

National Breaking the Cycle Initiative

April 2015

Frequently Asked Questions

Why would we want to do a perfect week?

Many trusts and wider health and social care systems are experiencing significant high levels of escalation and pressure. This has resulted in the use of escalation wards, patients being cared for in outlying beds and crowded emergency departments. Clinical and managerial staff can feel trapped in a 'ground hog' dog situation. A *Breaking the Cycle* week offers an opportunity to rapidly try something different with the aim of improving patient care by improving patient flow.

Do we have to do a Breaking the Cycle week?

Breaking the Cycle weeks work really well where there is local commitment to them and great clinical and managerial leadership. There needs to be a shared sense of purpose; an understanding of the challenges; organisation and, ideally, system wide participation; and an emphasis on *doing*, rather than lengthy discussions and 'overthinking'. There needs to be a real enthusiasm to do it and to sustain improvements after the week. Before deciding to undertake a perfect week, it's worth looking at the 'National Breaking the Cycle - checklist for senior teams'.

How does it work?

There isn't a set formula, but trusts and their health and social care partners that have run successful *Breaking the Cycle* Weeks, have followed some broad principles:

- All staff (clinical and managerial) are focussed on rapidly reducing all patient delays and trying something different without having to constantly seek permission.
- Non value adding meetings are stood down.
- All patients in inpatient beds are reviewed twice daily by a senior doctor, preferably a consultant supported by members of the multi-disciplinary team (this is typically a more detailed board round and or ward round review in the morning and a check, board round review in the afternoon).
- All wards and departments have liaison officers. These are usually non-clinical staff who give up time to help ward teams chase and resolve patient delays. Feedback from these roles is usually very positive and some trusts have gone on to make these roles permanent.
- There is a simple management structure during the week (sometimes referred to as silver and gold command) that ensures any delay that cannot be resolved at ward and or departmental level is raised to nominated leaders with a view to rapid resolution of the problem or delay.

- Information is visible at ward and or departmental level so everyone can see how delays have been sorted out and how everything is going at a glance.

It's ok for a week, but what about after the week?

Urgent and emergency care is a complex system that requires simple rules that everyone understands. A number of trusts have used the SAFER patient flow bundle to maintain momentum, sustain changes made and reduce variability. The SAFER patient flow bundle is based on similar principles to clinical care bundles (i.e. a set of actions that if consistently followed reduces variation and improves outcomes).

The week is about trying to implement processes that prevent unnecessary delays for patients and also enable front line staff to get on and do things without consistently seeking permission. After the week, permission to continue to do the right thing should not be required.

What should we measure?

Most organisations decide upon an outcome measure. The number of occupied beds at a given point in time (e.g. 8am) is an outcome measure that many organisations have used. There are a number of other measures that may be useful (e.g. the percentage of discharges before midday; the total number of discharges; and compliance with the SAFER patient flow bundle; cardiac arrest rates). It's also important to understand if there are any adverse effects, so it's worth considering balancing measures (e.g. re-admissions).

What help can our partner organisations offer us?

It's important before the week to have positive conversations with local partners (e.g. GPs, ambulance services, community services, social care and commissioners). An 'ask and offer' approach often works. For example, it may be worth offering direct GP phone access to hospital consultants and asking for earlier GP home visits and earlier patient conveyance to hospital.

A number of supporting documents can be found her:

For more information or assistance, drop us an email at: perfect.week@nhs.net.

This document was produced by the NHS Emergency Care Intensive Support Team (ECIST), which is part of NHS IMAS. The views expressed are those of ECIST. The content is copyright, but may be used freely within the NHS for non-commercial purposes. For further information about ECIST or to comment on this paper, email Russell Emeny, Director of ECIST, at nhs.imas@nhs.net

