

Aspiring to provide
Brilliant care to
One + all



Royal Cornwall Hospitals
NHS Trust

RCHT Flow and escalation resource pack

Right Patient, Right Place, at the Right Time, to see the Right Clinician

Working document – VERSION 2.4

Procedures for use 24 hours a day, 7 days a week to support flow through the hospital for Non-elective and planned care patients

Version: 2.4
Date: August 2023



Version control



Version	Date	Updates by	Comments	Approved for publishing and date
0.1	18/02/2023	Robin Jones, COO	Initial draft	N/A – draft document
0.2	22/02/2023	Matt Overton, Emergency Planning Lead	Logging slide added and hyperlinks for Major Incident Plan and Capacity Management Escalation Plan	N/A – draft document
0.3	23/02/2023	Robin Jones, COO	Updates ready for sharing with care groups	N/A – draft document
0.4	1/03/2023	Tom Roden	Updates post initial circ.	N/A – draft document
0.5	03/03/2023	Robin Jones, COO	Updates before publishing	N/A – draft document
0.6	3/03/2023	Tom Roden	Updates post 2nd circ.	N/A – draft document
1.0	04/03/2023	Robin Jones, COO	Document published as working document for ‘beta testing’	Robin Jones, COO – 04/03/2023
1.1	10/03/2023	Tom Roden	Minor updates post publishing.	Sent to COO 10/3/2023
1.2	14/03/2023	Tom Roden	Clinical support updates to Action cards	Sent to COO 14/3/2023
2.0	17/03/2023	Robin Jones, COO	Updates from user feedback incorporated Added Hyperlinks on the contents page Added section 2 (Roles and responsibilities) Added General Surgery Action Card Amendments highlighted in green for ease of reference on sections not listed above	Robin Jones, COO – 17/03/2023
2.1	18/04/2023	Jo Floyd DCOO	Minor updates post feedback session Operational Huddle	Sent to COO CDCOO and Tom Roden.
2.2	19/04/2023	Jo Floyd DCOO	Additional slides from SSS Patient Flow House	Sent to COO CDCOO and Tom Roden.
2.3	04.07.2023	Jo Floyd DCOO	Medical Model updates included from Rachael Pearce GM Specialty Medicine.	Sent to Robin Jones COO for approval and sign off.

Version control.



Version	Date	Updates by	Comments	Approved for publishing and date
2.4	17/08/2023	Tim Mumford	Agreed Discharge Co- Ordinator Roles and Responsibilities with HON and Paul Highton.	Approved and Signed off by J Floyd DCOO

Introduction – the purpose of this resource pack



- To be used 24 hours a day to be clear on escalation actions to maintain flow through the hospital ensuring there is never an occasion where an ambulance is not able to offload
- To enable the continued delivery of the Internal Professional Standards (next 2 pages)
- This pack DOES NOT replace the Major Incident Policy and procedures which can be access from the document library or this link [Major Incident Plan \(Majax\) \(cornwall.nhs.uk\)](https://www.cornwall.nhs.uk/document-library/major-incident-plan-majax)
- This pack is to be used in conjunction with the escalation policy and Flow policy [Capacity Management Escalation Plan](#)

Link to our values statement

R – Respect	We will respect the opinions of all involved in the flow of patients through the hospital, providing compassion to staff and patients encouraging honest escalation of issues and reporting of the position so that as a whole team we ensure our hospital is able to provide care for Cornwall. All actions and interactions with colleagues are to be supportive in nature to resolve issues and achieve the standards required for our patients
C – Compassion	
H – Honesty	
T - Teamwork	

Introduction - Internal Professional Standards



10 principles for effective emergency care at RCHT (approved in 2018)



1 An emergency department (ED) decision making clinician (ST4+) should see new patients within 60 minutes of arrival in ED.



2 The ED team should not admit a patient likely to be able to go home just to avoid a breach of the emergency care standard.



3 Receiving teams should have arrangements in place for sufficiently experienced staff to assess, treat and discharge or admit emergency patients within 60 minutes of referral.



4 If a receiving specialty has been unable to see, assess treat and discharge or admit a patient after 60 minutes then ED consultants have the authority to admit the patient to the receiving specialty that they consider best able to meet the patient's clinical needs.



5 Patients referred from primary care (or any other clinical service) should be routed directly for specialty assessment via the operations centre. If this does not occur and the patient attends the ED, the patient should be transferred to the receiving specialty unless immediate medical intervention is required.



6 Patients should only be sent to the ED as a result of advice by specialty teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. In this situation, the ED team should continue to provide clinical support to patients within the resuscitation area, and then refer to the most appropriate specialty for on-going management of the current clinical problem.



7 Transfer patients from level 2+ beds should take priority in in-patient bed allocation over and above any other calls for that available bed.



8 No specialty doctor should refuse a request to assess any ED patient following an ST4 or above review. The ED team will continue to provide clinical support to patients within the resuscitation area.



9 The ED team should identify any patient recently discharged from an inpatient admission or under current investigation or treatment for assessment by the suitable specialty. This should help the specialty team to avoid unnecessary admissions.



10 Patient care and admission should not be delayed by inter specialty dispute over clinical ownership or placement. ED consultants have the authority to allocate immediate clinical ownership to ensure timely care and admission, (within 60 minutes of initial referral).

Introduction - Being digital statement



- In order to effectively run the hospital sites, it is essential we can rely on our electronic systems for the information we need. It is the responsibility of the Care Group Clinical Director, Head of Nursing and General Manager to ensure that all of their areas are maintaining up to date records in real time of the status of patients and their location.
- There is a section in this resource pack to outline the minimum information to enable flow and Radar reports that will be used to inform escalation actions.
- Unless the Trust is in a Business Continuity event with a system not working the information from our clinical systems will be used in decision making and actions.

Contents



1. [Standards our patients can expect us to deliver.](#)
2. [Roles and Responsibilities summary.](#)
3. [Minimum elements needed to maintain the site:](#)
 - a) Minimum elements where Partner Organisation provides resources
4. [KPI triggers with actions.](#)
5. [Site Flow.](#)
6. [Actions for no expected patients in ED.](#)
7. [SDEC areas.](#)
8. [AMU / Emergency Village.](#)
9. [Outliers – selection and management.](#)
10. [Minimum data entry set to ensure safe flow \(use of systems\).](#)
11. [Single version of the Truth – Reports which are to be used for Flow decisions.](#)
12. [Preparations for the weekend.](#)
13. [Ring fenced areas and why.](#)
14. [Care Group specific action cards \(escalation procedures\).](#)
15. [Harm Reviews.](#)
16. [Emergency Log Book.](#)
17. [Equality Assessment.](#)
18. [Links to useful SOPs and Policies \(all will be in the Trust online Document Library\).](#)
19. [Best practice care group management process](#)

1. Standards our patients can expect us to deliver



There are a wide range of detailed standards we need to deliver for our patients when they access our services. The list below are the high level elements everyone involved in flow must understand and take immediate escalation actions if these are at risk of being delivered or are not being delivered

All patients can expect us to be clinically led, acting on the advice of our clinical leaders to ensure the right patient is in the right place, at the right time to see the right clinician without delay

- A patient arriving by ambulance should be brought into the hospital immediately (all admission areas) with no delays for handover to enable the ambulance crew to be released for other patients in the community.
- Emergency attenders should have initial triage within 15 minutes.
- Emergency attenders should have a maximum wait to be seen of 60 minutes.
- There should always be a space in Critical Care, Resus, RATS and a majors cubicle for the next emergency arrival to ensure no delays
- A patient should transfer out of the department within 30 minutes of a Decision To Admit or Decision To Discharge
- A patient who is 'expected' would not attend ED and be a direct attendance to the relevant admitting area
- Expected patients should not attend ED when specialty SDEC area is open for admissions (*Needs to be up to 2200 7/7*) unless critically unwell and requiring ED resus care
- Same Day Emergency Care (SDEC) areas to be kept flowing with no patient remaining in an SDEC area overnight (over midnight)

1. Standards our patients can expect us to deliver Cont..



- Medical Patients to be cared for on medical wards so that there is admitting capacity for planned care surgical patients on the surgical wards.
- On admission to the Hospital every patient has a plan for discharge (discharge planning starts on admission).
- Every patient should be updated against the following standards every day:
 - Why are they in Hospital?
 - What is the plan for them that day?
 - What needs to be achieved for them to be discharged?
 - What is the date that the patient will be discharged?
- Patients who require access to specialist care will access those wards/units without delay.
- All inpatients will have a clinical review every day they are admitted. (The Chief Medical Officer can approve MFFD patients having a once a week review as part of escalation actions)
- A patient who no longer meets the Criteria to Reside should be moved to the discharge lounge within 1 hour and then discharged from the lounge 2 hours later.
- Patients can expect the same level of care 24 hours a day, 365 days a year.

1. Standards our patients can expect us to deliver Cont...



- When a patient on Critical Care no longer requires high dependency care they will be moved from the unit within 4 hours. Transfers should be avoided between 22:00hrs and 06:00hrs.
- No patient will be held in Theatres recovery longer than is clinically necessary and will transfer to a ward/day case area promptly (30 minutes).
- All of our areas will be clean and we will be following IPAC guidance in the event of an infection.
- All inpatient white boards (Cardiology and Trauma) should be at Green, reviewed daily and a recovery plan in place.
- Care Groups must provide daily information by specialty on the length of stay for patients waiting for surgery in beds and ensure they are listed and prioritised accordingly. Elective cases must be reviewed by the Clinical Director against inpatient length of stay waits. ensuring minimal bed days lost.

2. Roles and Responsibilities summary (for flow)



The next slides outline the roles and responsibilities for key roles

- [Clinical Site Manager \(CSM\)](#)
- [Bed Manager](#)
- [Discharge Coordinator](#)
- [ED Nurse in Charge](#)
- [Clinical Point of Contact \(CPOC\) in ED](#)
- [RATS nurse in charge](#)
- [AMU Nurse in Charge](#)
- [SDMA Nurse in Charge](#)

Role of the Clinical Site Manager (CSM)

The Clinical Site Management (CSM) Team provide site management support and co-ordinate and facilitate patient flow, 24 hours a day, 7 days a week. In addition, the CSM provide senior nursing support, professional leadership, and advice to all clinical areas within the Trust, predominantly during the out of hours period



Delivering Quality, Safety and Performance

- The Clinical Site Manager on duty will have a strategic overview of all clinical capacity related to patient flow and will work closely with all clinical areas to balance the planned and unplanned demand through available site capacity (including peripheral sites).
- Work closely with NIC and EPIC in the Emergency Department to
 - Ensure departmental safety is always maintained.
 - ECAS standards are always maintained, and a recovery plan in place if not being met.
 - Attend 2 hourly board rounds, throughout the 24hour period with ED team (ED NIC, EPIC and Co-ordinator) starting at 07.45am.
 - Ensure all expected patients can attend assessment areas (SDMA, SDSA, TAU and Frailty SDEC), and monitor with unit leads capacity, flow and safety, ensuring takes remain in specialty areas
 - Provide ED Consultant at 18.00 full handover of night plan with SMOC – Senior Manager On call Overnight
- Maintain safe patient flow by monitoring the live electronic systems, including.
 - ☐ Ambulance information screen
 - ☐ Oceano
 - ☐ Swift plus
 - ☐ Radar – Live Bed state
 - ☐ Nerve centre
 - ☐ Transport system
- To understand and implement each level of the Trust's Patient Flow Policy working in conjunction with clinical areas and their management teams.
- Have overall responsibility for the collation and co-ordination of repatriated patients in and out of hours.
- Working closely with all department leads to ensure patient safety, experience and patient flow, with efficient and effective use of all resources including staffing and site capacity.
- Ensure effective use of available resources, reporting areas of challenge to the specialty manager of the day, clinical matron and then Care Group Triumvirate Member as appropriate.
- To advise on bed utilisation across the site during the management of any critical incident or infection control outbreak, liaising with infection prevention and control teams (IPAC) regarding utilisation of single rooms, cohorting options or identification for infective cases.
- To play a lead role in the Trust's involvement in a major incident as described in all emergency plans.
- At all times to act as an ambassador for the Trust and inspire staff groups to achieve local and national targets in patient access and care.
- The Clinical Site Manager has specific responsibilities in relation to the Mental Health Act 1983 and will act as the point of contact and co-ordination within the Trust. The Clinical Site Manager is responsible for accessing and retaining the required documentation, which will be stored in the Clinical Site Manager's office.
- The clinical site manager will escalate to the senior clinical site manager or senior duty manager (OOH) for any unresolvable issues impacting on patient safety, experience, and trust performance.



Role of the Clinical Site Manager (CSM) continued

The Clinical Site Management (CSM) Team provide site management support and co-ordinate and facilitate patient flow, 24 hours a day, 7 days a week. In addition, the CSM provide senior nursing support, professional leadership, and advice to all clinical areas within the Trust, predominantly during the out of hours period



Delivering Quality, Safety and Performance

Out of Hours responsibilities

- Communicating with outside agencies and escalating information as per appropriate policies.
- Coordinating of emergency situations i.e., fire, major incident, critical incidents.
- Manage staffing issues across the Trust.
- Assessing workload and offering support to staff by delegating and liaising appropriately.
- Join/Lead multi-professional clinical handover out-of-hours in line with handover policy as Clinical/Operational demands allow.
- Out of hours to support junior doctors' initiatives by providing the first point of contact for ward staff; undertaking clinical work as able and liaising with junior medical staff as necessary.
- Ensure clinical practice complies with Trust's policies and procedures.
- Provide clinical leadership and maintain credibility through practice and professional update.
- Provide clinical support, professional advice, consultation, and direct assistance to all colleagues, as necessary.
- To be the first point of contact for wards and departments, out of hours, relating to complaints, accidents and untoward incidents involving patients, staff and visitors and to take appropriate actions in response.
- Co-ordinating transfer of repatriations into and from the Trust.

Role of the Bed Manager



Delivering Quality, Safety and Performance

- The Bed Manager on duty will have an operational overview of allocated clinical areas related to patient flow and will work closely with all clinical areas to balance the planned and non-planned demand through available site capacity (including peripheral sites).
- Work closely with NIC and discharge co-ordinator of clinical areas to effectively use all available inpatient beds or day case capacity identified.
- Manage and identify with the NIC all confirmed and potential discharges in each Clinical area to inform Clinical Site Manager of bed availability.
- Manage all planned admissions, to ensure flow through assessment areas, theatres and recovery is maintained, resulting in all planned elective care lists are completed daily. Escalating any issues or delays to the Senior Clinical Site Managers immediately.
- To follow and implement each level of the Trust's Bed Management Policy working in conjunction with clinical areas and their management teams, ensuring that all necessary patients are discharged as required.
- Ensure effective use of available resources, reporting areas of difficulty to the Clinical Site Managers and Care Group Manager of the day as appropriate.
- To advise on bed utilisation across the site during the management of any infection control outbreak and liaise with IPAC regarding single room utilisation.
- To prepare Bed State for daily Bed meetings, 7 days a week.
- Assist clinical areas in timely manner to support discharge, for example support booking transport or chase TTO's and support with internal transfers.
- To be aware of all patients who require internal transfer within RCHT and work closely with the ward managers and clinical site managers to facilitate transfer/swap.
- At all times to act as an ambassador for the Trust and inspire staff groups to achieve local and national targets in patient access and care.

Role of the Discharge Co-Ordinator

To provide support to all staff to maintain high standards of care whilst promoting rapid flow through the ward.



Delivering Quality, Safety and Performance

Transport

Book/organise/chase Transport (including taxis)
Order taxis or Blood Bikes to deliver delayed medication post discharge
Progress chase referral, once clinically referred and accepted chase repat hospital with site team

Patient and Next of Kin Communication:

NOK contact and discharge updates
Discharge planning with NOK and patient
Find out patient's social history relevant to discharge
Support the clinical team, as delegated, in ensuring that the patients are aware of their plan of care (ECIST questions) are answered daily
friends and family test/ Patient surveys
Set up BIM, functional arrangements

Ward Team Communication

Attend Drs meeting/Ward/ Board Rounds
Attend rapid round
Attend handovers/ update nurses or Drs
Update message to service group e.g. spec' med chat
Update MOD/ managers

Electronic Systems

ENTER/ UPDATE DISCHARGE INFO ON NERVE CENTRE including updating PDDs from board/ward round
Update R2R (Reason to reside) as agreed with clinical team post rapid round
Utilise Trust electronic data bases to inform practice

Referrals

Complete STRATA Referrals and updating (formally SERF)
Liaise with other departments to arrange accepted patients moves
Coordinate the transfer of patients to discharge lounge
Check/ chase restart of POC with agencies

Liaise with external providers

liaise with systems partners including HUMANS, CHAOS, STEPS
Contact nursing and residential homes to confirm discharge arrangements
Liaise with community hospitals to confirm discharge arrangements
Liaise with Adult Social Care
Once End of Life referral has been accepted, liaise with Marie Curie on discharge arrangements

Administrative Tasks

PRINT DISCHARGE SUMMARIES
Chase Drs to complete Discharge Summeries
TTOs/ chase Dr to prescribe TTOs
WRITE/UPDATE PATIENT NOTES in relation to discharge

Trust and Escalation Communications

As directed by Nurse in Charge, to support patient low at times of escalation. Assuring that suitable training has been received
Identify which patients are leaving- progresschase what is stopping them and escalate delays/ escalations of treatment/discharge dependent procedures
Liaise with Imaging Inpatient Pathway Navigator for any outstanding CT, MRI, X-Ray, Ultrasound or Interventional Radiology requests
Confirm specialist reviews/MAXIMS referral has been requested and chase with relevant MoD (e.g. psych/ neuro)
Liaise with Inpatient Therapy Patient Flow Navigator (OT/PT/SLT/Dietician) including equipment requirements to facilitate discharge
Liaise with OT/PT to ensure equipment is with the patient ready for discharge
LIAISE WITH FLOW HUB/ SITE TEAM
Support administration of the white board/speciality patients

Portering

Support ward with patient moves in escalation (as second person)

Care Group Specific Tasks

Admit patients on CORE and utilise PAS

Role of the ED Nurse in charge

To provide leadership, support all staff and maintaining high standards of care whilst promoting flow through the department.



Delivering Quality, Safety and Performance

- NIC must ensure high standard of nursing care is being provided by all staff in ED as per sub role action cards.
- The NIC must ensure with the EPIC that the department is achieving the ECAS standards and the Internal Professional Standards and devise a plan to recover the position if not compliant. Support will be provided in hours by the CPOC and CSM out of hours.
- The NIC handover time 07.00 – 07.30 and 19.00 – 19.30 must be protected to ensure quality handover is supported.
- Ensure safety brief is delivered at the beginning of each shift 07.00 and 19.00, daily department checks are completed by 08.30 and 20.30.
- NIC will deliver daily safety huddles every 4 hours throughout the 24-hour period starting at 09.00am, they must act on escalations or escalate to CPOC if needed.
- Ensure safe allocation of staff for current shift. Escalate any problems for imminent shifts to CPOC in hours and CSM out of hours. This must be constantly balanced against surges and acuity levels.
- ED checklist must be completed hourly and 2 hourly care rounds for patients in the department over 4 hours.
- The NIC must be assured that the patient's medication are administered in all areas of ED including the ED waiting room and ambulance queue as per sub role actions cards.
- The NIC must ensure hydration and nutrition needs are met in all areas in ED including the ED waiting room and ambulance queue as per sub role action cards.
- The NIC must ensure that there is feedback from sub area nurses that there is patient satisfaction in all areas or escalate issues.
- NIC will Identify vulnerable, deteriorating, long stay and specific protocol patients in the department that require further short-term support or rapid treatment / transfer, and this must be escalated at huddles/board rounds. CPOC must be made aware of escalations immediately.
- NIC will lead 2 hourly ED board rounds, throughout the 24hour period with ED team and Clinical Site Manager starting at 07.45am.
- Ensure staff take breaks and that staff welfare is supported. Break allocation must not impact on timely transfers.
- Ensure all ED space including ADL and ED corridor is utilised to maximum capacity and prevent ambulance holds. Ensuring patient safety is maintained.
- CPOC will collate all the information for site meetings and share with the NIC. Either the NIC or CPOC will attend the bed meeting and escalate any department concerns if they can not be resolved internally.
- Maintain a visible presence at the NIC station, NIC breaks must be covered.
- Monitor IPAC concerns, ensure IPAC standards are met and liaise with Site co any specific patient needs.
- Monitoring of ambulance holds or threats of ambulance holds, handover time and that cubicles are ready to receive.
- Oversight of cleanliness of entire department.
- **Overnight Only :-**
 - Receive and action sickness calls from staff
 - Urgent HR issues only

Role of the ED Nurse in charge continued

To provide leadership, support all staff and maintaining high standards of care whilst promoting flow through the department.



Delivering Quality, Safety and Performance

Problem Solving

- Provide advice for colleagues with clinical and operational issues.
- Ensure patients requiring time critical treatment receive it within 4 hours and are discharged from the department.

Coaching and Developing capability

- Promote and empower individuals to make good safe clinical decisions.
- Lead by example to all staff ensuring they adhere to professional standards.
- Ensure Staff are aware of the need for prompt escalations of real time and potential problems to the CPOC.
- Ensure staff are aware and strive to maintain the Emergency Department pledge of safe nursing care.

Interaction within department and with Other Departments:

- Communicate effectively with EPIC/CPOC to maintain internal flow.
- Work in partnership to prioritise patient clinical plans from speciality doctors, ensuring no delays in care or discharge and transfer.
- Maintain good communication with AMU/SDMA/CSM/NIC wards to maintain external flow from department.
- Follow ED management escalation at times of need.
- Make sure all staff complete all written and electronic documentation immediately

Role of the Clinical point of Contact (CPOC) (Formally shop floor lead)

To provide senior nurse/navigator cover and support to the department 5 days a week (Mon – Fri 8am – 5pm)



Delivering Quality, Safety and Performance

Follow Department SOPs to maintain patient safety – Appendix 1 as per the V1.9 Surge plan ensure the following

- The CPOC is the senior clinical lead for the Emergency Department to offer advice and clinical support for the NIC to maintain, quality, safety and performance.
- CPOC must be available at all times to support NIC and have oversight of the department.
- The CPOC must be able to provide a snapshot of all patient safety concerns and compliance of performance measures hourly to the wider UEE Care Group and provide sitrep for the daily site meetings.
- Focus on any potential 4 hours breaches and ensure appropriate resolution or escalation via ED huddles, board rounds and site meetings.
- Ensure all space and escalation space is utilised within department as required.
- Ensure that the Internal professional standards are being adhered to with EPIC and NIC throughout the shift.
- Ensure close liaison with the Senior Site Manager.
- Escalate to other care groups for support in department where required.
- Ensure all redirection sops are being adhered to.
- Provide assurance through the 2 hourly board rounds that all patients that have attended ED have a clinical requirement to be there.
- Ensure all speciality patients are streamed to internal assessment areas.
- Work with HALO to ensure crews are clearing once handover has taken place.
- Monitor crew handover compliance and that EPCR is completed, support HALO in utilisation of other pathways for conveyance. Email any incidences of false delayed handover or inappropriate conveyance to the ED Service Manager.
- Ensure any risk of ambulance holds are escalated early to the Senior Site Manager to create a plan to avoid holding.
- If ambulances are being held, work with Senior Site Manager to monitor recovery plan and escalate to Deputy Coo for further support.
- Review live bed state with Senior Clinical Site Manager to support zero tolerance policy to empty beds.
- Ensure all transfers undertaken within 15 mins.
- Ensure all patients identified for intra-hospital transfer (i.e. CATU) are reviewed for alternative locations to wait for transport.
- Ensure all patients clinical identified for intra-hospital transfer for escalation of care is escalated for rapid transfer.
- Early escalation of mental health patients and social care patients to ensure the appropriate team are attending ED and assessing within their KPI. Then escalation for bedded care to Deputy Coo who is the tactical command representative.
- Ensure surge plan is being followed an appropriate actions taken.

Role of the Clinical point of Contact (CPOC) (Formally shop floor lead) – continued

To provide senior nurse/navigator cover and support to the department 5 days a week (Mon – Fri 8am – 5pm)



Delivering Quality, Safety and Performance

Managing performance and maintaining momentum

- Provide clinical leadership of the minors and waiting room area.
- Ensure that all majors in minors' patients are identified and that care is planned and delivered to a high standard.
- Maintain good communication with the Doctor, NIC and CPOC – progressing the clinical plan and escalating any concerns.
- Ensure all patients are seen, treated and discharged within 4 hours. As per ECAS standards.
- Identify vulnerable people in the minor's department or waiting room and act accordingly.
- Escalate patients requiring time critical treatment e.g., DIB, Sepsis deteriorating patients
- Ensure ED checklist via Nerve Centre is kept up-to-date identifying early patients for admission any issues with flow and liaising with NIC and ED activity coordinator.
- Organise staff, allocate breaks and ensure that they take them.
- Act as a role model to all staff and to ensure that essential nursing care needs are met to a high standard.
- Ensure that medication management standards are met.
- Ensure that minors and waiting room is clean and all IPAC standards are met
- Ensure that high standards of nursing care are provided, and that staff uphold the #ED pledges of safe nursing care.

- Monitor triage times and implement secondary or tertiary triage as required – escalate any concerns to NIC.

Problem Solving

- Provide advice for colleagues with clinical and operational issues.
- Reinforce Internal professional standards.
- Keep patients/relatives informed of clinical plans and delays.
- Continue to be a patient advocate for those patients who are unsuitable to be in minors or the waiting room.

Interaction within department and with Other Departments:

- Be present at all safety rounds.
- Regular communication with ED NIC and POC and bed manager - informing them of plans and escalating any concerns, including all majors in minors.
- Communicate with other members of the MDT and ED management team.
- Liaise with Domestic team to ensure cleaning of cubicles and bays are completed within 30 minutes.

Role of the RATS Nurse in charge

To provide senior nurse cover and support the department 7 days a week



Delivering Quality, Safety and Performance

- Responsibility and accountability for all patients whilst in the RATS area and ambulance queue.
- Co-ordinating flow of patients requiring assessment, treatments and transfers.
- Facilitating prompt transfers from ambulances to available spaces in ED and ensure expected patients are streamed to assessment areas.
- Monitor face to face triage (Best Practice) end of bed triage with a fresh set of observations.
- Revert to 'next best' practice of triage in times of high volume – take a verbal handover from SWAST crew and take their latest observations (within last 10minutes) to complete triage.
- Monitoring ePCR sign offs and prompt departure to ensure SWAST crews are available to the Cat 1 and 2 response calls.
- Ensure Red light to Green light process system for ambulance handovers is used in accordance to RCHT sop.
- Monitor adherence to policy and procedure i.e., bloods at bedside to reduce errors raised through Datix.
- Monitor nursing standards are achieved and maintained, i.e., Observations and the ED patient safety checklist.

- Ensure observations including Neurological observations are entered onto Nerve centre.
- Escalate priority patients (Sepsis, chest pain and high NEWS 2)
- Highlight - 'FIT TO SIT' OR 'EXPECTED' patients, to ensure maximum efficiency of ED footprint.

Problem Solving

- Provide advice for colleagues with clinical and operational issues.
- Ensure patients requiring time critical treatment receive it in accordance to triage tool.
- Highlight patients of concern to the RATS Doctor or EPIC.

Interaction within ED and with Other Departments:

- Attend ED huddles with NIC throughout the 24 hour period
- Liaising with ED NIC to ensure capacity within the department is known and utilised at all times.
- Work collaboratively with HALO/SWAST, RATS team, ED NIC, Doctor in Charge and radiology team.
- Liaise with HALO to ensure all Swasft crews are using alternative pathways and services to avoid attendance to ED.

Role of the AMU Nurse in charge

To provide leadership, support all staff and maintaining high standards of care whilst promoting flow through the department.



Delivering Quality, Safety and Performance

- Deliver Daily Safety (brief) Huddles 07.00 and 19.00hrs with nursing team.
- Ensure all actions in the Nurse in Charge Checklist is completed upon every shift.
- Ensure safe allocation of staff for current and upcoming shifts. Ensure all staffing gap mitigating actions are in place, only escalate to the Matron if they can not be resolved.
- Carry out board rounds with Consultant in charge 08.00, 11.30 and 15.30 to ensure the following is completed.
- 4 ECIST Questions are answered for all patients.
- All Maxims referrals are completed, all discharge summaries , TTOs completed, and transport booked.
- Lead the AMU patient flow huddle – escalate all specialty patients and long waiting patients to the specialty lead managers of the day.
- Ensure that daily NIC checklist is completed.
- Ensure the daily and monthly audits are completed on AMAT.
- Ensure all transfers are completed within 15 minutes of allocation.
- Ensure all boarding and holding spaces are utilised and patients monitored as per sop. Next boarding or holding patients must be identified to support swift flow.

Problem solving

- Provide advice for colleagues with clinical and operational issues.
- Ensure patients requiring time critical treatment receive it from the most appropriate team.
- Review skill mix and acuity and dependency allocating staffing as appropriate.

Coaching and Developing capability

- Promote and empower individuals to make good safe clinical decisions. Lead by example to all staff ensuring they adhere to professional standards.
- Prioritise clinical training to maintain the integrity of the unit.

Interaction within department and with Other Departments:

- Communicate effectively with CIC/Ward clerk/Discharge Co-ordinators to maintain internal flow.
- Any delays escalated to the appropriate person or team.
- Use board rounds to ensure effective communication and escalation.
- Work in partnership to prioritise patient clinical plans from speciality doctors, ensuring no delays in care or discharge and transfer.
- Maintain good communication with ED/MDU/SDMA/CSM/NIC of wards to maintain external flow from department.
- Make sure all staff complete all written and electronic documentation immediately.

Role of the SDMA Nurse in charge

To provide leadership, support all staff and maintaining high standards of care whilst promoting flow through the department.



Delivering Quality, Safety and Performance

- Deliver Daily Safety (brief) Huddles 08:00, 10:00 and 14:00 hrs with nursing team
- Ensure all actions in the Nurse in Charge Checklist is completed upon every shift.
- Ensure safe allocation of staff for current and upcoming shifts. Ensure all staffing gap mitigating actions are in place, only escalate to the Matron if they cannot be resolved.
- Allocate staff to demand and need of department.
- Attend ED at 08.15am to review all medical patients to pull patients to SDMA.
- Identify vulnerable, deteriorating and long stay patients in the department that require further short-term support or rapid treatment, transfer and escalate at huddles/board rounds.
- Carry out board rounds with Consultant in charge (12:00, 15:00, 18:00 and 21:00 as a minimum)
- **As per SDMA escalation checklist**
 - Number of patients in the department
 - Number due to come in
 - Triage time, WTBS, Decision to admit
 - Clinical acuity issues/escalation
 - Patients identified for an inpatient bed
 - Length of wait for allocation (Escalate to Site Manager)
- Ensure escalation to clinical teams and management as per escalation policy in conjunction with Consultant in charge.

Problem Solving

- Provide advice for colleagues with clinical and operational issues.
- Ensure patients requiring time critical treatment receive it within 4 hours and are discharged from the department.

Coaching and Developing capability

- Promote and empower individuals to make good safe clinical decisions. Lead by example to all staff ensuring they adhere to professional standards.
- Prioritise clinical training to maintain the integrity of the unit.
- Interaction within department and with Other Departments:

Communicate effectively with CIC/Ward clerk to maintain internal flow.

- Utilising OPEL status promoting effective communication and escalation to the UEE Matron.
- Work in partnership to prioritise patient clinical plans from speciality doctors, ensuring no delays in care or discharge and transfer.
- Maintain good communication with ED/MDU/AMU/CSM/NIC of wards to maintain external flow from department.
- Make sure all staff complete all written and electronic documentation immediately.

3. Minimum Elements needed to maintain the site



Every day the following minimum elements must be in place for our hospitals, they must be verified at each site team handover with escalation actions (as described below) to ensure they are in place. The elements are not listed in any specific order of importance

Care Groups **MUST** ensure they are planning ahead so that these minimum elements are always in place risks identified early with corrective actions.

Element	Operating Hours	Who is responsible	Escalation actions (in sequence)
ED Consultant - Department Oversight (shop floor) - In RATS	24/7 (general on site 0800 – 2200 and then on call) RATS hours *Mon,Wed,Thur 8.00 – 19.00 *Tues,Fri 13.00 – 19.00	Emergency Department	1. The ED Consultant team will ensure there is cover 2. If cover is not possible ED Registrar will cover and the Chief Medical Officer will arrange suitable redeployment 3. Out of hours the On Call Director will liaise with the On Call Medical Consultant and Registrar to agree mitigations 4. ED Consultant / EPIC Action card to be included (Mark Jadav)
ED nurse in Charge	24/7	Emergency Department	1. Manager safety and capacity across the ED template to ensure ambulances offload immediately and signed off within 15 minutes. 2. Highlight and patients not meeting Internal professional standards and work with ED/Hospital teams to resolve delays 3. Ensure timely transfers out of the department
ACE (Acute Care of Elderly) consultant in ED	9-5* - Mon – Fri*	UEE Care Group	1. Specialty lead for Frailty will ensure there is cover in ED 2. Work with MDT team, Frailty Nurse, Therapy, Community partners and CATUS to avoid attendance/admission and stream patients out of ED to Frailty SDEC Unit.

3. Minimum Elements needed to maintain the site (cont)



Element	Operating Hours	Who is responsible	Escalation actions (in sequence)
General Internal Medical Consultant on call (GIM) - On site commitment - On call availability	Out of hours on call	Medical Care Groups	- A GIM Consultant will be the first point of contact from 18.00 - A second GIM Consultant can be requested by the team through email group or text message via AMD or Deputy Medical Director - Additional Medical Reg support can be requested by the GIM and all Specialty Registrars to attend ED at 22.00 if ED overcrowded and WTBS over 90 minutes with no plan to recover.
On Site Speciality Consultants	In hours 08.00 – 17.00 Various weekends as per rosters	All Care Groups	Communication from Triumvirates to escalate support required and at which location.
Acute Medicine	- Mon – Fri 07.30 – 20.00 - Sat – Sun 07.30 – 18.00	UEE Care Group	- Acute Medical Consultant will escalate any operational issues to Care Group Triumvirate. - Referrals will be through maxim's as BAU, urgent referral by telephone to specialty for advice.
Eldercare	- Mon – Fri 07.30 – 20.00 - Sat – Sun 07.30 – 18.00	UEE Care Group	- Eldercare Medical Consultant will escalate any operational issues to Care Group Triumvirate or through Medical Consultant group. - Referrals will be through maxim's as BAU, urgent referral by telephone to specialty for advice.

3. Minimum Elements needed to maintain the site (cont)...



Element	Operating Hours	Who is responsible	Escalation actions (in sequence)
ACCT Critical Shift Cover Multiple roles across Critical Care, Theatres, Obstetrics and Outreach	24/7	Care Group - MOD and Matron - GM, HON and CDS	- MOD will identify gaps in critical staffing roles and report mitigation actions to the site meeting. - At weekends / OOH senior consultant on duty and nurse in charge to replicate MOD responsibilities
Clinical Site Managers 2 Site Co's	24/7	Senior Clinical Site Coordinators	- There are staff across the Trust trained to be Site Co to be redeployed - There are staff across the Trust who can support one Site Co - HON (in hours) would need to deploy resource to mitigate - Matron on site (weekends) to redeploy resource to mitigate
Director On Call	Out of Hours	COO	COO oversight to liaise with Executive Directors to ensure cover
Senior Manager on Call (SMOC)	Out of hours	Care Groups initially, then COO's office with coordination by EPRR team	- Care Group leaders to work with EPRR team to ensure cover - COO to liaise with all SMOC's if no cover - Out of hours Director on Call to use Switchboard cascade
Radiologist of the Day	9-5* - Mon – Fri *	Clinical Support Care Group	

3. Minimum Elements needed to maintain the site (cont).



Element	Operating Hours	Who is responsible	Escalation actions (in sequence)
Stroke Nurse - on site - Stroke nurse will be based in ED to facilitate /organise, triage , assessment, treatment and transfer to appropriate HASU or SDEC area.	24/7	UEE Care Group	- Care Group to have staffing plan to resource accordingly with Matron overseeing roster management - Safer Care to ensure Stroke nurse isn't in the ward numbers - Phoenix ward to hold bleep in the event of short notice sickness in order to monitor time critical strokes in ED
Frailty Nurse - On site - Focus on ED but supporting Frailty SDEC	7am – 17.30 7 days a week	UEE Care Group	- Care Group to have staffing plan to resource accordingly - Safer Care to ensure Stroke nurse isn't in the ward numbers - Frailty Nurse to be based in ED as part of Frailty MDT to facilitate assessment organise treatment plan with Consultants, stream to SDEC and CATU.
Cleaners On site	24/7	Facilities Management Team	If insufficient cleaners the sequence of escalation is - Facilities supervisors - Facilities senior management team - Deputy Director of facilities

3. Minimum Elements needed to maintain the site Cont.



Element	Operating Hours	Who is responsible	Escalation actions (in sequence)
Physio Therapists (AMU/ ED)	Monday to Friday: 8:15am-16:15pm full cover. Saturday: 8:15am-16:15pm reduced cover. Sunday: 8:15am to 16:15pm Respiratory cover only.	Clinical Support	In order: 1. Therapy lead for front door and general 2. Site team 3. Inpatient Therapies manager 4. CS TRI
Occupational Therapists (AMU/ ED)	Monday to Friday: 8:15am-16:15pm full cover. Saturday and Sunday: 8:15am-16:15pm reduced cover.	Clinical Support	In order: 1. Therapy lead for front door and general 2. Site team 3. Inpatient Therapies manager 4. CS TRI
Physio Therapists (wards for flow)	Monday to Friday: 8:15am-16:15pm full cover. Saturday and Sunday: 8:15am-16:15pm Respiratory cover only. * Where Physio is not assigned to specialist ward, referrals are picked up via ward visits	Clinical Support	In order: 1. Therapy lead for respective area 2. Site team 3. Inpatient Therapies manager 4. CS TRI
Occupational Therapists (wards for flow)	Monday to Friday: 8:15am-16:15pm full cover. Saturday and Sunday: 8:15am-16:15pm Phoenix and Trauma only. * Where OT is not assigned to specialist ward, referrals are picked up via Maxims referral only	Clinical Support	In order: 1. Therapy lead for respective area 2. Site team 3. Inpatient Therapies manager 4. CS TRI
Phlebotomists / lab support	See embedded document for details – Phleb cover Labs – 24/7 and on call via switch 	Clinical Support	1. Phlebotomy lead – Ade Caley – contact via switch 2. Site team for labs 3. CS tri if needed
ED Assistant	Shifts are 7am – 19.30 and 19.00 – 07.30 Minimum requirement 1 on every shift 24/7 cover required	Emergency Department	

3. Minimum Elements needed to maintain the site. (Cont).



In addition to the resources identified above the following principles will be applied in all areas with Care Group Tri's being responsible for ensuring it is delivered for their areas:

- Every patient to have a consultant review every day.
- All Diagnostic tests to be completed same day for inpatient requests unless there is a need to undertake preparation. Should read, diagnostic tests will be undertaken based on clinical urgency following clinical vetting of the referral. All preparation for the test must be undertaken by the ward area ahead of time.
- Ward Rounds will follow best practice (SHOP):
 - Sick.
 - Home today.
 - Other.
 - Potential for discharge.
- Every inpatient must have an Estimated Date Of Discharge (EDD) and Planned Date of Discharge recorded in Nervecentre within 24 hours of admission:
 - EDD is a fixed date, PDD moves as patient pathway is updated.
 - Care Groups to ensure a review is undertaken every day of PDD and EDD and actions taken where a patient's length of stay is being extended. Clinical peer review of EDD's should be used for Care Groups to have assurance they are accurate.
- Care Groups will ensure that no patient remains in an inpatient bed overnight if they are a pathway zero discharge and do not meet the criteria to reside.
- All pathway zero patients must be discharged from the hospital within 3 hours of no longer meeting the criteria to reside with escalations to Care Group Tri's by the wards if they are unable to achieve this.
- All internal delayed patients as reported from the Flow Hub to have the internal delay resolved by the 1600 meeting – to be verified the patient has been discharged, if not named Care Group Tri member to take patient level ownership of the action for the discharge.

4. KPI triggers with actions



There are many KPI's across flow, some specific to department, this is the areas of main focus each day setting out the levels and the escalation actions. It is not an exhaustive list but keeping these indicators within their tolerance ensures appropriate flow through the Trust

Indicator	Data source	Normal level	Escalation point	Escalation action or link to action card	Where to escalate
Wait to be seen in ED (WTBS)	OPEL dashboard in Radar	60 minutes maximum	120 minutes	- Monitor number of arrivals and triage status - Review staffing levels in all areas and reassign where required to meet demand/ skills required - Review S3 cases – to reduce priority rating with treatment/review - Identify patients for immediate review by specialty and escalate through Site Team - Escalate specialty expected patients including paediatrics/Trauma/Surgical (as SOPs) Waits over 2 hours: - Consultant to identify all patients not seen and create priority list based on acuity - Patients to be transferred to wards for review with appropriate documentation completed once reviewed by Doctor - Escalate to Care Group GM / Head of Nursing or On-call Exec to establish if senior clinical support from and specialties is required following discussion with ED Consultant / SpR doctor and NiC - If OOH, contact ED Consultant for advice and/or attendance as required - Ensure all specialties are in the department supporting WTBS.	Internal ED consultant and Nurse in Charge with support from ED Shop floor Manager and then Care Group Clinical Director. Site Co-ordinator to escalate to ED team Escalate to Care Group Clinical Director or DHON and Senior Duty Manager On-call Exec (OOH)
Decision time(time from arrival)	OPEL dashboard in Radar	180 minutes	210 minutes	- All decisions should be made within 3 hours as per ECAS standards - ED Consultant / SpR doctor and ED NIC to formulate recovery plan and chase decisions - Confirm diagnostic processing times are within SOP targets - Monitor WTBS times and prioritise patients appropriately where required - Identify patients for immediate review by specialties and escalate through Site Team - Send patients direct to base wards if specialty teams have not reviewed patients within 1 hour of referral as per SOPs.	Escalate to Care Group Clinical Director or DHON and Senior Duty Manager On-call Exec (OOH)
Total patients in ED	OPEL dashboard	45	60	- Escalate to Flow Hub/Transport and Clinical Site Team to prioritise external transfers - ED Service Manager / Matron for Flow to review steps to create flow out of ED (SMOC and Clinical Site Manager OOH) - Maintain sufficient space to enable triage and RATS to continue - Request additional staff to manage ambulance queue if required - Identify patients for immediate review by specialties and escalate through Site Team - Send patients direct to base wards if specialty teams have not reviewed patients within 1 hour of	Escalate to Care Group Clinical Director or DHON in hours and Senior Duty Manager On-call Exec (OOH) and Site team.

4. KPI triggers with actions.



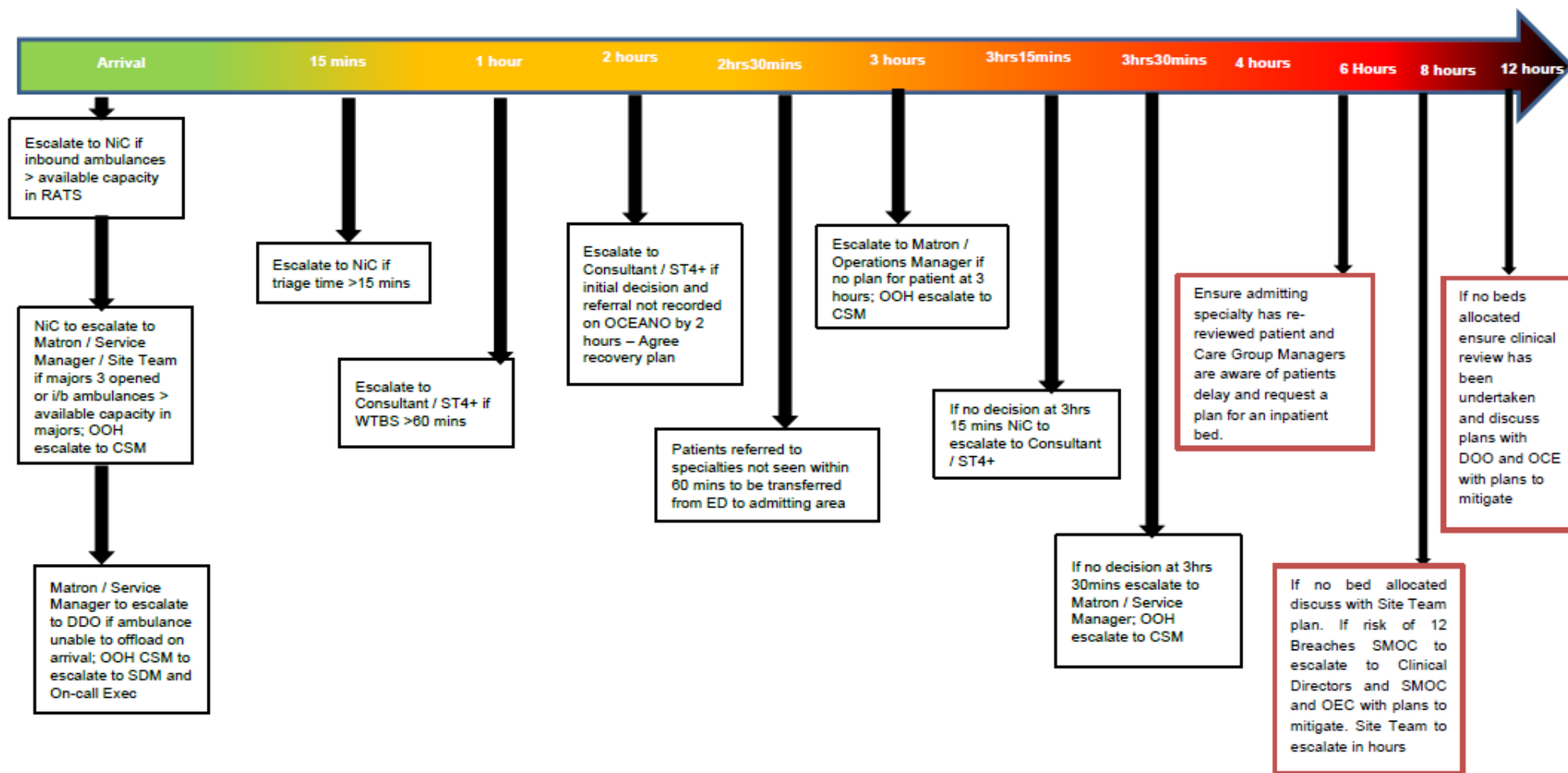
There are many KPI's across flow, some specific to department, this is the areas of main focus each day setting out the levels and the escalation actions. It is not an exhaustive list but keeping these indicators within their tolerance ensures appropriate flow through the Trust

Indicator	Data source	Normal level	Escalation point	Escalation action or link to action card	Where to escalate
Department stay of 12 hours	ED summary page in Radar	Zero	1 ambulance with no plan within 15 minutes	As per actions for patients in ED over 40 patients.	Escalate as per flow time line in surge plan. (Next Slide)
Ambulance handover delay	OPEL dashboard	Zero	If an ambulance queue has a patient at 15 minutes	• Increase number of staff to accept handover and complete initial treatment • Open escalation areas (corridor) to create sufficient capacity • Consultant to review the option to front load RATS and/or triage with ST4 or above in order to expedite treatment - instigating Consultant led triage • Ensure RAT's is 'ready to receive' with minimal of 3 bays empty at all times. If RATS is not ready to receive ensure this is escalated through ED Nic and Site Team to request beds to decant within next 30 mins. Request HALO attendance to manage inbound vehicles and flow into ED	Clinical Site Manager/ED Shop Floor to escalate to Deputy COO Clinical and Deputy COO to assess flow. On Duty Manager, OOH and they will escalate OCE if there is a risk of holding ambulances within the next 30minutes. OOH Site Team to ensure escalation to OCM and OCE to ensure escalate for sufficient resource to ensure timely transfer of patients from ED

Flow time line with triggers



12. ED timeline for achieving ECAS 4 hour performance, quality and safety metric with escalation prompts and actions to take if reaching 12 hour DTA.



4. KPI triggers with actions (cont)



Indicator	Data source	Normal level	Escalation point	Escalation action or link to action card	Where to escalate
Escalation beds open and in use		0		All Care Groups	
Critical Care capacity	Reported to site meeting Discharges - Nervecentre	Critical Care Capacity determined by patient acuity	When no level 3 admitting capacity available	- Patients fit for discharge transferred into suitable bed space as a priority. - All staffing concerns escalated for Triumvirate decision.	- Site team - Internal to Care group Tri
Total patients in SDMA	Nervecentre	15	20	Medical Care Group Tris to work together to bridge the gap	Internal to Care Group Tri
Patients on ESU over 48 hours	Nervecentre	0	3	Surgical Care Group Tris to work together to bridge the gap	Internal to Care Group Tri
Total patients in ESU	Nervecentre	15	20		
Medical Golden patients for next day	Reported in Site meeting at 1600	Minimum of 10	If minimum number not met	Medical Care Group Tris to work together to bridge the gap	Internal to Care Group Tri
Medical Bed deficit	Site report	Zero	20	Medical Care Group Tris to work together to bridge the gap	Internal to Care Group Tri

5. Site Flow



The roles and responsibilities section outlines who does what for flow, below is an outline for the minimum agenda items to be included for site meetings and shift handovers, 7 days a week

Element	Reason	Expectation	Escalation actions
Verification key site elements are in place (section 3)	The key elements are the minimum standards and therefore must be covered	Care Groups will ensure all minimum elements are covered by re-prioritising resources as required	As per section 3
Verify actions from previous meeting completed in full	Actions are set for a reason and there needs to be a positive confirmation they are completed	All actions completed by named owners on time	If actions are not completed then Care Group Tri to be contacted for them to intervene and resolve
KPI triggers (section 4)	To ensure all KPI's are being met	That all KPI triggers are reviewed and mitigations implemented in full	As per section 4
Review live bed state (on Radar) – ensure all beds are filled		All bed spaces are to be filled if there are patients in ED (or any other admitting space) who need them. No bed should be empty on the live bed state if there is demand for it	Care Group Tri's are responsible to ensure the live bed state is accurate Site Cos responsible for the allocation to the beds All to ensure the moves are completed within 15 minutes
At the 0815 bed meeting confirm all Golden patients identified the night before will be in the discharge lounge by 0900	The 10 medical transfers to the discharge lounge before 0900 is critical for flow	That all actions will have been completed the night before and at handover the day team are clear to ensure the patients on their ward have transferred to the lounge before 0900 (lounge opens at 0730)	Care Group Tri to ensure that this is completed and take corrective actions as required

5. Site Flow Cont.



Element	Reason	Expectation	Escalation actions
Verify the deficit / surplus position for medicine and surgery	There must be plans in place to ensure that any identified deficit is closed.	PDD's to be reviewed to ensure they are all being discharged that day. That senior clinical leaders are briefed on the deficit and have implemented the ward specific action cards	Medical and Nursing input into site office as per Opel 4 actions to ensure plans in place to accommodate planned and non planned care patients.
Take IPAC update after above sections covered	To maintain safety of patients and staff and a plan to minimise impact on bed availability	To ensure IPAC instructions and guidance is being followed, ensure site team are enabled to escalate issues and make a plan for patients that may be displaced due to IPAC constraints.	Site team or SMOC to ensure plans in place for patients who may be displaced from specialty base ward area.
Review discharges and moves from admitting areas by the next bed meeting	Maintain timely flow.	Ensure every patient in ED and the admitting areas will have moved	Opel 4 actions
Verify Critical Care position	To maintain Critical Care capacity for the Trust	4hr discharge target maintained	- Patients fit for discharge transferred into suitable bed space as a priority. - All staffing concerns escalated for Triumvirate decision.
Ensure all transport has been booked and has an ETA	To ensure no delays and provider within KPis	All patients booked within KPI and provider achieving this.	Prioritise transport journeys if required
Review patients identified for the next day	At every bed meeting there needs to be a review on the actions needing to be completed for the next day	All Care groups identify patients identified for next day discharge by updating the PDD. Golden patients noted on night plans.	Triumvirate to ensure this is covered in the 15.00 meeting

5. Site Flow (Cont).



Access to the virtual ward to avoid admission and facilitate earlier discharge

Referral Information

NHS@Home - Virtual Ward



Admission avoidance, early supported discharge, and personalised care to enable a patient to stay in their home.

The Virtual Ward can ...

Support people whose acute respiratory or frailty condition could be managed in their own home **as an alternative to hospital** e.g. exacerbation of COPD, hypertension, viral illness, new nebuliser regime, medication titration.



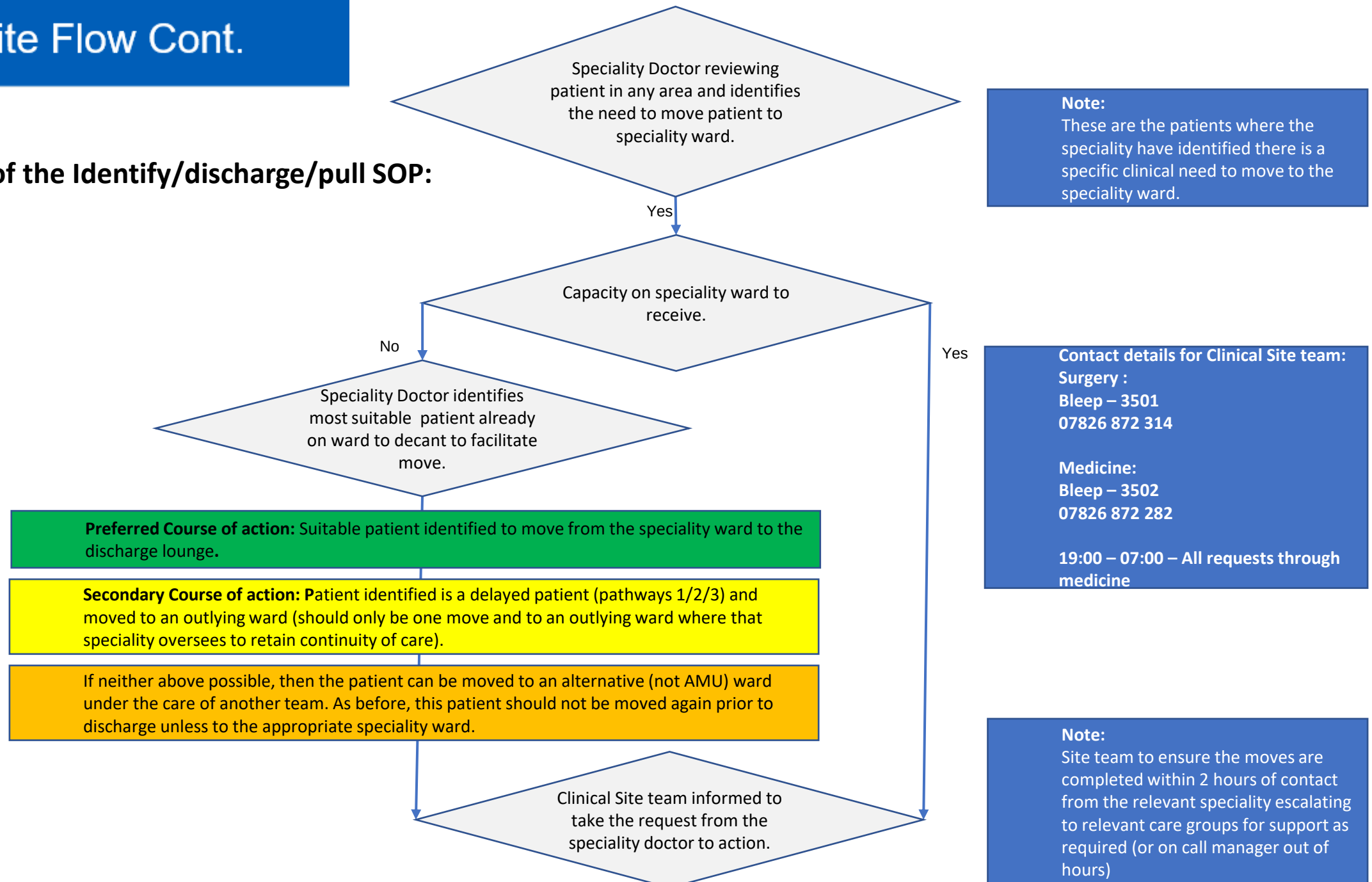
The Virtual Ward is open 7/7 providing remote monitoring of a patients NEWS score and self-reported wellness, using technology OR daily phone calls up to 3 times a day from a team of Nurses working with Acute Care @ Home, UCR, Community Matrons who can complete face to face treatments in the persons own home as required- i.e. provide IV's.

The Virtual ward has **daily ward rounds to review every patient** led by an Acute GP / ANP and can escalate to Eldercare /Respiratory Teams in Acute hospitals as required.

Referral Via SERF, email cft.nhsathome@nhs.net or ring 01726 873400 to discuss a referral

5. Site Flow Cont.

Principles of the Identify/discharge/pull SOP:



6. Actions to ensure no expected patients in ED



It is the responsibility of Specialties and then Care Groups to ensure no 'expected' patients attend the Emergency Department and are received in appropriate admitting areas, the table below outlines the actions set by Each Care Group to ensure 24 hours a day, 365 days a year this is delivered.

There are some exceptions which are listed, all exceptions have been agreed by the Chief Medical Officer via the Associate Medical Director for Urgent and Emergency Care

Care Groups will have ensured there are robust plans in place for out of hours periods to maintain no expected patient in ED and therefore it would be exceptionally rare that there is escalation needed out of hours. There will be no 'dropping of the take' without a Care Group Tri member attending the area to resolve issues before any escalation to either site team or ED

Speciality	Where patients are to be admitted, exceptions in brackets	Plan from the Speciality for escalations	Owner in hours	Owner out of hours
ENT	Tonsillectomies and quinsy patients to go to SDSA	SOP drafted – details to be added	Care Group Tri	
Medical Patients	All Medically Expected patients to attend SDMA (unless for resus)	OPEL 4 action card for SDMA SoP V1.9 is currently going through the governance process however this is already in use. The SDMA team escalate to Matron who then liaises with MoD and to TRI if they cannot resolve that we are at risk of dropping the take Triggers include - Overcrowding in the department - Delay in bed allocation leading to over-crowding - Prolonged wait to be seen - Unacceptable triage time >30 minutes	Steph Hollins, escalating to Tri member if unable to resolve (rarely happens)	Escalate to Site co SMOC
Oncology expected	oncology expected going to HODA in new Lowen			

6. Actions to ensure no expected patients in ED Cont.



Speciality	Where patients are to be admitted, exceptions in brackets	Plan from the Speciality for escalations	Owner in hours	Owner out of hours
Orthopaedic			Care Group Tri	
Oral and Max Fax	Under review		Care Group Tri	
Gynaecology	All gynae emergencies direct to Eden ward assessment room TR6 and they liaise with EPU and EGU to book	Escalate to site team and Tri when no capacity for emergencies and last resort admit via ED if site unable to facilitate release of bed on Eden	MOD with site team and ward NIC	Site team with ward NIC. Site to inform SMOC if unable to rectify.
Paediatrics	All Medically Expected patients to attend PAU	Only SWAST conveyance and walk ins will come through ED	PAU NIC and Consultant on take as BAU	PAU NIC and Consultant on take as BAU
Neonatal	All pre-arranged expected patients to attend NNU, all emergencies directly admitted if inborn, rapid reviews directly to NNU clinic	Only SWAST conveyance and walk ins will come through ED	NNU NIC and Consultant on take as BAU	NNU NIC and Consultant on take as BAU
Maternity	All expected and emergency admissions for delivery and assessment go to DAU or Delivery unit, readmissions with maternity related go through triage line and assessed as to need for maternity care	May be some admissions through ED if self present or symptoms not known to be maternity in origin	Maternity MIC and Consultant on take as BAU	Maternity MIC and Consultant on take as BAU

7. SDEC areas



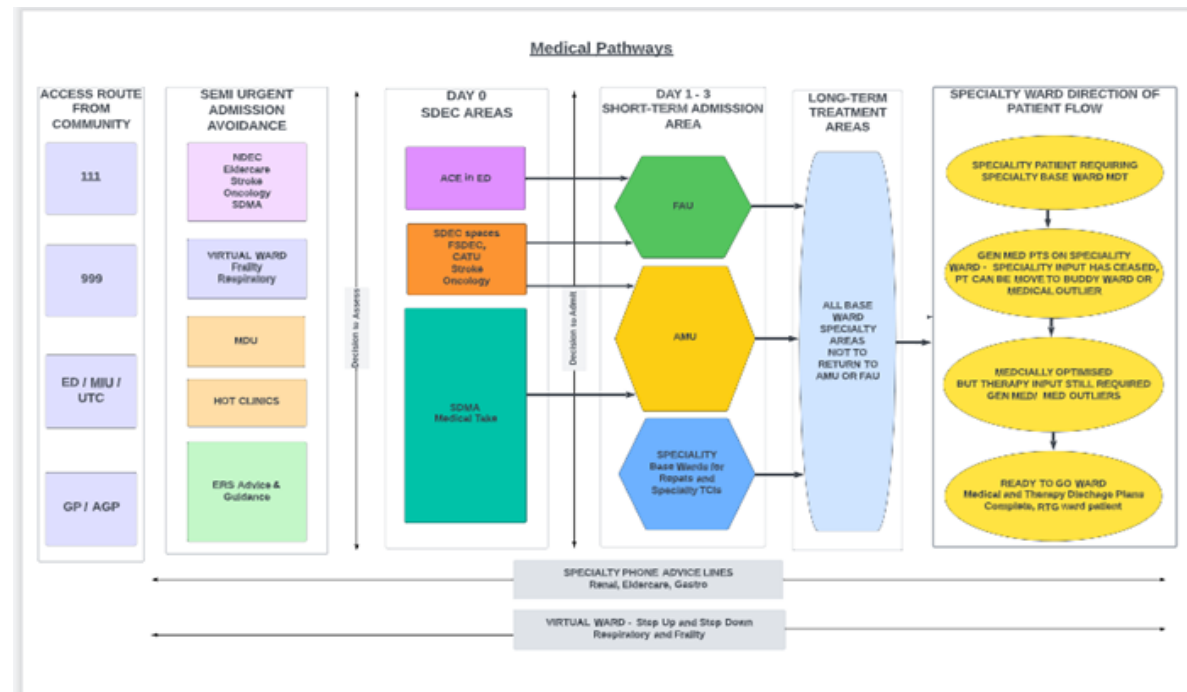
The Trust operates the following SDEC areas, they are to be protected and used to prevent patients attending ED and support discharge with a next day follow up. It is essential SDEC areas remain flowing

Area	Purpose	Hours of operating
SDMA	By keeping this space as SDEC up to 30 patients a day are diverted away from ED	0800 – 0200. Last attendance to the area circa 2200
Frailty SDEC (on Wheal Vor)	Part of the strategy to divert patients from ED by keeping 10 SDEC spaces up to 5 patients a day are diverted away from ED and also enable semi urgent next day community patients for specific investigations and review (next day emergency care NDEC)	0800 – 1500 (last patient sent there) However we can be creative with nurse led activities.
Same Day Surgical Assessment (SDSA)	This emergency ambulatory unit triages up to 30 patients per day directly referred from primary care or from ED. Following the initial assessment, a management plan is formulated, enabling a next day review following specific investigations	07.30-20.00 We are due to convert C bay on ESU into a 6 bedded trolley bay extending our assessment capacity

8. Medical Model



- The medical model is a pillar of the flow programme and in its initial phase is focussing on 4 key areas:
 1. Defined emergency village ownership and early specialist in-reach, which in turn also drives and develops the directory of services and admission avoidance pathways
 2. NerveCentre system updates to support specialty 'pull' and improve categorisation of patients early in the patient pathway
 3. Establish a good to go ward and develop linked outlier wards and pathways
 4. High impact post-take ward round: out of hours general medicine rota review that compliment in hours developments



9. Outliers – selection and management



- There are 4 Care Groups with Medical Beds who must have joined up ownership of Medical Outliers:
 - UEE
 - Specialist Medicine
 - Specialist Surgery and Services (Gastro)
 - Peripheral Sites (WCH beds)
- The 4 Care Groups have responsibility for ensuring at the end of each day there is a list of patients identified who could move to an outlying bed if needed.
- The 4 Care Groups have the responsibility for verifying every single medical patient on a surgical ward has a consultant allocated to them for review and that each day the patients have been reviewed.
- The Surgical Care Groups with the Medical patients must ensure all care standards are met for the patients and they have responsibility to escalate any delays and support discharge.
- The Clinical Site Managers have responsibility for using the list of pre-identified patients to outlie should there be a need to outlie and making sure that only the designated wards are used, this may mean additional moves of surgical patients.

10. Minimum data entry set to ensure safe flow (use of systems)



- Every patient to have a PDD recorded in Nervecentre within 24 hours of admission which is updated as the patient pathway progresses.
- Every patient to have an EDD set on admission and verified at first Board Round and then locked in Nervecentre.
- Every patient to have the reason to reside assessment updated in Nervecentre 0800 and 1400 daily.
- Patients COVID status to be updated in real time, to include downgrades.
- Patients to be moved into the bed space immediately they arrive on the ward in SwiftPlus.

11. Single version of the truth – reports that are to be used for flow decisions



- Manual records will no longer be used for flow decisions. The following Radar reports will be the single version of the Truth
- OPEL dashboard – on the day triggers and escalations
- Live Bed state – verification all beds are filled, used to allocated moves from admitting areas, AMU and ED in real time
- D2A dashboard – for all reason to reside patients
- D2A dashboard – for the delays by pathway and split internal / external
- Daily Dashboard – for review of previous day/trends in performance
- COVID dashboard – for the COVID position

Escalation from OPEL 3 (Red) to OPEL 4 (Black) checklist



The below represents realignment of some actions from 4 to CI and suggested new actions highlighted in **Red**.

- Care Group Triumvirate (including Matrons) to ensure that all inpatient areas under their jurisdiction are visited to offer support.
- 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.
- Ensure hospital status is cascaded to all areas in the hospital using SnapComms, side banner and 'all user email'. Ensure that communication is clear around targets and actions for staff. Ensure it is updated for each day the Trust remains on OPEL 4 (black).
- Utilisation of taxis for PTS journeys.
- Put out a request for GIM cover 5-7pm shift as a minimum but more hours if possible.
- Clinical Nurse Specialists to be redeployed to support front door or discharge.

Escalation from OPEL 4 (Black) to Critical Incident checklist



The below represents realignment of some actions from 4 to CI.

- **NB: Should be declared where there is a clear benefit to aiding the response.**
- Implement 'command and control' arrangements (including opening the ICC and loggist), allocate Strategic Commander and Tactical Commander.
- Consider Senior Duty Manager shifts be split into 12 hour day and 12 hour night shifts at weekends/bank holidays.
- Director On Call/Senior Duty Manager to stay on site until presence no longer deemed operationally beneficial.
- Cancel training and non-clinical duties where proportionate and will provide benefit. Link to Safer Care for redeployment of staff.
- Ensure public and 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.
- Request a Gold call (unless already being conducted).
- Review urgent elective admissions where possible - reschedule or cancel.
- Ensure all key staff are wearing CI tabards.

12. Preparations for the weekend



It is essential that the Trust has plans every weekend to maintain capacity and therefore as part of weekend planning every Care Group must have plans for discharge numbers to remain equal on a Saturday and a Sunday to any other week day.

This may include Care Groups allocating additional resources for the weekend based on expected demand / site position. It is a requirement that the Care Groups with Medical beds work together for one unified plan and the same logic for the Care Groups with Surgical beds do the same

The weekend plan will detail additional actions but the generic actions to be implemented every weekend are provided in the table on the next page. The Minimum Elements section in this resource pack identifies what should be available to support weekend flow

Care Groups will sign off their Planned Date of Discharge (PDD) position as reported on the Live Inpatient Details report in Radar for Saturday and Sunday as being sufficient to deliver no delays for ED over the weekend

Clinical Support will ensure the minimum elements for support services are in place

12. Preparations for the weekend Cont.



Ward discharge numbers – Care Group actions and escalation plans will support required number of discharges.

Grouping	Ward	Baseline beds	Escalation bed options	Discharges each day required	Grouping	Ward	Baseline beds	Escalation bed options	Discharges each day required
Medicine	CIU	20	1 Boarding, 1 Holding	4	Trauma	Trauma 1	26	1 Boarding, 1 Holding	3
	GLU	33	1 Boarding, 1 Holding	4		Trauma 2	24	1 Boarding, 1 Holding	3
	Grenville	25	1 Boarding	3	Maternity/ Paediatrics	Wheal Rose	10	Non identified	-
	Kerensa	25	None identified	1		Wheal Fortune	25 (+25 cots)	Non identified	-
	Lowen	16	None identified	3		Polkerris	12	PAU escalation cubicles – 8 beds	0
	Phoenix	28	3 gym spaces	3		Fistral	10	10 Harlyn	1
	Roskear	30	1 Boarding, 1 Holding	3		Neonatal Ward	20	Non identified	-
	Tintagel	29	None identified	2		Paeds HDU	3	Non identified	0
	Wellington	27	1 Boarding, 1 Holding	4	SMH site (for info)	St Josephs	29	Non identified	5
	Wheal Prosper	12	None identified	2		Marie Therese House	12	None Identified	1
	Wheal Vor (not SDEC end)	22		2		St Michaels	28	Non identified	3
	Zennor	28	None Identified	3	Adult Critical Care Areas	CCU	10	None identified	
	AMU 1 and 2	54	2 Boarding, 2 Holding	8		Critical Care	15 (funded)	None identified	N/A – patients not likely for discharge home from Critical Care
	Med 1	26	1 Boarding	2					
	Med 2	28	1 Boarding	2					

13. Ring fenced areas and why



The follow table is a list of areas that are ringfenced, these are clinically agreed and are essential for overall patient safety, delivery of all services and overall flow. They are not listed in any specific order

Area	Detail	Reason
Phoenix for Stroke only – including SDEC bed	Hyper Acute Stroke Unit (HASU) spaces on Phoenix to be kept clear for next stroke admission	Stroke patients must access the stroke unit within 4 hours as there is wide evidence of improved outcomes for stroke patients receiving the specialist care provided on the stroke unit
Trauma	Trauma 1 and 2 to be protected for Trauma patients, if needed for escalation there should be kept admitting space for a female and male #NOF patient	NOF mortality impacted if patient does not have surgery within 36 hours and need to be admitted without delay to Trauma unit. Trauma unit necessary for the Trust to provide trauma services for patients
SDMA (Same Day Medical Assessment)	To enable medically expected patients to avoid ED, provide admission avoidance and same day turnaround as well as discharge with next day follow up capacity	Generally SDMA reduces the number of patients through ED by 30. it also provides next day follow up and avoids admission which supports overall flow of the hospital

13. Ring fenced areas and why Cont.



Area	Detail	Reason	Escalation if at risk
SDSA (Same Day Surgical Assessment)	This emergency ambulatory unit triages up to 30 patients per day directly referred from primary care or from ED. Following the initial assessment, a management plan is formulated, enabling a next day review following specific investigations	If this unit is unable to function then patients will either have to remain in ED or be re-directed to ED.	NIC to escalate to the MOD/Matron when capacity and demand exceed the ambulatory chairs in SDSA and bed base across surgery has limited capacity with few planned discharges.
Gynae Emergency Assessment/treatment (on Eden)	X1 ward bed to be available to Gynae emergencies as well as treatment room 6	Direct admissions EGU and GP's for Gynae emergencies – if not bed available patient will be re-directed to ED.	NIC escalate to Matron/MOD who will request bed made available by site team by moving medical outlier.
Respiratory Higher Care (on Wellington)	D bay on Wellington is patients who require acute non-invasive ventilation.	In order to support safe clinical care a bed should be kept empty to receive patients who require acute NIV outside of critical care	NIC to escalate to MOD/Matron
Critical Care	National standard (ICS)	The unit is the only provider of level 3 care for Cornwall. Capacity is managed by Consultant Intensivists to ensure the patients most in need receive care.	ACCT Triumvirate
EPOC	Enhanced perioperative care area designated for acute planned care activity	To avoid cancellation of high level care capacity for planned care patients on cancer / urgent pathways	ACCT Triumvirate
Planned Care Unit	Admissions unit and inpatient bed facility for the care of post-operative planned	To avoid cancellation for planned care patients on cancer /urgent pathways	NIC to escalate to the MOD/matron when capacity

13. Ring fenced areas and why (Cont).



Area	Detail	Reason	Escalation if at risk
Lowen	Dedicated Haematology/Oncology ward	Lowen Ward delivers high intensity anti-cancer treatments to patients at high risk of mortality due to rapidly advancing disease (P1). They also care for patients post autologous stem-cell transplant.	COO/on call director
WCH Surgical Unit	Dedicated day case area	Area designed for daycase elective work	COO / on call director
Newlyn	Dedicated Day case area	Area designed for daycase elective work	COO / on call director
SMH (entire site)	Dedicated elective site for orthopaedics and breast surgery	Key part of RCHT elective care capacity	COO / on call director

14. Care Group specific action cards (escalation procedures)



In this section the Specific action cards for all areas of responsibility of each Care Group are provided, they include in hours and out of hours escalation actions to maintain flow 24 hours a day, 7 days a week

- a) [Anaesthetics Critical Care and Theatres](#)
- b) [Clinical Support](#)
- c) [General Surgery and Cancer](#)
- d) [Peripheral Sites \(SMH, Trauma and WCH\)](#)
- e) [Specialist Medicine](#)
- f) [Specialist Surgery and Services](#)
- g) [Urgent Emergency and Eldercare](#)
- h) [Women's and Children's](#)

14a – ACCT action card



Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
ACCT Senior manager huddle	8am virtual huddle to identify staffing, capacity or performance issues - Escalation contacts through the day as required.	- Critical staffing levels - Critical care / EPOC capacity - Theatre performance	- Matron / HON mitigate and escalate as required - Senior clinical review to confirm unit acuity and next steps - MOD / Matron to mitigate and escalate as required
Critical Care	Capacity managed by senior clinical Intensivist	No level 3 critical care bed capacity	- Patients fit for discharge transferred into suitable bed space as a priority. - All staffing concerns escalated for Triumvirate decision and mitigation
Emergency Theatre (CEPOD)	MDT senior clinician allocation of emergency operating	Surgical demand exceeds capacity and risk of harm identified	MOD escalation to Triumvirate for review / decision on planned care cessation to create additional emergency operating capacity.

14b – Clinical Support action cards



Links to Care Group Action cards

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
Inpatient Therapy support for ward and admitting areas IP Therapies Manager: Julie Cockerton (07775922610) Therapy leads: Front door and General: Marissa Heyman (07393249753) Trauma and Orthopaedics: Sarah Turpin (07554778347) Respiratory, Surgery and ITU: Kirsty Mitchell (07721237972) Stroke and Neuro: Michelle Hauge (07393249753) IP coordinator Caroline Jones (Teams)	- IP therapy support 08.00 – 16.00 (18.00 ED) Mon – Fri - Weekend light service as per weekend plan – supported by an onsite therapy lead (08.00 – 16.00) - Dedicated support for those specialist wards where Therapists are part of an MDT: Stoke, Tintagel, Trauma, Kerensa, ED, AMU, WCH and SMH. (No SLT and DT input for ED, WCH and SMH) - All other ward areas, therapy services are provided based on <u>referral only</u> (OT, DT, SLT). Physio referrals picked up by team following ward visits - IP Therapy coordinator Mon - Fri to support flow hub and site team. Validation of recorded 'therapy delays' - All therapy leads available at 08.15 bed meeting. An assigned therapy lead to support flow each day and present at 12.15 and 16.00 bed meet - No new escalations at 16.00 bed meet for therapy referrals - No escalations for equipment – this forms part of the SERF referral process	- A specialist ward area does not have access to therapies (BAU) and this is impacting MFFD patients and discharge (Matron to Therapy lead) - A referral made to therapies has not been actioned for >24 hours (Nerve Centre to be checked prior to escalation and ward nursing team to validate need for therapies input) – IP co-ordinator - Opel 4: Front door area under extreme pressure requires further input – Site team request to CS Triumvirate Weekend: - Specific request to aid patient safety issue or complex discharge: SMOC to Therapy lead for advice in first instance. *Note – equipment and specialist onward services are not always available to IP therapy teams at the weekend	<u>In order:</u> - Therapy leads to take escalated actions for their areas from Clinical Matron and site team - IP therapies manager (Julie Cockerton) to support with escalated issues from Heads of Nursing – issues not able to be resolved between Matron and Therapy lead - CS triumvirate to support with escalations if required and specific to Opel 4 additional actions

14b – Clinical Support action cards Cont.



Links to Care Group Action cards

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
Clinical Imaging: Management team and MoD support for CI Diagnostic Imaging lead: Emma Spouse Radiography Service Lead: Jackie Knox Operations Service Manager: Laura Biggs CT Team Lead: Tim O'leary CI IP coordinator: (01/04/2023) Hannah Davis (07500 579407) Hot Hub (Consultant Radiologist) 5182 – Clinical queries	- Access to imaging services available daily and overnight by request ED, SDMA, SDSA - CT and XR 24/7 - MR 7 Days 08.00 – 20.00. - Non-Obstetric Ultrasound by request 08.00 – 18.00 Inpatients: - CT, XR, MR, NOUS – Available via referral to clinical imaging - Patients will be pulled for scanning following clinical vetting of the referral and in clinically agreed priority - Referrals will be pushed back if information is not complete or requires further consultant to consultant conversation - Update on IP referrals with actions will be provided to the site team via the bed meeting chat in week - CI will have a dedicated MOD Mon-Fri to support escalations/queries or other issues impacting flow - CI IP coordinator available for ward discharge coordinators and to pick up escalations through the bed meeting teams chat - Hot hub (Radiologist on call) available on 5182 for clinical issues – 08.00 – 21.00 Reporting: - CT Hot reporting 24/7. XR reports available to 24/7. MR available in hours unless specialist reporting required.	- IP request has not been actioned >48 hours with no outstanding ward actions - Unresolved escalations >1hr to be handed over from the CI navigator to the CI MoD. - Doctor/consultant request for imaging to aid discharge of patient where discharge and follow up outpatient is not viable - Site team to CS tri for any specific issues that has not been resolved via the site team directly or the CI department Note: Clinical Imaging BCP will drive internal actions when required where staffing or equipment issues impact on flow or emergency services. The MoD will inform the site team of such issues and associated actions taken	- MoD/Ward to CI MoD when escalation is required meeting trigger for escalation action - Site team to CS tri for any specific issue that is not resolvable between site team and CI management team

14b – Clinical Support action cards Cont.



Links to Care Group Action cards

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
Pharmacy Chief Pharmacist Iain Davidson Principal Pharmacist for Clinical Services (+deputy chief pharm) Helen McClay Principal Pharmacist for Supply Service and Medical Gases Alison Hill	Dispensary hours including weekend cover - Weekday 7am to 7pm - Weekends and bank holidays-8.30am to 5pm. - On-call cover out of hours 7 days/ week Admitting area support (Front door) - Clinical pharmacy support 7 days a week 8.30am to 5pm. - Note- skeleton team at the weekends. Ward based support including wards with dedicated prescribing pharmacists and discharge support - Each ward has an allocated pharmacist/ pharmacy team. - Prescribing support and discharge support will vary depending on the ward type and team availability. SMH and WCH 8.30am to 5pm- Monday to Friday - Weekend provision via Treliske service. Out of hours provision - On-call pharmacy service 365 days a year	- Robotics/ IT/ ePMA failure - Lack of Staffing to deliver a service to a clinical area or turnaround prescriptions effectively - Drug shortages and supply issues. - Medical gas shortages and supply issues. - Urgent serious drug recalls or safety alerts	- MoD/Ward to pharmacy SMT when escalation is required meeting trigger for escalation action - Site team to CS tri for any specific issue that is not resolvable between site team and pharmacy management team

14c – General Surgery and Cancer action cards



Links to Care Group Action cards

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
GSC Care Group Huddles	08.00am to discuss staffing, escalation areas open and nerve centre information. 14.30 review of PDD, R2R and next day discharges, CLD, ensure all actions completed. MOD joins bed meeting and acts as point of contact	1. Critical staffing levels 2. Escalation areas bedded with no plan 3. Inaccurate Nerve centre information 4. Actions outstanding	1. Matron/HoN to formulate a staffing plan and for outstanding escalations to Safe care 2. Service manager escalation to GM/HoN for review of activity at risk 3. MOD/ Matron to review Boarding and TES patients 4. MOD/Matron to review discharge plans and referrals, plan with site team to de-escalate.
All Inpatient wards	Inpatient wards- BD Board Round-identification of escalations of care/urgent reviews, actions for discharge Confirmation of "Golden patient" Ward Rounds across all departments Theatre- full utilisation/efficiency of lists/all resources in place	1. Flow concerns including patients awaiting diagnostic investigations or procedures to be escalated to MOD 2. Potential on the day cancellations 3. Delayed review of specialty patients	1. MOD to escalate in priority order to relevant department. 2. Escalation by MOD/Matron to specialties for review to GM/HoN/CD and Clinical site team 3. Service Manager review and resolution of barriers 4. MoD and Clinical Matron to ensure all patients waiting for theatre are listed
Outpatient departments	Outpatient departments- review of all planned activity with all clinics, starting on time and utilised to full capacity	1. Inability to run at full capacity with clinic efficiency below standard 2. Outpatient short notice cancellation	1. Service manager/MOD/Matron to review and assist in resolution, review cross care group support and further escalation to GM/HoN/CD. 2. Matron to escalate through safe care if unable to mitigate nursing staffing gaps 3. Service manager will review medical staffing to

14d – Peripheral Sites action cards



Links to Care Group Action cards

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
Care Group Daily Status	08.00am daily status – bed status, confirmed and potential discharges, Trauma white board, plans for NOF's in ED, escalation areas open and resources (staffing and equipment). Nerve centre data review. 15.00 review of PDD, R2R and next day discharges, CLD, agreed actions completed. MOD – joins bed meeting and acts as point of contact.	1. Resource shortfalls – staffing / equipment unresolved by Matrons/Service Manager. 2. No Plan for NOF's in ED. 3. Escalation areas open with no plan. 4. Inaccurate Nerve centre information 5. Actions outstanding.	1. Matron/HON escalation at Safecare / Service Manager escalation to GM for review of activity at risk. 2. Matron to review Trauma holding/boarding, use of TAU/WCH beds. 3. GM/HON/CD review 4. Matron review with NIC / discharge co-ordinators 5. Escalation to Service Manager / HON / GM
Trauma service	Trauma 1 and 2 - BD board round – identification of escalations of care/urgent reviews, actions for discharge and suitable WCH transfers(today and pre-plan for tomorrow). 0800 Trauma MDT – confirmation of “Golden Patient” and Theatre list. Utilisation of TAU – TCI's / pull of suitable patients in ED. Fracture Clinic operational at full capacity.	1. Flow concerns. 2. “Golden” patient and theatre lists not confirmed. 3. TAU not fully utilised 4. Fracture Clinic unable to run at full capacity	1. Matron to assist in resolution, further escalation to HON/GM/CD and Clinical Site team. 2. Escalation to Service Manager. 3. Trauma co / Matron review of capacity and demand (ED key priority) 4. Service Manager review and resolution of barriers.
SMH site – Orthopaedic Service, St Josephs and St Michaels wards, Day case, Theatre, OPD and Marie Therese House	St Josephs, St Michaels and MTH - BD board round – identification of escalations of care/urgent reviews, TCI plan day case / inpatient requirements, actions for discharge. Theatre – full utilisation/efficiency of lists, all resources in place. OPD – full utilisation/efficiency .	1. Resource shortfalls – staffing / equipment unresolved by Matrons/Specialty lead. 2. Potential on the day cancellations 3. Utilisation/efficiency below standard	1. Service Manager/Matron to assist in resolution, review cross care group support, further escalation to HON/GM/CD. 2. Escalation to HON/GM/CD. 3. Service Manager review and resolution of barriers.
WCH site – Medical 1 and 2, Urgent Treatment Centre, Renal Unit, Surgical day case, Penlee Unit, Theatres and Outpatient department	Medical 1 and 2 - BD board round – identification of escalations of care/urgent reviews, actions for discharge and suitable transfers from Trauma (today and pre-plan for tomorrow). UTC – able to meet demand within 4 hours target and planned operational times. Day case/Penlee/Theatre – full utilisation/efficiency of lists, all resources in place. OPD – full utilisation/efficiency .	1. Resource shortfalls – staffing / equipment unresolved by Matrons/Service Manager. 2. Potential on the day cancellations 3. Utilisation/efficiency below standard	1. Matron/HON escalation at Safecare / Service Manager escalation to GM for review of activity at risk. 2. Service Manager/Matron to assist in resolution, review cross care group support, further escalation to HON/GM/CD. 3. Service Manager review and resolution of barriers.

14– Specialist Medicine action card

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
Specialist Medicine Care Group Huddles	08:00hrs Nursing Huddle (Quality, Safety, Staffing) 14.00 review of PDD, R2R and next day discharges, CLD, ensure all actions completed.	1. Critical staffing levels 2. Holding, Boarding & TES 3. Patient Harm Event 4. Discharge Failure Event	1. Clinical Matron Safecare Escalation for support 2. Clinical Matron creates a fill plan 3. Clinical Safety Review 4. Clinical Matron Review / Resolves & Identify Learning
Inpatient Wards	Team Board Round (AM) Ward Round Team Board Round (PM) - MoD complete daily review of all patients - Clinical Matrons complete daily review of all patients	1. Pts awaiting Diagnostic or procedures to MoD 2. Pts declining to move to Clinical Matron 3. Ward below admissions forecast to MoD with Clinical Matron	1. MoD escalates to relevant department 2. Clinical Matron supportive conversation patient 3. MoD and Clinical Matron gather inf with teams & escalate output to Care Group Tri as required
Outpatient departments and Cardiac Catheter Lab	09:00 Service Manager review all activity planned for that day, ensuring outpatient clinics starting on time and all capacity utilised. Ensure CCL activity commences on time and work with bed manager re elective bed requirement	1. Lack of Clinician Provision (Medical or Nursing or AHP) 2. Lack of General Nursing Cover 3. Short notice activity cancellation 4. Shortage of elective bed	1. Service Manager, Specialty lead & Rota Co-Ordinator (+/- Clinical Matron) reviews to reallocate staffing 2. Clinical Matrons escalate through safe care if unable to cover across care group
Care Group MoD Co-ordination (Service Manger or Clinical Matron)	08:00 Touch Point 08:15 Bed Meeting 08:45 AMU Huddle - Morning Ward Visit Review (Minimum 1 face to face) 12:15 Bed Meeting - Afternoon Ward Visit Review (Minimum 1 face to face) Construction of Care Group Night Plan 14:00 PDD & R2R Confirmation Review with CSM 16:00 Bed Meeting	1. Unable to accommodate ED or AMU demand 2. Wards below admissions forecast 3. Critical Staffing levels	1. Full patient review with Ward Consultant 2. MoD and Clinical Matron liaise with teams and confirm all elements of flow complete & escalate output to Care Group Tri as required 3. Construct risk based assessment on priority pull (IDP) 4. Construct Staffing Plan with Specialty Lead / Service Manager / Clinical Matron (Care Group Tri)
			<u>All actions if unresolved are escalated to a member of the Care Group Triumvirate Leadership Team</u>

14f – Specialist Surgery and Services action cards



Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
SSS Care Group Huddles	08:00hrs Nursing Huddle (Quality, Safety, Staffing) 14.30 review of PDD, R2R and next day discharges, CLD, ensure all actions completed.	1. Critical staffing levels 2. Holding, Boarding and TES 3. Patient Harm Event 4. Discharge Failure Event	1. Clinical Matron Safecare Escalation for support 2. Clinical Matron creates a fill plan 3. Clinical Safety Review (HoN) 4. Clinical Matron Review / Resolves and Identify Learning
Inpatient Wards	Team Board Round (AM) Ward Round Team Board Round (PM) - Team Implementation of SSS Patient Flow House - MoD complete daily review of all patients - Clinical Matrons complete daily review of all patients	1. Pts awaiting Diagnostic or procedures to MoD 2. Pts declining to move to Clinical Matron 3. Ward below admissions forecast to MoD with Clinical Matron	1. MoD escalates to relevant department 2. Clinical Matron supportive conversation patient 3. MoD and Clinical Matron full board round with team and escalate output to Care Group Tri 4. MoD and Clinical Matron to ensure all patients waiting for theatre are listed
Outpatient Departments	09:00 Service Manager review all activity planned for that day, ensuring outpatient clinics starting on time and all capacity utilised.	1. Lack of Clinician Provision (Medical or Nursing or AHP) 2. Lack of General Nursing Cover 3. Short notice activity cancellation	1. Service Manager, Specialty lead and Rota Co-Ordinator (+/- Clinical Matron) reviews to reallocate staffing 2. Clinical Matrons escalate through safe care if unable to cover across care group
Care Group MoD Co-ordination (Service Manger or Clinical Matron)	08:00 Touch Point PFC 08:15 Bed Meeting 08:45 AMU Huddle - Morning Ward Visit Review (Minimum 1 face to face) 12:15 Bed Meeting - Afternoon Ward Visit Review (Minimum 1 face to face) Construction of Care Group Night Plan 14:00 PDD and R2R Confirmation Review with CSM 16:00 Bed Meeting	1. Unable to accommodate ED or AMU demand 2. Wards below admissions forecast 3. Critical Staffing levels	1. Full patient review with Ward Consultant 2. MoD and Clinical Matron full board round with team and confirm all elements of SSS Patient Flow House Complete and escalate output to Care Group Tri 3. Construct risk based assessment on priority pull (IDP) 4. Construct Staffing Plan with Specialty Lead / Service Manager / Clinical Matron (Care Group Tri)
Care Group Patient Flow Co-Ordinator (PFC)	09:00 Sit-rep Tx (Discharges, Holding, Boarding, TES and Escalations) 10:15 PDD and R2R Confirmation Text 11:30 Sit-rep Tx (Discharges, Holding, Boarding, TES and Escalations) 11:30 Site-rep Email (Discharges, No R2R pts, Longest LoS RV and Escalations) 15:15 PDD and R2R Confirmation Tx	1. Escalate any barrier and obstacles with patient flow to MoD (or direct to Clinical Matron when senior nursing required)	1. Support resolution of barrier or obstacle <u>All actions if unresolved are escalated to a member of the Care Group Triumvirate Leadership Team</u>

14g – Urgent Emergency and Eldercare action cards



Links to Care Group Action cards

Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
UEE Care Group Huddles – See Roles and Responsibility cards.	07.30am to discuss staffing, escalation areas open and nerve centre information. 14.30 review of PDD, R2R and next day discharges, CLD, ensure all actions completed.	1. Critical staffing levels 2. Escalation areas bedded 3. Inaccurate Nerve centre information	1. HON, DHON to discuss a plan at Safe care. 2. Matron to review discharge plans and referrals, plan with site team to de-escalate. 3. HON/DHON and Matrons to ensure with Ward leaders and Discharge co-ordinators NC updated.
Emergency Department	2 hourly Board Rounds, Consultant led with ED NIC	As per ED Surge Plan.	Surge plan escalation actions led by action owners.
Acute Medicine (AMU)	08.45am huddle with MODS and AMU NIC. 11.30am Full Board round to review all patient actions	1. Patients over 48 hours 2. Delayed review of specialty patients	1. AMU Matron to review all patients with Specialty MODS to escalate in priority order. 2. Escalation by Matron to specialties for review
Acute Medicine (SDMA)	SDMA ready to accept Medical take. 2 hourly board rounds with SDMA NIC and Medical team.	1. Patients unable to move off the department. 2. Processing of medical patients is delayed	1. Escalation from SDMA NIC to Clinical Site Manager for rapid allocation of beds to allow for ambulance offloads to SDMA. 2. Escalation from SDMA NIC or Matron to Acute medical team, OOH SMOC to GIM.
Eldercare (Inpatients Inc. Tremel Frailty Unit. And Outpatients) *All actions if unresolved are escalated to the Care Group Triumvirate	07.30am Specialty Leads review all medical cover and Matrons oversee ward areas. 07.30am Service Manager responsible for outpatient clinics starting on time and all capacity utilised.	1. Lack of medical cover 2. Lack of nursing cover 3. Stroke metrics not being met/no Stroke HASU 4. Outpatient short notice cancellation	1. Specialty lead reviews rosters with roster co-ordinator to reallocate staffing 2. Matrons escalate through safe care if unable to cover across care group 3. Matron for Stroke works with Site team, medics and community partners to create capacity. 4. Service Manager will review medical staffing to reallocate cover

14h – Women's and Children's action cards

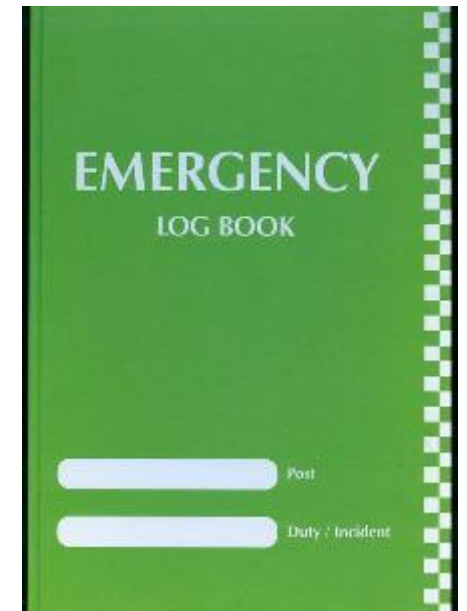


Element	Business as Usual	Trigger for escalation action	Details of actions to take with owners or link to action card
Eden: Gynae emergency capacity	X1 GE ward bed available for Gynae Emergency direct admission from home/EGU and treatment room 6 to be kept available	Room 6 in use with GE and no planned base bed discharges to move into within next 2 hours.	- In hours: NIC to escalate to Matron who will escalate to MOD to request Site team to move medical outlier to accommodate GE pt. - OOH: NIC to escalate directly to Site co - MoD and Clinical Matron to ensure all patients waiting for theatre are listed - Senior decision makers to hold bleeps and provide advice lines to GPs to ensure essential admission only and that those who don't need to be in acute hospital are streamed away to include provision of mutual support between ED and PAU and review in ED of patients who may be discharged if there is capacity to do so. - Set up internal Child Health Hub with MDT team to manage communication as per BCP's including daily estates communication regarding oxygen requirements - Request staffing support at safer care meetings. - Deploy nursing and medical staff from cancelled activity to support acute function. All paediatric
Acute Paediatric wards	Opel 1: In patient capacity available Cubicle capacity available PAU capacity available HDU capacity available Paediatric observation clear of in patients Harlyn day case area clear for elective activity CLIC able to admit oncology	TRIGGERS TO MOVE TO OPEL 2 Staffing unable to meet activity needs BUT mitigation available from non patient facing roles Number of HDU patients < or equal to 2 BUT anticipate inability to step patients down within 12 hours TRIGGERS TO MOVE TO OPEL 3 Ward space is maximised and PAU being used to accommodate in-patients HDU activity > or equal to 3 AND anticipate inability to step any patient down within 12 hours RESOURCE REQUIRED Senior nursing and medical decision makers GP hot hubs and MIU clinics to be functional ensuring triage and streaming away from acute care Appropriate testing resource in the right place – This will be PAU before patient placement allocation TRIGGERS TO MOVE TO OPEL 4 Using Harlyn beds for in-patient capacity HDU > or equal to 5 patients and anticipate inability to step any patients down within 12 hours	

16. Emergency Log Book



- Assists the decision maker in reaching a reasoned, lawful and justifiable decision
- Protects you should there be an enquiry or inquest
- The log entry should include....
 - - Key events
 - - Key decisions
 - - Reasoning behind them
 - - Other options considered
 - - Actions taken
- Should be filled in chronologically with date, time, persons present (or consulted) and written in black ink
- Completed at the time of the event or as soon as reasonably practicable afterwards
- No erasures, overwriting or correction fluid – score through errors with a single black line and initial
- No pages to be torn out (the pages are numbered!)
- No blank spaces to be left
- Do not take it home, take notes at 4am and then make the entry when next in the Site Office
- Write in the Emergency Log Book yourself if no Loggist is available at that time



18. Links to useful SOPs and Trust policies



ED Surge Plan



SDMA
Operational Policy



MOD Expected
actions

Aspiring to provide
Brilliant care to
One + all



Royal Cornwall Hospitals
NHS Trust

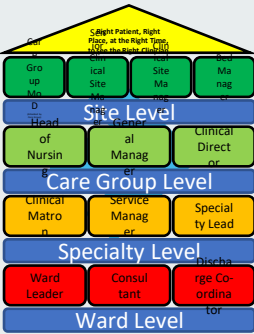
Specialist Services and Surgery Patient Flow House

A conceptual model that represents the
different levels, roles, responsibilities actions
and tasks related to patient flow

Ian Moyle-Browning
Head of Nursing
Specialist Services & Surgery



Context



Patient Flow

- The co-ordination of patient flow and patient pathways is complex at a ward, specialty, care group and site level
- The operational ask often changes and therefore requires us to be agile in our response and at times take more risk
- There are some agreed and proven principles and actions that contribute to achieving positive and timely patient flow
- This model helps to bring together these tasks and assign them to teams that work at different levels
- The intention is that the Patient Flow House can be used:
 - to orientate new and existing colleagues
 - as a checklist or action card in operational practice
 - as a reminder of what we have already got in place that supports organizational Patient Flow
- Completing the actions consistently in the Patient Flow House will support achieving our collective vision of:

'Right Patient, Right Place, at the Right Time, to see the Right Clinician'



Overview



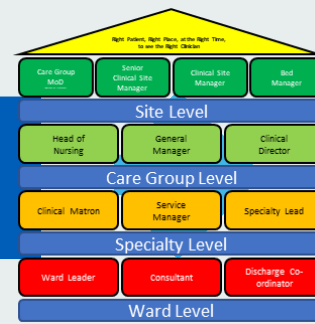
Patient Flow House

- Patient Flow is everyone's responsibility
- We all have a part to play depending on our role
- There are multiple Levels of Accountability
- We all want to achieve the same goal

‘Right Patient, Right Place, at the Right Time, to see the Right Clinician’



Ward Level



Summary

- Working together as a Ward Level triumvirate to lead the multi-professional team to achieve positive patient flow

SAFER Bundle:

S – Senior Review
A – All Patients (PDD/EDD/CCD)
F – Flow 'Early'
E – Early Discharge
R – Review

Structured Board Round:

S: Sick Patients
H: Home Patients
O: Other Patients
P: Plans (Inpatients/Outliers/Weekend)

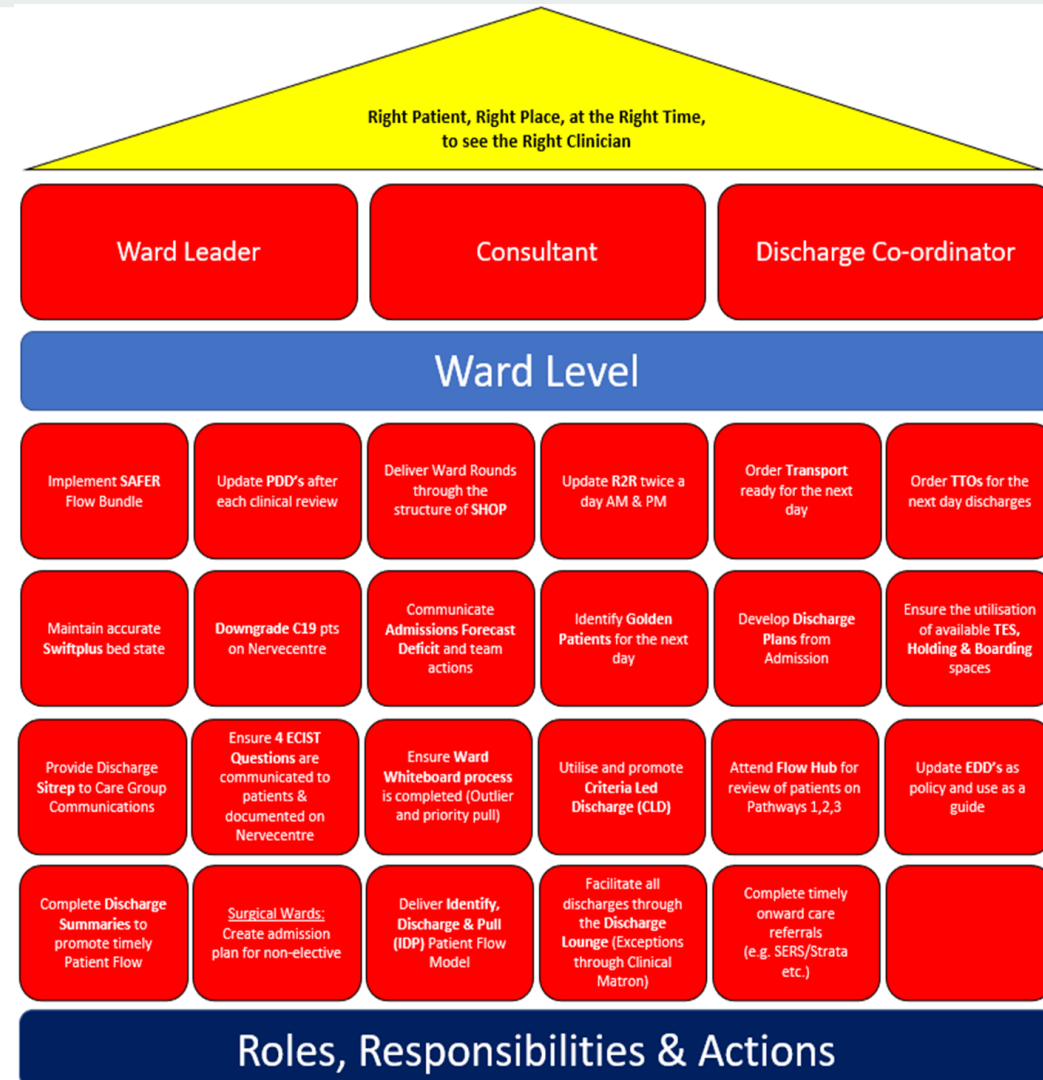
4 ECIST Q:

Every patient should be updated daily:

- Why are they in Hospital?
- What is the plan for them that day?
- What needs to be achieved for them to be discharged?
- What is the date that the patient will be discharged?

IDP Flow Model:

I: Identify
D: Discharge
P: Pull



Specialty Level



Summary

- Working with the Ward Level teams as the ongoing senior visible presence on the ward to support them to achieve their actions, roles and responsibilities
- Providing advice, support and leadership on:
 - the complex discharges and overcoming barriers to discharge
 - frequent reviews of discharge and patient flow performance based on data whilst supporting improvement actions



Care Group Level



Summary

- Visible senior presence to support both the Specialty and Ward Levels to achieve their roles and responsibilities
- Focus on assurance with processes and being a critical friend suggesting areas of improvement and efficiencies
- Will provide advice, support and leadership with frequent reviews of discharge and patient flow performance based on data whilst supporting improvement actions

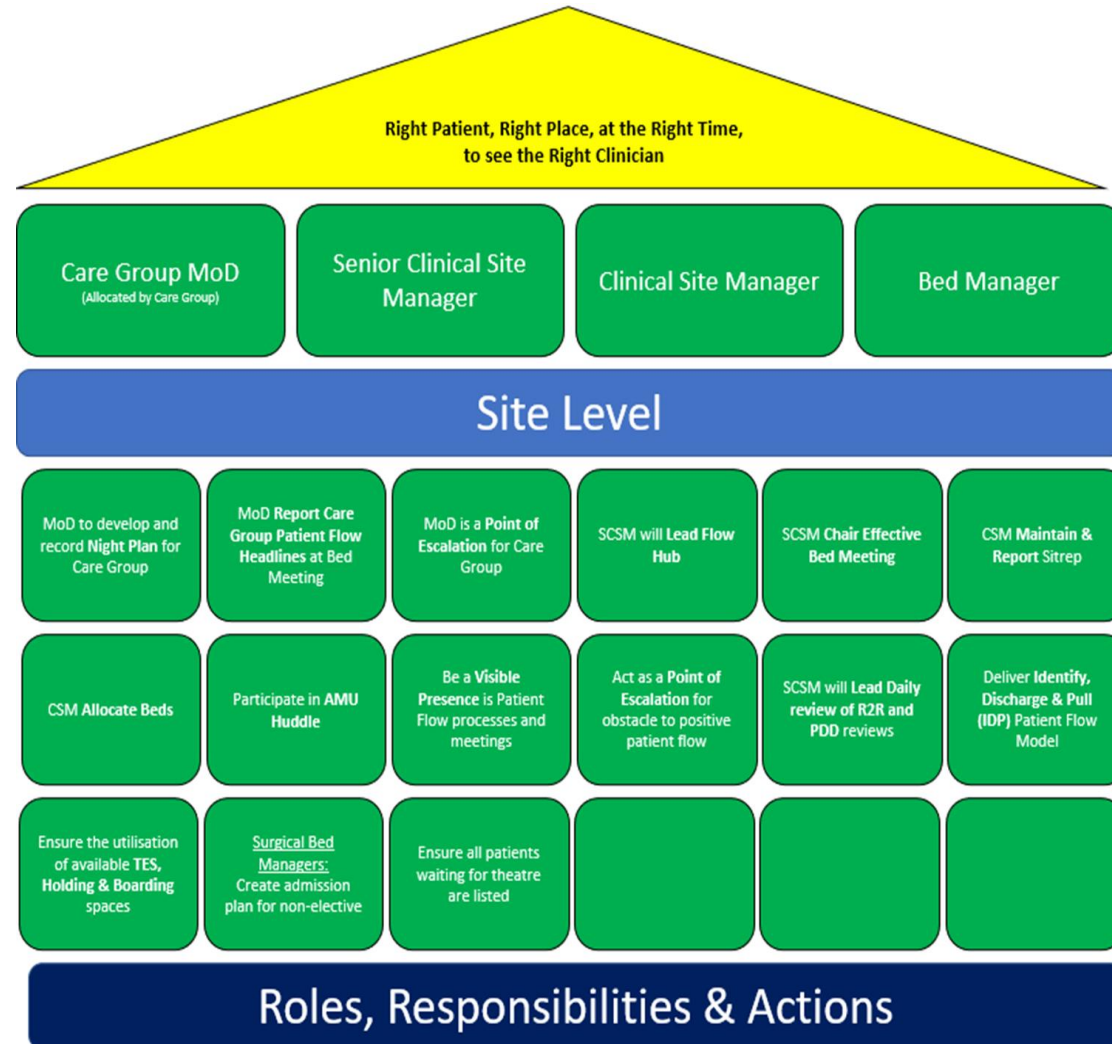


Site Level



Summary

- The daily operational team in the co-ordination of patient flow at all levels
- Bringing together the contribution of Ward and Specialty level activity to a Site Level



Aspiring to provide
Brilliant care to
One + all

Specialist Services and Surgery Patient Flow Coordinator

Structured Activity and Communication

Author: IMB
Created: 2023 02 27



Royal Cornwall Hospitals
NHS Trust



Care Group Patient Flow Co Daily Guide



Patient Flow Co-ordinator Daily Guide

Time	Location	Action	Comment
08:00	Wheal Coates	Wheal Coates Verbal Discharge Update	
08:15	Wheal Coates	Wheal Coates Verbal Discharge Update	
08:30	GLU	GLU Board Round	
08:45	GLU	GLU Board Round	
09:00	Phone	Update Tx to Care Group	See Guide
09:15			
09:30			
09:45			
10:00			
10:15	Phone	Update Tx to Confirm PDD & R2R up to date	See Guide
10:30	Office	Download Live Inpatient Details & RV Report	
10:45	Office	Download Live Inpatient Details & RV Report	
11:00	Office	Email Daily SitRep for Flow: To CG Trn & CG Clinical Matrons and Ward Leaders	See Guide
11:15			
11:30	Phone	Update Tx to Care Group	See Guide
11:45			
12:00			
12:15			
12:30			
12:45			
13:00	Wheal Coates	Wheal Coates Touch Point	
13:15	Wheal Coates	Wheal Coates Touch Point	
13:30	GLU	GLU Board Round	
13:45	GLU	GLU Board Round	
14:00			
14:15			
14:30			
14:45			
15:00			
15:15	Phone	Update Tx To Confirm PDD & R2R up to date	See Guide
15:30		Ensure: - No PDD in Past - PDD correct for today / tomorrow - No R2R outstanding	
15:45	Phone	Update Tx to Care Group	See Guide
16:00			

During Unblocked Time:

- Ensure Discharge Lounge use and exceptions
- Ensure clear Holding / Boarding / TES utilisation plans
- Support SERF Referral completion
- Support Nerve centre Accuracy
- Informing Bed Managers, Clinical Site Managers & MoD's of availability
- Ensure Discharge Prep (TTO's, Discharge Summary, Transport)
- Support & Promote CLD for tomorrow
- Support & Promote Golden Patients
- Support Ward Leaders at Flow Hub
- Update Enhanced Reporting (Silver / Reset)

- Structured day supporting expectations of organisation including reporting

Standard Messages to Care Group WhatsApp Group



First Message
After Board
Round
09:00-09:30

Current Discharge Info

Already Discharged
0 GLU
0 Wheal Coates

Predicted Discharges
GLU
00 Aw XX
00 Aw XX
00 Aw XX
00 Aw XX

Wheal Coates

00 Aw XX
00 Aw XX
00 Aw XX
00 Aw XX

Operational Asks:
Holding on GLU – Yes
Boarding on GLU – Yes
TES on GLU – Yes

For Escalation:
Nil all BAU Actions

Delivered

PDD and R2R
Confirmation
10:15 and
15:15

The PDD and R2R have been
reviewed are confirmed to be
correct on GLU & Wheal Coates

End of Day
Update
15:45

End of Day Discharge Info

Already Discharged
0 GLU
0 Wheal Coates

Predicted Discharges
GLU
00 Aw XX
00 Aw XX
00 Aw XX
00 Aw XX

Wheal Coates

00 Aw XX
00 Aw XX
00 Aw XX
00 Aw XX

Operational Asks:
Holding on GLU – Yes
Boarding on GLU – Yes
TES on GLU – Yes

For Escalation:
Nil all BAU Actions

Plans for Tomorrows:
Golden Patients
GLU
00 Aw XX
Wheal Coates
00 Aw XX

Delivered

Second
Message Update
11:30-11:45



*All Care Group Tri and
MoD's and PFC are on
a group*

11:30 Care Group Sitrep



Daily Care Group Flow Update:

Ward	First Discharge Left Ward At	No. of Patients Already Discharged	No. of Patients Confirmed to Go Later	No. of Patients Queries for later
	00:00hrs	0	0	0
	00:00hrs	0	0	0

The following patients have No Reason to Reside and are on not on a Pathway 1,2 or 3:

Ward	Patient Initials	Reason for Delay Description	Reason to Reside	Action



The following patients are our longest LOS patients:

Ward	Patient Initials	LOS	Clinical Summary	Action

The following are escalations the wards need help with:

Ward	Patient Initials	Situation	Request

Aspiring to provide
Brilliant care to
One + all



Royal Cornwall Hospitals
NHS Trust

Specialist Services and Surgery Patient Flow Reporting

Ward Meetings and
Specialty Business and Governance
Meetings

Author: IMB
Created: 2023 02 27



Ward and Team Meeting



Structured Reporting at Ward Level

- Using the Base Ward Dashboard to shape and monitor performance
- Used at ward level discussions



Inpatient Patient Flow – Track and Trigger

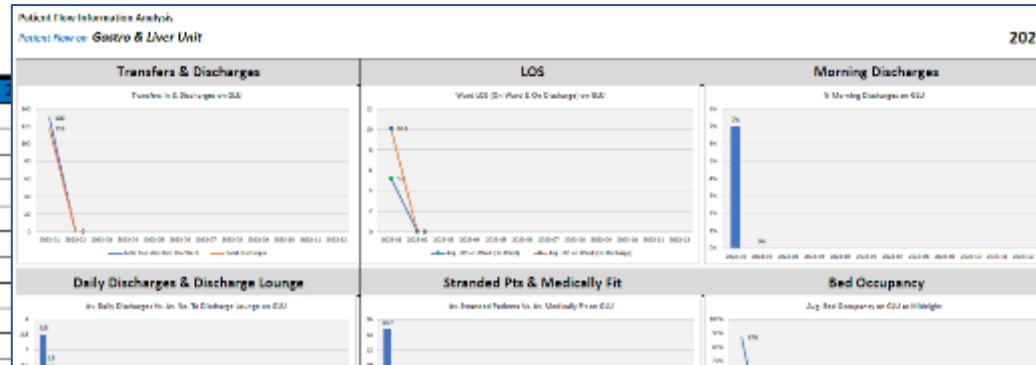


Specialist Services & Surgery Patient Flow Information Analysis

Gastro & Liver Unit				
	2023-01	2023-02	2023-03	2023-04
Total Transfers Into The Ward	130	0		
Total Discharges	118	0		
Avg. Daily Transfers Into The Ward	4.1	0		
Avg. LOS on Ward (On Ward)	5.2	0		
Avg. LOS on Ward (On Discharge)	10.1	0		
% Morning Discharges	7%	0%		
Avg. Daily Discharges	3.5	0		
Avg. To Discharge Lounge	2.5	0		
Avg. Bed Occupancy	87%	0%		
Avg. Stranded Patients (>7 LOS)	14.7	0		
Avg. Medically Fit	3.1	0		
No. transferred to DC Lounge	12	0		

Wheal Coates				
	2023-01	2023-02	2023-03	2023-04
Total Transfers Into The Ward	137	0		
Total Discharges	133	0		
Avg. Daily Transfers Into The Ward	3.9	0		
Avg. LOS on Ward (On Ward)	3.4	0		
Avg. LOS on Ward (On Discharge)	4.7	0		
% Morning Discharges	13%	0%		
Avg. Daily Discharges	3.9	0		
Avg. To Discharge Lounge	2.1	0		
Avg. Bed Occupancy	95%	0%		
Avg. Stranded Patients (>7 LOS)	6.4	0		
Avg. Medically Fit	1.7	0		
No. transferred to DC Lounge	16	0		

* Data extracted from Based Ward Dashboards



- Using the Base Ward Dashboard and other Radar reports to create our Care Group Dashboard

2022 Dashboard



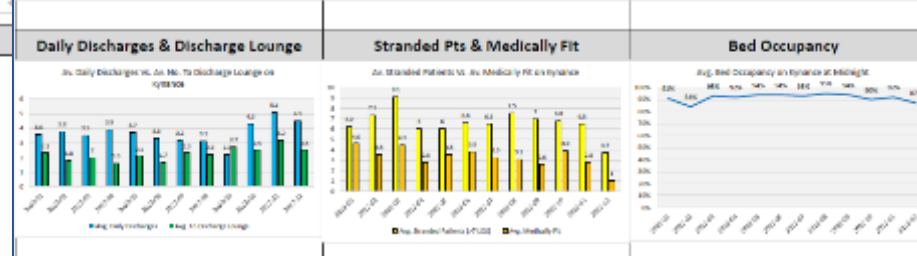
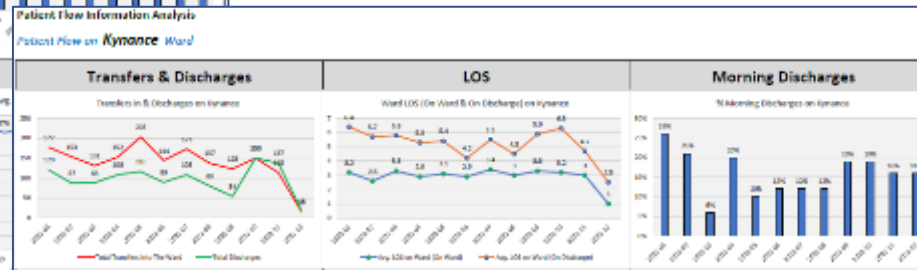
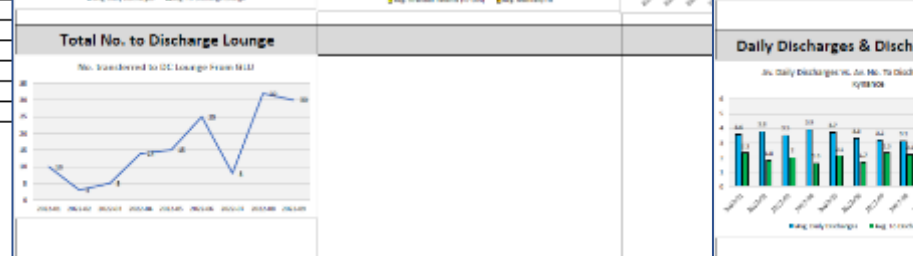
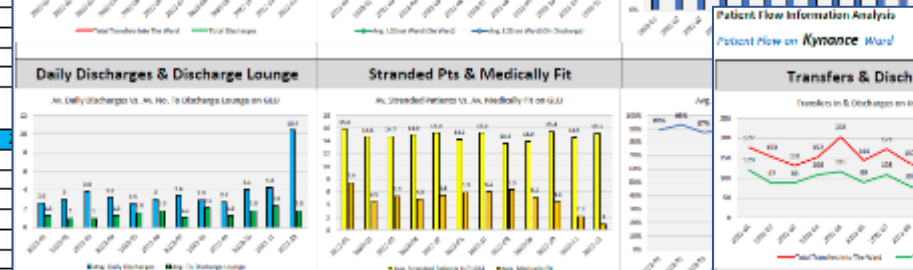
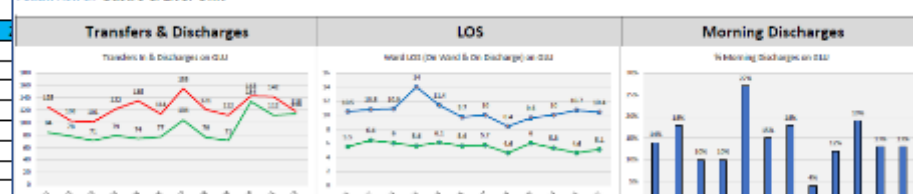
Specialist Services & Surgery Patient Flow Information Analysis

Gastro & Liver Unit				
	2022-01	2022-02	2022-03	2022-04
Total Transfers Into The Ward	125	103	101	122
Total Discharges	84	78	71	79
Avg. Daily Transfers Into The Ward	3.9	4	3.7	4.4
Avg. LOS on Ward (On Ward)	5.5	6.4	6	5.6
Avg. LOS on Ward (On Discharge)	10.5	10.8	10.9	14
% Morning Discharges	14%	16%	10%	10%
Avg. Daily Discharges	2.6	3	3.9	3.2
Avg. To Discharge Lounge	1.3	1	1	1.3
Avg. Bed Occupancy	89%	93%	87%	89%
Avg. Stranded Patients (>7 LOS)	15.8	14.6	14.7	14.9
Avg. Medically Fit	7.4	4.5	5.3	4.9
No. transferred to DC Lounge	10	3	5	14

Kynance Ward (New Wheel Caters)				
	2022-01	2022-02	2022-03	2022-04
Total Transfers Into The Ward	177	153	131	152
Total Discharges	120	87	88	108
Avg. Daily Transfers Into The Ward	5.1	5.5	4.7	5.4
Avg. LOS on Ward (On Ward)	3.2	2.6	3.3	2.9
Avg. LOS on Ward (On Discharge)	6.4	5.7	5.8	5.3
% Morning Discharges	26%	21%	6%	20%
Avg. Daily Discharges	3.6	3.8	3.5	3.9
Avg. To Discharge Lounge	2.3	1.8	2	1.6
Avg. Bed Occupancy	91%	84%	93%	92%
Avg. Stranded Patients (>7 LOS)	6.2	7.3	9.1	6
Avg. Medically Fit	4.6	3.5	4.5	2.8
No. transferred to DC Lounge	39	13	12	20

* Data extracted from Based Ward Dashboards

Patient Flow Information Analysis Patient Flow on Gastro & Liver Unit



2022 Successes

- Discharge Lounge Use
- Using Data to shape conversations and priorities
- Reducing LOS
- Getting our data right!



Structured Reporting at Specialty Level

- The next slide is cut and pasted into the Specialty BandG Pack
- Information is taken from Base Ward Dashboard and Admission, Discharges and Transfer Report

Inpatient Patient Flow



Discharges By Hour Admission, Discharges and Transfers (Filter by ward, Filter by DC Year Use Graphs)	Ward Name	
	Total Transfers Into Ward	
Discharges By Date, Discharges and Transfers (Filter by ward, Filter by DC Year Use Graphs)	AVG. Daily Transfers Into Ward	
	Total Discharges	
	AVG. Daily Discharges	
Discharges By Specialty (From Base Ward Dashboard and filter to the previous month and snippet from Discharges from Ward Section)	AVG. LOS on Ward (On Discharge)	
	% Morning Discharges	
	AVG. To Discharge Lounge	
	AVG. Bed Occupancy	

Successes

Highlight successes / positives

Lessons Learnt / Shared Learning:

Highlight any learning from cases

Challenges:

Highlight obstacles to success

Next Steps:

Highlighted actions

Thank you

