NHS

Office of the Strategic Health Authorities

EMERGENCY SERVICES REVIEW

Good Practice in Delivering Emergency Care: A Guide for Local Health Communities

July 2009

East of England East Midlands London North East North West South East Coast
South Central South West West Midlands Yorkshire and The Humber

NHS

Interim Management and Support

Emergency Services Review

Good Practice in Delivering Emergency Care: A Guide for Local Health Communities

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The Emergency Services Review was co-ordinated by NHS Interim Management and Support on behalf of the Office of the Strategic Health Authorities

Thanks go to everyone involved with the project

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The Emergency Services Review has produced a set of guidance and tools. The following publication is part of this series of documents. The publications are:

- A comparative review of international Ambulance Service best practice
- Good practice guide for Ambulance Services and their commissioners
- Good practice in delivering emergency care: A guide for local health communities
- System resilience: A review of NHS emergency care performance during recent winters
- Intensive support diagnostic toolkit: Tools and user guide

These publications are all available in PDF from http://www.osha.nhs.uk. Please contact programmes@osha.nhs.uk for hard copies or with any queries.

PREFACE

Since the publication of 'Reforming Emergency Care' in 2001, there have been many significant and helpful guides, checklists and tools produced to assist Local Health Communities to deliver the improvements in Emergency Care recommended in that report.

We do not believe that there is a need for further guidance. What is needed is an easy way to access existing guidance so that it can be used by busy managers and clinicians. This Guide aims to do just that.

The following sections bring together the guidance, checklists and tools from multiple websites that have been developed over the last 6-8 years to support improvements in emergency care. The URLs linking to all documents referenced in the text can be found at Appendix B.

The Guide follows the sections of the Emergency Care Intensive Support Team's whole systems diagnostic tool: '*Emergency Services Baseline Assessment – Local Health Communities'*. The aim is to help managers and clinicians access resources that will help them bring about desired improvements following self-assessment or a diagnostic facilitated by the IST.

If you would like to comment on this guide, email: russell.emeny@southwest.nhs.uk.

1. INTRODUCTION

1.1 The aim of this guide is to provide easy access to good quality guidance on the delivery of emergency care for busy people. It is aimed at:

- NHS provider service managers and directors, clinical managers and medical managers to highlight established good practice
- NHS Commissioners to:
  - Highlight established models, techniques and efficiencies
  - Foster innovation and efficiency through informed commissioning of emergency services

1.2 Other partners will find help to advance improvements in unscheduled care pathways for the benefit of patients and local health communities.

1.3 In writing this guide, we have carried out an extensive literature review and consulted senior NHS leaders, commissioning and provider specialists. A full bibliography is contained in Appendix B.

1.4 The flow of this document is intended to follow a typical pathway for patients who need emergency or urgent care. The most relevant sections of guidance have been sign-posted in each section for easy navigation, with full URLs included as footnotes, to help the reader find relevant documents without the need exhaustively to search DH and NHS websites.

2. GOVERNANCE AND WHOLE SYSTEM PARTNERSHIP

Agreeing a vision for urgent and emergency care

2.1 To commission and provide emergency and urgent healthcare services that are safe and provide value for money, there needs to be a locally agreed vision for emergency and urgent care. Ideally, this should link with the SHA vision for the future of its local healthcare services.

- **Reforming Emergency Care** published in 2001, sets out the standards for care and treatment in emergency services that provides the basis for a health system to develop and agree its vision for these services
- The December 2008 DH **Guidance on the Standard NHS Contract for Acute Hospital, Mental Health, Community and Ambulance Services and supporting guidance** explains how the Contract can be used as a tool for assuring accountability between Providers and PCTs, and for improving performance. The guiding principles and expected behaviours in section 2 outline a whole system approach where effective partnerships are fundamental
- The 2008 Healthcare Commission's **"Not Just a Matter of Time" – a review of urgent and emergency care services in England**, is an extensive review focussing on how services are accessed, delivered and managed across an area. It highlights a lack of awareness and understanding of the range of new services that have been introduced in recent years. It also identifies many of the problems patients experience on the pathways they follow into urgent and emergency care. Where patients are dealt with by the first service they contact, their care usually proceeds smoothly. But where patients are transferred or referred between services, they can experience problems. A summary of its recommendations is contained in 'Next Steps' on pages 52-60. The first recommendation is "PCTs should ensure that they have a clear plan for the delivery of integrated urgent and emergency care services across their area"

Effective mechanisms to enable a whole systems approach

2.2 Pressures within emergency and urgent services affect the whole health and social care system. Faster, more convenient access to emergency care cannot be delivered and sustained without co-operation. The 2007 DH **Emergency Care Network Guidance** describes why Emergency Care Networks are a vital part of Reforming Emergency Care. This framework aims to clarify their purpose and makes suggestions for **membership** and **terms of reference**.

2.3 The 2004 DH **Emergency Care Networks Checklist** shows how networks can improve patients' care by uniting all the members of a health community and provides a 'how to' guide to create this key mechanism for achieving and managing co-operation. It offers suggestions for membership and an example terms of reference, as well as early steps and specific actions for building effective local networks and also contains links to useful support and resources.

2.4 The 2005 **SHA Top Tips** was developed by SHA Chief Executives for SHA Chief Executives, providing a consolidation of the common whole system factors of high performing trusts. These tips are intended to help SHAs to support their trusts in maintaining the operational standard.

3. COMMISSIONING

3.1 Delivering quality improvements in access and care, focussing on patient safety, outcomes and experience, is more complex in the urgent care pathway than the elective pathway. As the severity of the acute episode and any co-morbidities increases, so does the number of organisations involved in the care of the patient. Both the 4-hour standard and the ambulance standards are highly sensitive to 'bottlenecks' due to delays anywhere along the urgent/emergency care pathway. Delivering high quality, efficient and timely care, by achieving the emergency care standards, is the responsibility of the whole system and in particular the commissioners of that service.

3.2 Commissioning intentions for urgent care need to be clear and shared amongst all partners. There is a need to create a vision of 'what good looks like' amongst all partners. The focus should be on the quality of care for patients, whilst reducing bottlenecks and delays created by transfers of care between services. This requires integration of services with clear alignment to the strategic vision and aimed at markedly reducing the steps in the process of care.

3.3 The **World Class Commissioning Vision** provides a framework to help commissioners direct investment to secure the maximum improvement in health and well-being outcomes. As world class commissioners, primary care trusts (PCTs) must take on the mantle of trusted community leaders, working with their local population, partners and clinicians, leading the local NHS.

3.4 The 2007 DH **World Class Commissioning: Achieving the Competencies** is a statement of intent, aimed at delivering outstanding performance in the way we commission health and care services in the NHS. The vision and competencies describe what this shift towards world class will involve, and the organisational competencies that primary care trusts will need.

3.5 The 2006 DH **Care and Resource utilisation: Ensuring appropriateness of care** sets out for commissioners techniques to help identify areas where services can be redesigned, thereby freeing up resources to focus on clinically needy patients. The 80 plus pages of *Care and Resource Utilisation* (CRU) describes how patients should receive the right treatment, in the right place, at the right time, and provides a sound grounding in supporting commissioners to achieve the important balance between quality of care and value for money.

3.6 Other useful resources for commissioners include the DH 2004 **Managing Predictable Events,** a 10 page guide to capacity planning and operational arrangements that can assist in the preparation and management of predictable events that may impact on patients in an Emergency Care setting.

3.7 The NHS Centre for Involvement has produced **A guide to patient and public involvement in urgent care** for commissioners and providers that provides a step-by-step process to implement an effective system of patient and public involvement in urgent care. This guide was produced in 2008 in response to the 2006 consultation on the 'Direction of Travel for Urgent Care', which identified low levels of public and patient involvement in urgent care.

4. INFORMATION

4.1 There is significant variance in the volume and quality of information within the service to support the strategic planning of services and day to day operational management. Good starting points include run charts, supported by analytical processes, such as statistical process control (SPC) and a proper understanding of demand and capacity at the key steps in the patient's pathway. Outlined here are some of the more specific information resources available.

4.2 The NHS Institute's **ILG 2.2 Matching Capacity and Demand** compliments the Improvement Leaders' Guide to process mapping. By identifying and reducing where delays to patient flow occur, dramatic improvements to patients' healthcare journeys can be achieved, often without investment in more staff, equipment or facilities.

4.3 The NHS Institute's **NHS Better Care, Better Value Indicators** cover the Ambulatory Care Sensitive conditions where preventative measures and improved chronic disease management programmes could bring about significant reductions in emergency admissions. For more information on potential reductions in emergency admissions for this group of patients, go to the very detailed **The Victorian Ambulatory Care Sensitive Conditions Study** (This is not to be confused with the *Directory of Ambulatory Emergency Care for Adults* mentioned below in Section 10, Assessment Units, which provides guidance on how patients who have presented with a range of acute illnesses can be managed in an ambulatory manner).

4.4 The following resources may help commissioners and primary and community services to plan a more standardised approach to patients with chronic disease, and those at risk of admission/re-admission to hospital. The considerable potential for significant reductions in emergency admissions for these groups of patients is support by:

- **King's Fund PARR++ and Combined Predictive Model**
- **Dr Foster High-impact User Manager Tool**
- **Improvement Foundation Emergency Admission Risk Likelihood Index**

4.5 With all these approaches, developing, testing and implementing services that aim to reduce admissions, requires robust measures to ensure the desired impact is achieved and sustained. Of help is the **DH Emergency Care Checklists Analysing Data,** which takes you to the three Emergency Care Checklist Tools, (standard, mental health and patient flow). In the first instance, use the Standard Tool to analyse your organisations data. The three Excel spread sheets have to be downloaded into a single folder on their own. There is a pdf guide on how to use this tool in the same section. This is the recommended starting point for any organisation that is experiencing delays in the Emergency Department.

4.6 **DH Emergency Care Checklists Analysing Data** (mental health) - If there is a significant number of delays for patients with mental ill health, then using this tool will provide a detailed analysis of the problems. Like the Standard tool, the Mental Health tool needs to be downloaded into a stand-alone folder. Once there is an understanding of the causes of delays for this group of patients, then utilising the resources in the mental health section (section 9 of this guide) will assist in planning improvements.

4.7 **DH Emergency Care Checklists Analysing Data** (patient flow) - The final tool on this webpage helps you to understand the mismatch between when beds are required and when they become available. Once you have an understanding of this mismatch, utilising the tools under the bed management section will assist in planning improvements.

5. PRIMARY CARE

5.1 The greatest proportion of urgent care provision is delivered by primary care and local pharmacy services. Small percentage shifts away from these providers to Emergency Departments will result in significant increases in attendance at EDs. Safe, high quality, consistent and effective provision of both in-hours and out-of-hours primary care is crucial to provide care as close to the patient's home as possible.

5.2 **Implementing Advanced Access in Primary Care** is the Improvement Foundation webpage for 'primary care access and responsiveness'. It provides a link to the 'Improving Access' webpage. This contains lots of advice based on the two phases of the National Primary Care Collaborative that significantly improved patient access to primary care across the country.

5.3 **Urgent care: a practical guide to transforming same-day care in general practice** from the Primary Care Foundation in May 2009, provides practical insights and tested ideas to improve same-day access. **National Benchmark Out of Hours** is the Primary Care Foundation webpage on the progress of the National Benchmark OOH project commissioned by DH. Content is developing and this will become an extremely useful resource for commissioners and providers of OOH services to evaluate performance.

5.4 The 2008 DH **Report of the National Improvement Team for Primary Care Access and Responsiveness** recommends a series of actions by the DH, SHAs, PCTs and individual practices to ensure equity of access and responsiveness in primary care. The recommendations on Page 7 are supported by numerous case studies in the main report.

5.5 **National Quality Requirements in the Delivery of OOH Services** mandates compliance with the OOH Quality Requirements, which were first published in October 2004.

5.6 **Assuring patient safety through risk assessment** is a 2006 guide, from the National Patient Safety Agency. It helps commissioners ensure that patient safety is appropriately considered by all OOH service providers during service development, service reviews and during quality review and monitoring.

5.7 In 2008, the *Management Medicines Network North West* published the **Medicines in Unplanned Care Toolkit** to help both commissioners and providers of out-of-hours services ensure that the patients they serve have access to the medicines they need. It sets out a series of steps that can be taken to review current practice, identify those areas in which it still falls short of the standards that were set out in the Guidance, and suggests ways in which those shortcomings can be tackled successfully.

5.8 **Providing Medicines Out of Hours: Achieving Safe Practice** made 22 recommendations following the '*Carson Review*' of out-of-hours Services. Two of those twenty-two recommendations addressed the issue of patient access to **Securing proper access to medicines in the Out of Hours period.** This 53 page 2004 DH guide supports the implementation of recommendation 19 of the 'Carson review'. The recommendation states: 'Other than in exceptional circumstances, patients should be able to receive the medication they need at the same time and in the same place as the out-of-hours consultation.' Thirteen Action Points were developed as a guide to implementation. The same link accesses a 12 page summary of the main guide.

5.9 Through **Weather Watch,** NHS Direct and the Met Office plan to reduce the numbers of COPD-related hospital admissions by providing a support system for patients. The scheme warns patients when bad weather is on the way and helps them care for their own health whenever this is possible. This helps to slow the progression of COPD in patients, and reduces the demand on local health care services. Weather Watch is in use in South West SHA.

6. COMMUNITY SERVICES

6.1 There is considerable potential for community services to have a significant impact on the journey of patients with urgent/emergency care needs. For those services designed to support the urgent care pathway, it is important to measure whether there has been a positive impact on demand from main stream services (e.g. a sustained reduction in ED attendances) since they were established. Simply counting activity from the new service is inadequate.

6.2 **Transforming Community Services: Enabling new patterns of provision** was very detailed enabling guidance published in January 2009 to help PCT providers of community services move their relationship with their commissioners to a purely contractual one.

6.3 In June 2009 DH published **Transforming Community Services Quality Framework: Guidance for Community Services** which describes best practice guidance that sets the direction for implementing the Quality Framework within community services.

6.4 This is supported by Transforming Community Services: Ambition, Action, Achievement which is a series of 6 good practice guides for transforming community based services that set out ambitions, taking action and measurement of the achievement and should be read in conjunction with the quality framework/quality indicators.

6.5 **Transforming Community Services: Ambition, Action, Achievement** covers health, wellbeing and reducing inequalities. The other five guides cover:

- **Children, Young People and Their Families**
- **Acute Care Closer to Home**
- **Rehabilitation Services**
- **Long Term Conditions**
- **End of Life**

6.6 The 2009 Kings Fund **Shaping PCT Provider Services** comprehensively examines the issues surrounding the placement of community health services, the options proposed for their reorganisation, and the steps that must be taken to deliver the desired transformation in community health services.

6.7 **DH NSF Standard 3-Intermediate Care** promotes integrated services to enable faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. This DH web site provides links to an example summary report, a one-page summary of results, the assessment tool, guidance and the patient data collection sheet.

6.8 **Medical aspects of Intermediate care** is the 2002 report from the Federation of Medical Royal Colleges that advises on the knowledge and skills required of doctors, whether in primary or secondary care, who work in intermediate care type services. It argues for a greater emphasis on clinical governance in intermediate care type services and makes recommendations at local/national level for those setting up such services.

6.9 The DH **8 tips for quick wins: Improving responses for older people,** provides 3 pages of concise practical advice for professionals aimed at helping to improve the quality of care in the community and so reduce the likelihood of a sudden emergency requiring acute hospital care. Other tips are aimed at improving the care patients get when they do need emergency hospital care.

6.10 **Partnerships for Older People** (POPP) is the 2008 interim report of progress based on the National evaluation of 470 Partnerships for Older People Projects. It concludes that POPP pilot sites continue to have a demonstrable effect on reducing hospital emergency bed-day use when compared with non-POPP sites.

6.11 **Supporting people with long term conditions** from DH in Jan 2009 is a guide that provides commissioners of health and social care services with the information and support they need to embed personalised care planning in their localities. This should ensure that people with long term conditions receive more individualised care and services to help them manage their conditions better and achieve the outcomes they want for themselves.

6.12 The July 2008 DH guidance in **Delivering care closer to home: Meeting the challenge,** is a resource for commissioners and others interested in shifting care closer to home. It aims to share local emerging practice, how national enablers can support shifting care, and highlights new products developed to support local commissioners and providers.

6.13 The DH **Disease Management Information Toolkit** issued in May 2009, is a good practice toolkit to help service providers identify which conditions contribute to high numbers of emergency bed days. *DMIT* models the effects of possible interventions at a local level. It can help decision makers analyse the likely impact of possible commissioning options before they are taken, helping with planning decisions.

6.14 **DH End of Life Care Webpage** shows how The National End of Life Care Programme aims to help support the Government's end of life care strategy – by promoting high quality care for all adults at the end of life, through sharing good practice in collaboration with local and national stakeholders. The programme website contains information on a variety of aspects relating to end of life care, including over a hundred good practice case studies.

6.15 The 2009 **Advanced Care Planning** from the Royal College of Physicians of London (jointly produced with a number of key stakeholders) describes good practice in the development of advanced care plans. Pages 9 (recommendations) and 10 (an algorithm) that support "making best interest decisions in serious medical conditions in patients over 18 years" are particularly useful.

6.16 The Jan 2008 Nuffield Foundation **Advanced Care Planning in Care Homes - Final Report** recommends how to improve the process of discussing and recording wishes for future care and treatment. Their review of the literature demonstrated that whilst 60–90% of the general public is supportive of ACP, only 8% of the public in England and Wales has completed an ACP document of any kind, compared to 10–20% of the public in the US, Canada, Australia, Germany and Japan.

6.17 **Advanced Care Planning and Hospital in the Nursing Home** published in Age Ageing 2006 is an article from Sydney, Australia, demonstrating the efficacy of advanced care planning and care delivery to the patient in the Nursing Home with reduced hospital admissions and improved outcomes.

6.18 The **Gold Standard Framework** for Advance Care Planning (ACP) is a key part of quality provision of end of life care. Improving the pre-planning of care has been found to be one of the most important ways that we can ensure reliable patient-focused care. It is anticipated that it will be an important part of the new NHS End of Life Care Strategy.

7. URGENT CARE CENTRES / WALK-IN CENTRES / MINOR INJURY UNITS

7.1 These services are intended to provide alternatives to Emergency Department attendance. They should be located to give easy access to a high number of potential users. They should be fully integrated with intermediate care. Impact assessments should be carried out to evaluate planned reductions in demand at the Emergency Department. The model has two main forms:

- "Front door" pre-Emergency Department, where the service is an optional stream for patients attending without an appointment, who have a minor injury or illness
- Remote services that build, in some cases, on existing community facilities, such as a walk-in centre, minor injury unit or community hospital

7.2 The **DH Urgent Care Centres** web page contains presentations from established centres. The 2007 report of The Royal College of Physicians' Acute Medicine Taskforce, **Acute medical care: The right person, in the right setting – first time,** has a useful summary for Urgent Care Centres on pages 10 and 11.

7.3 **Measuring the Benefits of the Emergency Care Practitioner** (ECP) details how emergency care networks can determine the effectiveness of more recent initiatives, such as the ECP role. It includes sections on 'Quantifying the Benefits'; 'Measuring Against Targets'; 'Cost Effectiveness of ECPs in the Emergency Pathway'; and 'Calculating the Business Case – Return on Investment'.

8. AMBULANCE SERVICE AND PATIENT TRANSPORT SERVICES

8.1 Please refer to the *Good Practice Toolkit for Ambulance Services and their Commissioners*, published by the Emergency Services Review 2009. This guide takes the reader through a wealth of published good practice guidance. It is aimed at operational ambulance managers, commissioners of ambulance services, and others who wish to gain a grounding in ambulance service provision.

9. EMERGENCY DEPARTMENT

9.1 In 2001, **Reforming Emergency Care-Practical Steps** was published to provide a ten-year strategy to drive changes in emergency care and give priority to staff and patients in emergency care settings. The overarching aim of the strategy was to think about services from the patient's perspective and offer high quality, timely care for all patients wherever they access the system. The NHS can be proud of the improvements in patient experience in EDs over the last eight years through more effective working both within EDs and across the whole system. However, there is still much which can be achieved and this is both across the whole system, where the opportunities are greatest, as well as within the ED.

9.2 During 2003 and 2004, there were several DH publications to support the delivery of this strategy and particularly to achieve the 98% 4 hour standard:

- **Emergency Care Access Algorithm** identifies actions that reduce waiting times and improve the experience for patients requiring emergency assessment and treatment
- The **4 Hour checklist: Reducing delays for A+E Patients** is intended to help health care organisations streamline emergency care for patients. It focuses on some of the most important actions trusts can take to improve patient care and achieve the 4-hour standard
- **Faster access: Wait for assessment - implementation guide** is still a useful reference source providing guidance to help reduce breaches caused by waits for assessment
- **The Emergency Department: Medicine and Surgery interface problems and solutions,** sets out across eight pages to identify the particular issues relating to the interface between the Emergency Department and medical and surgical specialties

9.3 More recently, **The College of Emergency Medicine-The Way Ahead 2008-12,** looks ahead to how Emergency Departments should work in the future and what more is required to support emergency and urgent care.

9.4 The DH 2007 **Urgent care pathways for older people with complex needs**, is a practical ambulance and ED urgent care pathway for older people with complex needs caused by falls, confusional states or hip fracture. It identifies best clinical practice in these three areas and constructs a clear and auditable clinical care pathway.

9.5 The British Geriatrics Society 2008 revision of **The Older Person in the Accident & Emergency Department** offers guidance on good practice for the care of older people, who are increasingly frequent users of EDs, and who often have complex medical and social needs over and above the clinical cause of attendance.

9.6 The 2005 DH **Tips for Quick Wins: Improving responses for children and young people requiring emergency or urgent care** provides practical advice, in the form of top tips, which focus on specific actions that can be taken to improve outcomes and patient experience for children and young people. The NHS Institute's **Focus on: Emergency and urgent care pathway for children and young people** covers their most common illnesses and injuries.

10. MENTAL HEALTH

10.1 Patients with mental ill health without significant physical ill health are best served by effective and responsive mental health services rather than defaulting to the ED.

10.2 **Improving the management of patients with mental ill health in emergency care settings** is a 2004 DH checklist that offers practical support and guidance to help those working in emergency departments, mental health trusts and ambulance trusts to improve the care of patients with mental ill health who access emergency care services.

10.3 Delivering high quality urgent mental health services is well supported by the 2006 **10 High Impact Changes for Mental Health Services** produced by CSIP and NIMHE. It has numerous case studies illustrating how these services can be improved.

10.4 Supplementary guidance in 2007 came in **10 HIC for Mental Health Services - Older People** created to support Older Peoples Mental Health services.

10.5 The **10 High Impact Changes for Mental Health Services Measurement Tool** supports assessment of implementation of the 10 HICs for Mental Health Services. The guide extends the scope of the original work to include a 'whole systems' approach to incorporate all types of services that support people with mental health problems, whatever level of support and care is required.

10.6 The NHS Institute's **Focus on: Acute Admissions in Adult Mental Health,** aims to help local health communities and organisations improve the quality and value of care for acute adult mental health patients and aims to support the NSF for Mental Health.

10.7 In 2008, the Academy of Royal Colleges published **Managing urgent mental health needs in the acute Trust.** This argues that patients with mental health problems should receive the same priority as patients with physical problems. There should not be any discrimination against an individual because of mental health problems whilst being treated in any part of an acute hospital.

11. ACUTE ASSESSMENT UNITS

11.1 Acute medical emergencies are the most common reason for admission to an acute hospital, and acute medicine is the fastest growing medical specialty. Processes in assessment units need to be focussed on effective decision making with the development of clear case management plans.

11.2 The 2003 DH **Emergency Assessment Unit Checklist** is aimed at NHS Acute Trusts and their staff to ensure that all possible steps are being taken to improve and streamline the care of patients presenting to emergency care.

11.3 The 2007 report of The Royal College of Physicians' Acute Medicine Taskforce, **Acute medical care: The right person, in the right setting – first time,** highlights the drivers that have necessitated the way acute medical services are delivered. Among these are patient safety, improved quality of clinical care, clinical governance, and the need to train within the specialty. It also clearly states the College's recommendation of setting **expected dates of discharge**. This very detailed report has a helpful ten page executive summary and recommendations.

11.4 The NHS Institutes **Directory of Ambulatory Emergency Care for Adults**, provides guidance designed to help local health and social care communities deliver more emergency care without an overnight stay in a hospital bed and care closer to patients own homes.

11.5 The 2005 DH **A guide to emergency medical and surgical admissions**, provides twelve pages of best practice guidance on the assessment and admission of emergency medical and surgical patients, and the supporting processes that need to be in place. It has tips to help plan and set up such units.

12. SHORT STAY UNITS

12.1 The early identification of patients who will have a short length of stay needs to be managed by processes that will deliver their required interventions safely and effectively. Up to 60% of acute emergency admissions can have a short length of stay (72 hours or less). If these patients are admitted to traditional ward areas, their length of stay can be unnecessarily prolonged. **Acute medical care: The right person, in the right setting – first time** from the RCP Acute Medicine Task Force highlights the importance of managing this stream effectively.

12.2 The starting point for the identification of short stay patients is the setting of an **expected date of discharge** at the point of first senior clinical decision. The NHS Institutes **Focus on: Short Stay Emergency Care** aims to help local health communities and organisations improve the quality and value of care for short stay emergency care patients.

12.3 The 2009 Royal College of Paediatrics and Child Health **Short Stay Paediatric Assessment Units** promotes discussion about Short Stay Paediatric Assessment Units (SSPAUs) among NHS commissioners and providers of hospital paediatric care. It proposes that SSPAUs can improve the provision of safe emergency services for children and that they should be developed more widely. Pages 6 and 7 compare the options of locating SSPAU next to Paediatric Wards or the Emergency Department.

13. GENERAL WARDS AND SPECIALTY TEAMS

13.1 Flow on wards downstream from the ED and Assessment Units needs to be maintained at the tempo required to 'pull' patients from the ED/Assessment Units who require specialty services. If flow is compromised on the downstream wards, this creates a bottleneck for admission of other patients who require specialist care. Proactive case management to an expected date of discharge is as important in these clinical areas as it is in the ED, assessment and short stay units.

13.2 The 2004 DH **Checklist – Wait for a specialist,** helps senior management teams decide what actions they can take to prevent waits for a specialist that could cause 4-hour breaches in the ED. It focuses on ensuring senior decision makers are available to emergency arrivals when needed, particularly for high volume specialties. It advocates protocol driven ED admitting rights and direct access to assessment units, particularly for lower volume specialties.

13.3 The **Implementation guide – wait for a specialist,** is intended to help senior management teams at trust level implement the *Wait for a Specialist Checklist* to help eliminate waits that may cause 4-hour breaches in the ED.

13.4 **Checklist – Wait for a bed** is intended to help senior management teams at trust level decide what action they can take to prevent waits for a bed causing 4-hour breaches in the ED. It focuses on the need to match inflows and outflows from beds and improve corporate control of arrivals and discharges from all beds. It also helps diagnose mismatches between in and out-flows.

13.5 The improvements in the processes for frail older people (the fastest growing segment of the population) described in the NHS Institute's **Focus on: Frail Older People,** have the potential to improve both the quality of care and the efficiency of care for this important patient group. Their **Focus on: Fracture neck of femur,** aims to help local health communities and organisations improve the quality and value of care for fractured neck of femur patients.

14. BED MANAGEMENT

14.1 Effective bed management should be based both on predictions of admissions and discharges (determined by examining historical data), and on real-time information on expected discharges. The latter should be derived from effectively set expected dates of discharge combined with proactive case management.

14.2 The 2002 NHS Healthcare Operational Intelligence: Information for Action - A good practice guide to **Anticipatory Management in Healthcare,** helps resources to be used to the full, and matched to demand. This ensures that the right care is available at the right time in the right place. Pages 13-24 focus on effective bed management.

14.3 The 2004 DH **Toolkit - Wait for a Bed: Bed Management further guidance** was designed as part of the wider bed management programme. It aimed to give Trusts guidance on developing strategic thinking to identify operational solutions to resolve bed management constraints. This is supported by the **Faster access: Bed management demand and discharge predictors** webpage, which provides an overview of the functionality and access links to software for bed management, demand and discharge predictors. In particular, both the **Bed Capacity Ready Reckoner Excel Spreadsheet** and its **Bed Capacity Ready Reckoner Guide** have been developed to enable operational managers to predict whether there will be sufficient beds or a bed shortage on any particular day. This allows for pre-emptive action to prevent a beds crisis.

15. DISCHARGE PLANNING

15.1 Discharge planning commencing at the point of admission (or even before if a GP initiated admission) must be the aim of all bed holding services. Effective process planning ensures all the necessary elements are in place. The majority of discharges are simple and predictable. For complex patients with complex needs, the key is identification at the point of assessment/admission. They should be managed as a specific stream, with focussed multi-disciplinary case management.

15.2 **Achieving timely simple discharge from hospital: A toolkit for the multi-disciplinary team**, provides best practice guidance to simple discharge from hospital. It focuses on the practical steps that health and social care professionals can take to improve discharge.

15.3 **Faster access: Bed management demand and discharge predictors,** provides an overview of the functionality and access links to software for bed management demand and discharge predictors, and supports the guidance given in the *Wait for a Bed Checklist* and the *Bed Management Toolkit.*

16. SOCIAL SERVICES

16.1 The **Practical Guide to Integrated Working** has helpful sections on integrated services and care (pages 61-88). A key measure of success is a joint understanding between health and social care of the expected or planned demand/need for care packages.

16.2 Some key measures that characterise integrated care systems are:

- There a simple, single phone call process for re-start of current care packages to allow same day discharge
- Social services hold packages of care for 2-3 days following admission, allowing elderly patients to be discharged after an overnight stay
- For new, simple care packages, call-off procedures are available to clinical teams in the ED and assessment units without the need for care manager assessment prior to discharge
- For complex care packages (e.g. beyond two single-handed visits per day), the frequency of funding approval is at least daily

17. ESCALATION

17.1 Year round capacity planning and accompanying escalation plans are recognised as essential for all health care organisations.

17.2 As a minimum, local health community escalation plans should:

- Clearly define the trigger levels for escalation
- Name the executive leads to whom issues are escalated
- Encompass plans to open additional capacity to support excess demand above normal variance across the whole system
- Define timely de-escalation protocols
- Involve sufficient clinical leadership and involvement in primary and secondary care to resolve local issues in relation to escalation
- Ensure linkages between the escalation plans of partners across the local health community, so that mutual support is achieved at times of stress

17.3 One of the obvious symptoms during periods of pressure is ambulance handover delays. The table in Figure 2 of **'Ensuring Timely Handover of Patient Care'** illustrates a suggested local health community escalation plan for handover delays.

17.4 Step 8 of the **Emergency Care Network Checklist** and checklist 2 of **Driving change: Good practice guidelines for PCTs on commissioning arrangements for emergency ambulance services and non-emergency patient transport services** consider the actions such networks should consider.

APPENDIX A – EMERGENCY CARE – GENERAL IMPROVEMENT SKILLS RESOURCES

This appendix summarises sources / resources for improvement skills. These will be helpful for those involved in implementing the improved practice described in this guide.

1) Improvement Leaders' Guides
http://www.institute.nhs.uk/building_capability/building_improvement_capability/improvement_leaders%27_guides%3a_introduction.html
Requires registration to login – open to all staff with an NHS email. These are the starting point for those who have not used improvement methodology.

2) Clinical Systems Improvement Forum
http://www.steyn.org.uk/
An excellent site with presentations, models and discussion forums on demand, capacity, flow and managing variability in health care.

3) Improvement methodology
http://www.institute.nhs.uk/index.php?option=com_quality_and_service_improvement_tools&Itemid=551.html
NHS Institute website collating all the improvement tools under the banner of nodelays equally valid for elective and non-elective.

4) Statistical Process Control (SPC) – Basic Guide
http://www.indicators.scot.nhs.uk/SPC/Statistical_Process_Control_Tutorial_Guide_010207.pdf
A basic description of SPC and the guide to choosing which chart to use.

(a) **ControlCharts_beta**
http://www.indicators.scot.nhs.uk/SPC/Main.html
Linked to above guide
(b) **BPChart400**
http://www.skills4change.org/
Link to Excel Run & SPC Charting Tool at bottom right of website
(c) **Run and Control Charts**
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationMeasurement.htm?TabId=2
A free, on-line presentation on, 'Using Run and Control Charts to Understand Variation', from Robert Lloyd, Institute for Healthcare Improvement (IHI). This series of free, on-line presentations make an excellent introduction to improvement methodology from an Internationally recognised expert. You do need to enrol to access - enrolment is also free, just follow the tabs. The presentations can be saved to your desktop - just follow the instructions on the website. To play the presentations from your desktop, you need to download 'Network Recording Player' which is also free from the IHI website or from Network Recording Player website

5) Model for Improvement
A free on line presentation on, 'An introduction to the Model for Improvement', from Robert Lloyd, IHI. Understanding variation.
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationMFI.htm?TabId=10

6) Building Skills in Data Collection and Understanding Variation
A free on line presentation on 'from Robert Lloyd, IHI
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationVariation.htm?TabId=2

7) Introduction to Lean in Healthcare
http://www.institute.nhs.uk/building_capability/general/lean_thinking.html
http://www.networks.nhs.uk/networks/page/211

8) The Primary Care Foundation's Telephone Capacity Calculator
A very helpful webpage that provides all the links and instructions on how to calculate the number of call handlers that are required to obtain consistent call handling performance based on the work of Erlang. The work from Erlang also explains why service failure (not just call handling) is guaranteed if average resource utilisation exceeds 80-85%. This explains why achieving bed occupancy rates of 80-85% across the adult emergency bed base in hospital is vital.
http://www.primarycarefoundation.co.uk/page9/page18/page18.html

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