Royal Cornwall Hospitals
NHS Trust

Patient Flow Policy

V4.0

August 2023

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- Performance and monitoring
- Escalation

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

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Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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1. Introduction

This policy is to be read in conjunction with the "RCHT Flow and Escalation Resource Pack" RCHT Flow and Escalation Resource Pack. This is a live document and is updated regularly.

1.1. The aim of this policy is to ensure that patients receive prompt, safe and effective treatment upon arrival and throughout the period they are within the care of RCHT. In addition, this policy provides a guide to the expectations and information to be discussed in each Capacity and Flow meeting (Site Management Meeting).

1.2. The purpose is to ensure effective patient flow by following the principle of "right patient, right place, right time, right clinician". This will ensure effective flow throughout the site with the benefit of releasing pressure on Ambulance holds and effectiveness of ED.

1.3. RCHT will support the aims of the Patient Flow Policy by ensuring that processes meet the following criteria:

- Sets a clear framework that will support staff when moving patients from "Emergency Village" to the most appropriate place of care which includes the assessment areas.
- Deliver a consistent approach by all clinicians as detailed in Care and Treatment (section 6.4).
- Identifies key steps to take during normal working hours, out of hours and at times of Full Capacity as detailed within Full capacity Protocol.
- Enable collaboration within departments and between external organisations/partners.
- Provide clear and strong clinical leadership along the pathway.

1.4. This policy is linked to the Hospital Discharge and Community Support Guidance dated 31 March 2022 (current at the time of updating this policy). At all times, the principles of the National Discharge Policy should be applied.

1.5. In determining if an admission is required, consideration needs to be given to "reason not to admit" including the use of assessment facilities to avoid the need to admit on the day, improve patient experience.

1.6. The policy will consider the site management of hospital flow and the four main phases of a patients' journey from point of admission through to discharge, these are:

- Site Management (Section 6.1).
- Emergency Village (Presentation at a front door) (Section 6.2).

- Decision to admit – Bed Management (Section 6.3).
- Care and treatment on ward (Section 6.4).
- Discharge planning (Section 6.5).

1.7. Please see section 4 for Definitions / Glossary of abbreviations used in this document.

1.8. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. Overarching principles:

- Support decision making on arrival to ED to ensure the appropriate pathway is chosen before Decision to Admit (DTA).
- Reduce the time patients spend in ED following a decision to admit.
- Reduced number of bed moves at night.
- Increase admission avoidance, by ensuring "right patient, right place, right time, right clinician.
- Reduce medical outliers maximising surgical capacity.
- Maximise the use of Same day services.
- Enable forward early planning of discharge.
- The actions and decisions made in the capacity and flow meetings will need to reflect the actions detailed in the RCHT Flow and Escalation Resource Pack. Flow Resource Pack provides detailed guidance for senior managers on the priorities for achieving flow.

2.2. Delivery Principles

- Provide regular daily understanding of the flow/bed needs of the site and detailed escalation actions to respond through the site management processes described (Section 6.1).
- Provide flow from admitting areas to base wards to minimise ambulance delays and holds.
- Minimise the time patients spend in ED following a decision to admit. Via the principle of right patient, right bed, right clinician at the right time.
- Increase direct transfer of patients from AMU/Surgical/Trauma to appropriate specialty wards.

- Early senior review of all patients along all parts of the pathway will be undertaken (if not adhered to this will be escalated via the site office).

- All team members will implement internal professional standards.

- Clinical decision makers to seek to avoid unnecessary overnight stays.

- Optimise the use of Same Day Medical Assessment Area (SDMA) and Same Day Surgical Assessment area via appropriate engagement with SDMA and SDSA teams.

- Ensure patients are on the right pathways and ensure that the pathways are communicated to all of the team. Via the site office/team.

- Maintain the momentum of care – there should be a senior review (board or ward) of the care plan for every inpatient, every day.

- Ward rounds and board rounds should follow the priorities based on S.H.O.P. priorities described in Section 6.4 and associated policy.

- Follow the actions defined in the in the IDP SoP (Section 6.3) including use of holding and boarding spaces to promote flow at times of escalation.

- Ensure robust plans are in place for the management of outlying patients.

- Ensure patients are reviewed regularly regarding their status (Criteria to Reside – Appendix 8).

- Ensure that the Trust's electronic systems (i.e. NerveCentre, MAXIMS, Oceano, Swiftplus and Strata/SERF) are kept up to date with regards to plans for discharge and when a patient no longer meets the criteria to reside.

- Getting at least 50% of our P0 patients (those with no ongoing care or support need) home before midday; that alone will free up the capacity we need to eliminate our ambulance waits.

- Aims that patient leaves a ward within one hour of no longer meeting the criteria to reside.

- Ensure that for every patient they and their family know 1) what is a matter with me, 2) what is going to happen today, 3) what is needed to get me home, 4) when am I going home? (ECIST 4 Questions).

- Maximise the use of Same Day services and admission avoidance pathways in the community such as Virtual Ward, Acute care at Home and the IToCH.

- Enable forward planning, monitoring and delivery of discharges in line with:

- EDD and PDD processes.
- CLD.
- IToCH SoP.

2.3. This policy is linked to the Hospital Discharge and Community Support Guidance dated 31 March 2022 at the time of updating this policy. At all times the principles of the National Discharge Policy should be applied.

3. Scope

This policy applies to all staff who are involved in the decision making, treatment and care of patients from admission through to discharge.

4. Definitions / Glossary

- CCU Coronary Care Unit.
- ED Emergency Department.
- ECG Electrocardiogram.
- AGP Acute General Practitioner.
- ITU Intensive Therapy Unit.
- AMU Acute Medical Unit.
- RAT Rapid Assessment and Treatment.
- Resus Resuscitation.
- TTO To take out (refers to drugs being sent with patient).
- EDD Estimated Date of Discharge.
- CLD Criteria Led Discharge.
- PDD Planned Discharge Date.
- iToCH Integrated Transfer of Care Hub.
- SDMA Same Day Medical Assessment.
- SoP Standard Operating Policy.
- SHOP Sick, Home, Others and Planning.
- TES Treatment and Escalation Space.
- EPOC Enhanced Perioperative Care.
- SDSA Same Day Surgical Assessment Area.

- TES Treatment Escalation Space.
- MDT Multi-Disciplinary Team.
- ECIST Emergency Care Improvement Support Team.
- **Pathway zero:**
  Simple discharge home, no new or additional support is required to get the person home.
- **Pathway one:**
  Able to return home with new, additional or a restarted package of support from health and/or social care.
- **Pathway two:**
  Recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting before returning home (Community hospital bed/Care Home).
- **Pathway three:**
  For people who require bed-based 24-hour care, includes people discharged to a care home for the first time and existing care home residents returning to their care setting.

5. Ownership and Responsibilities

The policy is owned by the Chief Operating Officer who in turn reports to the Trust Management Group.

The roles and responsibilities for key staff is detailed in the Roles and Responsibility summary in the RCHT Flow and escalation Resource Pack (Section 2).

5.1. Role of the Managers

Line managers are specifically responsible for:

- **Chief Operating Officer** – To ensure the policy is executed. To be the link to clinical staff. Review and update as required.
- **Clinical Directors (Care Group)** to support the implementation of this policy and other linked policies and Standard Operating Policies.
- **Heads of Nursing** to support the implementation of this policy and other linked policies and Standard Operating Policies.
- **Care Group Managers** to support the implementation of this policy and other linked policies and Standard Operating Policies.
- **Care Group – Managers of the Day (MOD)** to support the implementation of this policy and other linked policies and Standard Operating Policies.

- **Clinical Site Managers** to facilitate the monitoring, actions and reporting arrangements described in this policy.

- **On Call Managers and Executives** to facilitate the monitoring, actions and reporting arrangements described in this policy.

5.2. Role of Clinical Directors

- To ensure that there are robust clinically led plans in place for the overall safety of the site and maintaining flow for both planned and emergency patients.

- To ensure clinical ownership of patients within their Care Group area.

- Ensure implementation of the clinical standards identified within this policy.

- Ensure consultant colleague adhere to the board and ward round actions.

- Adherence with the professional standards (Appendix 8).

5.3. Role of Care Groups (Heads of Nursing and Care Group General Managers and Managers of the Day)

- Attendance at meetings, described in policy.

- Ensure appropriate attendance at site management meetings and deliver actions identified in the site management meetings and support wards to ensure timely admissions and discharge of patients to support flow.

- Provide point of escalation for site management.

- Support attendance and actions identified during periods of escalation.

- MOD to provide point of escalation for issues identified for each care group.

- Inform site of any staffing challenges for that day/shift.

5.4. Role of Clinical Site Management

- Clinically manage the site as the senior Clinical Nurse.

- Complete bed state and situational report following each bed meeting.

- To be visible on the wards as senior nurses and to engage with staff with difficult decisions around patient moves and discharge.

- To make decisions on the appropriate placement of patients working to the principles of “right patient, right place, right time, right clinician.

- To influence the plans for the safe staffing of the site (Out of Hours).

- To work in collaboration with the ED team to avoid delay of transfer out of ED and delivery of the Emergency Access Standards.

- To work in collaboration with the ward teams to avoid delay of transfer in and out of emergency village (AMU/SDSA/TAU).

- To ensure the effective running of the site management meetings which includes the need to understand why patients who do not meet the criteria to reside have not been discharged and to support any escalations required.

5.5. **Role of Senior Manager on Call and Executive on Call**

- Attendance at meetings, described in policy during weekday evenings and weekends.

- Ensure appropriate attendance at site management meetings and deliver actions identified in the site management meetings.

- Support wards to ensure timely admissions and discharge of patients to support flow.

- Provide point of escalation for site management.

- Support attendance and actions identified during periods of escalation.

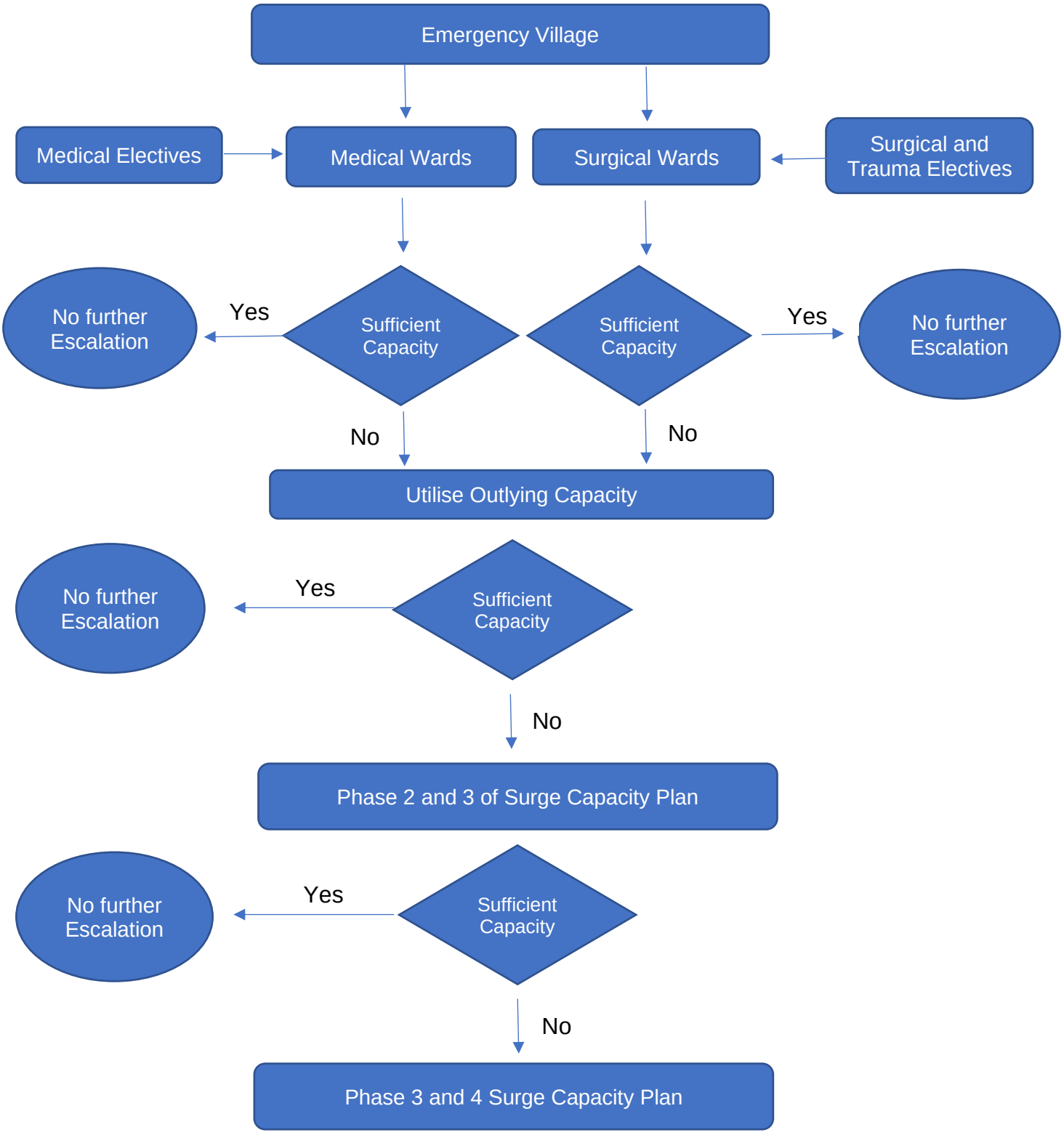
5.6. **Role of Support to Transfer of Care Hub**

- To be added once clear and process and policies agreed across RCH and Community Services.

6. Standards and Practice - Patient Flow

- Site Management (Section 6.1).
- Emergency Village (Section 6.2).
- Decision to admit – Bed Management (Section 6.3).
- Care and treatment on ward (Section 6.4).
- Discharge planning (Section 6.5).

The ‘patient flow’ flowchart is shown on the next page.


Emergency Village
Medical Electives
Medical Wards
Surgical Wards
Surgical and Trauma Electives
No further Escalation
Yes
Sufficient Capacity
Sufficient Capacity
Yes
No further Escalation
No
No
Utilise Outlying Capacity
No further Escalation
Yes
Sufficient Capacity
No
Phase 2 and 3 of Surge Capacity Plan
No further Escalation
Yes
Sufficient Capacity
No
Phase 3 and 4 Surge Capacity Plan

6.1. Site Management

6.1.1. Capacity and Flow Meetings

6.1.1.1. The site meetings and responsibilities of the care groups in relation to daily flow, discharges and planning is detailed in the Flow Resource Pack.

6.1.1.2. The specific details for Care Group Actions are detailed in the Flow Resource Pack.

6.2. Emergency Village (Presentation at a front door)

Bringing together our emergency admissions areas (Emergency Department, Same Day Medical Assessment, Same Day Surgical Assessment area, Acute Medical Unit, Trauma Assessment Unit) under the umbrella of an 'emergency village'. Beds will be ringfenced, allowing clinicians to make rapid decisions to get patients home or to the right place for their care and treatment.

The Emergency Village includes all the emergency access points across the hospital and aims to provide a focus on flow from these areas to enable these areas to accept new patients, which will improve ambulance delays, improve the performance of all admitting areas and enhance the ability to respond to demand in a timely manner providing enhanced patient safety and experience and deliver the principle of "right patient, right place, right time, right clinician".

6.2.1. Emergency Department

- Discharge or transfer within 4 hours.
- Operating Hours - 24/7.
- Adherence to the Internal Professional Standards (Appendix 13).

6.2.2. SDMA

- Agreed plan and treatment, discharge, or transfer within 4 hours.
- Operating 08.00 to 22.00 –7 Weekdays.
- SOP in place (See Resource Pack).

6.2.3. AMU

- Agreed plan and treatment, discharge, or transfer within 24 hours.
- Operating Hours - 24/7.
- SOP in place (See Resource Pack).

6.2.4. **Same Day Surgical Assessment area**

- **SOP required** (See Resource Pack).

6.2.5. **Trauma Assessment Unit**

- **SOP required** (See Resource Pack).

6.3. Decision to admit – bed management

6.3.1. The Site Management team is responsible for the coordination and allocation of all beds, managing the demand for inpatients areas (not in priority) from:

- Emergency Village.
- All Elective Lists.
- Higher Care Areas.
- Repatriations.
- White Boards.

6.3.2. The use of in-patient capacity is based, in the first instance, on the principle of right patient in the right place, at the right time with the right clinician, that is the ward which is supported by the designated medical or surgical team corresponding to the patients' needs.

6.3.3. The principle that the assessment areas (Emergency Village) areas should not be bedded overnight and that the care group escalation plans will address capacity requirements.

6.3.4. The Flow Resource Pack provide the actions to ensure this area are ringfenced and kept flowing.

6.3.5. Patients with surgical pathology should be managed by the surgical teams even if they are not planning to operate. This ensures surgical conditions are managed optimally and ensures the surgical bed base is filled with appropriate patients.

6.3.6. Should there not be enough capacity to meet demand, primarily demand for medical beds, then in line with the escalation processes, then the following should be considered:

- Use of "outlying beds".
- Boarding and holding spaces (Identify, Discharge and Pull Policy).
- Use of surge capacity.

6.3.7. **Outlying Beds**

- Outlying beds are used when there are insufficient speciality beds to meet demand. Primarily this is surgical beds used to admit medical patients. The patients' medical needs are then managed by the speciality assigned to provide cover for that ward. (Appendix 7).

- Specialities are required to identify patients on base wards that would be suitable to outlie and update care group plans accordingly to enable patients to be transferred from base wards to outlying wards.

- This will create space for new specialty patients to be admitted from AMU and non-speciality wards.

- Patients moved from base wards should be transferred as outliers to respective speciality outlying ward unless they have been accepted by another speciality.

- Criteria to identify patients to outlie are:

  - The patient has a confirmed diagnosis and/or a treatment and discharge plan is in place.

  - The patient has not experienced symptoms of infective diarrhoea or vomiting within the last 72 hours or the patient is moving to an appropriate side room (applies to ED patients as well).

  - The patient has not experienced deterioration in their condition in the previous 24 hours. NEWS score is within expected limits for patient. (NEWS score to be added).

  - Further details in appendix 7.

6.3.8. **Outlying Wards**

Outlying ward	**Speciality**
Wheal Prosper	Respiratory/Endocrine
SAL (Zennor)	Renal/Endocrine
Eden	Renal/Respiratory
Wheal Coates	Endocrine
Pendennis	Gastroenterology

Outlying ward	Speciality
Lowen	Gastroenterology
St Mawes	Care of the Elderly
Trauma 1and 2	Care of the Elderly
ED and SDMA	Acute Medicine

Appendix 5. Criteria for outlying beds

- **IDP Model (Includes Boarding, TES, and Speciality Whiteboards).**

6.3.8.1. The IDP (Identify, Discharge and Pull) model promotes the movement of patients from ED to AMU to create capacity on AMU by the base wards pulling speciality patients as early as possible. The model expects 2 patients to be pulled from ED by AMU every hour (08.00 to 20.00) and speciality patients to be pulled from AMU to the speciality wards. This model will enable flow from ED and allow ambulances to offload.

6.3.8.2. The speciality wards will be able to pull specific patients from AMU or other wards to facilitate the right person on the right ward at the right time. Patients are identified on the speciality whiteboard, which has patients and the consultants identified.

6.3.8.3. The use of Boarding, holding and Treatment Escalation Spaces are to be utilised when the demand exceeds the baseline capacity, Boarding is an additional bed on the agreed wards while TES is used during the day. The boarding and holding spaces are only available when the escalation triggers are achieved and may be in the form of either bedded or chair capacity.

6.3.8.4. This *SOP (Policy: Enabling timely flow of Medical Patients through the Identify, Discharge, Pull (IDP) Model V1.3 add appendices) provides details of which wards could be utilised to facilitate boarding/holding and, who can approve and at what point this will be triggered.

6.3.9. **Surge Capacity and Escalation Beds**

RCHT Order of escalation

Summary position

Phase	Change existing capacity (Medicine)	Increase Bed capacity
	Business as Usual – all base beds utilised	
1	Outlie medical patients in surgical wards	Up to 38 spaces
		38 spaces
2	Discharge lounge bedded overnight	9 spaces
	Zennor Ward	7 spaces
	Boarding	17 spaces
	Holding and chairs	9 spaces plus 4 chairs
	ED ADL	4 spaces
	ED Corridor	5 spaces
	Top Floor Tremenel Unit (Frailty SDEC)	10 spaces
		61 spaces
3	Phoenix Stroke beds	5 spaces
	Planned Care Unit	6 spaces **surgical patients only**
	Eden Day Case	4 spaces **surgical patients only**

6.3.9.1. The principle of the RCHT surge plan is that at each phase, all the capacity is utilised before the next phase is considered.

6.3.9.2. This also needs to reflect the use of core community hospital capacity and escalation capacity to be utilised to enable flow from RCH.

Appendix 8. Surge Planning and associated Beds

6.4. Care and treatment on ward

6.4.1. The care and treatment of patients on the wards is essential to promote flow and deliver the discharges needed to ensure that patients are proactively managed to optimise their minimum length of stay.

6.4.2. The discharge performance of each ward is monitored through the daily ward flow meeting (Section 7.1) and provides the opportunity to identify and escalate issues that are impacting on the length of stay as well as identifying actions that support flow.

6.4.3. Care and treatment on the ward is underpinned by the SHOP methodology and other best practice initiatives, including PJ paralysis.

6.4.4. The main ways in which this is delivered is by adhering to the ward processes that promote timely care for patients described below.

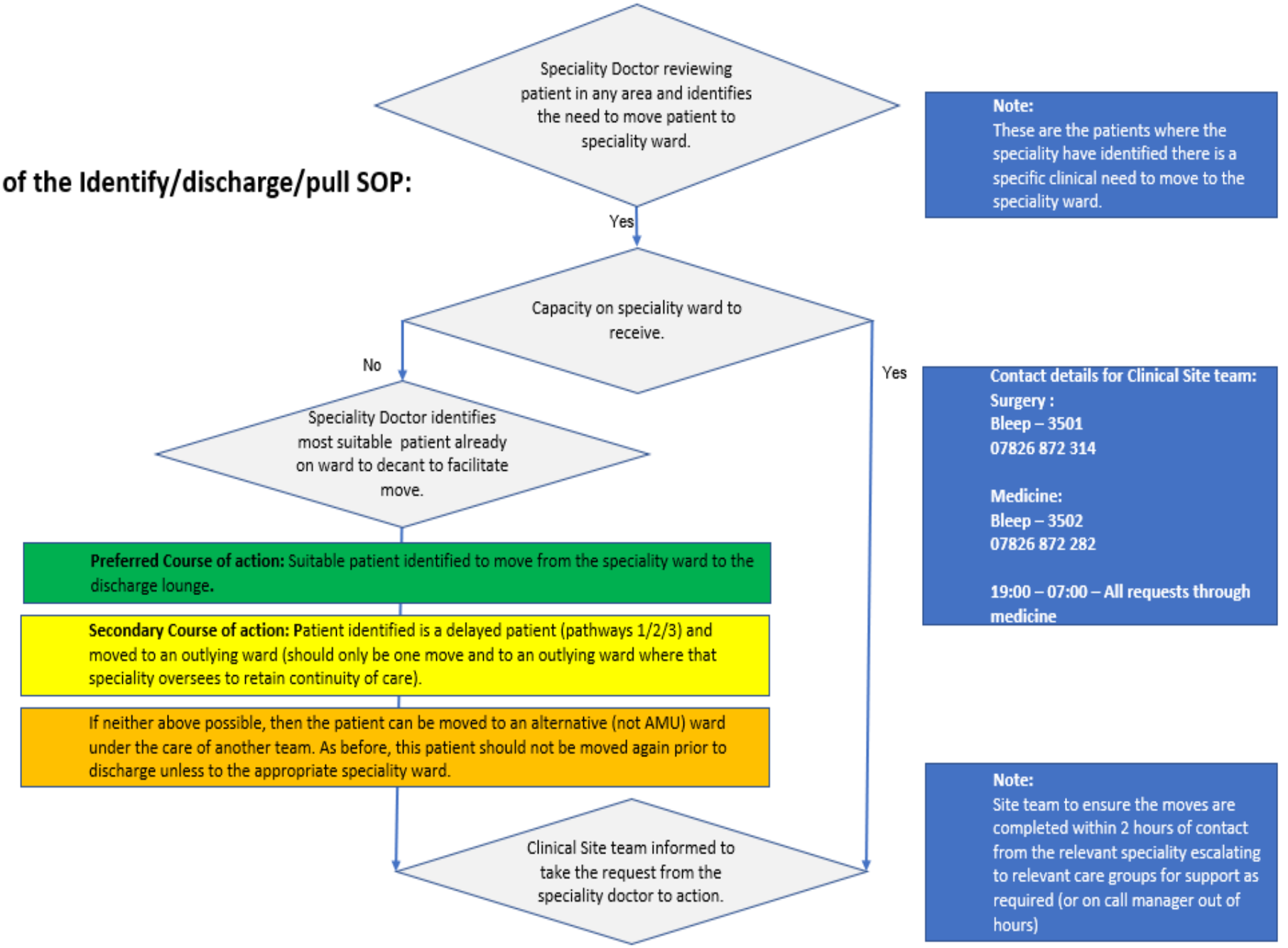
6.4.4.1. **Speciality Bed Base (White Board)**

The ability to pull the right patients into the specialist wards is detailed in the IDP model, in which speciality teams are able to identify the patients that are currently outlying, in the Emergency Village and on other wards.

It is the responsibility of the specialist teams to identify those patients require to be returned to their specialist base ward. The white board should be kept by the ward and used to pull patients from other wards, including outliers, this is to be done in conjunction with the site team to balance the needs across the site.

The flowchart for principles of the identify / discharge / pull SOP are shown on the next page. This flowchart is provided in Section 5 of the RCHT Flow and Escalation Resource Pack.

Principles of the Identify/discharge/pull SOP:



6.4.4.2. **Ward and board rounds**

This policy standardises the expectations for the Board and Ward Rounds on each ward and supports the flow of patients including the identifying of those patients for the discharge lounge, identifying the golden patient and agrees the PDD and EDD.

Ward rounds and board rounds also need to reflect the four ECIST questions on a daily basis. These are:

- What is a matter with me?
- What is going to happen today?
- What is needed to get me home?
- When am I going home?

The policy stipulates that each ward will have:

6.4.4.3. **Morning Board Round (between 08.00 and 09.00) attended by the MDT and including**

- Ward Consultant (required).
- Junior Doctors (required).
- Senior Nurse (required).
- Therapy Professionals (where available).
- Pharmacist (where available).
- Discharge Coordinator (required).

6.4.4.4. **The board round will focus on ensuring prompt discharge planning activity is undertaken following actions identified during board rounds. The priorities based on S.H.O.P. methodology:**

- Sick.
- Home today and tomorrow.
- Other patients.
- Plan for incoming patients or outlier.

6.4.4.5. **Morning Ward Round**

The morning Ward Round will commence immediately after the Board Round overview has finished and will include:

- Ward Consultant (required).
- Junior Doctors (required).
- Therapy Professionals (where available).
- Ward Nurse(s) (as required for further input).
    - Dedicated support for those specialist wards where Therapists are part of an MDT: Stoke, Tintagel, Trauma, Kerensa, ED, AMU, WCH & SMH. (No SLT & DT input for ED, WCH & SMH).
    - All other ward areas, therapy services are provided based on referral only (OT, DT, SLT). Physio referrals picked up by team following ward visits.

6.4.4.6. **Afternoon Rapid Round:**

The afternoon Rapid Round will commence as agreed at approximately 13:00 but no later than 14:00 every day and include:

- Senior Nurse.
- Junior Doctor.
- Discharge Coordinator (required).
- Therapy Professional (if available) .

A Consultant is not required to be in attendance

The Rapid Round will:

- Ensure that today's discharges and treatment and care activity has occurred, as planned.
- Where there are remaining actions that have not progressed as planned, these must be prioritised or escalated promptly via the site office or via HON or matron.
- Confirm that the Discharge Summary has been fully completed within the clinical systems, including ensuring a copy has been provided to the patient on leaving the ward. (NHS England Standard Contract: A Discharge Summary must be fully completed within 24 hours of a patient being discharged).

6.4.5. **Expected Date of Discharge and Planned Date of Discharge**

6.4.5.1. Expected Date of Discharge (EDD) is set by the multi-disciplinary team (MDT) for every in-patient. EDDs highlight the constraints or waits (both internal and external). Every patient will receive an informed EDD on admission which should be set at the first consultant review. This date should not be changed after 48 hours.

6.4.5.2. The Planned Date of Discharge (PDD) should be done in consultation with the MDT and the patient and/or their family or care provider based on their individual circumstances.

6.4.5.3. Expected Date of Discharge (EDD) and Planned Date of Discharge (PDD) Standard Operating Procedure.

6.5. **Discharge planning**

6.5.1. The discharge planning for the patient should be commenced at the earliest opportunity and led by the MDT in line with setting the EDD and PDD and identifies the onward care requirements, if any, and governed by the National Discharge to assess guidelines. Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

6.5.2. The discharge plan and date are determined by the ward MDT but may include the options of utilising Criteria Led Discharge or the Discharge Lounge (if available).

6.5.3. **Discharge Planning**

This policy is linked to the Hospital Discharge and Community Support Guidance dated 31 March 2022, at all times the principles of the National Discharge Policy should be applied, this includes the aim that patients are leave the ward within an hour of no longer having the right to reside.

The discharge planning needs to ensure that a patient is ready for discharge, including having their discharge summary, TTOs, transport organised etc to ensure flow is optimised.

6.5.4. **Referral to Community Services**

Requests for onward care need to be submitted to the Community Health and Social care teams through the electronic system Single Electronic Referral Form (SERF) (STRATA planned for April 2023) and provide the description of the patients' needs rather than the type of service they require.

6.5.5. Criteria Led Discharge

Criteria Led Discharge (CLD) is the documented clinical criteria and parameters to support the nurse, Junior Doctor, or Therapy Allied Health Professional (AHP) to accomplish the discharge without consultant's involvement providing the patient's clinical condition achieves the criteria, set by the MDT.

- Criteria Led Discharge (CLD) Standard Operating Procedure (

6.5.6. Discharge Lounge

It is the expectation that all patients who are to be discharged on the day and are not discharged directly from the ward are transferred to the discharge lounge at the earliest opportunity. The aim is that all discharged patients are home for lunchtime.

The discharge lounge provides a bedded environment to allow a patient to be transferred from.

the ward whilst awaiting actual discharge from the hospital. For example, whilst awaiting transport or TTO'S.

This promotes the flow of patients earlier in the day.

7. Dissemination and Implementation

This document will be published on the Documents Library.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Patient Flow will be measured from discharges taken from clinically stable dates to actual discharge date.
Lead	Chief Operating Officer.
Tool	Radar data will supply the ward-by-ward data and the RCHT. Daily Dashboard.
Frequency	Reporting is available daily but monthly will give an overall trend Reporting to be shared at Patient Flow Programme.
Reporting arrangements	To be reported at Patient Flow and Discharge Group meeting and at Trust Management Group.
Acting on recommendations and Lead(s)	Regular review will take place as part of the Patient flow team daily work. Any lessons learned or new ideas will be considered and enacted if agreed by the Deputy Chief Operating Officer (Clinical).
Change in practice and lessons to be shared	Patient Flow will be measured from discharges taken from clinically stable dates to actual discharge date.

9. Updating and Review

9.1. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval, and dissemination processes.

9.2. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Head of patient Flow for signatory approval and can be re-published accordingly without having gone through the full consultation and ratification process.

9.3. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Patient Flow Policy V4.0
This document replaces (exact title of previous version):	Patient Flow Policy V3.4
Date Issued/Approved:	17 August 2023
Date Valid From:	August 2023
Date Valid To:	August 2026
Directorate / Department responsible (author/owner):	Tim Mumford, Unplanned Care Lead
Contact details:	07721 024 340
Brief summary of contents:	A policy to ensure patients receive prompt, safe and effective treatment within RCHT.
Suggested Keywords:	Patient flow, admission, discharge
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Operating Officer
Approval route for consultation and ratification:	Trust Management Group
General Manager confirming approval processes:	Liz Trew Deputy Chief Operating Officer Clinical
Name of Governance Lead confirming approval by specialty and care group management meetings:	Patient Flow Programme
Links to key external standards:	ED national breach standards
Related Documents:	Discharge Lounge local procedure
Training Need Identified?	None

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Chief Operating Officer / Patient Access

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
07/10/16	V1.0	Initial Issue	Dr Duncan Browne, Clinical Director of Patient Flow
07/03/17	V2.0	Executive Lead updated	Transformation Lead
03/05/17	V3.0	Addition of section 6.6	Dr Duncan Browne, Clinical Director of Patient Flow
21/03/18	V3.2	Additions to section 6.1	Dr Duncan Browne, Clinical Director of Patient Flow
27/06/18	V3.3	Addition of Appendix 4 and additions to sections 2 & 6.5	Dr Duncan Browne, Clinical Director of Patient Flow
04/09/18	V3.4	Addition of Appendix 5 and additions to section 6.5, Change text throughout from MAU to AMU. Minor text change to 6.6.	Frazer Underwood Consultant Nurse – Associate Director of Nursing Jo Floyd – Head of Patient Flow
29 June 2023	V4.0	Full review and update with comments from Angela Madigan, Robin Jones, Ian Moyle-Browning, Jemma Moore, Richard Andrzejuk and Sarah Budden. Comments and amendments from OLG on 24/05/23 - Removed sections as per OLG.	Tim Mumford, Unplanned Care Lead

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

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

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

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Patient Flow Policy V4.0
Directorate and service area:	Corporate – all adult wards admitting elective and non-elective patients.
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Tim Mumford, Unplanned Care Lead
Contact details:	07721 024 340

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	The policy is aimed at all aspects of the Patient Flow pathway. Aim is to ensure the “right patient, right place, right time, right clinician. The Policy will also prevent ED overcrowding and demonstrate areas to utilise during Full Capacity.
2. Policy Objectives	To create a regular and uninterrupted flow of patients across the Trust from admission through to discharge in a consistent way.
3. Policy Intended Outcomes	Reduce frequency of ambulance holds. Reduce number of people waiting in the emergency department for more than 4 hours. Reduced Delayed Transfers of Care. Reduced delays of patients in ED to meet the national standards. “right patient, right place, right time, right clinician”.

Information Category	Detailed Information
4. How will you measure each outcome?	Reduction in Delayed Transfer of care. Reduction in 12 and 4 hour breaches in ED of national standard. Reduction in hours lost by ambulances.
5. Who is intended to benefit from the policy?	Patients RCHT staff. Transport.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Trust Management Group and all triumvirate members.
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

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

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

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

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

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

Name of person confirming result of initial impact assessment: Tim Mumford, Unplanned Care Lead.

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

Appendix 3. Criteria to identify patients to outlie.

Outlying beds are used when there are insufficient speciality beds to meet demand. Primarily this is surgical beds used to admit medical patients. The patients' medical needs are then managed by the speciality assigned to provide cover for that ward. (Appendix 3).

Specialities are required to identify patients on base wards that would be suitable to outlie and update care group plans accordingly to enable patients to be transferred from base wards to outlying wards.

This will create space for new specialty patients to be admitted from AMU and non-speciality wards.

Criteria to identify patients to outlie are:

10.1. The guiding principles and considerations for specialties to identify patients on base wards to outlie on their aligned wards are:

- NEWS score below 5.
- Acuity manageable by outlying ward.
- PDD agreed and documented.
- CLD in place, where appropriate.
- Clear diagnosis and treatment plan documented.
- Not complex/long waiter for external exit plan.
- Acuity/ Nursing needs appropriate for the outlying ward, especially considering delirium, dementia, or other behavioural issues.
- Correct consultant cover on outlying ward, noting that some patients maybe General Medical.

10.2. The patient has a confirmed diagnosis and/or a treatment and discharge plan is in place having received a senior clinical review at least once in every 24-hour period Monday – Sunday unless clinically stable with no active medical problems.

10.3. The patient has not experienced symptoms of infective diarrhoea or vomiting within the last 72 hours or the patient is moving to an appropriate side room (applies to ED patients as well).

10.4. The patient has not experienced deterioration in their condition in the previous 24 hours. NEWS score is within expected limits for patient.

11. Actions

11.1. Prior to moving a patient from a medical base ward to be an outlier, patient treatment plans must be updated and documented in the patient notes to include pending investigations and discharge plans.

11.2. Ward Rounds must identify patients who are suitable to outlie should it be required and ensure actions are taken to enable a transfer without delay.

11.3. Once identified, the patient details must be added to the white board list held by the ward and communicated with the site teams. Clinical teams must be informed of patients who are actually placed as outliers. Clear information must be provided to inform the clinical team of where the patient has been placed.

If it is deemed necessary to place a patient as an outlier and/or open additional capacity (as opposed to direct transfer from ED ground floor template) clinical teams must identify which patients are most appropriate be placed as outliers.

12. The number of bed moves during each patient's stay must be minimised. Ideally, once a patient has been placed as an outlier from their original ward, they should not be moved again, unless clinically indicated.

13. The Patient Administration System (PAS) must be updated promptly so that the clinical teams are able to identify the outlying ward from the original admission ward. This information is also available on SharePoint. Once identified, the patient details must be added to the take list by the on-call medical team if there has not been a prior consultant review. Clinical teams must be informed of patients who are actually placed as outliers. Clear information must be provided to inform the clinical team of where the patient has been placed.

The clinical team must ensure that patients who have been placed as outliers get prompt and appropriate medical assessment and interventions. The patients should receive a senior clinical review at least once in every 24-hour period Monday – Sunday unless clinically stable with no active medical problems.

A patient is a medical outlier if placed on a surgical ward, patients who are admitted as surgical patients who are considered to require a medical review need to be referred to the relevant speciality for review and if appropriate acceptance as a medical patient.

Outlying ward	**Speciality**
Wheal Prosper	Respiratory/Endocrine
SAL (Zennor)	Renal/Endocrine
Eden	Renal/Respiratory
Wheal Coates	Endocrine
Pendennis	Gastroenterology
Lowen	Gastroenterology
St Mawes	Care of the Elderly
Trauma 1and 2	Care of the Elderly
ED and SDMA	Acute Medicine

Appendix 4. Surge Plan

RCHT Order of escalation - Summary position

Phase	Change existing capacity (Medicine)	Increase Bed capacity
	Business as Usual – all base beds utilised	
1	Outlie medical patients in surgical wards	Up to 38 spaces
		38 spaces
2	Discharge lounge bedded overnight	9 spaces
	Zennor Ward	7 spaces
	Boarding	17 spaces
	Holding and chairs	9 spaces plus 4 chairs
	ED ADL	4 Spaces
	ED Corridor	5 spaces
	Top Floor Tremenel Unit (Frailty SDEC)	10 spaces
		61 spaces
3	Phoenix Stroke beds	5 spaces
	Planned Care Unit	6 spaces **surgical patients only**
	Eden Day Case	4 spaces **surgical patients only**

The principle of the RCHT surge plan is that at each stage, all the capacity is utilised before the next phase is considered.

This also needs to reflect the use of core community hospital capacity and escalation capacity to be utilised to enable flow from RCH.

Phase 0 – Normal Operating framework.

Utilise designated staffed surgical and medical bed base on all sites, RCHT, SMH (including MTH) and WCH.

Utilise “Safer Staffing” to maximise staffed capacity across all sites.

Surge Phase 1 – (Outlie medical patients).

To meet increasing demand for medical beds, commence medical outlying on surgical and trauma wards in line with agreed process and associated speciality support on the RCH site. This will reduce elective capacity across all specialities.

Outlying Wards, bed numbers and speciality cover.

Medicine

1 CIU – A bay elective and radial lounge (up to 6 +2 beds).

2 Eden - 2 bays – Renal and respiratory (up to 8 beds).

3 Kynance – Endocrine (up to 6 beds).

4 Pendennis – CoE and Gastroenterology (up to 6 beds).

5 Trauma 1&2 – CoE (up to 10 beds).

Trauma

1 RCH Trauma patients post-surgery move to SMH (up to 28 beds) and outlie in medicine in Trauma.

Surge Phase 2 - (Commence boarding)

Utilise discharge lounge for tomorrows' planned discharges.

Implementation of the Boarding SOP (17 spaces across the RCH and WCH sites).

Use the Ambulatory Decision Lounge in ED as a cohorting space (either queue in or queue out) but staffed by RCHT so ambulance handover happens. This is 4 seated or 3 trolley spaces.

ED corridor will provide 5 spaces, staffed by RCHT, for either pre or post ED cohorting but ambulance handover will have happened.

Use the 10 space Frailty SDEC on Wheal Vor, reducing the ability to assess and admission avoidance.

Surge Phase 3 – (Utilise some same day care capacity and implement holding spaces).

Extend stroke capacity on Phoenix.

Utilise PCU and Eden to provide surgical capacity.

Surge Phase 4

Dynamic risk assessment to be completed for the following areas (not listed in any order of priority).

West Cornwall Hospital – day surgery unit converted to overnight, provides 16 spaces (risks are identifying overnight staffing resources and the reduction in operating which includes cancer, urgents and long waits).

If ITU space needed existing plans in place for network support and using recovery.

Surge Phase 5

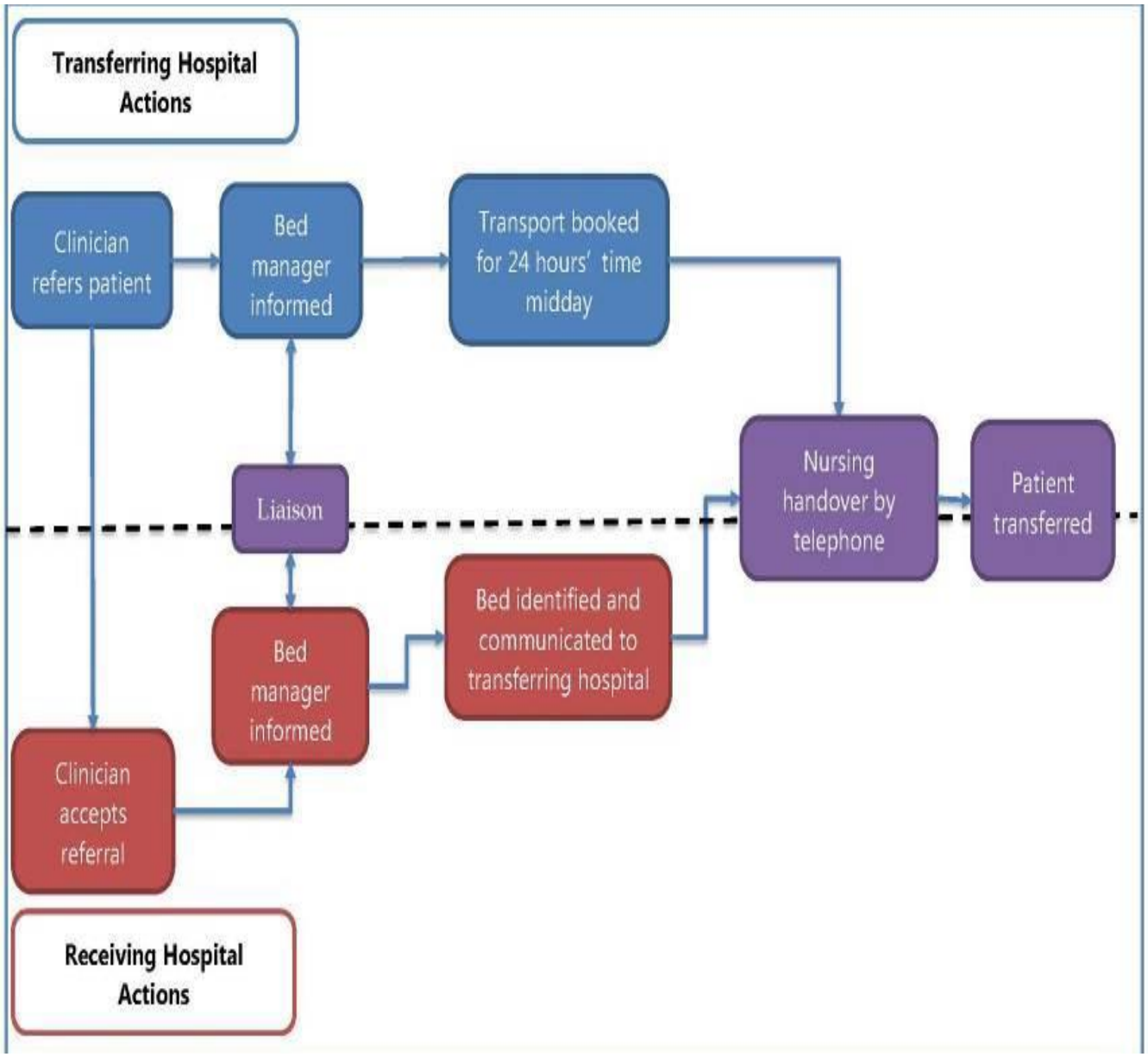
This provides the process to manage the ambulances awaiting to off load.

Emergency measures implemented when holding ambulances.

- If CAT 1 offload needed ED to use chair spaces in ED corridor (up to 5).
- If CAT 1 off load needed ED to fill RATS managing risk of assessments.
- If RCHT unable to staff ADL or ED Corridor, then liaise with SWAST to cover these spaces as one crew can care for multiple patients (noting priority is RCHT to staff the areas and all crews released).

Appendix 5. Repatriation Process

The purpose of the repatriation procedure is to reduce unnecessary delays when fit for transfer.



The above information is provided in page 5 of the RCHT Flow and Escalation Resource Pack.

Appendix 6. Expected Date of Discharge (EDD)

1.1. EDDs must be set by consultants, or by a senior delegated clinician, and only changed with their permission.

1.2. EDDs should be set and recorded in Nervecentre at the first consultant review and no later than the first consultant post-take ward round the next morning.

1.3. If a patient is to be transferred to a ward-based specialty team, then the EDD should be set by the team who will be responsible for their discharge. Crucially, the sooner the patient is identified as in need of sub-specialty care and that sub-specialty team reviews and sets the EDD the sooner that patient's care will be progressed.

1.4. An EDD reflects when the patient is 'medically optimised.' Someone is 'medically optimised' when the consultant or their empowered medical representative makes the decision, (based on the input and advice from the relevant multi-disciplinary team and the patient), that the patient no longer needs the care of the consultant-led acute service and could be discharged.

1.5. The EDD must consider the time it will take to ensure the patient is safe for discharge from a multi-disciplinary perspective and so is an outcome of the assessment for discharge. When setting the EDD, the Consultant should take into consideration the average length of stay for the patient's condition but also the mobility, social and functional situation of the patient and other factors affecting recovery times.

1.6. It is important that EDDs are set assuming an ideal recovery pathway unencumbered by either internal or external waits. If the EDD is set embedding anticipated waits and delays in the system (for example waits for clinical decisions, diagnostics, inter-specialty referrals, social care decisions etc.), then these waits become hidden and thus not amenable to resolution.

1.7. If a patient's clinical condition changes from predicted and the date, they are planned to reach medical optimisation is extended due to the change in their clinical condition then to ensure the EDD is clinically led it can be reviewed and amended.

1.8. The EDD is a clinical, not managerial, tool. Together with a comprehensive clinical care and discharge management plan, they describe the objective for the admission. It can be used to support coordinate care and minimise unnecessary waits in the patient's journey. The system's managerial capacity should focus on tackling unnecessary waits in support of the clinical team. In most circumstances, it will be the internal waits within the acute hospital that predominate.

1.9. If a patient's stay goes beyond the EDD, best practice is to highlight this as EDD +1, +2 etc. and clearly identify the constraint(s) that caused this (for example, internal delays, imaging etc.; external delays, pathway 1, 2, 3 provision). It is the responsibility for the Nurse or the Discharge Coordinator to update this in the discharge planning section of Nervecentre.

1.10. In addition, routinely recording medically optimised status on Nervecentre will provide data to support future Consultant EDD decisions with greater accuracy according to the patients presenting clinical condition.

1.11. Patients and their families, or care providers, must be informed of the initial EDD and be involved in subsequent discussions about reviews to their EDD; by communicating the four key questions:

1. What's the matter with me?
2. What's going to happen to me today?
3. When am I going home (EDD)?
4. What is needed to get me home?

1.12. EDDs must be reviewed daily throughout the patient journey involving all members of the multi-disciplinary team.

1.13. The purpose of setting an EDD early on is to ensure that all the elements of the medical/surgical management and discharge plan will come together in a timely manner to support a safe discharge and any barriers to this can be identified early and action to migrate delays can be taken whilst the patient is being treated.

1.14. This EDD must form part of the patient's clinical treatment plan, developed by the Consultant. This Plan of Care should include criteria that, when met, will indicate when the patient will be "Medically Optimised" and reinforced with the patient by communicating the four key questions.

1.15. EDDs for each patient should be communicated to the MDT at each Board Round. It is the responsibility of the members of the MDT to then take actions to ensure that the EDD for that patient is achieved by meeting both their clinical and non-clinical needs within that timeframe. This will form the discharge plan for the patient.

Please read Expected Date of Discharge (EDD) and Planned Date of Discharge (PDD) Standard Operating Procedure for more information.

Appendix 7. Criteria Led Discharge (CLD)

1.1. Ward rounds taking place with Nurse and AHP presence.

1.2. A ward round will take place using the SHOP (Sick patients, Home patients, Other patients, Plan) method.

1.3. Rapid Rounds taking place twice a day.

1.4. Completion of a criteria for discharge will lead to the patient being medically optimised.

1.5. The criteria set will be clear, unambiguous and the minimum that is needed to safely discharge the patient. Patients will often need ongoing follow up in the community to get back to their prehospital state, this can take place in the community for many patients.

1.6. The decision to discharge the patient can be safely undertaken by a delegated practitioner, thereby avoiding potential delays associated with a medical team review, release the medical teams to review those patients in need of a review/attend other activities.

1.7. When a patient is discharge using CLD, the pull of the patient will take place within 30 minutes.

1.8. Nurses/AHP's discharging patients in accordance with this SOP must be NMC or equivalent registered.

1.9. The discharging practitioner must be competent to administer criteria led discharge. This will be defined as the registered practitioner being comfortable with the criteria that is set and having a knowledge base around that criteria, escalating to the NIC for support if required.

1.10. To be confirmed as competent to conduct criteria led discharge a nurse must have read the CLD SOP.

1.11. The CLD met section will have detail regarding the assessment completed.

Please read Criteria Led Discharge (CLD) Standard Operating Procedure for more information.

Appendix 8. Guidance on Reason to Reside

The information below can be accessed at the following link:
Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Annex D: criteria to reside – maintaining good decision-making in acute settings

Every person on every general ward should be reviewed on a twice-daily ward round to determine the following. If the answer to each question is ‘no’, active consideration for discharge to a less acute setting must be made:

- Requiring ITU or HDU care?
- Requiring oxygen therapy/NIV?
- Requiring intravenous fluids?
- NEWS2 greater than 3? (clinical judgement required in persons with AF and/or chronic respiratory disease).
- Diminished level of consciousness where recovery realistic?
- Acute functional impairment in excess of home/community care provision?
- Last hours of life?
- Requiring intravenous medication > b.d. (including analgesia)?
- Undergone lower limb surgery within 48 hours?
- Undergone thorax-abdominal or pelvic surgery with 72 hours?
- Within 24 hours of an invasive procedure? (with attendant risk of acute life-threatening deterioration).

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review and challenge questions for the clinical team

Is the person medically optimised? Do not use ‘medically fit’ or ‘back to baseline’.

What management can be continued as ambulatory, for example heart failure treatment?

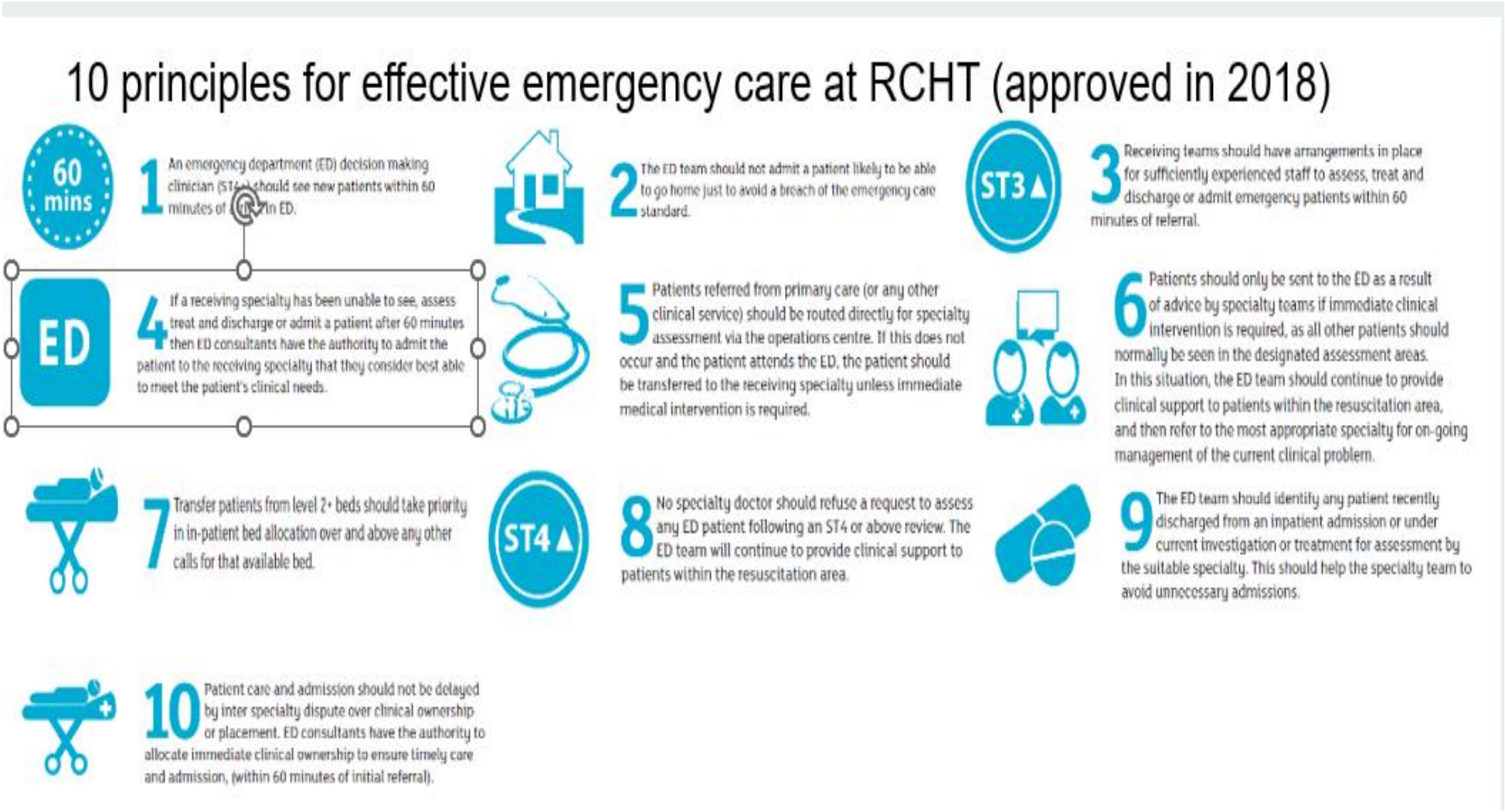
What management can be continued outside the hospital with community/district nurses? For example, IV antibiotics?

Persons with low NEWS (0 to 4) scores – can they be discharged with suitable follow up?

- If not scoring 3 on any one parameter – for example, pulse rate greater than 130.

- If their oxygen needs can be met at home.
- Stable and not needing frequent observations every 4 hours or less.
- Not needing any medical or nursing care after 8pm:
    - People waiting for results – can they come back, or can they be phoned through?
    - Repeat bloods – can they be done after discharge in an alternative setting?
    - People waiting for investigations – can they go home and come back as outpatients with the same waiting as inpatients?

Appendix 9. Internal Professional Standards



The above information is provided in page 5 of the RCHT Flow and escalation resource pack which can be accessed here: [RCHT Flow and Escalation Resource Pack].

Appendix 10. RCHT Discharge Flow Chart for Adults who Lack Capacity