The Faculty of Intensive Care Medicine

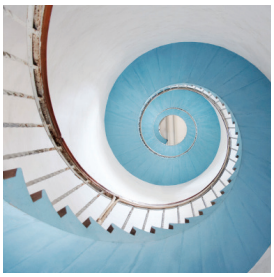
CRITICAL FUTURES

ENHANCED CARE:

Guidance on service development in the hospital setting

May 2020

EXECUTIVE SUMMARY & KEY PRINCIPLES



Royal College of Physicians

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This report was produced as part of the Critical Futures initiative, looking to the future for Critical Care services. **www.ficm.ac.uk/criticalfutures**

No-one could have predicted how quickly the landscape in Critical Care would change between delaying publication of the report in March and now. It seems appropriate therefore to provide further context in view of COVID-19 and its impact on service provision.

ENDORSING ORGANISATIONS

British Anaesthetic and Recovery Nurses Association
British Thoracic Society
Centre for Perioperative Care
Getting It Right First Time (GIRFT) Programme
Intensive Care Society
Royal College of Anaesthetists
Royal College of Surgeons, Edinburgh
Royal College of Surgeons, England
Society for Acute Medicine
UK Critical Care Nursing Alliance

The guidance is also supported by NHS Commissioning's Adult Critical Care Clinical Reference Group

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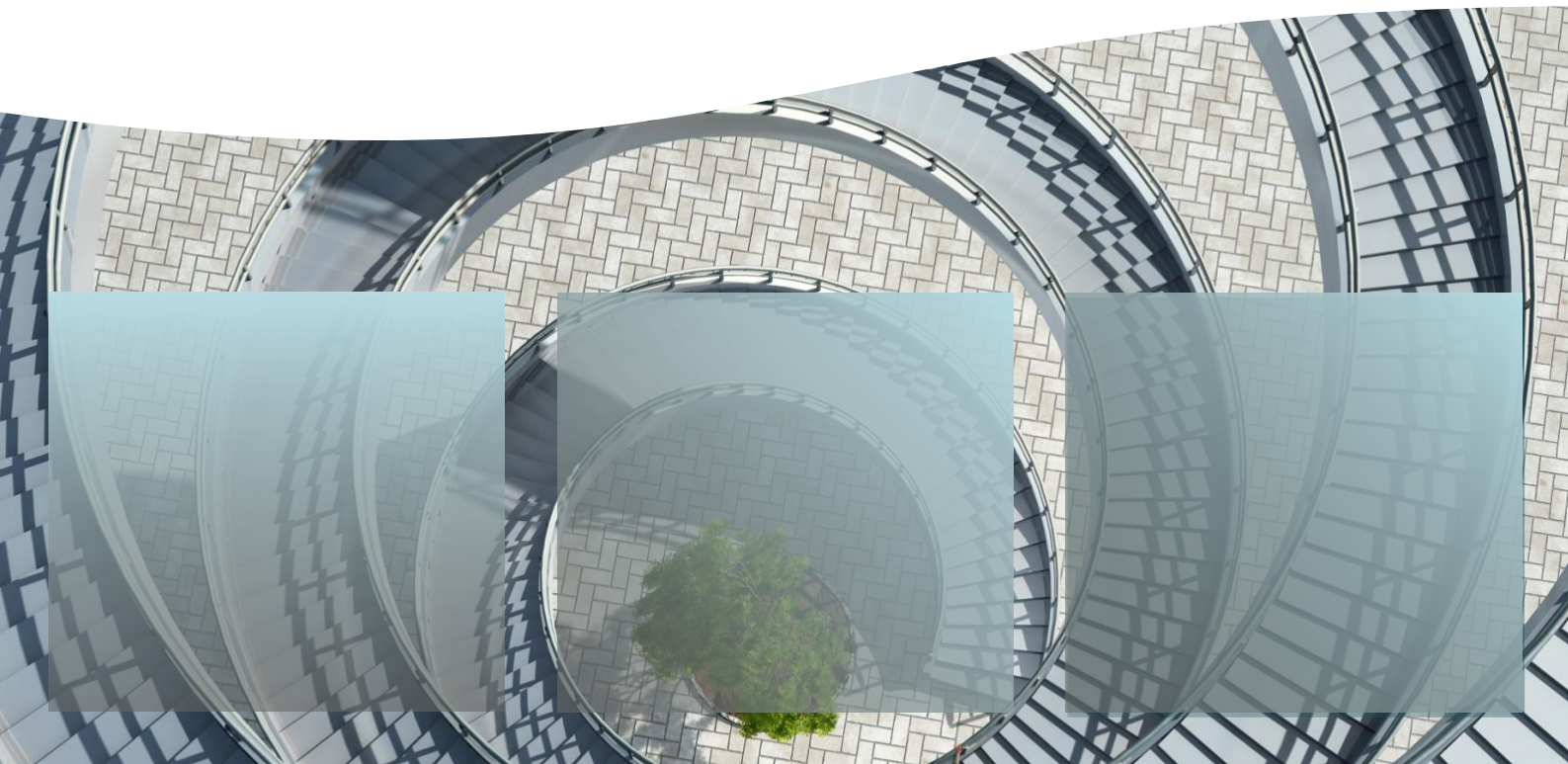

Lay and patient views were sought during the consultation period via the lead contributing organisations and their lay committees.

"Patients are right at the heart of the Enhanced Care initiative. The clear focus is on providing safe and effective personalised care for those whose needs mean they are at the boundary between the ward and Critical Care. The initiative addresses the pressing requirement to develop well-organised and well-led facilities where patients benefit from the improved quality of care flowing from collaboration and co-operation between health care professionals in the extended multidisciplinary team. Patient pathways are not a series of defined steps between levels and locations. Rather they represent a continuum of care. The Enhanced Care initiative recognises this and sets out principles to guide targeted investment in the development of responsive, locally appropriate services. I wholeheartedly welcome and support this initiative."

Pauline Elliott
Lay Representative, Board of the Faculty of Intensive Care Medicine

Foreword

Enhanced Care takes place in a ward setting, by a motivated and upskilled workforce, but provides ready access to the Critical Care team through established communication links. It is a pragmatic approach to reducing the risk of patients falling into a service gap: patients who would benefit from higher levels of monitoring or interventions than expected on a routine ward, but who do not require admission to Critical Care. This type of care has grown organically, originally for perioperative patients (elective and emergency), expanding into the fields of maternity and medicine to deliver safe care to the patient at risk of deterioration.

Patient outcomes have significantly improved as a result of the development of Critical Care services. Demands on the service are constantly growing as patients' needs vary and the importance of anticipatory care is increasingly recognised. Development of Enhanced Care is part of the essential modernisation of effective, safe and efficient services. It carries the necessary hallmarks of success – developed by clinical staff to meet patient need; collaborative, being multi-specialty and inter-disciplinary; flexible and non-prescriptive; promoting staff development at all levels through education and training and developed specifically to improve patient centred care.

The need for guidance in this area – which is both welcome and necessary – is clear. Enhanced Care is already happening, but not everywhere and this document provides practical advice from those experienced in the field. It does this in an open and pragmatic fashion, which will prove essential to embed the concept wherever it is required and to provide the basis for future direction to enhance safer patient care.

Professor Carrie MacEwan
Chair, Academy of Medical Royal Colleges

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Unwarranted clinical variation in NHS practice has long been accepted as a barrier to quality care. Getting It Right First Time (GIRFT) is a recent initiative sponsored jointly between NHS England, NHS Improvement and the Royal National Orthopaedic Hospital NHS Trust. The programme uses national data sources to inform clinical peer to peer discussions at trust level to explore practice variation in a wide spectrum of hospital specialties.

In the context of access to Critical Care services, the GIRFT programme has uncovered a greater than twofold variation between comparable organisations, for patients with similar care requirements including post-acute or elective major surgery, acute Diabetic Ketoacidosis (DKA) or acute exacerbations of Chronic Obstructive Pulmonary Disease (COPD). In many cases this variation is related to the history of service development, an engrained service culture, deficiencies in current resource allocation, or more simply through a valiant attempt to provide as good a service as possible with what is available.

The change in provision of higher levels of care, as with other changes in medicine and surgery, has been an evolutionary process. Intensive Care began with the polio epidemics of the 1950s and became the place that cared for the very sickest hospital patients. It also contributed significantly to the successful advancement of complex major surgery, in increasingly older and sicker patients. The publication of

Comprehensive Critical Care and the allocation of significant financial investment to the specialty in 2000 saw the creation of High Dependency Units (HDUs) for patients who required single organ support and those that could be managed with a reduced nurse:patient ratio. As the process continues to evolve, Critical Care has developed as a service that supports the delivery of the most appropriate level of care for hospital inpatients, whilst playing an important role in recognising actual or potential deterioration and responding to prevent or abort further deterioration.

This document on Enhanced Care is a major step forward in recognising how services can be further evolved to deliver in the care gap that exists between the Intensive Care or High Dependency Care Unit and normal ward care. It is recognised that many hospitals have already developed this service in a way that suits their particular needs. There is no simplistic 'correct' model and in most cases cross-specialty collaboration will determine the most appropriate model for that hospital. However, too many hospitals continue to struggle to reduce frequent cancellations from elective major surgery, whilst trying to optimise the management of other patients requiring enhanced support.

Delivering the right level of care to the right patients at the right time is an overriding ethos for Critical Care. This document aims to provide guidance to ensure that through efficient resource utilisation, Enhanced Care may be targeted towards providing the best possible patient outcome with the swiftest possible return to the community.

GIRFT is very happy to support this and we look forward to working with organisations to implement Enhanced Care.

Dr Anna Batchelor
National GIRFT Clinical Lead for Intensive and Critical Care

Dr Mike Jones
National GIRFT Clinical Lead for Acute and General Medicine

Dr Chris Snowden and Dr Mike Swart
Joint National GIRFT Clinical Leads for Anaesthesia and Perioperative Medicine

Executive Summary

Enhanced Care is a relatively new concept. It can act as a bridge between Critical Care and normal ward care and takes different forms. It is an efficient way to utilise resources and may result in improved quality of care, reduced cancellation of elective surgery and provide cost savings. This document provides guidance on how Enhanced Care could be developed, based on current knowledge and expertise, recognising that the model will vary both between and within organisations. It is not a substitute for High Dependency Care but fills a gap allowing patients to be managed safely in an appropriate environment dependent on their needs. It facilitates access to Critical Care teams for enhanced advice and support, but not delivery of, Enhanced Care for the benefit of patients. This document will be of interest to clinicians as well as commissioners and policy makers.

The last 15 years have seen a significant change in the delivery of healthcare in hospitals and a national drive to recognise deterioration of health and deliver a timely response. Indeed, the National Early Warning Score (NEWS2) has successfully become our descriptive language to describe a patient's acuity, supplemented by the institution of medical emergency teams and/or Critical Care outreach to deliver the response to deterioration and hasten admission to Critical Care. Concurrently, the number of patients aged 85 and over, being admitted to acute medical beds, has grown by over 58%, a rate greater than any other age group over the past decade. Older patients with complex comorbidities increasingly have 'Treatment Escalation Plans' establishing a ceiling of treatment, often appropriately precluding the escalation to Critical Care facilities. Specialty specific, higher care Acute Medical and Surgical Units have been developed in response to the above challenges where sicker emergency patients are cohorted, though they remain the exception rather than the rule. These units frequently have a higher ratio of nurses per patient and a corresponding skill mix to match the needs of the patient population, becoming default places of safety.

Alongside this transformation of emergency ward care, significant changes to elective high-risk surgical pathways have occurred. This area of practice has benefited from the introduction of objective predictors of individual patient risk and measures to minimise this risk in the preoperative, perioperative and postoperative phases of a patient's pathway. The frailty and comorbidity of patients undergoing elective surgery has increased and the ability to assess this has resulted in a greater degree of predictability in elective high-risk surgical patients' postoperative course. This facilitates clear identification, at an early stage, of any deviation from the predictable path. For the majority of this population, admission to Critical Care has become the norm with the possibility of delayed transfers to wards for ongoing care and risking loss of information due to multiple handovers.

At the same time there has been an expansion of Critical Care capacity, predominantly at the High Dependency Unit (HDU) level, supporting changes in ward care and the development of predictable pathways for elective surgical patients. It has also helped address the increasing demands for Critical Care from complex comorbid medical and surgical patients and to accommodate high-risk elective surgical patients. Some patients use these facilities for less than 24 hours, require no organ support or receive continuous monitoring alone. Despite not meeting the current criteria for admission to HDU, patients do need a level of observation and monitoring that cannot be provided on a general ward. In the absence of an alternative they are referred for HDU care as the safest option. Despite the increased capacity, there remains a daily challenge to meet the needs of both patients who are critically ill and those for whom there is a risk of critical illness developing. Flow into and out of Critical Care is challenging; the greatest impact of this is on the high-risk elective surgical patients. Inadequate capacity results in patient cancellation on the day of surgery with rates in some providers being above 5% of all patients being pre-booked into Critical Care. Some providers have commissioned designated units offering a level of care between high dependency and ward level care. These facilities are frequently described as 'Enhanced Care' or 'High Care'

areas. Within these facilities, providers cohort patients with the same level of dependency and a predictable skillset is required from the clinical team. It is imperative that such facilities do not exist in isolation from Critical Care in order to permit the seamless escalation of care, should this be required. Patients ready to step down from Critical Care will not normally be admitted to an Enhanced Care area unless this forms part of a Standard Operating Procedure (SOP). Rotation of staff from wards and Critical Care will provide a rich educational environment alongside optimal clinical care, will facilitate learning and mitigate the risk of deskilling. It will also enhance quality of patient care and staff wellbeing. One of the immediate learning points from the pandemic response was the ability to rotate staff into critical care areas to enable rapid learning. Additionally, critical care staff have been 'enablers' to allow the delivery of Enhanced Care in ward areas. This has been most notably seen in the rapid expansion of medical ward capacity to deal with COVID-19 affected patients along with additional respiratory support on existing medical wards. This has meant predominantly increased use of CPAP and High Flow Nasal Oxygen in ward areas.

This document provides examples of successful implementation of Enhanced Care areas with clear benefit to patients and the overall system. It highlights relevant educational opportunities and adoption of The National Outreach Forum's Competency Framework for registered practitioners working in Enhanced Care areas. This approach complements courses such as the Royal College of Surgeons of England's 'Systematic Training in Acute Illness Recognition and Treatment for Surgery' (START Surgery) and 'Care of the Critically Ill Surgical Patient' (CCrISP®) as well as the multi-professional, 'Acute Life-threatening Events - Recognition and Treatment' (ALERT™), 'Ill Medical Patients' Acute Care & Treatment' (IMPACT) and 'Acute Illness Management' (AIMS) courses. We have made recommendations for the planning, delivery and governance of Enhanced Care services that could be incorporated into a business case. At present there is no central source of funding and staff recruitment may be a barrier but despite this, many organisations either already have, or are about to establish Enhanced Care services. It is hoped that, in time, evidence will be gathered on the effectiveness of these recommendations, which will then become minimum standards and key performance indicators. An appropriate legacy from the COVID-19 pandemic must include capturing the good practice and cooperation that has been developed between critical care and other areas to enable the continued delivery of Enhanced Care. Recognising and ensuring effective integration and partnership with Critical Care will be essential. A clear understanding of the patient population will govern the required competence of the extended multidisciplinary team and the determination of what constitutes safe team staffing. At the heart of service design for the perioperative patient will be the predictability of the patient population to be admitted. The pathway for acutely unwell patients is much more variable and therefore Enhanced Care for this patient population will require a different model. Development of Enhanced Care will ensure patients receive the right care, at the right time and by the right people.

Dr Alison Pittard
Chair, FICM Enhanced Care Working Party and Dean, Faculty of Intensive Care Medicine

Professor Jane Eddleston
Chair, NHS England Adult Critical Care Clinical Reference Group

Dr Sanjay Krishnamoorthy
Chair, National Working Group for Enhanced Care in Medicine

SERVICE DESCRIPTION:

WHAT IS ENHANCED CARE?

- Levels of care are based on the monitoring and support patients require, rather than the location they are in.
- The boundaries between the levels of care have become blurred.
- Enhanced Care, previously described as Level 1+ or 1½, is an intermediate level of care where a higher level of observation, monitoring and interventions can be provided than on a general ward but not requiring high dependency care/organ support.
- Enhanced Care needs to become part of the continuum of care from the ward to Intensive Care.
- There is not a single model of Enhanced Care that should be adopted and the boundaries between Level 1, Enhanced Care and Level 2 may be blurred depending on casemix and staff skill mix.

SERVICE OBJECTIVES:

- Current service provision is heterogeneous, mainly due to variation in the target population, making production of generic guidance difficult but the choice between planned and unplanned care seems the most fundamental one.
- It is important that the patient is the focus, recognising how these services are an integral component of the continuum of care between the ward and Critical Care.
- Whatever the driver for development it will be important to consider what the service will deliver and then establish the competencies required to achieve this.
- Planned care is currently the commonest reason for developing Enhanced Care services. The postoperative course can be clearly defined facilitating scheduling and improving patient flow.
- Patients requiring emergency surgery have a less predictable pathway.
- Patients admitted under the Acute Medical team are increasingly higher in number, frailer and more complex
- The acutely unwell patient who cannot be managed on a general ward but does not meet the criteria for requiring HDU poses a difficult problem.

KEY PRINCIPLES:

1. PERSONALISED CARE

Irrespective of the reason for development, some generic considerations will facilitate a service that is safe, equitable and which becomes part of the continuum between Critical Care and the ward. We recommend that the following principles be used to guide local development of Enhanced Care:

- The Enhanced Care environment should be welcoming for the patient and their family/friends. Patients benefit from an environment that is quiet and calm, with adjustable lighting to allow rest and sleep.

- Consideration must be given to providing adequate capacity for single sex accommodation. This requirement is likely to dictate the minimum number of beds to make the service viable.

PERSONALISED CARE

1.1	The environment should be quiet, calm with adjustable lighting to allow rest and sleep. There should be natural daylight and an appropriate level of darkness during the night.	Responsive
1.2	The environment should be welcoming for the patient and their family/friends with an area to wait before visiting and a private room for consultations. Relatives will need access to food and drink. Toilets and washing facilities should be available which, for patients, should ideally be single sex. There should be access to open Wi-Fi.	Responsive
1.3	We recommend open visiting but accept that this is balanced by clinical care and patient privacy and dignity.	Responsive
1.4	Ideally, patients should be cohorted on the basis of medical need however, in order to provide single sex accommodation, we recommend giving consideration to the minimum number of beds required for efficient service delivery.	Responsive
1.5	Post COVID-19, triage using a traffic light system will become the norm for a period. The ability to transition patients in and out of these areas will provide challenges but must be considered essential as part of reconfigured services.	Responsive

KEY PRINCIPLES:

2. GOVERNANCE

- Enhanced Care services will typically sit within and be accountable to a home Directorate
- In order to deliver a safe and efficient service the educational needs of staff, on a multi-professional level, should be addressed during the development phase. Consideration should also be given to staff delivering education as this will need to be adequately funded.
- Clear Standard Operating Procedures for admission, daily operation, transfer and discharge should be developed.
- There should be a clear route of clinical escalation when a patient falls outside the unit's inclusion criteria; this includes procedures for escalation to Critical Care in the event of patient deterioration within the Enhanced Care service. The Critical Care Outreach Team (CCOT) will be integral to this.
- National clinical performance indicators should be identified, along with Colleges, Faculties and specialist organisations, for mortality, specific outcomes and patient experience.
- There should be a strict policy on changing operational parameters of the service at times of capacity strain, which needs to be considered when developing the service.

GOVERNANCE

2.1	ORGANISATIONAL	
2.1.1	The service should sit within a lead Directorate and Division, engaging in appropriate national data collection, QI activity, patient and carer feedback at this level or as part of local processes.	Well-Led
2.1.2	A designated leadership structure with a named lead clinician and lead nurse will be required with a clear reporting path up the Directorate or Divisional management chain.	Well-Led
2.1.3	The Enhanced Care service should have a distinct identity for operational and governance purposes. Operational and governance data should be clearly identified with and attributable to the unit.	Well-Led
2.1.4	To promote cooperation, all specialties and clinical leads interfacing with the Enhanced Care service, including Critical Care, should meet on a regular basis.	Effective
2.1.5	In order to deliver a safe and efficient service the educational needs of all staff should be addressed during the development phase. Consideration should be given to staff delivering the education as this will need to be adequately funded. We recommend development of training resources prior to service implementation.	Effective

2.2	OPERATIONAL	
2.2.1	There should be clear Standard Operating Procedures (SOPs) for admission, daily operation, transfer and discharge.	Well-Led
2.2.2	Nurse:patient ratios should be reviewed on a regular basis, especially during implementation, and be in accordance with current national guidance.	Safe
2.2.3	Clear arrangements for gatekeeping and escalation decisions will be required in the event of clinical disagreement or the inability to match capacity to demand.	Well-Led
2.2.4	There should be clear clinical escalation procedures in the event of patient deterioration, including referral to Critical Care.	Safe
2.3	**QUALITY**	
2.3.1	The service should engage in Trust/Health Board-wide audit and data activity, including nosocomial infection, pressure sore and falls audits.	Effective
2.3.2	A common data set, linked to population treated, should be established that includes longer-term patient-centred outcomes, as well as structure and process, with robust systems for prospective collection and review.	Effective
2.3.3	In conjunction with Colleges, Faculties and specialist organisations, national clinical performance indicators should be identified for mortality, specific outcomes and patient experience.	Effective
2.3.4	Consideration should be given to the key research questions to be prioritised that will provide information to drive improvement in care and develop standards for the delivery of Enhanced Care services.	Effective

2.3.5	Regular multidisciplinary meetings will facilitate the ongoing review of current care, including incidents and significant events, morbidity and mortality, as well as the operational aspects of the unit, including appropriate staffing and levels of care.	Safe
2.3.6	There should be a strict policy on changing operational parameters of the service at times of capacity strain, which needs considering during service development.	Well-Led

KEY PRINCIPLES:

3. SERVICE MODEL

- Although we are describing a service, it is recognised that for ease of delivery, specialty specific Enhanced Care areas may be more appropriate.
- The service model needs to be configured to ensure continuity of care and continuous availability of medical staff.
- A policy detailing the agreement between specialist teams, including Critical Care, for providing clinical input to patients receiving Enhanced Care should be established.
- Patients admitted to an Enhanced Care area should have a clearly documented escalation plan of treatment.
- Staffing levels should be organised to meet the needs of patients, the service and the organisation. Once safe staffing has been determined it should not normally be changed unless there has been an alteration in the type of patient admitted or the complexity of monitoring/intervention.
- Staffing for an Enhanced Care service will depend on a number of factors including the specialty being served, location of the service and reason for development. However, a multidisciplinary approach will provide the best care for patients and provide opportunities for training and education.
- The medical scope of practice will vary depending on the type and location of unit. Referring to the relevant curriculum will help

SERVICE MODEL

3.1	**CONFIGURATION**	
3.1.1	Consideration should be given to the staff and patients' environment. The location of the service will determine if amenities will be dedicated or shared with another area such as the general ward. Access to natural light, toilets, washing facilities and food are essential.	Responsive
3.2	**RISK MANAGEMENT**	
3.2.1	A policy, agreed with other specialist teams including Critical Care, should be established detailing the agreement for providing clinical input for patients receiving Enhanced Care.	Effective
3.2.2	A clear process and clearly documented criteria for escalation and transfer of the deteriorating patient will be required.	Safe
3.2.3	Staffing levels should be organised to meet the needs of patients, the service and the organisation.	Safe
3.2.4	Any proposed amendments to established safe staffing levels should be considered through the local governance structure.	Safe
3.2.5	A clear policy on the level of monitoring and treatment that it is appropriate to provide should be established in conjunction with Critical Care. This will vary depending on local need, but the use of local protocols/SOPs will ensure patient safety. Regular reviews should be undertaken.	Safe
3.3	**SAFE STAFFING**	
3.3.1	By first describing the service and then defining the required skills, it will be easier to identify the personnel best equipped to deliver this safely. The team will consist of a variety of medical and non-medical staff based on local factors and will vary both within and between organisations.	Safe
3.3.2	We recommend referring to the relevant curriculum and published guidance to determine the grade of doctor or Advanced Non-Medical Practitioner most appropriate to deliver care. There may be a requirement to provide additional training, and funding must be identified for this prior to implementation.	Safe
3.3.3	Enhanced Care is an interface between the ward and Critical Care. We recommend a combination of staff from both areas to benefit the service and patients.	Safe
3.3.4	Safe staffing models need to be adhered to wherever possible. Changes in staffing ratios need to be based on immediate need and may be necessary in 'surge' situations. Where they are downgraded there needs to be a clear time frame for review and should only be considered as temporary arrangements.	Safe
MEDICAL		
3.3.5	It will be necessary to identify a consultant lead for the Enhanced Care service.	Well-Led

3.3.6	We recommend a closed model of care by identifying a consultant to take overall responsibility of patients whilst receiving Enhanced Care.	Well-Led
3.3.7	The parent team should be consulted regarding issues arising while the patient is receiving Enhanced Care. How this is delivered will vary at a local level but it is important to preserve continuity of care.	Responsive
3.3.8	There should be a daily, consultant-led ward round with the nurse in charge and input from other appropriate specialties.	Responsive
3.3.9	At all times a senior clinical decision maker should be clearly identified and undertake twice daily (24 hour pro rata) ward rounds, one of which should be with a consultant.	Responsive
3.3.10	A competent clinical decision maker should be identified to undertake an initial patient assessment, request investigations, review and respond to results and be able to prescribe. Their role should be clearly defined when managing the acutely deteriorating patient as well as their responsibility when a patient requires transfer to a higher level of care.	Responsive
3.3.11	A robust handover policy should be established, including documentation of clear parameters for escalation.	Safe
NURSING		
3.3.12	A nurse lead/unit manager should take responsibility for the clinical supervision of patients and staff, manage the unit and nurse staffing and maintain oversight of the strategic development or maintenance of the service.	Well-Led
3.3.13	Staff caring for patients in acute hospital settings are required to have a level of competence commensurate with the level of care being provided. We recommend the 'National Competency Framework for registered practitioners: Level 1 and Enhanced Care Areas', developed by the National Outreach Forum (NOrF) and Critical Care Networks - National Nurse Leads (CC3N), as the recommended standard of competence for registered practitioners working in Enhanced Care areas.	Safe
3.3.14	The nurse:patient ratio should match patient acuity, skill mix, volume of work and the variety of services offered. Due to the variability of patients and care delivered it is not possible to set clear staffing ratios. However, it is highly unlikely that Enhanced Care can be consistently delivered where the nurse patient ratio falls below 1:4. Consideration must be given to the dependency of the patient on admission. If, due to the planned casemix, a short period of increased dependency is to be expected, a higher nurse:patient ratio should be factored into the nursing establishment to safely accommodate this flexibility. Where national guidance exists (for example for the delivery of Non-Invasive Ventilation (NIV)/the use of arterial lines), it should be followed.	Safe

ALLIED HEALTH PROFESSIONALS AND ALLIED SERVICES		
3.3.15	We recommend that there are clearly defined referral pathways where these services are not required routinely. The type of service provided, its location, patient acuity and length of stay will determine to what extent each is required.	Effective

KEY PRINCIPLES:

4. PATIENT PATHWAY

- The local collaborative development of criteria for admission will be heavily dependent on the type and location of service provision.
- The requirement for Enhanced Care could be part of a patient's care pathway or based on a complicated or high-risk intervention in a particular patient.
- It is difficult to determine fixed admission criteria for the more unpredictable admission from the ward or the Emergency Department. The more variation in patient population, the greater the risk to patient safety and the higher the level of competence required by nursing, medical and AHP staff.
- Patient care pathways for common medical conditions should be developed for those situations where, currently, referral to a Critical Care environment occurs due to the frequency of observations or the need for continuous monitoring.
- Where a patient requires intervention for more than a single process, referral to Critical Care should be considered when developing protocols.
- The ward round is an opportunity to review patient progress and update the management plan if necessary. As a minimum, there will be one multidisciplinary ward round a day with an increased frequency decided at a local level.
- Local policy in terms of frequency of observations, NEWS2 scores and deteriorating patient escalation should be followed. Input from Critical Care/Outreach will facilitate timely escalation of patient care, if required. The degree of input will be dependent on the casemix, should be predetermined when the service is being designed and funding identified.
- Length of stay in an Enhanced Care service should depend on clinical need. However, to promote efficient use of the service, it is important that patients are cared for in the correct environment and therefore discharge should be considered during the admission process.

PATIENT PATHWAY

4.1	**ADMISSION**	
4.1.1	There should be local collaborative development of criteria for admission that will be heavily dependent on the type and location of service provision.	Responsive
4.1.2	A clear booking process should be enacted for patients admitted following elective procedures (operative, endoscopic or interventional radiology delivered). For other patients, appropriate risk models should be adopted.	Responsive
4.1.3	We recommend using a fitness assessment tool (such as the CFS), or an individualised patient assessment, as a simple, measure to identify patients who might benefit from Enhanced Care.	Responsive
4.1.4	The National Early Warning Score 2 (NEWS2) should be used to help identify patients who may require Enhanced Care. Identifying a trigger, where the clinical response includes a senior clinical decision maker, Critical Care staff or outreach will be required.	Safe
4.2	**WARD ROUNDS**	
4.2.1	As a minimum there should be one multidisciplinary ward round a day with an increased frequency decided at a local level. This should be led by the responsible consultant and include, where rostered, the nurse in charge. We support other senior clinical decision makers in this role where deemed appropriate.	Effective
4.2.2	We recommend that there is a formalised handover process when care is transferred either between clinicians on different shifts or ward locations.	Safe
4.3	**REFERRALS AND ESCALATION**	
4.3.1	Local policy in terms of frequency of observations, NEWS2 scores and deteriorating patient escalation should be followed.	Safe
4.3.2	There should be input from Critical Care/Outreach to facilitate timely escalation of the patient, if required. The degree of input will be dependent on casemix.	Safe
4.3.3	Clear referral processes to specialties for input and advice should be established.	Effective
4.3.4	We recommend that an escalation plan of treatment is agreed on admission and documented in the patient record.	Responsive
4.4	**DISCHARGE**	
4.4.1	Length of stay in an Enhanced Care service should depend on clinical need. However, to promote efficient use of the service, it is important that patients are cared for in the correct environment and therefore discharge should be considered during the admission process.	Responsive
4.4.2	Discharge decisions should be made during a multidisciplinary ward round. We support nurse-led discharge where it is based on prerequisites, such as NEWS2, but this should be a local agreement and will be dependent on diagnosis.	Safe

4.4.3	Where admission is part of a care pathway, e.g. elective surgery, the length of stay may be predetermined. To maintain patient flow, we recommend that there is a local policy, agreed with Critical Care, for when the patient is not ready to be discharged.	Responsive
4.4.4	When a patient's stay is much shorter than expected we recommend consideration is given to the admission criteria and amendments made accordingly as part of routine review processes.	Responsive
4.4.5	It is possible that Enhanced Care areas will compete with Critical Care for ward beds when patients are ready to step down to a ward. We recommend that this is considered when establishing the service to ensure that ward beds are equally available to Enhanced Care and Critical Care.	Responsive
4.4.6	The escalation plan of treatment should be reviewed at the time of discharge including suitability of readmission for Enhanced Care.	Responsive

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