion Information

If a patient receives care for more than 45 minutes in any non-designated clinical space that does not meet the criteria for a clinically appropriate and safe setting as defined by NHS England (PRN02367: Additional actions to virtually eliminate corridor care2026), then this document should be reviewed and completed where necessary to ensure that care delivered in temporary escalation space, including corridors, is being delivered safely, monitored appropriately, and escalated and de-escalated in line with local policy.

Information	Please Complete:
Trust:	
Site:	
Date:	
Time of escalation:	
Completed By:	
Job title:	
Email address:	

3 Observation & Escalation

3.1 Escalation

Escalation occurs when operational pressures—such as ED crowding—begin to threaten patient safety or flow, prompting activation of the structured actions set out in local escalation policies and the OPEL framework.

In times of escalation, the following principles are of paramount importance:

- **Patient safety is the overriding priority.**
- **Escalation must occur early** to mitigate risk and prevent deterioration of conditions.
- **Crowding and temporary escalation spaces are safety issues**, not capacity management tools.
- **Executive oversight is mandatory** when escalation impacts patient placement, use of non-clinical spaces or ambulance offloading.
- **System-wide collaboration** (NWAS, SCC, ICB, community services) is essential to recover flow.
- **All escalation decisions must be documented**, including rationale, actions, and safety mitigations.

Executive leadership must be continuously sighted when the ED is in escalation. The use of corridor care requires explicit executive decision-making, ongoing review, and documented rationale. **Escalation should occur when any of these thresholds are reached.**

Trigger Points for Escalation		**Comments/ Observations**
Capacity / Flow Triggers	• All ED cubicles or treatment spaces occupied • Patients waiting >60 minutes for initial assessment • Ambulances queuing or unable to offload within 15 minutes • Boarding patients accumulating without inpatient flow • Corridor care being considered or initiated	
Clinical Risk Triggers	• NEWS2 outliers can't be safely monitored • Multiple patients with physiological deterioration • Mental health patients awaiting assessment in inappropriate locations • Delay in time-critical medicines or analgesia • Safeguarding concerns heightened by the environment.	
Staffing Triggers	• Staffing below safe minimum levels • High sickness levels creating skill-mix gaps • Inability to provide 1:1 care when required (Mental Health, paediatric or high-risk patients)	
Environmental/ Infrastructure Triggers	• No visibility of patients due to overcrowding • Fire safety or access risks • Inadequate call bell access • Lack of available monitored spaces	

3.2 Process

Where possible, patients at NHS trusts should be seen, assessed and cared for in a cubicle or bed in a designated clinical area. Non-clinical areas should only be used when all other options have been exhausted; using TES for patient care should not be normalised. When clinical spaces for patients are not available, escalation to TES and or corridor care may be required.

When escalating to corridor care, these prompts should be used to ensure that the correct process has been followed and that the documentation of this process is completed and available.

Prompt		Comments / Observations
3.2.1	Do you have access to your trust's local **'Flow'** Standard Operating Procedure (SOP)? This SOP outlines how patients move through your department, timeframes, escalation processes and actions to follow to maintain patient flow within your emergency department. All staff should be aware of and have access to this SOP. This SOP should be regularly reviewed to ensure it is accurate and correct.	
3.2.2	Are senior leaders visible within the emergency department to support decision-making, capture and escalate concerns? Best practice includes huddles/rounds by the emergency department coordinator and senior clinician every 2 hours.	
3.2.3	Are structured two-hourly real-time risk assessments being completed by the Nurse or Consultant in charge? These should include: • Patient acuity vs staffing • Ambulance cohorting risk • NEWS2 deterioration risk • Environmental safety • Safeguarding and mental health considerations • Flow blockages and constraints	
3.2.4	Have you confirmed the current escalation level (e.g., OPEL) and ensured it aligns with system-wide reporting?	

	Clear identification of escalation level ensures consistent communication and appropriate activation of actions across the organisation.	
3.2.5	Please confirm if all areas of the ED are full. If so, this should trigger the local escalation policy. • Trust OPEL status must be updated and communicated in line with the local escalation policy. • Action cards should be clear and provide clarity of roles and responsibilities. There should be clarification of decision makers and accountable officers	
3.2.6	Is ambulance cohorting in place when required, with clear oversight by a designated cohort nurse? This supports timely ambulance handovers and ensures safe monitoring of multiple patients awaiting assessment.	
3.2.7	Corridor care may be necessary to support timely ambulance handovers. • This should only occur following a 'fit to sit' assessment (with a target of 95% ambulance handover within 15 minutes). • There must also be oversight of patients in the waiting room, who must be monitored regularly by a healthcare professional. Has corridor care been authorised through a senior clinical safety assessment and explicit executive-level approval? Corridor care must be: • Time-limited • Actively overseen • Continuously risk assessed	
3.2.8	Have you ensured the appropriate arrangements for patients with mental health needs, including safe spaces, observation requirements and liaison psychiatry involvement?	
3.2.9	Have you identified a designated temporary escalation space that can maintain privacy and dignity when providing treatment and personal care? Patient experience will not be optimal for anyone being cared for in non-clinical areas; it is important to maintain patient privacy and dignity.	

3.2.10	Do patients or visitors have access to wireless call bells or other means of gaining the attention of staff if needed? Safety remains paramount during episodes of corridor care. Each area should be easily identifiable. This may require areas to be numbered.	
3.2.11	Has the patient safety checklist been commenced for patients in temporary escalation spaces such as corridors? Hourly comfort rounds must be considered.	
3.2.12	Is there sufficient and safe staffing of temporary escalation areas where patients are being cared for?	
3.2.13	Have infection prevention and control (IPC) risks been assessed for all temporary escalation spaces?	
3.2.14	Have you maintained regular reviews of patients' conditions to promptly identify any changes or deterioration that may require the person to be moved to another area of the hospital? Is there clear ownership for monitoring, escalation and reassessment of patients in temporary escalation spaces? Responsibility must be explicitly assigned to ensure safe and continuous oversight.	
3.2.15	Have you continued communication with patients who are being cared for in temporary escalation spaces? This is essential and should be regularly provided, including any progress with moving the patient to a bed/cubical, if appropriate.	
3.2.16	Have you considered hospitality staff or volunteers to provide food and drink to support the patient experience? Ensure reasonable adjustments are applied for those identified as requiring support.	
3.2.17	Are all care, reassessment, escalation activity, and communication with patients documented clearly and contemporaneously?	

3.3 Local Escalation Framework

Trusts are advised to add their local escalation framework and triggers here to support staff when using the Red Lines Toolkit.

3.4 Escalation Levels / Thresholds

Escalation Tier	Trigger	Required Actions	Decision Maker
Tier 1 Departmental		Internal huddle; divert staff temporarily	ED Coordinator
Tier 2 Divisional		Activate ED escalation policy	ED Matron/Duty Manager
Tier 3 Organisational		Executive approval; organisation-wide actions	COO/Exec on Call
Tier 4 System		SCC escalation; system-level mitigation	Place/ICB

3.5 Compliance Monitoring and Incident Reporting Framework

The following sections are designed to prompt the user to ensure all regular checks and monitoring are completed promptly, all breaches and risks are escalated accordingly, and that patient safety and comfort are ensured.

Compliance Monitoring Framework & Incident Reporting		Comments
3.5.1	Have you completed daily monitoring of the following areas: • Corridor occupancy, • Length of longest ED wait, • Staffing vs establishment, • Skill Mix, including Mental Health • Completion & quality of patient safety checklists, • OPEL triggers and response times, • Incident reporting (including volume/themes), • Patients breaching time thresholds in all department areas • Themes with MH delays.	
3.5.2	Daily/weekly documentation of compliance with policies, including: • Patient flow SOP • Continuous flow/Corridor care SOP • Boarding/Your Next Patient SOP • Trust escalation/full capacity policy • Mandatory checks	
3.5.3	Delayed or Missed Observations / Patient Deterioration is the single biggest driver of avoidable harm during crowding. **Report via the Trust incident Management system when:** • Required observations (NEWS2) are missed or delayed. • A patient deteriorates without timely recognition because they were in a non-visible or non-monitored area.	
3.5.4	Delay in Time-Critical Treatments directly increase clinical risk and are common during overcrowding. **Report via the Trust incident Management system when:** • There is a delay in analgesia, critical medicines, sepsis treatment, or clinical interventions caused by the escalation environment.	

3.5.5	Unsafe Locations or Environments for the Patient are red-line safety breaches.
	Report via the Trust incident Management system when:
	• A patient is placed in an area that cannot meet basic safety needs, e.g.:
	  ○ No call bell
	  ○ No oxygen/suction access
	  ○ Poor visibility
	  ○ Blocked access or fire safety concerns
	  ○ Mental health or high-risk patients are placed in corridors or temporary escalation spaces.	

3.5.6	Breaches of Dignity, Privacy, or Confidentiality are common in crowded departments and are a national priority for eradication. **Report via the Trust incident Management system when:** • Examinations occur without adequate screening. • Conversations involving sensitive information are overheard. • A patient's dignity cannot be protected due to the environment.	
3.5.7	Staffing or Skill-Mix Insufficiency Affecting Safety directly affects the ability to recognise deterioration and deliver safe care. **Report via the Trust incident Management system when:** • There is insufficient staffing to safely monitor escalation areas such as corridors. • Skill mix is unsafe (no RN covering escalated space). • Staff express that care is unsafe or morally distressing due to the environment.	

3.6 Associated SOP/Guidelines Organisations Should Consider

- ED escalation policy,
- Corridor care,
- Patient safety Checklist,
- Ambulance triage,
- Continuous flow model/boarding to wards.
- S136 Escalation Framework

4 Care & Comfort

This is a clinical assessment tool designed to support patient experience for patients cared for in non-emergency department (ED) areas. Healthwatch and departmental staff should complete this section.

For wards that have escalated due to continuous flow or boarding, local audit tools should be completed by ward staff

4.1 Patient Safety, Care and Comfort

Patient Safety		**Comments / Observations**
4.1.1	Is the TES staffed to the agreed safe staffing establishment?	
4.1.2	Are there any inappropriate patients being nursed in the TES? • Patients with mental health conditions, dementia and delirium, learning disabilities and or high NEWS score.	
4.1.3	Are medications for patients in temporary escalation spaces stored safely?	
4.1.4	Have patients received prescribed medications?	
4.1.5	Is there a call bell system in place?	
4.1.6	Can all patients in the corridors be safely observed?	
4.1.7	Is there a safe utilisation of space? Access to patients in emergencies, beds don't block fire exits, etc.	
Information Governance		**Comments / Observations**
4.1.8	Are there any confidential conversations taking place that can be easily overheard?	
4.1.9	Are medical and nursing notes stored securely?	

Privacy & Dignity		Comments / Observations
4.1.10	Does the corridor environment appear clean and tidy?	
4.1.11	Are privacy and dignity maintained during examinations/personal care?	
4.1.12	Do patients have access to nearby toilet facilities?	
4.1.13	Do patients report that their personal hygiene requirements have been met?	
4.1.14	Have patients been given pillows and blankets?	
4.1.15	Are patients appropriately dressed to receive care in temporary escalation spaces?	
4.1.16	Are patients' personal belongings recorded and stored securely?	
4.1.17	Supporting Rest at Night: • Can lights be dimmed in their area overnight? • Are patients offered sleep packs to support rest? (Eye mask and earplugs).	
4.1.18	Is "intentional rounding" being undertaken, as per trust policy?	
Nutrition & Hydration		**Comments / Observations**
4.1.19	Have staff been specifically aligned to support nutrition and hydration?	
4.1.20	Have regular hot and cold drinks been offered to patients and visitors?	
4.1.21	Do patients have access to a choice of both hot and cold meals?	
4.1.22	Are patients assisted in preparing to eat and drink? i.e., safe surfaces, hand hygiene and positioning.	

4.1.23	Is food and drink being served using appropriate crockery, cutlery and cups?	
Communication		**Comments / Observations**
4.1.24	Does the department have literature for patients and carers specific to receiving care in temporary escalation spaces? Has this been given to patients and their families?	
4.1.25	Do patients receive regular updates and understand their treatment and care plan?	
4.1.26	If families are not present, are patients assisted to maintain communication with their families?	
4.1.27	Visiting: • Are patients, relatives/carers aware of the visiting policy within the A+E department? • Do visitors have access to seating whilst maintaining safe access to patients? • Are visitors aware of facilities i.e., toilets, access to food and drink?	

4.2 Mental Health Patients

Emergency Department (ED) staff should be aware of the key elements of the Section 136 and escalation process along with using the mental health action cards when supporting patients with mental health needs in the ED.

Care of Mental Health Patients		Comments/Observaions
4.2.1	Patients with: • Acute MH crisis • Active risk of harm to self or others • Severe agitation, distress, behavioural disturbance • Safeguarding / mental capacity vulnerabilities Must never be cared for in corridor environments due to risks to themselves and others.	
4.2.2	Have MH Patients received a parallel assessment (ED and MH triage) on arrival to determine immediate risk and potential for diversion? Has an MH risk assessment been completed following parallel assessment to determine environmental risk, identification of risk related objects, and the level of supervision required, whilst in the department?	
4.2.3	Where additional staffing is required to support 1:1 supervision, is this provided? Where 1:1 supervision is not required, has the frequency of observation required has been identified and communicated to staff and partners	
4.2.4	Following parallel assessment and risk assessment, has a nursing care plan that corresponds with the level of risk identified is developed collaboratively with the mental health team, been communicated to the clinical team and documented in both MH and Acute Trust electronic patient records?	
4.2.5	Can you provide patients access to alternative and low-stimulation environments where practicable and in alignment with identified risk?	

	Has transfer to MHCAS or MH Neighbourhood Hub facility been considered?	
4.2.6	Have you clearly documented the response times from liaison mental health teams in relation to assessment and escalated where breaches have occurred?	
4.2.7	Have all MH patients placed in a corridor or another unsuitable area been escalated to the Site Manager, Liaison MH team and department Matron for resolution?	
4.2.8	Have you escalated to the mental health liaison team to request an urgent review of all MH patients in ED to ascertain if anyone can be discharged to accommodate corridor patients?	
4.2.9	Can you escalate to MH provider the need to redeploy staff to support acute corridor care and whether any additional MH support can be provided to the wider ED environment?	
4.2.10	If there is any change in risk, environment or presentation the MH risk assessment and care plan should be reviewed collaboratively by ED and MH team and amended accordingly.	

4.3 Staff Wellbeing and Moral Injury

Moral injury refers to the psychological or emotional distress that arises when a person witnesses or is unable to prevent actions that violate their deeply held moral or ethical beliefs. Moral injury occurs when staff feel unable to deliver the standard of care they believe is ethically required. Given pressures within urgent and emergency care services, this should be explicitly recognised, and staff should be adequately supported by following the steps below.

Staff Wellbeing and Moral Injury		Comments / Observations
4.3.1	Shift leads and department leaders undertake routine (at least twice daily) monitoring of staff emotional burden during times of escalation, and this is discussed in department huddles throughout the day.	
4.3.2	Where staff express that the care being delivered is unsatisfactory, or breaches local and professional standards, this is escalated to the ED Matron / EPIC, department leaders and to the site management team out of hours. This means that concerns are acknowledged and appropriate support can be provided.	
4.3.3	Where staff express concern that care is unsatisfactory and breached local/professional standards, this is recorded via the incident management system.	
4.3.4	In times of escalation, a daily debrief should be undertaken with staff who wish to participate to allow staff to raise concerns and reflect on any learning from the shift(s) in question. (Debrief should be guided by a formal debrief template that incorporates a moral injury reflection prompt, should be documented by the debrief lead, and used to inform quality improvement activities)	
4.3.5	Support should be available to shift leaders, including protected time, visibility of executive leaders and well-being support.	
4.3.6	On-call executives should be visible in areas experiencing escalation to speak to staff and patients. Identify concerns and provide support to leaders.	
4.3.7	Staff who have been moved to ED to support pressures should be supported in their new areas, including: • Using a buddy system with an experienced nurse. • Having a welcome pack with basic and practical ward information. • Have a mechanism for feedback on their experience.	

Patient Feedback	Comments / Observations	
How would you rate your experience of being cared for in a temporary escalation space?	Very good	
	Good	
	Neither good nor poor	
	Poor	
	Very poor	
Any other comments/observations?		

5 Evidence

This checklist outlines the evidence and documentation that should be collected during episodes of care in TES, including wards or ED corridors]

5.1 Evidence Checklist

Evidence		Comments / Observations
5.1.1	Is real-time monitoring visible to Trust Executives via dashboards? Including: • Missed physiological observations • Analgesia delays • Delayed/missed critical medicines • Patient deterioration	
5.1.2	Can you provide evidence that mandatory clinical harm huddles are completed every 2 hours while patients are accommodated in temporary escalation spaces?	
5.1.3	Have you documented concerns regarding occupancy and safety that have been escalated? Including concerns escalated to nursing and medical coordinators, ED matrons or CBU management team.	
5.1.4	Have you documented escalation to the Care Group, manager of the day or senior manager on call (OOHs)?	
5.1.5	Is documentation from bed meetings as per Trust processes and bed reports documented?	
5.1.6	Do you have documented evidence of adherence to the Trust escalation policy?	
5.1.7	Do you have evidence of communication with NWAS to support planning?	
5.1.8	Have you documented the Trust's OPEL status and associated actions?	
5.1.9	Ensure that you documented evidence of actions, including: • Risk Assessments completed • Continuous flow • Boarding / double boarding • Opening escalation areas	

5.2 Governance Framework

There are several ways to monitor the quality and safety of care in non-ED areas. Any governance structure put in place should consider oversight of the following (not an exhaustive list)

- Harm profile review
- Thematic review of incidents
- Risk register
- Complaints/Concerns/PALs thematic review
- Weekly NEWS2 audits by area
- Patient feedback/patient stories into sub-committees
- Audits of intentional rounding
- Mandatory 48hr review of the care of all patients accommodated on the corridor, using a standardised methodology (PSIRF harm classification, IHI Global Trigger Tool)
- Ensure learning from harm reviews is fed into ED, Divisional and Trust governance meetings.
- Hold a SWARM huddle in response to real-time incidents where the team would like to identify real-time learning or understand the situation.
- Compliance against patient safety checklist
- Compliance against ambulance/corridor/boarding SOP
- Will need to be reflected in risk register
- Clinical incidences to report on DATIX system
- Audit programme plan
- Data collection/IT solutions for future
- Monitoring of action plans and learning
- ED governance group, Directorate / divisional quality committee/ Corporate quality committee/Place and system oversight
- Link to risks/BAF - needs to dynamic assessments/reviews
- Update to Trust board
- Communication with external stakeholders, Place, ICB, CQC, NHSE, Healthwatch, local authority, NWAS.

6 De-escalation

Principles for supporting de-escalation from providing care in non-Emergency Department (ED) areas. For all staff, this information should be relayed to senior leadership regularly.

6.1	Is the situation deteriorating or improving, and have triggers for escalation or de-escalation been considered based on OPEL/SHREWD status alongside professional clinical and operational judgement?
6.2	The Full Capacity Protocol (FCP) should align with the OPEL framework.
6.3	OPEL framework triggers and SHREWD utilised and included in bed/escalation meetings. The decision to de-escalate is taken at a capacity meeting and authorised by the person with delegated authority in the meeting, e.g., capacity director/COO.
6.4	De-escalation should follow a reverse sequence to escalation. However, a dynamic risk assessment should be utilised to support de-escalation, as risk may vary in different areas depending on the time of day.
6.5	Direct line of communication to the SRO in your organisation regarding reinstatement of elective activity.
6.6	The same line of communication is used to convey the de-escalation process.
6.7	Process in place to provide a debrief following escalation. This is designed to support staff, understand and document lessons learned and review internal SOPs, policies and procedures.
6.8	Ensure staff have the resources and time to allow them to locally de-brief their teams, for example, ED teams and Wards impacted by TES.

6.1 Learning to Inform Quality Improvement

- Hold regular debriefs at department/ward level, this will inform improvement work but also provide safe reflection and support to staff
- Patient experience feedback
- Staff experience feedback
- Quality Assurance of data
- Potential opportunities for the use of QI methodology to support continuous improvement.