NHS England (London)

Emergency Department Capacity Management, Redirect and Closure Protocol (ED Policy)

v7.3

Effective 22 December 2015

NHS England (London) Emergency Department Capacity Management, Redirect and Closure Protocol (ED Policy)

Version number: 7.3

Version	Date / Updated By	Comments
1	2008/9	Initial Policy
2	2009/10	Updated following review of use in 2008/9
3 3.1 3.2	2010/11 Richard McEwan	Updated following review of winter 2009/10, incorporating Trust, sector and LAS feedback and released to the NHS in London for implementation from 16th August 2010. Go live date subsequently amended to 11 October and role of LAS Gold Doctors incorporated. Replacement of informal / formal redirect concept with immediate / planned, and clarification of requesting and notifying process.
4	2011/12 EP Team/ R McEwan	Updated to reflect changes to the NHS and on-going learning.
5	2012/13 Richard McEwan	Updated with input from PCT Clusters, LAS and London ED Consultants from the College of Emergency Medicine.
6	Feb 2013 Richard McEwan	Updated to reflect new NHS management structures, and including new chapter on temporary closure of EDs due to planned “engineering works”.
7 7.1 7.2 7.3	Nov 2013 Richard McEwan Jan 2014 Richard McEwan Richard McEwan Dec 2014 Richard McEwan Dec 2015	Updated and reorganised to include information on intelligent conveyance and the London wide change to a policy of “in extremis” redirections only. Addition of section 4.3 – Resus redirects Updating of IC text and addition of resus redirect checklist Update of corporate format, inclusion of additional decision tree, and reordering of sections to more logical flow.
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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

1 Contents

1 Policy statement

This document provides high level guidance on the systems and London wide approach to the management of Emergency Department (ED) capacity. ED capacity across London must be proactively managed to ensure that all patients are taken to the nearest ED with capacity and the appropriate clinical resources to treat that patient's presenting condition within a clinically appropriate time frame.

Redirecting or closing a hospital ED can result in increased clinical risk to patients as well as increased pressure on other local services. The following principles apply:

1.1 The acute trust (hospital) takes full clinical responsibility for the patient from the point of clinical handover or at 15 minutes from arrival of the patient with the LAS crew at the hospital, whichever occurs earlier. **This includes departments other than EDs, e.g., HASU, cardiac care etc.**

1.2 Close cooperation and coordination between the LAS / CCG/ CSU/ surge hub and the trust is essential to ensure patient safety.

1.3 Redirect or closure of an ED due to capacity issues should be the last escalation measure considered. **Unless all escalation measures have been enacted, a redirect or closure will not be considered, unless an imminent threat to life of patient safety exists.**

1.4 Redirect or closure will be based on proven clinical safety concerns, not performance against either the relevant ED or LAS standards.

1.5 Redirect is not a way of routinely managing trust capacity issues. This includes split site Trusts. There will be no internal redirects and split site trusts wishing to utilise capacity on other sites must have a robust *see and treat* policy with appropriate transport planned to support the movement of patients. If a multi-site trust wishes to arrange a redirect to another of it's sites, it must follow the process under section 6.

1.6 At times of high pressure, consultants of relevant specialities must be available to help prevent bottlenecks around the ED from occurring. **EDs must be supported by other disciplines at all times to improve flow.**

1.7 Escalation measures with CCG/CSU/LAS/surge hub involvement, should be taken early to ensure maximum impact.

1.8 Trusts should involve CCGs / CSUs / LAS / surge hub closely in any decision making processes in the lead up to a request for a redirect being made. **Requests made to NHS England which have not been discussed previously with the CCG/CSU, may be refused.**

1.9 If a trust seeks a redirect (excepting a resus redirect – section 7), it must do so via the Chief Executive* to NHS England (London) through NHS01.

1.10 Trusts must focus on managing discharge processes to maximise throughput and prevent bottlenecks occurring at the ED.

1.11 Intelligent Conveyance is not designed to mitigate or manage the consequences of poor hospital discharge arrangements or a poor discharge profile.

1.12 Trusts seeking to obtain a redirection (excepting a resus redirect) must have declared a critical incident. A redirection should be viewed in the same way as a Serious Incident (SI) and investigated using the Root Cause Analysis (RCA) process agreed by the Tripartite panel. This includes resus redirects. See NHS England London Surge Guidance v3 for more details.

*In hours or nominated deputy if the CEO is absent or incapacitated. Out Of Hours, this may be through the director on call with the knowledge of the CEO.

2 Introduction

The vast majority of ED redirects are requested as a result of overcrowding in the EDs due to hospital capacity issues. It is recognised that the variation in the number of ambulances attending a pressurised ED can compound the problem and to try to help address this LAS oversee a process known as “Intelligent Conveyance” (IC) to try where possible to reduce the variation in numbers of ambulances attending per hour.

It is expected that health systems should be managing discharges and capacity across the hospital in order that hospitals can run in a balanced manner. Intelligent Conveyance does not remove responsibility for managing onward demand from the ED department from the acute trust.

NHS England will monitor the number of redirects which take place. If there are concerns regarding the numbers being requested by or granted to any organisation, this will trigger further investigation with the relevant CCG to ensure there are no issues regarding the safety and quality of the service. This may lead to further action being taken, including referral to the relevant regulator.

3 Contact Numbers / Call Signs

LAS Initial Contact Number	020 7783 2329
LAS Control Room (Alternate Contact):	020 7921 5197
LAS Senior Clinical on-call:	Page via LAS control room

The following can be contacted via PageOne on **0844 822 2888** and the call sign below (leave a name and contact details):

NHS England (London) **NHS01**

CSU/CCG On Call:

CSU/CCG	Pager	Area
North East and Central CSU	NEL CSU1	Barking & Dagenham, Havering, Redbridge, Waltham Forest, Hackney, Newham, City, Tower Hamlets Camden, Islington, Barnet, Enfield, Haringey
NWL	NWLCP01	Brent, Ealing, Harrow, Hammersmith & Fulham, Hillingdon, Hounslow, Kensington & Chelsea, Westminster
SEL	SEL1	Lambeth, Southwark, Lewisham Greenwich, Bexley and Bromley
SWL	SWL1	Croydon, Kingston, Richmond, Merton, Sutton and Wandsworth

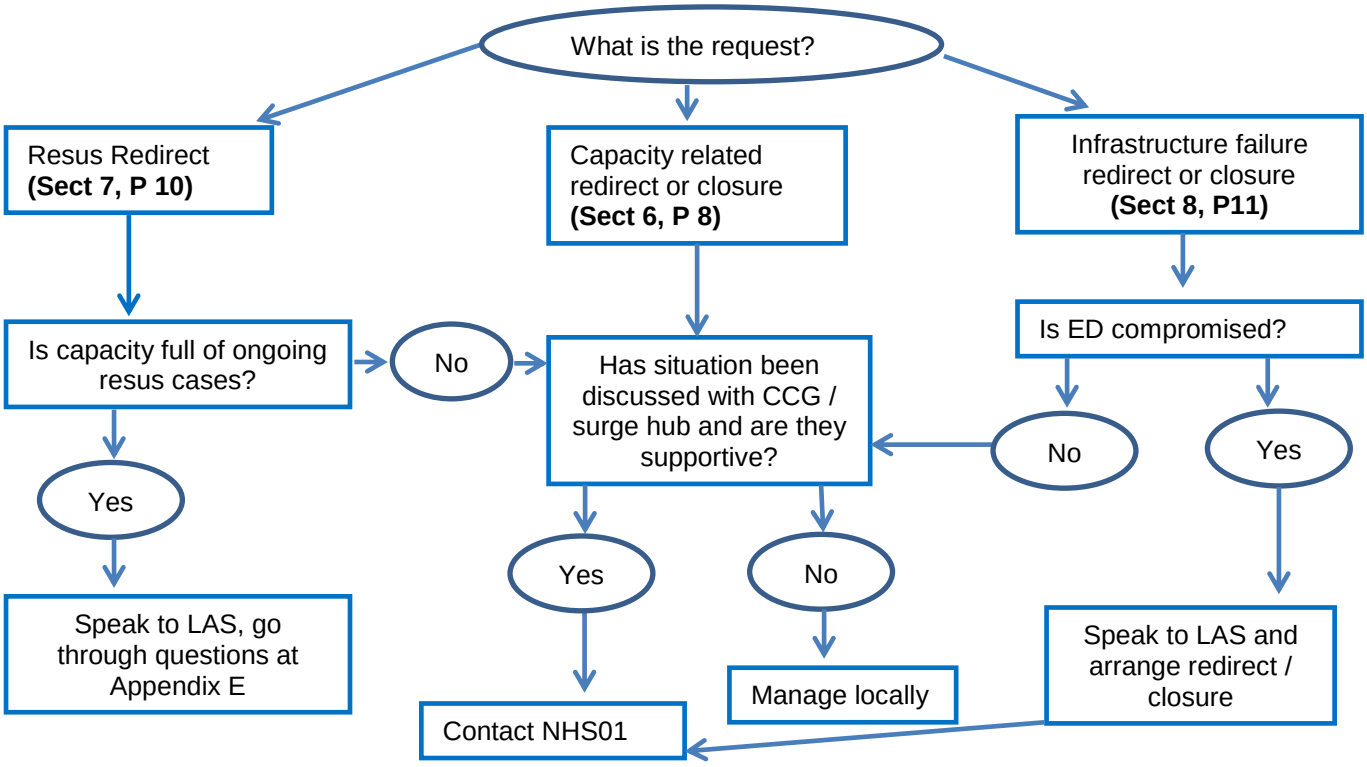
Teleconference Line (LAS Provided)

Dial In:	**0800 032 8069**
Participant code:	**58612663#**

4 Scope

This protocol covers all London acute trusts and is primarily focused on governing the arrangements for implementing redirects of ambulance born patients to ED's. It does not cover maternity diverts for which separate guidance exists. Diverts or closures of tertiary services including HASU and cardiac centres should follow the principles and actions set out in this document. If in any doubt regarding the applicability of this document and the arrangements it contains to your circumstances, you should contact the Emergency Preparedness, Resilience and Response team (EPRR) at NHS England (London), via NHS01, who will be happy to advise.

5 Redirect Quick Guide Flowchart



Contacting LAS re general pressure:

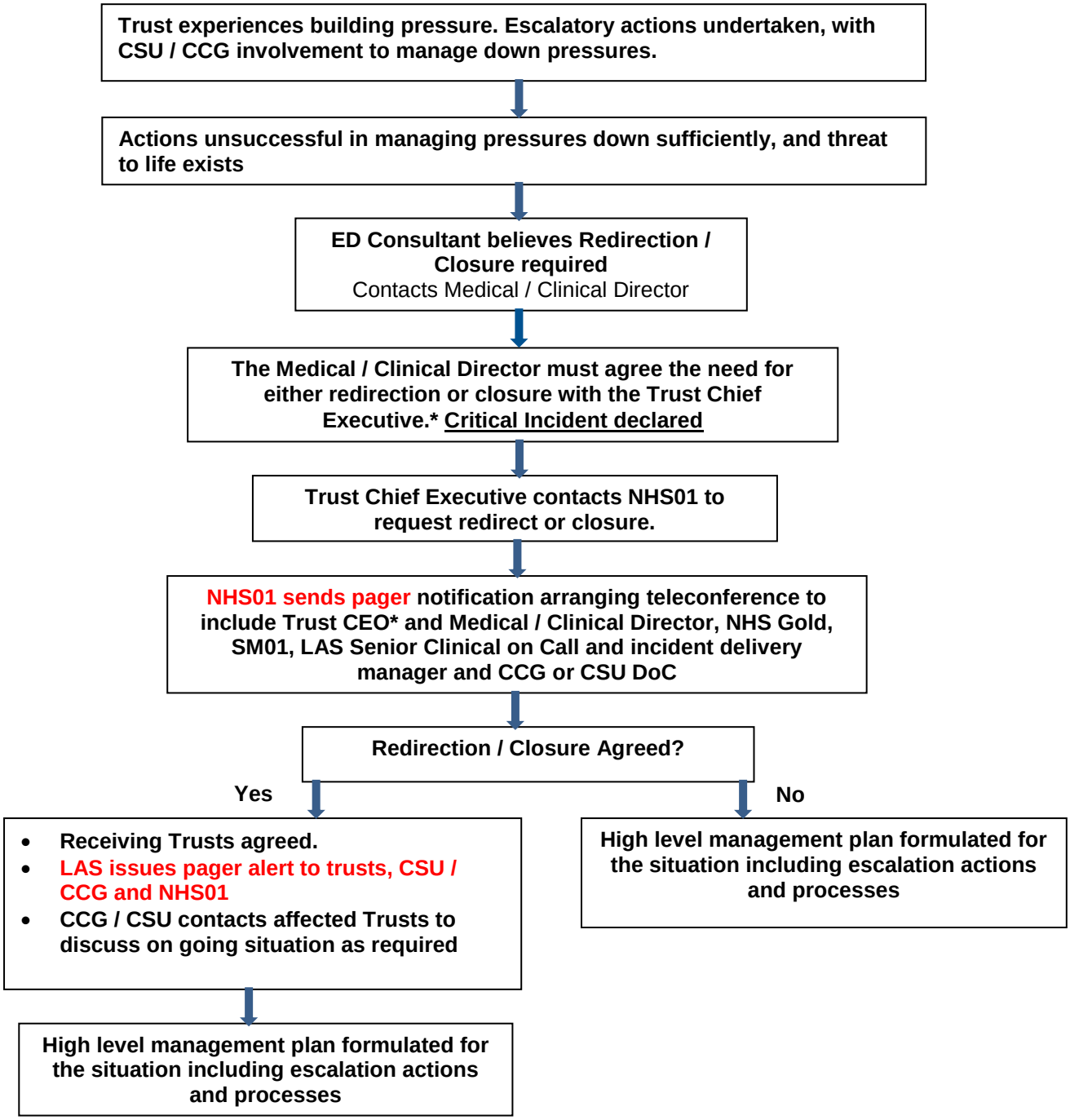
Trusts / CSU / Surge Hubs are asked to refrain from contacting the LAS control to inform them that a trust is busy / request IC support to a site, as this places an additional burden on the control room, and there is often no further action which they can take. It is understood that this action is taken by organisations to try to assist the management of a building pressure situation, but with IC operating to agreed thresholds, this should impact without the need for additional input.

Important Note re Paging of NHS01

If NHS01 has not been able to respond to an initial page within 15 minutes, a second page with the same message, prefixed "second page" should be sent again to NHS01. This will indicate to the senior EPRR manager that NHS01 may not have been able to respond, and will trigger their intervention on NHS01's behalf.

6 ED redirect or closure due to patient safety concerns

The Chief Executive must be assured that all possible escalation measures have been taken, working jointly with the CSU / CCG. If all local steps have not been exhausted, it is unlikely, unless an immediate threat to life is imminent by the continued acceptance of patients by the department, that a redirect or closure will be agreed.



*In hours or nominated deputy if the CEO is absent or incapacitated. Out Of Hours, this may be through the director on call with the knowledge of the CEO.

6.1 Redirect or Closure – Actions required and responsibilities

Trust

- Trusts must seek to manage pressure locally, without resorting to a redirection or closure.
- Trusts must have processes in place to receive, process and act on the information received from LAS, and handover delays.
- Trusts must prioritise the management of discharge related activities, in order to keep the outflow of patients constant, thereby preventing bed related queuing at the ED from occurring.
- Escalation actions must be taken early in order for them to be effective, preferably in business hours.
- If all local measures have been enacted, but failed to safely contain pressures at the ED, and a threat to patient safety is now imminent, the ED Consultant should contact the Medical / Clinical Director to request a redirection or closure.
- The Medical / Clinical Director should speak to the CEO regarding the situation and recommend a redirection or closure if they think that is appropriate. If that is the case, the trust should declare an Critical Incident, to ensure the gravity of the situation is understood throughout the organisation and that the appropriate command and control structures for managing the situation are in place.
- The CEO should contact NHS01 and request a teleconference be arranged.
- The trust must treat any redirection or closure in the same way as a Serious Incident (although not formally reported via STEIS), which must be investigated and reported to the CCG and the trust Board. Full details of the process to undertake are included in the NHS England London Surge Guidance v3.
- Trusts should notify their usual contacts at NHS Improvement in hours or the next working day for out of hours.

CCG

- **CCGs / CSU must be involved in discussions around a building pressure situation, in order to help maintain the trust in a safe situation, and scope out the availability of additional resource to assist.**
- CCG / CSUs will provide support to NHS England (London) through arranging for other potential participants to join any ongoing calls from surrounding trusts etc.

LAS

- If a redirection / closure is agreed, LAS will provide advice on the supporting trusts and notify via pager this should include neighbouring surge hubs / CSUs. CCG / CSU Director on Call to contact affected trusts as required to discuss ongoing impacts. Affected trusts should not contact the LAS with queries, but direct them to the CSU/CCG on call.
- In and out of hours, LAS will notify neighbouring ambulance services of the situation and ensure LAS Gold (strategic manager) is aware (if not on the call).

NHS England

- NHS01 will arrange a TC (dial in details section 3) with the following participation:
  - NHS Gold, SM01, CBL02
  - Trust CEO / (Director on Call OOH) & Medical / Clinical Director
  - LAS Senior Clinical on Call and Incident Delivery manager

- CCG / CSU / Hub Director on Call (Multiple if CSU/Hub boundaries likely to be crossed)

- The Participants will discuss the situation, and confirm that all available escalation steps – see Appendix C have been taken. **The trust representative will be asked the questions at appendix D, and must be in a position to provide this information**.
- Whether a redirection is agreed or not, the call will agree the high level management plan, including the need for additional conference calls, escalation actions and monitoring.
- NHS01 will ensure that the relevant DCO team at NHS England (London) has been notified of the situation and NHSI counterparts.

- The duration of the redirect or closure will be agreed, and would not normally exceed a maximum of three hours in the first instance.
- Redirects will automatically lapse after their agreed duration, unless specifically authorised for extension.

ED closure due to capacity issues may be sufficient cause for NHS England (London) to trigger command and control arrangements depending upon the circumstances. See NHS England (London) Surge Management Guidance v3 for details.

7 Resus Redirects (Blue Light Redirect) due to patient safety concerns

If a trust's resus capacity has been reached with **active ongoing cases**, (all patients need to have been in Resus less than 90 minutes)

- Trusts can contact the LAS directly on 020 7783 2329 to request a discussion about a resus re-direct for a maximum of 60 minutes. Redirects will not be granted if the unit is full of patients being monitored or awaiting transfer. A clinician to clinician discussion will be needed and so a direct contact number must be provided (either an extension number or bleep number) for the Duty Consultant who it is expected will be on-site given this is a clinical safety issue.

- Whilst LAS will support these requests for movements wherever possible, it may not always be feasible, depending on the pressures in the rest of the system at the time. If it is possible to support the request then a maximum of one or two resus cases (**excluding tertiary services, cardiac arrests and paeds**) will be directed to an alternative suitable provider - any ambulances already en-route to the trust will not be re-directed.

- Where resus is full but all patients are not undergoing active resuscitation, but rather awaiting transfer to a more appropriate care setting, a resus redirect is unlikely to be granted. Capacity issues are for the trust to manage, not the LAS. If patients are being monitored in Resus or held awaiting suitable beds (including level 2 or level 3) beds this is not a reason for a redirect.

- The LAS will inform NHS01 / CSU / Surge Hub by pager if this re-direct is invoked, so that they are aware of the situation for the purposes of local surge management. Given the dynamic nature of these re-directs and small numbers of ambulances which will normally be re-directed, neighbouring trusts will not routinely be notified but their capacity will be monitored through the Intelligent Conveyance Hub.

- NHS England (London) will be informed by LAS via NHS01, initially for information only. If further concurrent resus redirects are requested by the same trust, NHS England London may decide to take action to investigate the situation and any wider issues which it may have for the management of pressures.

- Trusts will be expected to investigate each redirect, using the RCA process, as for other redirects. LAS will record and report on each request made, including those refused.

8 Trust Infrastructure failure

8.1 Closure or redirection of the ED or tertiary services will only be accepted in the event that the hospital is unable to provide ED and resuscitation facilities due to infrastructure failures, for example fire, flood, major electrical failure etc, and should be for the shortest duration possible.

ED or tertiary service closure should only be considered as a last resort as it may subject the most seriously ill patients to increased clinical risk as a result of travelling further to receive immediately life-saving treatment. GP calls will be expected to be sent directly to a ward or Admissions Unit rather than via ED if practical, depending on the nature and scope of the infrastructure failure or incident.

8.2 Where as a result of an infrastructure failure a *Critical Incident or Major Incident* is declared, trusts are expected to follow their Incident Response Plan**, which includes notifying LAS** (via 0207 783 2329) and **NHS01**, and their commissioning CCG/CSU on call function for information. LAS will take action to effect the closure, including issuing pager notifications to trusts to be affected by the redirect or closure, the CCG / CSU and NHS01.

8.3 If not a *Major Incident or Critical Incident*, the trust On Call Director will:

- Contact NHS England (London) via NHS01, and inform of reason and need for closure. *(If NHS01 has not been able to respond to an initial page within 15 minutes, a second page with the same message, prefixed "Second page" should be sent again to NHS01, which will indicate to the senior EPRR manager that NHS01 may not have been able to respond, and will trigger their intervention on NHS01's behalf.)*
- Notify their usual contacts at NHS Improvement, in hours, and the next working day for Out of Hours.

8.3.1 NHS England (London) will:

- Inform the LAS and NHS Gold01.
- Convene a teleconference if required to review the situation.

- Inform the CSU / CCG and inform NHS England (London) communications for information only.
- In hours (09.00 – 17.00), ensure that DCO teams and surge staff in the performance team in NHS Improvement are aware.

8.3.2 The CCG/CSU will:

- Contact affected surrounding trusts including those outside of London if relevant.
- Organise further local conference calls if required on an ongoing basis to assist in managing the situation.

8.3.3 LAS will:

- Notify neighbouring ambulance services of the situation if required.

8.4 Consideration will need to be given if for example a tertiary unit needs to close, regarding the process for evacuating patients if necessary, and how this will be achieved, with surrounding trusts creating capacity to receive, assisted by LAS and Patient Transport Service providers.

9 ED temporary closures for planned works

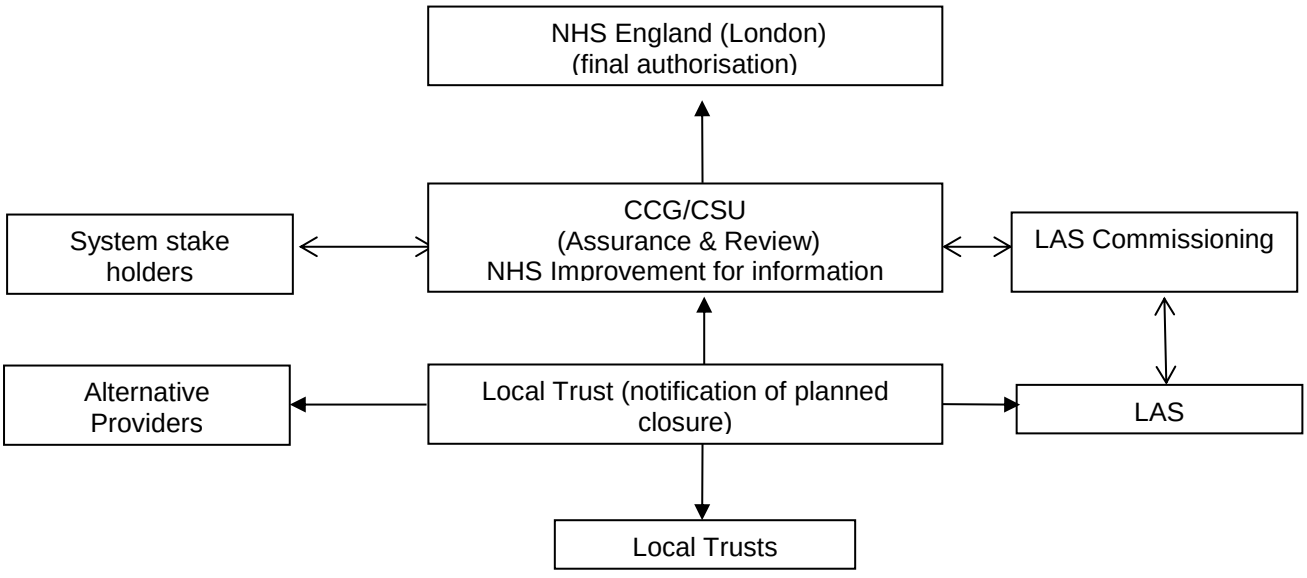
9.1 Purpose

To provide guidance on the planning and arrangements required in the event of a **planned** temporary ED closure (e.g., to accommodate building or electrical works), including:

- Assurance criteria
- Engagement and communication requirements
- Organisational roles and responsibility

In the event that an **unplanned** ED redirect or closure is required, see flowchart at Section 5.

Fig1: Planning a temporary Closure:



9.2 Overview

In order to ensure the provision of continued high quality patient care, NHS organisations across London may occasionally need to temporarily close emergency and unscheduled care services. This may be to enhance service provision or change the location of service delivery.

During these periods it is important that patients still receive high quality care delivered in the most effective and efficient manner. It is therefore critical to ensure temporary closures are well planned, well communicated and well managed across all key partners and stakeholders.

In all cases closure should be implemented as a last resort. Given the significant impact a closure may have on patient care, an evidence based need for a closure must be identified at the earliest opportunity and be supported by a clear rationale. Where possible, especially during department reconfigurations, priority should be given to keeping the department open for services and the changes made in a phased manner to enable this.

9.3 Governance and Assurance required

Trusts planning a temporary closure are expected to work closely with their CCG/CSUs and provide formal notification of the proposals. Commissioners will assume an assurance role throughout closure preparations to stress test plans and assess system wide impact.

All planned temporary closures must be agreed and finalised by the CCG/CSU before implementation. Commissioners will then seek permission from NHS England (London) to formally proceed. The trust requesting the closure / redirect will be responsible for underwriting the costs associated with obtaining the requisite assurance that the action is required in the way that it is proposed – e.g., independent review etc.

The decision to temporarily close an ED should be taken as a last resort and as a result must be subject to a robust process of assurance led by the CCG/CSU. In order to agree to a planned temporary closure the following assurance is required:

- The time and duration of the closure is acceptable in relation to requirement.
- Contingency plans are in place should the closure exceed agreed timeframes.
- The expected volume of patients affected is known including the impact of redirecting elsewhere in the system.
- The impact on performance has been assessed with mitigations implemented as far as possible.
- Systems are in place to manage impact across the whole economy (this includes any cross border flows with non London trusts or ambulance services, or indeed, inter-London flows as appropriate) and that arrangements are in place to mitigate impact to other direct access services (e.g. stroke, major trauma).
- Arrangements to reinstate ED in the event of a major incident are established.
- On-call arrangements are clear.
- Designated contacts across each organisation involved are known and understood with clear communication lines established.

- Communication with the public / service users.

The CCG/CSU is responsible for recommending planned temporary closures to NHS England (London) for approval, following a full planning review.

Organisation	Key Actions
Trust	• See Section 9.4 - Planning. • Ensure plans consider assurance criteria as above.
CCG/CSU/surge hub	• Review final operational plan and principles of closure. • Formal notification to NHS England (London) requesting support to implementation.
LAS	• To submit any necessary and specific LAS plans that complement or support the temporary closure to CCG/CSU via LAS Commissioning team to check alignment. • Ensure events cross London that may be taking place during the redirect are taken into account if geographically relevant • Consider the impact on performance of ambulance service • Ensure appropriate communication takes place with neighbouring ambulance services
System Stakeholders	• To submit relevant plans to CCG/CSU/surge hub to check alignment.
NHS England (London)	• To review proposals for planned temporary closures, constructively challenge planning assumptions to ensure the robustness of the assurance undertaken is commensurate with the proposed actions and approve as appropriate. • To note implications for the purposes of Emergency Preparedness. • Authorise implementation.

9.4 Identification & Notification:

Formal notification should be submitted to NHS England (London) via england.londonsubmissions@nhs.net cc'd to normal operational contacts in EPRR and DCO Teams and Trusts should also inform their usual contacts at NHS Improvement.

All partners across the health system must be informed at the earliest opportunity of the intention to temporarily close an ED, with at **least 4-6 weeks** advance notice dependant on the scale of the closure, and the urgency of the work needing to be carried out. This will ensure that closure plans are inclusive and take into account the requirements of other partner services that will be directly impacted, e.g., LAS. This will enable other providers to review their own internal plans for the period and implement any necessary changes with enough notice to ensure patient safety, clinical quality and staff engagement.

It is important for Trusts to provide clarity regarding the scope of the closure expected. Areas for consideration should include:

- Self presenting patients.
- Ambulance conveyances.
- Health Care Professional (HCP) referrals.
- Resus and Critical Care.
- Any specialist or tertiary services provided at the site e.g. Major Trauma, HASU or Maternity whose access routes may have been through the ED.

An impact assessment should be conducted by the trust in the first instance to inform which approach is most appropriate and help discussions with the CCG/CSU.

Organisation	**Role**	**Key Actions**
Trust	To decide whether there is need for temporary closure and provide formal written notification to **CCG/CSU/surge hub** of temporary ED closure proposal.	• Identify and test need for closure, ensuring all other alternative options have been fully explored. Dependent upon circumstances, e.g., electrical works, the trust should obtain an independent view on the proposed course of action to provide assurance to the CCG that the planned disruption to normal operations is commensurate with the scale of the undertaking proposed. • Liaise with key partner organisations e.g. LAS and surrounding EDs to discuss proposed approach. • Conduct impact assessment to scope the type of closure expected. • Provide evidence based decision making and rationale including anticipated timeframes of patient/clinical and organisational impact. • Provide detail regarding which services will be affected and which will continue to be provided and where. Particularly providing clarity as to whether closure is for all patients or only ambulance born patients. If all then an appropriate public communication strategy will be required. • Ensure medical/ clinical ownership of the closure at trust level regarding the potential impact on patients. • Agree with surrounding trusts

		repatriation plans for appropriate patients, transport methods and timescales.
CCG/CSU/surge hub	Provide assurance and system management.	• Test rationale and decision making behind proposal including review of independent review of the rationale for carrying out the plan as proposed by the trust and impact of proposal against whole system e.g. planned events, closures, and any local issues that may have an adverse impact. • Ensure wider stakeholders that may be impacted by the closure have provided appropriate capacity to support increased volumes of patients during the closure to minimise impact on patient care. • Inform NHS England (London) of discussion and intention, providing assurance of planned process.
LAS	Engage with early planning process to help inform decision making	• Identify Strategic and Operational leads. • Understand and inform impact assessment. • Establish internal communication links to raise awareness at local level.
System Stakeholders	Engage with early planning process to help inform decision making	• Understand and inform impact assessment. • Review any internal process change required. • Establish internal communication links.
NHS England (London)	Liaise with neighbouring regional offices as required Provide final authorisation of closure	• Liaise with CCG/CSU. • Review plans as required. • Keep other NHS regional teams abreast of the developments and planning progress.

9.5 Planning

- Detailed planning is essential when preparing for a temporary planned closure of an ED and should be overseen by the Trust CEO. Careful consideration, effective engagement and system collaboration at this stage will help develop a robust operational plan for the period of closure and mitigate risks to patient care, key partners and the wider system economy.
- Risks and issues should be used by the Trust to inform the planning process and include necessary actions with nominated leads identified for mitigation.

- Escalation planning must be included in this process. These plans should be patient focussed whilst also taking into consideration the impact on the whole system. Escalation plans should be developed in collaboration across the local health economy affected and shared early to ensure they are stress tested and key partners understand their roles and the associated actions required at each escalated level. This approach will provide enough opportunity for individual organisations to consider the type of response (e.g. an alternative operation model for the duration) necessary as required.
- Planning should include the provision to repatriate patients including patient transport and transfer functions once the planned closure has been stood down.

Organisation	Role	Key Actions
Trust	To lead planning process and develop Operational Plan for duration of the closure	• Establish planning team and secure clinical leadership. • Conduct full and formal impact assessment and risk register including impact on external organisations, travel times and cost. • Develop engagement and communication plan both internally and externally with designated points of contact across all partners including out of London trusts if appropriate. • Develop command and control arrangements with clear escalation plans setting out both internal and external actions expected.
CCG/CSU	To agree operational plan, provide support and maintain oversight Work with LAS and local Trusts to co-ordinated nominated recipient trusts during closure	• Test operational plan and quality assure risk register and impact assessment. • Review ambulance activity and impact with LAS and LAS Commissioners. • Inform NHS England (London) of progress, providing assurance of planned process.
LAS	To support development of operation plan and agree alternative destinations for ambulance conveyance	• Review ambulance activity, capacity and resourcing for affected local economy. • Ensure local leaders are aware of plans and are communicating to local crew.
System Stakeholders	To engage with planning process and review internal requirements necessary	• Review capacity and resource requirements need throughout closure period. • Confirm actions and escalatory steps.
NHS England (London)	Ensure other regions sighted on the plan and any cross border impacts	• To brief other regional partners on work and expected impacts. The neighbouring regional office will liaise with the affected trusts external to London. • To agree reporting and communication routes before during and after the planned work.

9.6 Communication

- Early engagement with key partners is vital, and should be held across strategic and operational areas. Nominated leads for both the planning and implementation of a planned closure should be identified with contact details shared across the local health economy affected.
- Each affected organisation should nominate an internal delegate to take responsibility for cascading agreements and decisions internally to ensure key messages are understood.
- Out of Hours and on-call arrangements should be formalised with pre-arranged escalation arrangements, communication channels and reporting timetables set out and agreed in advance.
- Regular meetings and conference calls should be scheduled and prioritised with clear routes for communicating agreements and actions to internal and external staff identified.

Organisation	Role	Key Actions
Trust	To take overall responsibility for engagement and communication across the system during the preparation and implementation of a planned closure.	• Ensure lead nominees have been identified across the trust including clinical and managerial staff. • Ensure lead nominees have been established with external partners including the commissioner and LAS. • Establish communication links and reporting arrangements. • Agree conference call schedule to provide progress updates and written confirmation of actions following call to participants. • Schedule daily ops meetings with internal staff • Provide clear communications plans as to who will be informed, how and when of closing and re-opening especially if this occurs ahead of schedule or out of hours.
CCG/CSU/ surge hub	To facilitate conference calls and local engagement across the local health economy.	• Retain system management oversight • Attend necessary conference calls and meetings as required. • Inform NHS England (London) of progress, providing assurance of communication networks. • Cascade agreements internally to key partners.

LAS	To attend conference calls and local ops meetings as necessary.	• Attend necessary conference calls and meetings as required providing internal progress updates • Establish clear communication links internally between strategy and operations and ensure bulletins and communications are disseminated to all ops and clinical staff • Ensure local leaders are aware of plans and are communicating to local crew
System Stakeholders	To attend conference calls and local ops meetings as necessary.	• Attend necessary conference calls and meetings as required providing internal progress updates. • Cascade agreements internally to key partners.
NHS England London	Ensure neighbouring NHS Regions are briefed as appropriate	• Provide relevant briefing papers etc to neighbouring regional teams • Ensure during duration of work that agreed communications take place across borders

10 Issues affecting areas bordering London

- London should seek to manage pressures within its own borders.
- Only under the most extreme circumstances should consideration be given to measures which will impact on Trusts outside of London.
- Areas outside of London have different procedures for managing pressures and this must be taken into account when actions are considered which may affect border areas.

10.1 London trust wants to redirect to a non London trust

- London trusts cannot redirect to non London trusts except by prior agreement, as part of pre-agreed escalation plans. Permission to redirect is through the process outlined in Section 6.
- The receiving trust must be contacted by the London trust requiring mutual aid, prior to a redirect taking place, to ascertain ability to take redirection and gain permission to do so.
- If a conference call is arranged, to discuss the redirection, non London trusts must be invited to attend if they will be affected.
- LAS should notify other out of area ambulance services if a redirection is agreed.

10.2 Non London trust wants to redirect to a London trust

- If a trust outside of London wants to redirect to a London trust, the receiving trust must be contacted and agree prior to the redirection being effected. This includes if it is only LAS ambulances which will be redirected.
- If a London trust agrees, it should notify the CCG/CSU and NHS England (London) so that they are aware of any likely impact, and so that they can

become involved in any discussions regarding the duration of the redirect at a later stage if required. The CCG/CSU will inform NHS England (London).

- The relevant Ambulance service will ensure that LAS are made aware, making contact via the control room and NHS England (London) via NHS01.
- If a London trust thinks it is being affected via a redirect from a non London trust to which it has not agreed, they should contact the CSU/CCG/surge hub, who will make enquiries on their behalf. This will be followed up with NHS England (London), who will liaise with the relevant Regional Office.

10.3 NHS England Regional Office mutual information sharing

- NHS01 will ensure other regional offices are made aware of any issues within London likely to impact outside of the London area, if it occurs out of hours.
- If a Major Incident occurs, procedures will follow the Incident Response Plan.
- Neighbouring regional offices should follow the same arrangements in reverse, and inform NHS01 if a situation in their area is likely to impact London.

NHS01 will then ensure relevant staff are informed

- In Hours (09.00 – 17.00) – NHS Gold, SM01, DCO teams / NHS Improvement, Surge Staff, Communications.
- Out of Hours – NHS Gold, SM01, Communications – (DCO teams, NHS Improvement, Surge Staff – next working day).

11 Intelligent Conveyance

- IC operates during peak times and is dynamic – hospitals do not need to ring in to request it.
- IC takes into consideration the pressure across the whole patch – at times of extreme pressure there may be no opportunity to move ambulances.
- The pre-agreed number of ambulances will vary according to time of day and the overall pressure being felt in the health system.
- It is expected that each ED will accept and offload within 15 minutes
- Ambulance attendance under IC will not alter due to bed capacity problems.
- Certain groups of patients will, on clinical grounds, be excluded from IC – see section 11.3 for details.

11.1 Aim

To monitor, proactively manage and minimise surge impact of ambulance arrivals at ED, reducing pressure on the ED and benefitting the patient through improved experience and the LAS through improved turnaround times.

11.2 Background

Historical LAS evidence suggests that surges in ambulance arrivals at ED's occur primarily during weekdays with a peak on Mondays & Fridays. Similarly these peaks occur between the hours of 0800 – 2300 with the busiest times between 1000 -1700. The IC Hub is operational between the hours of 0800 and 0000, 7 days a week. These hours will be kept under review.

11.3 Process

The rationale behind IC is to try to manage the flow of patients to EDs, reducing spikes in ambulance attendances thus helping to prevent capacity issues and bottle necks that result in increased handover times and delays to definitive care for the patient. To ensure patient safety IC will apply to adult patients attending for ED treatment. The following exclusion criteria will be used:

- Paediatric Patients.
- Blue Calls.
- Acute Specialist Care Pathways (HASU/Trauma/Cath Lab).
- Patient currently receiving specialist treatment at destination hospital.
- HCP referrals with specified receiving team.
- Elderly patients who will require social services intervention prior to ED discharge.
- Patients who are ambulatory, with minor injuries / illness who will not require a majors hospital trolley and can be treated within a co-existing UCC or be safely triaged to the waiting room.

Trusts / CSU / Surge Hubs are asked to refrain from contacting the LAS control to inform them that a trust is busy / request IC support to a site, as this places an additional burden on the control room, and there is often no further action which they can take.

Further information is available in the NHS England (London) Pressure Surge Management Guidance v3 document, and also from the LAS Operational Briefing Notes, available from the LAS.

12 Information to support decision making

12.1 Capacity Management System (CMS)

12.1.1 The Capacity Management System (CMS) provides a near-real time view across a range of indicators of the relative pressures being faced by acute trusts.

12.1.2 Information update frequency:

- ED information in CMS should be updated every two hours, 24 hours a day.
- Bed state information should be updated every four hours between 06.00 and 22.00.

12.1.3 CCG/CSUs/surge hubs and acute trusts will use this information and live Hospital Based Alert (HAS) data (does not include non London ambulance traffic, private or voluntary ambulance services) to inform the discussion of issues being faced and actions being taken. (**If organisations do not keep the information up to date, it will be assumed that they are not experiencing capacity pressures, and are in a position to offer mutual aid.)**

12.1.4 If Trusts need to redirect, it is particularly important to ensure that information is up to date on CMS, so that they have the relevant information to discuss with the CCG/CSU/surge hub and NHS Gold 01.

12.1.5 LAS will look to use CMS and HAS information to help manage pressures at EDs across London but it is not the only consideration which will affect where ambulances are directed. A poor score on CMS will not automatically result in ambulances being redirected.

12.1.6 Where possible, NHS 111 patients will not be referred to EDs reporting black on CMS but the closest hospital reporting red, amber or green.

12.2 Activity Information

Information will be provided to trusts in order to give as much advance warning as possible of increasing surge conditions. This information will be provided to all acute trusts, CCGs and surge hubs on a regular basis. This information will be drawn from a number of potential sources including:

- NHS111
- LAS Activity data – current and historic
- Temperature trends
- Events related information

13 Ambulance turnaround times

13.1 Queuing greater than 15 minutes

In the event that patient handover at the acute trust exceeds 15 minutes, it is the acute Trust's responsibility to attempt to resolve these issues as quickly as possible. This applies to all areas of the hospital including HASU, Heart Attack Centres, Maternity and Assessment Units accepting ambulance born patients.

13.2 Queuing greater than one hour

Patients may be at major clinical risk if ambulances are queuing for more than 60 minutes for handover. The following actions should be taken:

- Trusts should use the inbound HAS screen to monitor pressure mounting in the department and to trigger appropriate escalation actions in response to lengthening handover delays including activating support and action from senior managers.
- 60 minute patient handover waits recorded via HAS will be tracked via NWL's Ambulance Turnaround & Patient Handover Portal 24 hours in arrears.
- Trusts are required to carry out a daily review of all 60 minute patient handover waits tracked via NWL's Ambulance Turnaround & Patient Handover Portal.
- All tracked 60 minute patient handover waits must be validated in line with the 60 Minute Patient Handover Breach Validation Process .
- All tracked 60 minute patient handover waits under dispute must be owned and investigated by the Trust. Where required investigation should involve LAS input.
- CCG/CSUs will review evidence provided by the Trust within the timescales agreed.

Appendix F gives further details regarding 1 hour breaches and the agreed reporting definitions and responsibilities.

14 Distribution and implementation

From 21 December 2015, this document replaces the NHS England London Emergency Department Capacity Management, Redirect and Closure Policy (ED Policy) *v7.2*

This Protocol should be read in conjunction with NHS England (London) Pressure Surge Guidance

This guidance document is circulated to the following:

NHS England (London) directors and senior managers, NHS trust and NHS foundation trust chief executives, London Ambulance Service, Clinical Commissioning Groups, Commissioning Support Units, Surge Hubs, Acute Trust EDs and emergency officers. NHS England (London) EPRR leads, assurance managers, NHS Improvement

Version 7.3 of this Policy replaces earlier versions which should be removed and destroyed.

15 Monitoring

Q1. Element to be monitored i.e. measurable policy objective
The application of this protocol across all sections will be monitored for compliance and fitness for purpose.
Q2. Position responsible for monitoring
Surge Capacity Manager
Q3. Method
Monitoring will be carried out via an annual review, as well as on an ongoing basis. The day to day application of the policy will be noted by the EPRR team.
Q4. Frequency
Annually and ad hoc
Q5. Reporting arrangements – Committee/Group that monitoring is reported to, including responsibility for action plans
– London Health Resilience Partnership – Tripartite Oversight Group

16 Associated documentation

This Protocol should be read in conjunction with NHS England (London) Pressure Surge Guidance v3

Appendices

Appendix A - Definitions

Redirect
Self presentations* and all blue lights still accepted

Resus (blue light) redirect
Self presentations* and cardiac arrest / paeds blue lights still accepted (60 minutes duration only)

Closure
Self presentations redirected* and all blue and non blue lights** not accepted

Clinical responsibility
The acute Trust (hospital) takes full clinical responsibility for the patient from the point of clinical handover or at 15 minutes from arrival of the patient with the LAS crew at the hospital whichever occurs earlier. Close cooperation and coordination between the LAS and the trust is essential to ensure patient safety.

*Ambulatory patients for co-located Walk In Centres or Minor Injury Units would continue to be accepted, except infrastructure failure. During a closure trusts will need to make provision for self presenting patients to be redirected or treated at alternative EDs etc.

** A “blue light” is defined as an ambulance born patient warranting the use of the ambulance’s blue lights on the inbound journey, where the ED will have been pre-alerted (“blue call”) to the patient arrival. Cardiac arrest and paediatric patients will still be brought to the closest appropriate unit except in cases of critical infrastructure failure.

For the purposes of this document, the processes outlined in this document for requesting a redirect or closure, do not apply to those cases where due to service configuration issues, and with the agreement of commissioners, there is a requirement to apply an ongoing partial, (e.g., overnight) closure of a site, with patients being taken to other sites of a multi-site trust.

Appendix B - Tertiary Services, including Trauma, Cardiac Care and HASU

Tertiary services can either be open or closed due to the very limited nature of their resource. There is an expectation that units will remain open. The only likely reasons for the closure of a tertiary service would be for infection control purposes, or during

a significant infrastructure failure. If the closure of a service is required, contact should be made through NHS01, and a conference call convened to include the Provider, CSU / CCG, LAS and other tertiary centres who will need to agree to take the patients. The call will be chaired by NHS Gold01.

A redirect on grounds of significant clinical safety would only be considered as a last resort and where the influx of critically ill patients exceeds the units ability to manage the patients safely. Bed availability is not a consideration for a redirect. In these situations it is the responsibility of the unit requesting the redirect to arrange cover from a minimum of two neighbouring equivalent units prior to discussion with LAS / NHS01. A complete redirect may not be possible due to the geographical location of other suitable units.

Appendix C – ED Escalation Actions Checklist

The following actions require implementation as early as possible when ED pressure starts to build in order to minimise the need for redirect or closure.

Escalation Activity	Completed
Acute Trust – managing and reducing demand	
• There should be senior clinical leadership (i.e., consultant level) immediately available within the ED department.	
• All on call consultants informed and asked for support in reviewing their areas of responsibility to free up capacity in the system where possible. • Senior clinicians to support Acute Medical Units to optimise flow.	
• All patients in resus or majors to have initial assessment by registrar or consultant grade, to determine appropriateness of attendance or need for admission – re-direction wherever possible and not life threatening, all admissions to be reviewed and agreed by a consultant. • Waiting room to be screened for those who need care by a senior nurse. • Optimise use of WICs and UCCs by sending appropriate patients from Minors stream, potentially releasing staff / physical capacity to support Majors.	
• Maximisation of alternative care pathways, prior to arrival of patient at A&E, through telephone triage of all GP referrals for admission, led by consultants (e.g., acute physicians, not necessarily ED consultants – see above) to ensure that admission levels are kept to a minimum, including: ○ Advising on more appropriate care pathways (e.g., community based) for specific patients or conditions. ○ Enabling access to diagnostics not normally directly available to primary care. ○ Re-assurance to GPs about continuing to manage palliative care patients being managed at home, rather than admitting to hospital. ○ Brokering urgent outpatient appointments in other consultant clinics, to avoid unnecessary admissions to hospital etc. ○ Restrict admitting rights through ED to consultant staff only	
• GP patients (not calls) sent directly to a ward or Admissions Unit rather than via ED or to alternative site within same trust if relevant.	
Acute Trust - Improving supply	
• All inpatients reviewed early in the morning for discharge by consultants before 10am, followed by second ward round later in the day as a minimum.	
• "Case conferences" between consultants, medical directors and managerial staff to review all inpatients individually and agree appropriateness of continued stay.	
• Opening of all possible extra escalation beds, private ward beds etc.	
• 7 day working to ensure continued flow of discharges, access to therapies and diagnostics etc. Tight performance management of	

ward to take out requests to pharmacy to reduce delays.	
• Maximisation of use of day case and laparoscopic procedures to maintain elective programme, but reduce requirement for beds.	
• Cancellation of all clinically non urgent electives (including private work) / transfer of work to private sector.	
• Consideration given to cancellation of some urgent electives / move of work to other NHS Trusts / transfer of work to private sector.	
• Social Services on call managers have been notified of the situation and requested to expedite care packages. Social Services to be in contact several times a day.	
• Inclusion of Social services, Borough's, LA's etc in ED bed meetings to ensure actions required are understood by the whole system.	
Acute Trust - Improving supply - Support Services	
• Pharmacies have been tasked to prioritise TTOs and ensure that medication is dispatched to wards immediately (or discharge lounge if appropriate).	
• Facilities and porters tasked to prioritise cleaning and transfers.	
• Scheduled maintenance has been reviewed, and if likely to impact on capacity or patient flow, rescheduled.	
• PTS providers are prioritising patient transfers (discharges) above other work.	
Staffing	
• Cancellation of staff leave, training courses and re-direction of clinical staff from managerial duties to front line care.	
• Plan local accommodation for staff.	
• Consider supporting staff childcare when schools are closed.	
• Staff to be redeployed from around the Trust to support the ED and Acute Medical Unit as necessary.	
Community Care / Primary Care / Commissioner Actions	
• Maximise discharges from community facilities to increase capacity.	
• Purchase extra capacity in community to enable discharges from acute care / prevent patient admissions. Requires full discussion, clarity and agreement between CCGs / Trusts prior to the surge to enable swift and responsive spot purchasing where appropriate, supported by locally agreed guidance.	
• Use of community resource (community nursing teams etc) to pull patients from the Trusts, if appropriate, including use of intermediate care in-reach to ED and assessment units.	
• Placement of patients "without prejudice" arrangements triggered for out of area patients where there are issues with repatriation.	
• Early domiciliary visits to assess urgent care needs.	
• Provide extra GP resource / more hours to WICs, UCCs etc to deal with primary care presentations, enabling ED to focus on acute presentations.	
• Provide support by contacting OOH and GPs to ensure that only the very sick are referred for admission, and that where possible, conditions are managed in other settings either at home or in community facilities. E.g., OOH providers to provide increased and	

more rapid visits to patients left at home by LAS crews.	
• Where an infection outbreak in the community appears to be occurring ie: D&V in a nursing home use a small nurse/Dr team to visit & treat patients in situ, thus preventing admissions – work in liaison with PHE and acute trust if more specialised clinical experience required.	
• Direct liaison with GP practices if there appears to be an inappropriate increase in referrals.	
LAS Escalation Actions	
• LAS to use pressure information on CMS, HAS etc to help manage vehicle flows away from trusts under high sustained pressure through Intelligent Conveyance.	
• LAS, acute trusts / CCG's discuss and agree additional conditions / levels of acuity that can be dealt with via WICS / UCC, to provide more options for LAS crews to convey patients to, other than just ED.	
Final escalation action:	
• Request to NHS England (London) for re-direction or for closure of the ED.	

Appendix D – Questions to be asked of trusts when requesting a redirect or closure.

(In addition, the Escalation checklist at Appendix C should be used for further detail).

	Question			Response
1a	Who is making the request? If not the CEO, is the CEO aware?			
1b	Has the situation been discussed with the CSU / CCG Director on Call?			
2	What are the concerns that have initiated the call/decision?			
3	Are the following consultants on site and available:	ED Consultant		
		Acute Medical Consultant		
		Acute Surgical Consultant		
4	Has a Critical Incident been declared?			
5	Are all specialty teams assisting in the ED?			
6	What are the number of patients in each area of the ED compared to trolley space now?	Capacity		Actual
		Resus		
		Majors		
		Minors		
		Paeds		
		UCC		
7	What is the current predicted discharge v admission forecast?	So Far	Disch	
			Admit	
		Predicted	Disch	
			Admit	
8	Ambulance conveyances	How many ambulances have been received in the last hour?		
		How many of these have been HCP referrals?		
		How many ambulances are currently on route?		
		How many ambulances are waiting to offload at nearby trusts?		
9	What is the estimated time to be seen in each area?	Resus		
		Majors		

		Minors	
		Paeds	
		UCC	
10	What is the longest time in department (Often up to 4 hours different to the DTA)?		
11	What is the longest Decision To Admit (DTA) time?		
12	Are there any staffing or bed issues (e.g. closures for infection)?		
13	What internal measures have been taken by the trust – e.g. escalation beds opened, cancelation of surgical lists, extra medical and nursing staff utilised, actions taken to address in flow through the front-door, forecasting for the next 3 days to manage as business continuity, links with community /social services etc?		
14	What is the CSU / CCG view of the situation – what actions have you taken to try to help manage the situation?		

Information in the section below to be distributed to call participants
Outcome of Call – eg redirect agreed / not agreed, duration, receiving hospitals etc:
Other actions agreed and who responsible:

Appendix E – Questions when requesting a resus redirect

LAS:	
1. How many pre-alerts in past hour / two hours	
Hospital:	
1. Who is the requesting consultant and are they in the department?	
2. Number of resus beds in dept (adult and paeds)	
3. Number of patients undergoing active resus	
4. Number of patients being managed outside of resus who should be in resus itself	
5. Length of stay for those not undergoing active resus, but who are still in resus beds	
6. How many of these patients are going to level 2 or 3 beds (if not then they can move out of resus potentially)	
7. Time to expected bed availability for patients not undergoing active resus	
8. Actions being taken to manage the situation	

Appendix F – LAS 1 hour handover breach information (taken from the NHS England (London) Pressure Surge Management Arrangements v3)

During the winter, it is inevitable that ED's will experience heightened pressures, and the risk of One Hour (plus) handover delays increases significantly. Considerable progress has been made in reducing handover delays. Trusts are expected as part of their planning process to ensure that these incidents are eliminated as far as possible.

11.1 Reporting

Where delays of over an hour do occur, trusts are expected to investigate their causes. CCG / CSUs are expected to ensure that both they and their Trusts have implemented robust monitoring arrangements, to ensure that one hour breach's are identified, reported, investigated and the lessons learnt implemented to reduce the likelihood of recurrence in the future.

11.2 Hospital Based Alert System (HAS)

Trusts are expected to maximise usage of the HAS to ensure accurate data collection on handover times, reducing disagreements between trusts and the LAS about the number of One Hour (plus) breaches taking place, enabling resource to be focused on investigating those which did occur.

11.3 The following definitions and reporting processes have been agreed Nationally

* Everyone Counts Technical Definitions
http://www.england.nhs.uk/wp-content/uploads/2013/04/ec-tech-def.pdf

- ***LAS arrival at Hospital:*** The time that the LAS vehicle parks at the Emergency Department off loading bay (handbrake applied and 'Red at Hospital' button' pressed on the MDT).
- ***Clinical Handover:*** The point at which essential clinical information about the patient is passed from the attending LAS crew to a clinician within the Emergency Department to allow a decision about where ongoing treatment can safely be delivered.
- ***Patient Handover / Trolley is Clear:*** The time when clinical handover has been completed and the patient has been physically transferred onto apparatus. LAS apparatus must have been returned, enabling the LAS crew to leave the department. LAS staff should not delay giving the PIN code to hospital staff once handover is completed.
- ***Crew Clear:*** *The time at which the ambulance crew has repatriated equipment, finalised paperwork, restocked where appropriate and cleaned the vehicle ready for the next call (*notified to the LAS Emergency Operations Centre via 'Green Available' button press).
- ***Arrival to Patient Handover / Trolley Clear:*** The time from when the LAS vehicle arrives at Hospital to Patient Handover.
- ***Patient Handover / Trolley Clear to Crew Clear:*** The time from when the patient handover has taken place to the ambulance being made available for further deployment.

11.4 Local Clarifying guidance

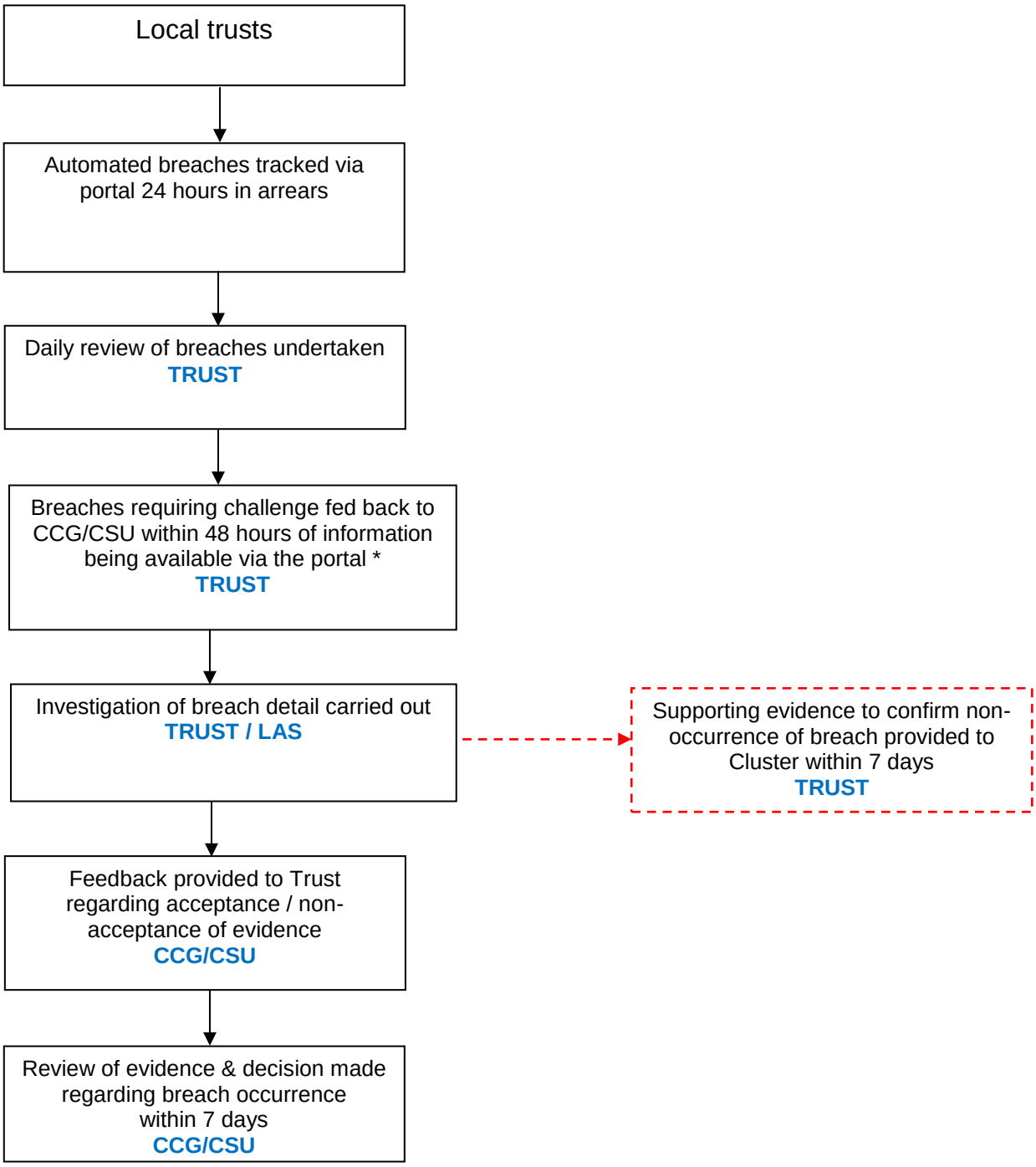
- Patient Handover / Trolley Clear - the time when the clinical handover has been completed and the patient has been transferred from the LAS trolley / chair on to a hospital trolley / chair and all removable LAS monitoring equipment has been returned to the crew thus enabling the LAS crew to leave the department.
- The LAS crew should not delay in giving the PIN code to the hospital once the patient has been removed from LAS trolley / carry chair / monitoring equipment.
- LAS crews are not responsible for the undertaking an administrative handover in addition to the Clinical handover.

11.5 Reporting Responsibilities:

Hospital Turnaround Stage	Data Capture Mechanism	Responsibility	Comment
LAS arrival at Hospital	Handbrake applied and 'Red at Hospital' button press via the LAS MDT	LAS crew	The 'Red at Hospital' button press triggers time of LAS arrival on the Hospital Based Alert System (HAS).
Clinical Handover	Written on to the Patient Report Form (PRF)	LAS crew / ED clinician	The Patient Record Form (PRF) is scanned by LAS available to LAS IM and input into internal reporting processes. **HAS should not be clicked off at this stage.**
Patient Handover / Trolley Clear)	'Patient Handover' button press (either LAS PIN code entry or override) on Hospital Based Alert System (HAS)	Acute trust /LAS crew	The patient handover' button on the HAS screen is used to record when the patient handover is complete. This is when the clinical handover has occurred and the patient has been removed from LAS trolley / chair / monitoring equipment enabling the LAS crew to leave the ED.
Crew Clear	'Green Available' button press via the LAS MDT	LAS Crew	This time is available to LAS IM and input into their internal reporting process.
Administrative Handover	Patient Administration System (PAS)	Acute trust	Patient information is taken from LAS PRF.

Appendix G - LAS One hour handover breach validation protocol

60 Minute Patient Handover Breach Validation Process

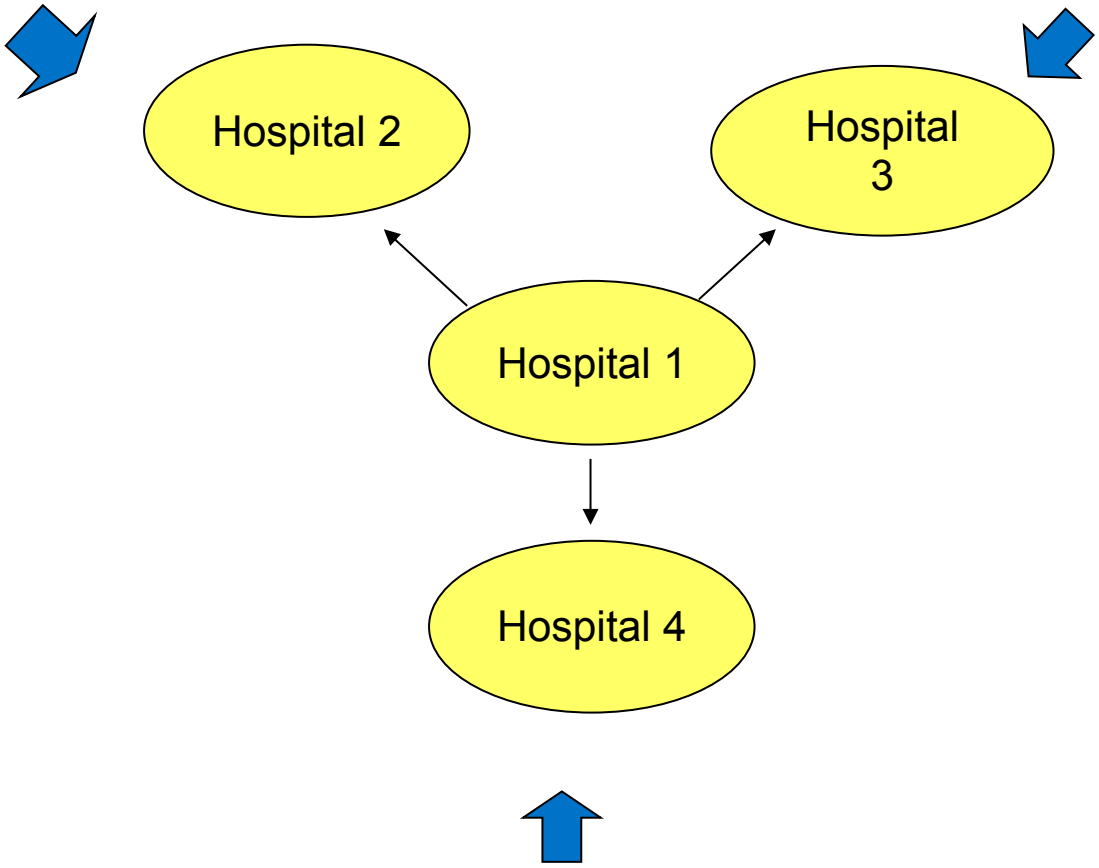


***Please note**:*

** The portal is populated 24 hours in arrears via a manual daily upload process. This means information for the previous day will be available from 12pm (noon) Monday to Friday. Weekend data will be available in full from 12pm (noon) the following Monday.*

Appendix H - How 360 Degree redirects works

In order to lessen the impact of redirection on any one trust, it is preferable that a redirect is made to a number of surrounding trusts (360 degree) instead of just one trust. In the example below Hospital 1 goes on redirect. The closest surrounding trusts will be nominated as receiving trusts, spreading the load so that other trusts are not overwhelmed with additional ambulance borne patients (blue arrows).



Appendix I – Version Notes

Notes to Version 7.3

Main changes from version 7.2:

1) A new flow chart (page 7) has been produced to help trust staff when working out who to contact when considering the support they require.

2) 2) Reorganisation of sections into more logical flow.

3) Update to current NHS England corporate format

Notes to Previous Versions

Version 7.2

Main changes from Version 7.1

1) Intelligent Conveyance
Updates have been made to the text for the sections on IC to reflect changes which have been made to the working practices following evaluation in spring 2014.

2) Resus redirects
A checklist has now been included at Appendix E setting out the questions trusts can expect to be asked when requesting a resus redirect, and the wording to the section has been amended to stress that these should only be requested where resus is full with ongoing active cases, not patients awaiting care in another part of the trust.

3) Checklist for redirects
The previous checklist (Appendix D) of questions to be asked of trusts when requesting a redirect has been updated and tabulated for ease of use.

Version 7.1

Main Change from Version 7

1) Resus Redirects
Addition of section 4.3, covering resus redirects. These should only be requested if the unit is full of ongoing concurrent resus cases, not patients waiting to be moved to other facilities, such as ITU.