

NHS England: Improving A&E Performance
Gateway ref: 00062

A. The Issue

1. Long waiting times in A&E departments (often experienced by those awaiting admission and hence ill patients) not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness.
2. We have an operational standard of 95% for patients being seen and discharged within 4 hours and we use this to be sure patients are being treated quickly. This operational standard is designed to deliver patients' rights under the NHS Constitution. A&E performance has deteriorated significantly over the last six months. In the last quarter of 2011/12, 47 out of 152 providers failed to meet the 95% standard for patients being seen and discharged within 4 hours. For the last quarter of 2012/13 this figure had increased to 94 out of 148 providers, double the previous number.
3. Despite much analysis there is no single trend or factor to explain the deterioration and there remains a wide variation in performance both across the country and within the same areas where similar factors apply. This has also been borne out in the perceptions from Clinical Commissioning Group (CCG) commissioners, gathered through the NHS Commissioning Assembly Rapid Reference Group.
4. A number of factors are assumed to have played a part in this deterioration, and not all of them pertain to every situation:
 - Increased numbers of patients arriving at A&E. There is a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10. However, the total numbers attending in Q4 of 2012-13 (which is when the significant deterioration began) was 1.7% lower than the previous Q4.
 - Increased number of acute admissions putting pressure on beds. There were 10.6% more emergency admissions in 2012/13 than in 2009/10. There is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays.
 - Hospitals being less proactive in process management which plays a very significant part in their ability to admit patients. Patients who require admission are the ones who are most likely to wait over 4 hours.

- A lower threshold in hospitals for admitting or discharging patients to ensure safety standards. In some cases, this is perceived to be linked to the seniority of the workforce in A&E.
 - A lack of specific services available to acute trusts in a timely fashion for certain specific patient groups, such as those with mental health, alcohol or drug abuse problems.
 - More delayed discharges because primary, community or social care services are not place.
5. There are also many assumptions as to why these factors have played a greater part than in previous years:
- Perceived lack of availability of primary care and community services, especially out of hours.
 - Reduction in bed numbers and staff as hospitals try to deliver cost improvement plans.
 - The Francis report and its impact on clinical decision making thresholds.
 - Lack of focus during transition for commissioners and uncertainty about changing roles in the new system.
 - Pressure on social care budgets.
 - Introduction of NHS 111.

B. Response

6. NHS England's role is to oversee the whole commissioning system and to ensure that, working in partnership with CCGs, patients receive the right standards and quality of care. Resolving the current situation will require the commissioning system to work with all key partners in hospitals, primary care, and local authorities to create a single national framework to ensure that we see rapid and sustainable improvement. The work needs to be considered in 3 phases:
- i. An urgent recovery programme with significant attention given by local and national commissioners and providers to all factors which can help recover the standards, (including clear performance management).
 - ii. A medium term approach to ensure delivery over the next winter period. This will include care system planning as well as a review of the levers and incentives in the system.
 - iii. In the longer term, the implementation of the urgent care strategy in order to deliver safe and sustainable services.
7. Although all the above elements are inter-related and aspects of the work can be undertaken in parallel, this paper focuses specifically on the

- immediate plan to improve A&E performance thus ensuring patients are seen swiftly and treated safely.
8. The plan builds on existing planning and contracting arrangements and discussions taking place to deliver Everyone Counts: Planning for Patients 2013-14. This includes the triangulation of plans and assessment of confidence in delivery, particularly where a reduced number of A&E attendances and emergency admissions is planned. We will need to be very clear about the level of tolerances in these assumptions, the potential impact on providers and the mitigating actions if assumptions prove to be incorrect.
 9. In its planning guidance to CCGs published in December 2012, NHS England highlighted the importance it puts on commissioners and providers ensuring that waiting times for patients in A&E departments are kept to a minimum. It has set out that the NHS Constitution minimum of 95% of patients to be admitted, transferred or discharged within 4 hours of their arrival must be met. To follow through on this requirement, it was made part of the standard contract between commissioners and providers and will be part of CCG Assurance – i.e. CCGs will be subject to intervention if their providers are not maintaining a sufficient level of performance.
 10. In addition, Everyone Counts has set out that no patients should wait more than 12 hours on a trolley in an A&E department – a requirement that did not exist under the previous system – and CCGs are empowered to take action (i.e. fines) against providers that breach this condition.
 11. This document has been prepared in conjunction with NHS Trust Development Authority (TDA) and Monitor, as they themselves work closely with providers to support the changes they need to make internally. However, NHS TDA, Monitor and NHS England all recognise the need for there to be a joint approach and one which is also agreed, at both national and local level, with our partners in local authorities, particularly social services.
 12. A range of national actions have been agreed between us, including a joint oversight function which is detailed here.
 13. Much of the document focuses on the actions expected of NHS England's Area Teams. However, local commissioners have the key role in supporting and ensuring the delivery of high quality emergency services, including that they are delivered in line with the NHS Constitution rights and that the 95% operational target is met.

14. This document focusses specifically on that commissioning role and the need for commissioners to ensure that:
 - They bring the system together and ensure good relationships and prevent fragmentation.
 - They provide strategic oversight for the system.
 - They have a clear focus on outcomes.
 - They tackle the obstacles.
 - They ensure that all the appropriate services are in place and they hold each provider to account for playing their part.
 - They promote integration and close working between all partners but especially health and social care.
15. They should ensure that providers, including primary care providers, are given a strong leadership role in determining the best way to deliver high standards.
16. We are asking all Area Directors to facilitate a local partnership approach. This will include providing assurance that an Urgent Care Board is set up for each local health community, ensuring coverage for every A&E department. In some parts of the country, Urgent Care Boards (or a similar arrangement) are already in place and these should be utilised as appropriate.
17. In addition, we will undertake a review of the financial levers and incentives that will contribute to improved performance.
18. NHS England would like to acknowledge the excellent work undertaken by the King's Fund in a review of urgent care in the South of England. This describes a range of actions which are needed to improve urgent care, and particularly A&E services. We have drawn on this work significantly in the production of our plan. The work also includes a comprehensive checklist of actions which is appended to our plan. We commend this to local health economies as an excellent source of good practice.

C. National Oversight and Actions

19. Implementation of local and national actions will be overseen by a tripartite group from NHS England, NHS TDA and Monitor. This group will also work closely with Local Government Association and Association of Directors of Social Services and with CCGs through the NHS Commissioning Assembly. The group will include:
 - Chief of Staff and a regional director, Monitor;

- Director of NHS Operations and Delivery (Corporate), NHS England; and,
 - Director of Delivery and Development, NHS TDA.
20. This group will:
- a. Set the timescales for the delivery of recovery and improvement plans which set out when performance will be achieved and maintained;
 - b. Have oversight of the delivery of recovery and improvement plans, with each organisation operating in line with its regulatory framework to hold individual commissioners and providers to account for delivery where required.
 - c. Sponsor the requirement for regular information which gives insight into the system;
 - d. Working with the NHS Commissioning Assembly, and the full range of provider representatives, to determine the specifications for any national support programme.
21. The detailed Terms of Reference for the group and the partnership agreement which underpins these are currently being developed and will be shared during May.
22. The group will commission research in a number of A&E systems to understand why there has been this change in performance. In essence, we need to understand what has happened between October 2012 and April 2013 that was different to previous years and have the evidence base to underpin this.
23. The group would be given delegated authority to act on behalf of the three organisations with access to organisational plans, to monitor and manage the reversal of the current situation in line with the regulatory framework for each sector. In response to current performance we will implement the winter management model which includes regular system wide conversations, deep-dives into organisations with difficult problems, trajectories for improvement and monitoring of progress and in parallel we will ask all communities to undertake an urgent review of winter and bring forward arrangements for next winter (we note that many commissioners are doing this).
24. We have already agreed that NHS IMAS will run a series of workshops across the country to support local health systems identifying best practice and the methods to implement this.

25. This tripartite arrangement will be mirrored at regional level. The regional arms of the NHS TDA, Monitor and NHS England, in line with the regulatory framework for each sector, will set up tripartite panels which will review and monitor the delivery of the plans. This will include intervention where plans are not delivered as agreed.
26. NHS England, Monitor and NHS TDA will be part of a programme oversight group which will include CCGs and will ensure the work is co-produced and learns from best practice.

D. Local Actions

27. NHS England Area Teams should facilitate the production of a recovery and improvement plan for each health community by working in partnership with CCGs, providers and local authorities. Recovery and improvement plans will need to look at each step of the patient's journey through the emergency system in three phases: firstly, prior to arrival at A&E; secondly, the patients journey through the hospital system; and thirdly, the discharge and out of hospital care.
28. Area Teams will ensure that Urgent Care Boards have been convened for all communities, which will feed into individual A&E departments. The Urgent Care Board will need to include all key stakeholders from health and social care as well as patient representatives and the appropriate clinical expertise.
29. We expect those Urgent Care Boards to ensure that:
 - They review the full range of appropriate data.
 - Best practice is adopted by all concerned.
 - The effectiveness of primary care services is reviewed, including out of hours and admission avoidance schemes.
 - The effectiveness of community services is reviewed, including any walk in centres, minor injury units and how they integrate with secondary care.
 - The effectiveness of ambulance services is reviewed.
 - The effectiveness of NHS 111 is reviewed.
 - There are local plans in place to support the care of the key categories of patient who attend or are admitted frequently:
 - Patients with multiple comorbidities especially those with poorly controlled chronic disease:
 - Frail elderly, especially those with mental health problems;
 - Sick children; and,

- High dependency individuals, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems).
 - A full range of services is available to acute trusts for those patients in A&E who need services not provided by acute hospitals are in place.
 - Working with local authorities, a review to ensure early discharge is feasible is undertaken.
30. Where areas have not already agreed plans and committed funds, we expect the Urgent Care Board to oversee the use of the 70% funding retained from excess care urgent tariff. In particular, the use of this money must be clearly identified to support any aspect which will support the urgent care system and acute providers' ability to deliver the operational standard.
31. We would expect the use of this money to be signed-off jointly by CCG leaders, NHS England Area Directors, provider Chief Executives, and local authority Chief Executives by the end of June, so that schemes can be implemented ready for next winter. The use of the money must be clearly linked to specific delivery of outcomes and improvements in standards.
32. Urgent Care Boards will be expected to sign-off all aspects of the local recovery and improvement plan.
33. Recovery and improvement plans will need to include:
- An agreed local plan to bring the performance back on track by the end of Q1, including a sustainability plan, produced by the Area Team, including sign-off from Health and Social Care Partners.
 - Preparation for working on a winter plan 2013/14 to sign-off by Area Team by November 2013.
 - Evidence the best practice from Emergency Care Intensive Support Team (ECIST).
34. Recovery and improvement plans should consider the following aspects of care although this list of actions is not exhaustive and we must acknowledge there may be different issues at a local level:
- A. Prior to A&E:
- Strengthening primary and community care for frail and elderly patients.
 - Use of community diversion schemes.

- Strengthening GP out-of-hours services.
 - Use of virtual wards in the community.
 - Support to care homes to avoid emergency referrals.
 - Peer review of GP emergency referrals.
 - Reducing ambulance conveyance rates.
 - Patient education on appropriate use of emergency services.
 - Roll-out arrangements for NHS 111.
- B. Flow within the hospital:
- Prompt booking of patients to reduce ambulance turnaround delays.
 - Full see-and-treat in place for minors.
 - Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed
 - Prompt initiation of blood and radiological tests with rapid delivery of test result.
 - Prompt access to specialist medical opinion.
 - Full use of computer-aided patient tracking and system for progress-chasing.
 - Regular seven-day analysis should be in place for rapid identification and release of bottlenecks.
 - Bed base management
 - Daily consultant ward rounds.
 - Provision of specific services for patients groups such as those with mental health problems.
- C. Discharge and out of hospital care:
- Designation of expected date of discharge (EDD) on admission.
 - Maximisation of morning and weekend discharges.
 - Full use of discharge lounges.
 - Minimisation of outliers.
 - Delayed transfers of care reduced.
 - Flexing of community service capacity to accept discharges.
 - Review of continuing care processes.
 - Assessment of use of reablement funding by local authorities.
35. In developing recovery and improvement plans, communities are encouraged to think about innovation and not simply commission traditional approaches. To facilitate this we would advocate the use of the NHS IQ improvement function, in particular ECIST, to ensure that best and good practice is adopted.

36. The recovery and improvement plans should draw on existing ECIST reports on local services and ensure these reports recommendations are implemented.
37. The recovery and improvement plans should also describe how the 70% funding retained from excess care urgent tariff will be used in the health community to reduce pressure on A&E (either within the hospital setting or in the community) or make improvements within A&E itself. It should demonstrate how all parties have been involved in the use of this funding and the responsibilities associated with the receipt of any of this funding, particularly in describing the expected outcomes and improvements in standards.
38. NHS England will ask its Area Teams to collate recovery and improvement plans and carry out initial quality assurance. These plans need to be completed and submitted to Regional Directors by 31 May 2013 to enable tripartite discussions with the NHS TDA and Monitor to commence.

E. Conclusion

39. Working closely with other key stakeholders, and building on the views already shared from CCGs and providers, NHS England will put in place an approach that will support the emergency and urgent care system, reduce pressure and ensure that patients do not have to wait longer than the agreed standards as identified in the NHS constitution and thus meet the national operating target of 95%.
40. This document outlines the overall approach and identifies the actions which Area Directors should now put in place to ensure that the commissioning system responds appropriately to support providers of A&E and urgent care services.

9 May 2013

Appendix: Emergency Care Checklist – Urgent and Emergency Care: A review for NHS South of England (The King’s Fund, March 2013)

It is vital that health communities intelligently adapt what is known to work effectively and then ensure that this is actively managed and kept under review. The following approaches are based on current guidance from the Emergency Care Intensive Support Team and findings from our research.

Note that the evidence to support the ideas that follow is variable and many depend on the local context.

Urgent Care Boards

Establish a local Urgent Care Network (UCN) which incorporates strategic and operational leads across the emergency care system including consultants, GPs and ideally patient representatives. Develop robust terms of reference for the local UCN using the good practice set out in the DoH Emergency Care Network guidance.¹

- Map out the range of existing groups/boards to ensure there is clarity with regard to both process and communications between the UCN and the local Trust Boards.
- Align commissioner and provider priorities and incorporate within a local strategy.
- Ensure all urgent care work streams report back to the UCN to support improved communication.
- Ensure all work streams are supported by programme management and leadership to enable whole system implementation.
- Develop a dashboard to monitor the overall impact of the programme and manage system resilience. The following example of a suite of whole system metrics may be helpful:
 - A primary care access metric at general practice level.
 - Ambulance turnaround times (30 minute arrival to clear) and category A and B response time delivery.
 - The four hour standard (underpinned by disposal profiles, showing the % of patients leaving the department after three hours forty five minutes has elapsed (for admitted patients, and two hours for non-admits)
 - Adult non-elective bed occupancy rate using an agreed non-expanded bed number consistently as the denominator.
 - Percentage of discharges from hospital before and after midday.

¹ Emergency care networks checklist (2004) Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086939 (accessed 6th Jan 2012) This checklist shows how networks can improve patients' care by connecting all the members of a health community. It offers suggestions for membership and an example terms of reference, as well as early steps and specific actions for building effective local networks. It also contains links to support and resources.

- Community service based performance metrics (e.g. rate of delivery of a 4 hour standard for admission avoidance and a 12 hour standard for early supported discharge).
- Average time from referral to assessment for mental health patients with no physical illness.
- Social care response and performance metrics.
- Outcome and patient experience metrics (mortality, effectiveness of pain control, patient reported outcome measures etc).

Communication and information

- There should be a clear vision aligned to an emergency care system strategy aimed at improving capacity, demand, patient experience and quality across system. There should be a narrative that focuses on the safety and quality benefits for patients, and the development of a culture that views the system flow as everyone's responsibility across the health and social care community.
- A broad campaign to implement and embed practices known to work (particularly in the hospital) should be considered, this should engage all members of staff in understanding their roles and actions required to improve emergency care performance, and patient flow. There are mobilising and organising techniques which are useful to win hearts and minds and gain commitment - further information on large scale sustainable change is available from the NHS Institute.²
- Identify champions to optimise delivery of the emergency care strategy and engage other staff in making a high performing emergency care system "everyone's business". Clinical Directors should view good patient flow and capacity and demand management as part of their responsibility for quality and safety.
- A real time directory of services with capacity information seems to be an important aspect of management.
- The idea of notification systems, GP dashboards and other methods to inform GPs and case managers that their patients are in hospital should be explored.

Root cause analysis of emergency care system failures

Root cause analysis of system failures (such as ambulance handover delays, closure of multiple wards from Norovirus etc.) should be owned and undertaken by individual organisations, but findings shared across the system. There should be a robust assessment of the root causes, with a genuine effort made to get to the real root causes, rather than trying to demonstrate system failure was unavoidable.

The system must ensure findings result in action and improvement – a process of senior review would demonstrate the importance that organisations place on root cause analysis and learning from it.

² NHS Institute information on large scale change:

http://www.institute.nhs.uk/general/general/leading_large_scale_change.html (accessed June 2012)

Commissioning

Unscheduled care commissioning intentions need to be clear, shared and communicated. The strategy and commissioning intentions need to be owned by local stakeholders and therefore developed with meaningful input from providers.

Commissioning decisions should be made around the approaches that are known to be effective in managing emergency care, these are outlined below. Commissioners should also ensure that the financial flows and contracts for services support patients moving through the system, and do not create dis-incentives and gaming.

Encouraging CCGs to federate and have a single dialogue with providers would go some way to enabling positive relationships to be established.

Commissioning around outcomes and allowing the provider to determine the detail of how services should be provided seems to be a key factor in successful approaches. The model of commissioning emergency care needs to be rethought, with providers given a stronger leadership and responsibility role in determining delivery. Commissioning emergency care needs to shift from a sometimes adversarial approach of micro-managing to one where CCGs take an oversight and scrutiny role, supported by a system dashboard that highlights the system capacity and demand.

Internal professional standards

- Response standards should be agreed for the whole system, including community, ambulance and hospital services, and cover time to:
 - Assessment (including diagnostics, investigations and therapy services). Within this implement single assessment processes to reduce duplication.
 - Treatment.
 - Review.
 - Referral. Within this simplify referral processes, rather than using them as mechanisms to “hold back” work.
 - Discharge (refer to the section below on discharges).
- Use metrics to measure performance and consistency of delivering IPS.

Staff training

Ensure relevant staff are trained in practices known to be effective (RAT, See and Treat etc.) Primarily focus effort on training key staff and consider using a “train the trainer” approach to roll out new practices quickly.

GP practices

- Ensure there are appointments available for urgent cases and follow published guidance.^{3,4}
- Consider the use of GP telephone triage and GP call-back to manage demand, although studies around this approach are small scale the evidence is encouraging. Note that it also requires significant redesign of workflows – it is not a simple intervention
- Stagger home visits to reduce ‘batching’. Using the ambulance service, nurses or a physician of the day may be one solution.
- Raise patient awareness of alternative services available (other than the emergency department, note that there is limited evidence of the effectiveness of patient education around emergency department avoidance.
- Undertake training and education around end of life.
- Ensure advanced planning is implemented consistently.
- Ensure all patients who need advanced care plans and end of life plans have them in place and that all health professionals they are in contact with are aware of these plans.
- Extending primary care hours is an approach that has yet to be proven and should be monitored.
- Implement productive general practice and other approaches to increase the availability of same day appointments.
- Consider methods for improving continuity of care for complex patients.
- Ensure high quality input into nursing and residential homes, this may require some reallocation of responsibilities.

GP out of hours

- Out of hours service contracts should be outcome based to promote joint working and integration with other services.
- Ensure GP out-of-hour services have access to patient records and care plans.
- Promote a greater emphasis on using alternative systems and patients being able to access the appropriate service based on their need.
- Look to co-locate GP out of hours within the hospital.

Walk-in centres and minor injury centres

- There are growing concerns around the effectiveness of walk in centres and these centres should be evaluated rigorously.
- Ensure opening times are aligned to other parts of the emergency care system to reduce duplication.

³ Urgent care: a practical guide to transforming same-day care in general practice. Primary Care Foundation (2009) <http://www.primarycarefoundation.co.uk/report.html> (accessed 26th November 2012)

⁴ Introduction and User Guide - Urgent Care in General Practice Toolkit - A practical Toolkit to help GP Practices and GP Consortia improve patient experience and surgery workload. ECIST

- Where possible co-located and integrate with emergency departments.⁵
- Consistently use the See and Treat model.⁶
- Ensure clinical governance and management is integrated with the emergency care system.
- Ensure access to diagnostics.
- Ensure consultant advice is accessible.
- Work with the ambulance service to promote the centre as an alternative when appropriate.

Community services

As noted above the number of evidence based models and actions for community services are less well understood but appear to include the following:

- Critically examine pilots, projects and approaches. Ensure that initiatives are thoroughly evaluated and only roll out the most cost effective and promising.
- Remove some of the complexity, overlaps and individual schemes to create services on a large enough scale to be able to make significant differences in terms of supporting patients with long term conditions
- Ensure community services can anticipate demand and are able to flex capacity to meet needs.
- Ensure there are simple referral criteria and streamlined assessments and documentation that enable patients to be transferred quickly.
- Consider basing community services around key hospital providers to enable strong relationships and integrated teams to be established.
- Use case management and risk stratification when appropriate.⁷
- Provide integrated health and social care crisis support teams.⁸
- Provide IV support to patients in the community.

Nursing and care homes

There is evidence that nursing and care home residents receive low levels of clinical care and that making good these shortfalls significantly reduces the number of emergency

⁵ Chalder. M., *et al* (8 March 2003) Impact of NHS walk-in centres on the workload of other local healthcare providers: time series analysis. *BMJ: Primary Care*. Vol 326
<http://www.bmj.com/content/326/7388/532.reprint?maxtoshow=&HITS=80&hits=80&RESULTFORMAT=&fulltext=%22walk%20in%20centres%22&searchid=1&FIRSTINDEX=10&sortspec=date&resourcetype=HWCIT> (accessed 26th November 2012)

⁶ Keep things moving – see and treat patients in order (2008) Quality Service and Improvement Tools. NHS Institute
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/keep_things_moving_-_see_and_treat_patients_in_order.html (accessed 1st Nov 2012)

⁷ Purdy, S. *et al*. (2012) Interventions to reduce unplanned hospital admission: A series of systematic reviews. Final Report June 2012. University of Bristol, University of Cardiff, National Institute for Health Research

⁸ Thistlethwaite. P. (2011) Integrating health and social care in Torbay: improving care for Mrs Smith. London: King's Fund

attendances and admissions.⁹ It is estimated that between 8% and 40% of patients seen in the emergency department that come from care homes could have been cared for outside of the department.¹⁰ These patients are also at risk of rapidly decompensating once in the hospital, and where possible should be treated within nursing and care homes.

- Provide and end of life education, training and support to nursing and care homes.
- Implement advanced care plans.¹¹
- Ensure regular case review and medicines management reviews.
- Increase the level of medical care and access to specialist advice (geriatricians and GPs) in nursing and care homes.^{12,13,14}
- Provide IV support.

Frail elderly

Although these represent a relatively small number of overall admissions this patient group has a very high propensity to be admitted and once in hospital often decompensate, have a long length of stay and are problematical to discharge, therefore generating a large number of bed days.

The successful discharge of frail older people following an emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector. In organising discharge systems, a whole systems approach is important. This should aim to anticipate and promptly respond to potential bottlenecks or obstacles, smooth patient flow, and recognise the interdependency between partners.

It is important to commission and embed practice and processes with a proven record of enhancing patient flow within acute hospitals – a summary of these effective

⁹ Steves. C.J., Schiff. R., Martin. F.C. (2009) Geriatricians and care homes: Perspectives from geriatric medicine departments and primary care trusts, *Clinical Medicine* 9:6 528-533

¹⁰ Carter., Skinner., Robinson. (1998) Patients from care homes who attend the emergency department: could they be managed differently *Emerg Med J* doi:10.1136/emered-2012-201630)

¹¹ Caplan. G.A., *et al* (2006) Advance care planning and hospital in the nursing home. *Age and Ageing* 2006; 35: 581–585 <http://ageing.oxfordjournals.org/content/35/6/581.full.pdf+html> (accessed 26 November 2012)

¹² Steves. C.J., Schiff. R., Martin. F.C. (2009) Geriatricians and care homes: Perspectives from geriatric medicine departments and primary care trusts, *Clinical Medicine* 9:6 528-533

¹³ Crilly. J., Chaboyer. W., Wallis. M. (2011) A structure and process evaluation of an Australian hospital admission avoidance programme for aged care facility residents, *Journal of Advanced Nursing* 68:2, 322-334.

¹⁴ Evans. G. (2011) Factors influencing emergency hospital admissions from nursing and residential homes: positive results from a practice-based audit. *Journal of Evaluation in Clinical Practice*. 17:6. 1045-49.

approaches is available from the Intensive Support Team.¹⁵ These approaches should also ensure there is an active 'pull' from the community to ensure frail elderly patients who are medically fit to be discharged can return to the community.

Addictions and mental health

There is evidence from local studies that a small number of users of emergency services are 'frequent attenders' that often result in admission. Many of these frequent attenders suffer from drug and alcohol addictions or mental illness, or have social problems such as homelessness or unemployment.

- Develop and implement an alcohol strategy. Alcohol abuse has been found to account for 12% of emergency department attendances and 6.2% of hospital admissions.¹⁶
- Establish rapid response services for people with mental illness.¹⁷ This should include approached for both known and unknown users.
- Implement psychiatrist input out of hours; case management; assertive outreach services; and within hospital liaison services especially for mental illness and alcohol abuse to reduce attendances, admissions and costs.^{18,19}

Paediatrics

- Evaluate GP access, particularly between 3pm-8pm.
- Look at the GP skill mix and ensure paediatric primary care is available at a high standard.
- Review the appropriateness and availability of paediatric cover in hospital.

Ambulatory emergency care directory

The Ambulatory Emergency Care Directory was published in 2007 by the NHS Institute, identifying 49 emergency conditions and clinical scenarios that have the potential to be managed on an ambulatory basis.²⁰ Actively managing patients with ambulatory care sensitive conditions (through vaccination; better self-management; disease-

¹⁵ Effective Approaches in Urgent and Emergency Care. Paper 3. Whole system priorities for the discharge of frail older people from hospital care. (2012) ECIST

¹⁶ Pirmohamed. M., *et al* (2000) The burden of alcohol misuse on an inner-city general hospital. QJM (2000) 93 (5): 291-295.doi: 10.1093/qjmed/93.5.291.

<http://qjmed.oxfordjournals.org/content/93/5/291.short> (accessed 2 Nov 2012)

¹⁷ Glover. G., Arts. G., Babu. K.S. (2005) Crisis Resolution teams and inpatient mental health. Centre for Public Mental Health, University of Durham.

¹⁸ Althaus. F., Parox. S., Hugli. O., Ghali. W.A., Daeppen. J-B. *et al* (2011) Effectiveness of interventions targeting frequent users of emergency departments: a systematic review, *Annals of Emergency Medicine*, 58:1, 41-52.

¹⁹ Tadros. G., Salama. R., Mustafa. N., Pannell. R., Balloo. S. (2011) The Rapid Assessment Interface and Discharge Liaison Team, City Hospital Birmingham: Evaluation Report December 2009 – September 2010.

²⁰ Ambulatory Emergency Care Directory (2007)

www.institute.nhs.uk/option.com...194/.../products_id,181.html (accessed 5th December 2012)

management or case-management; or lifestyle interventions) prevents acute exacerbations and reduces the need for emergency hospital admission.

- Ambulatory care services should be provided as an unscheduled service with closer working between the emergency department consultants and acute physicians. Have a clear plan to roll out at least two emergency conditions to the service each year and mainstream them.
- Ensure senior clinical decision makers are available to decide on the need for admission.
- Ensure ambulatory emergency care is available for all patients who meet the criteria.
- Ensure access to timely investigations to support clinical decision making.
- Community clinics for diabetes, heart failure and respiratory patients can be very expensive and the approaches to these inconsistent. Linking these outreach clinics to ambulatory care models may be a good use of scarce resources.

Ambulance services

Analysis of ambulance demand is key to understanding where to focus attention in the emergency care system.

Although there are some known approaches to improving performance (outlined below), the ambulance services still remains a largely untapped resource of skills and experience, both clinical and managerial, that should be explored further.

- Access to care plans and advanced care plans was flagged as an important area.
- Establish emergency care practitioners.^{21,22,23}
- Ambulance handover should follow guidance available.²⁴
- Review contracts to ensure that transport is available in a timely manner for patients who are medically fit and require ambulance transport back into the community.
- Analyse ambulance call outs to identify causes and areas of increase. Target frequent callers – including GPs

The emergency department²⁵

²¹ Mason. S., O’Keeffe. C., Coleman. P., Edlin. E., Nicholl. J.(2007) Effectiveness of emergency care practitioners working within existing emergency service models of care, EMJ. 24:239-43

²² O’Hara. R., O’Keeffe. C., Mason. S.. Coster. J.E., Hutchinson. A. (2012) Quality and Safety of care provided by emergency care practitioners, EMJ. 29:327-32

²³ *ibid* O’Hara *et al* (2012)

²⁴ NHS South West - Ensuring timely handover of patient care - ambulance to hospital (2008)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089072 (accessed 30th Nov 2012)

- Implement Rapid Assessment and Treatment (RAT) for “majors” patients.²⁶ Early senior review is likely to increase the number of people able to be managed at home and to prevent adverse outcomes.²⁷
- Implement See and Treat for patients with minor injuries and illnesses.²⁸
- Reduce or eliminate triage.
- Emergency department crowding – Adopt the College of Emergency Medicine guidance around full capacity protocols.²⁹
- Use appropriately trained nurses to admit patients in liaison with specialities.
- Review layout and physical capacity of the emergency department.
- Review services provided in the emergency department to ensure that inappropriate services (such as review services and follow up services) are removed to free up clinical time.
- Trusts need have a clinical staffing strategy to ensure the provision of the required competencies on an hour by hour basis. An appropriate mix of consultants, middle grades, advanced nurse practitioners, majors nurse practitioners, physician assistants and extended role HCAs need to be developed. This needs to be underpinned by robust job planning.

Patient streaming

- Create separate streams for minors and majors, with dedicated staff, processes and coordination. Create processes to ensure that the major’s stream is not halted by a full resuscitation room.
- The ED should avoid acting as the default arrival point for referrals that do not require resuscitation or stabilisation (e.g. most GP or clinic referred patients) – these patients should by-pass the emergency department and go directly to acute medical units or specialist beds.

²⁵ Effective Approaches in Urgent and Emergency Care. Paper One. Priorities within Acute Hospitals (2011) ECIST

(http://www.nhsimas.nhs.uk/fileadmin/Files/ECIST_Conference_October_2012/ECIST_papers/FINAL_ECIS_T_Paper_1_-_Priorities_within_Acute_Hospitals.pdf (accessed 5th December 2012)

²⁶ Effective Approaches in Urgent and Emergency Care. Paper Two - Rapid Assessment and Treatment Models in Emergency Departments. (June 2012) ECIST

(http://www.nhsimas.nhs.uk/fileadmin/Files/ECIST_Conference_October_2012/ECIST_papers/FINAL_ECIS_T_Paper_2_-_Rapid_Assessment_and_Treatment_in_EDs_June_2012.pdf (accessed 30th Nov 2012)

²⁷ Caring to the End? A review of the care of patients who died in hospital within four days of admission A report of the National Confidential Enquiry into Patient Outcome and Death (2009)

(http://www.ncepod.org.uk/2009report2/Downloads/DAH_report.pdf (accessed 7th Jan 2013)

Emergency Admissions: A journey in the right direction? A report of the National Confidential Enquiry into Patient Outcome and Death (2007) (<http://www.ncepod.org.uk/2007ea.htm> (accessed 7th Jan 2013)

²⁸ Keep things moving – see and treat patients in order. Quality Service and Improvement Tools. (2008) NHS Institute

(http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/keep_things_moving_-_see_and_treat_patients_in_order.html (accessed 1st Nov 2012)

²⁹ The College of Emergency Medicine - Crowding in Emergency Departments (August 2012) (<http://secure.collemergencymed.ac.uk/code/document.asp?ID=6296> (accessed 1st Nov 2012)

- Ensure senior decision makers in high volume specialties are available to attend the emergency department within thirty minutes of referral.
- Ensure the emergency department has direct admission rights using agreed protocols.
- Provide short stay capacity for patients with an anticipated length of stay of up to two midnights (assessment and short stay capacity is usually co-located in acute medical units). A review of what is achievable through short stays in unscheduled care has been published by the NHS institute.³⁰
- Further streams should be to specialist beds (for complex speciality patients requiring greater than seventy two hour stays), beds for patients with complex discharge needs (e.g. the frail elderly) and catastrophic illness (e.g. critical care and stroke patients).
- Ambulatory emergency care should be provided where appropriate.

Acute Assessment Unit (AMU)

There is an issue with a lack of standard terminology across the country (they can also be known as Clinical Decision Units / Observation Units /Acute Medical Units / or Surgical Assessment Unit), which can lead to confusion as to what is being described and what the core function of these units is. The ownership, role and responsibility of all such units should be clearly defined and agreed by the clinical leadership of the trust. The Royal College of Physicians has set out a clear set of standards for medical assessment units; these have been supplemented recently with guidance on workforce and job planning.³¹

- When undertaking clinical duties on the AMU, the consultant should be free from any other specialty, ward or management commitments.
- Individual consultants' duties on the AMU should be for two or more consecutive days; any variation must be specifically designed to optimise continuity of care on the AMU.
- Appropriate diagnostic and support services should be provided seven days per week, to ensure that the full benefits of consultant delivered-care to patients are realised.
- During the period of consultant presence on AMU, all newly admitted patients should be seen within six to eight hours, with the provision for immediate review as required according to illness severity.
- A newly admitted patient must be seen by a consultant within 14 hours after arrival on AMU.

³⁰ Focus on Short Stay: NHS Institute (2007)

http://www.institute.nhs.uk/option.com_joomcart/Itemid,26/main_page,document_product_info/products_id,192.html (accessed Jan 7th 2013)

³¹ <http://www.rcplondon.ac.uk/sites/default/files/documents/acute-care-toolkit-4.pdf> (accessed 7th Jan 2013)

- All patients in the AMU should be reviewed twice each day by the AMU consultant or appropriate specialty team.
- Consultant presence on the AMU should start no later than 8am.
- Duration of an individual consultant’s presence on the AMU should usually be between eight and 12 hours.
- Extended evening working until 10pm should be considered, depending on local patterns of patient referral and arrival.

The units should also ensure:

- It stays below 85-90% utilisation at all times so that it has capacity to care for the anticipated number of arrivals hour by hour.³²
- Consultant-led rolling ward rounds to avoid batching patients to be seen on “set piece” ward rounds.
- Clear systems for patients requiring specialist care, so they can be cared for in the most appropriate setting as quickly as possible.
- A targeted discharge standard of all patients to be discharged by 1pm, to be reviewed at an 8am board round (anything beyond that would be regarded as a breach and attract the same root cause analysis as an emergency department breach).
- Standardised clerking documentation.
- “Home for Lunch” schemes, whereby the hospital gives patients written commitment to get them home for lunch on their day of discharge, and therefore to plan to move the patient from their bed to the discharge lounge early in the day; family members and carers are also alerted.
- Regular patient experience monitoring supported by performance information as the patient experience of these busy, noisy units is often very poor and patients often stay there for inappropriately long periods.

The Surgical Assessment Unit at one trust had a clear patient cohort and it takes referrals from the emergency department and direct from GPs. The Unit is well supported, with a co-ordinator undertaking a nursing assessment and a junior doctor reviewing within 30 minutes. More senior support at middle grade or consultant level is easily accessible, with an operating list close by providing ready access if required. Access to diagnostics was good, with ring-fenced ultrasounds and reserved CT slots, duplex scanning and a set weekend consultant radiologist schedule. There are twice-daily board and safety rounds of each patient with a multi-disciplinary team present around the white board (scripted morning meeting at 9am focussing on actions required to discharge home, then a briefer handover meeting at 12pm). The estimated discharge dates are consultant-led and a discharge lounge available for “fit for discharge” patients.

³² Planning for predictable flows of patients into unscheduled care systems beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST

Escalation beds

- Adding the capability to flex capacity has the risk of changing admission thresholds and the story of winter wards that prove impossible to close is well known. Solutions that allow capacity flex, without creating supplier-induced demand are required. The effective use of AMUs (that maintain approximately 15% free capacity) can mean specialities wards can operate at close to 100%.

Specialty Wards

- Ensure that a consultant sees all patients, and their care plans are confirmed, within two to three hours of admission to the ward (or a maximum of twelve hours if admitted out of hours), and sooner if the patient's clinical need requires it.
- Twice daily one-stop board-ward rounds should be the standard. Develop 'one stop ward rounds', where tasks such as completing a 'To Take Out' form and filling request forms are completed before the round moves onto the next patient (avoid batching work to the end of the round).
- Ward managers need to be supernumerary to coordinate and drive care.
- Schedule main ward rounds for the mornings, and see potential discharges first, so that beds are freed as early as possible.

Step down facilities

Look into establishing step down beds for patients awaiting complex care packages, and private funded nursing home patients deciding on placements. This would improve the flow of the hospital. Using community services or contract home care nursing providers for rapidly creating home care support also seems to be effective

Readmissions

Discharge planning, risk stratification of patients being discharged, support with medications and community and social care support are all well understood interventions in this area.

There have been some successful approaches to hospital led discharge teams, who provide continuity of care to patients in the first few weeks after discharge and have prevent readmissions. Another approach is to have a dedicated number for possible readmissions and access to a clinic for patients to come to and be reviewed by a consultant.

Discharge planning

- Every patient having a consultant-led expected date of discharge (EDD) completed within 12 hours of admission (a number of trusts have found specifying a morning discharge helps improve bed availability earlier).

- Care plans must include an EDD and criteria for discharge. Empower the multi-disciplinary team to discharge when criteria are met (particularly at weekends), rather than waiting for senior medical confirmation.
- There should be daily, early morning board rounds by a senior clinical decision maker (normally a consultant) to ensure that the care plan is on track.
- Schedule short board rounds for the mornings, and see potential discharges first, so that beds are freed as early as possible and those patients who are deteriorating are picked up early by a senior doctor.
- Clinical criteria for discharge recorded in each patient's notes.
- Any non-clinical change to the EDD should be captured separately and reviewed.
- Identify patients at risk of prolonged stay at an early stage using simple tools like the Blaylock assessment.³³
- Manage planning for frail elderly people assertively to avoid in-hospital decompensation with associated prolonged stays.³⁴
- Ensure services required for discharge are accessible at weekends.
- Co-locate social services staff with the discharge planning team in the hospital. Another option which has been effective is twice weekly conference calls with a strong chair and with decision makers present.
- Simplify the documentation and forms surrounding patient transfers.

System capacity and demand management

- Develop system wide predictive modelling based on demand and capacity utilising the national bed management tools.^{35,36,37} Often the bed bureau / bed management office within trusts is operated by staff retaining knowledge in their heads and being reactive, rather than operating easy to understand systems that are aimed at increasing capacity up-stream.

³³ Mistiaen. P., Duijnhouwer. E., Prins-Hoekstra. A., Ros. W., Blaylock. A. (1999) Predictive validity of the BRASS index in screening patients with post-discharge problems. Blaylock Risk Assessment Screening Score.

J Adv Nurs 1999, 30(5):1050-1056

³⁴ Effective Approaches in Urgent and Emergency Care. Paper 3. Whole system priorities for the discharge of frail older people from hospital care. (2012) ECIST

³⁵ Faster access: Bed management demand and discharge predictors (2004) Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4091598 (accessed 26 November 2012)

³⁶ Planning for predictable flows of patients into unscheduled care systems beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST

³⁷ Demand and Capacity – Basic Concepts (2008) Institute for Innovation and Improvement http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/demand_and_capacity_-_basic_concepts.html (accessed 5th December 2012)

- Develop an agreed system wide escalation protocol that has input from all relevant stakeholders.
- Use a tool to predict the expected number of admissions – if anticipated admissions exceed expected bed availability, escalate early.
- Where there has been a spike in admissions systems to anticipate the following spike in demand for community and social care is required
- Undertake demand and capacity management within primary care.
- Within the acute trust each specialty and supporting department should plan to match capacity to demand. Staffing rotas should be designed to match demand profiles. In general, focus on early assessment by senior and experienced staff to plan care is likely to be the most important step to reduce the unnecessarily long acute hospital stays which some patients endure. Experience of hospitals which have worked hard to follow the principles of best practice is that length of stay does fall substantially. More importantly perhaps, patient satisfaction increases and complaints fall. Critical incidents become less frequent and the safety of the patients in hospital is improved.³⁸

³⁸ Planning for predictable flows of patients into unscheduled care pathways beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST