NHS
Improvement

National priorities for acute hospitals 2017

Good practice guide: Focus on improving patient flow

July 2017

support collaborate challenge improve inspire

Produced in collaboration with and endorsed by:

Royal College
of Physicians

The Royal College of
Emergency Medicine

ASSOCIATION OF
AMBULANCE
CHIEF EXECUTIVES

RCS
ADVANCING SURGICAL STANDARDS

BRITISH
GERIATRICS SOCIETY

sam
THE SOCIETY FOR ACUTE MEDICINE

Contents

Introduction

This guide outlines good practice in 10 areas that will improve patient flow.

The good practice is not new. It was recommended in Bruce Keogh's *Safer, Faster, Better: Transforming urgent and emergency care services in England.*[1] It features guidance from the Royal Colleges, the National Institute for Health and Care Excellence (NICE), specialist societies and from publications by the Nuffield Trust and King's Fund.

We know it works. Where implemented effectively by well-led teams using effective improvement techniques, hospitals have seen real benefits to patient outcomes and staff satisfaction. Hospital crowding reduces. Emergency departments (EDs) decongest. Mortality falls. Harm is reduced. Staff feel less pressured.

Implementing the good practice in all 10 areas will have a positive, cumulative effect on improving patient flow. Implementing it piecemeal will be much less effective.

This guide focuses on acute hospital care but should be considered within the context of collaboration and effective collective leadership across whole health and social care systems. While it captures and brings together existing good practice, implementation will need to be tailored to local circumstances. Therefore, we have taken a balanced approach and tried not to be overly prescriptive.

This guide is aimed at senior operational and clinical staff and especially medical directors, nursing directors and chief operating officers. Clinical teams will benefit from a concise guide that highlights priorities for patient care.

Together we can make a difference.

---

[1] www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

Why focus on patient flow?

The term 'patient flow' refers to the ability of healthcare systems to manage patients effectively and with minimal delays as they move through stages of care.

The consequences of poor flow are well known:

- EDs becomes crowded, stressful and unsafe[2,3]

- patients are admitted as 'outliers' to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes[4]

- ambulatory care services, clinical decision units, even catheter labs and endoscopy units may fill with patients waiting for ward admission

- inpatients are shuffled between wards to make room for newcomers

- staff are overstretched and routine activities slow down dramatically

- clinical outcomes are measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds[5]

- patients' and carers' time is wasted due to delays and slow care processes, and their experience is adversely affected.

Discharge delays and increased demand contribute to poor flow. Health and social care systems that have adopted best practice to improve flow find themselves much better able to cope with external pressures than those that have not.

Focusing on implementing good practice in the 10 areas in this guide will improve flow through your hospital.

Achieving good flow requires expertise and focus. Getting it right brings job satisfaction, reduces stress and improves patient outcomes.

[2] Carter EJ, Pouch SM, Larson EL (2014) *The relationship between emergency department crowding and patient outcomes: a systematic review* www.ncbi.nlm.nih.gov/pmc/articles/PMC4033834/

[3] Hoot NR, Aronsky D (2008) *Systematic review of emergency department crowding: Causes, effects, and solutions* www.annemergmed.com/article/S0196-0644(08)00606-9/fulltext

[4] Beckett D (2014) *Boarding: Impact on patients, hospitals and healthcare systems* www.acutemedicine.org.uk/wp-content/uploads/2014/11/Plenary-5-1030-Wrong-Place-Anytime-Why-Boarding-is-Bad-for-Patients-Hospitals-and-Healthcare-Systems.pdf

[5] Campbell CS *Deconditioning: The consequence of bed rest:* http://aging.ufl.edu/files/2011/01/deconditioning_campbell.pdf
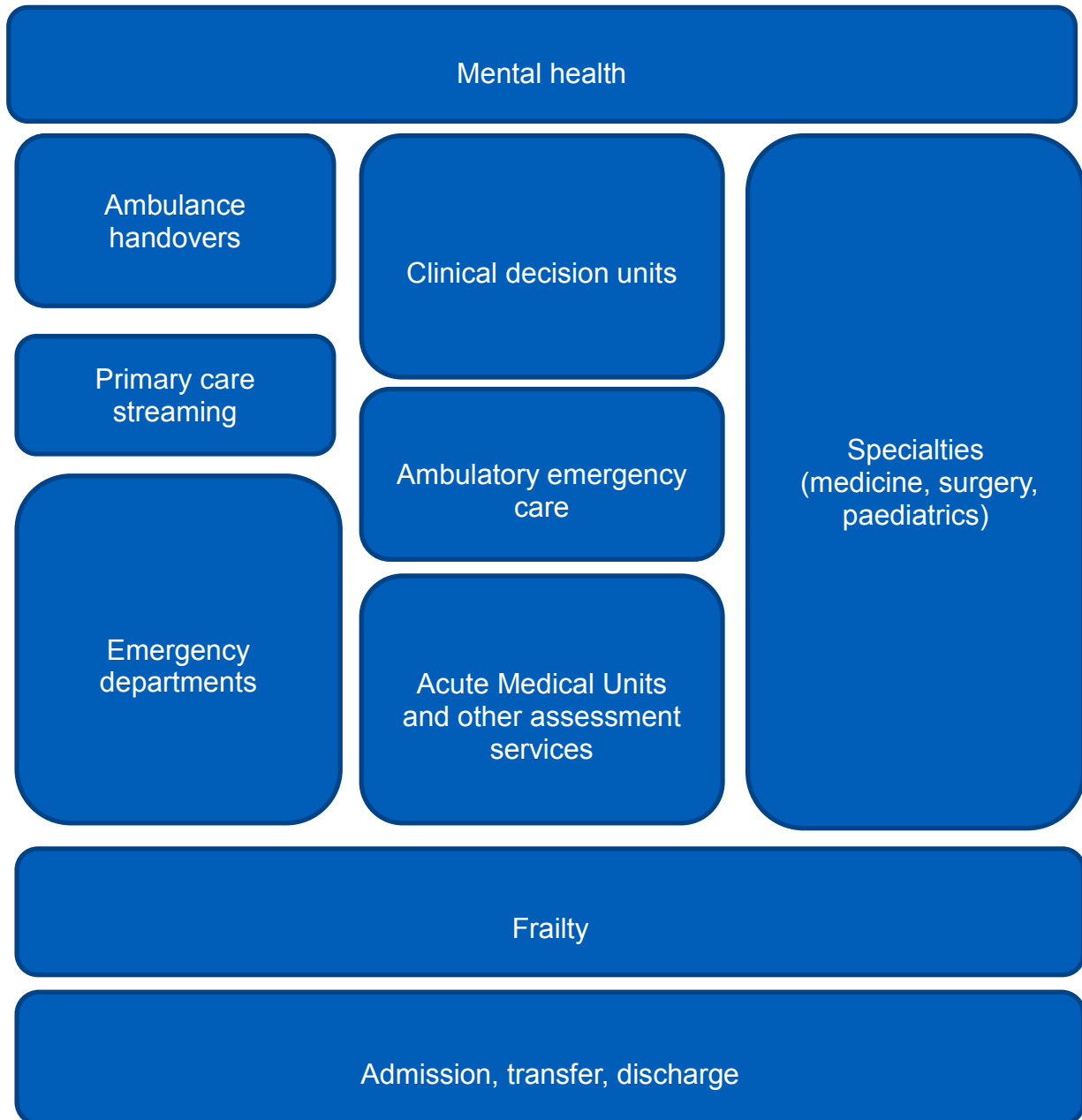
Making it happen – principles of patient flow

Delivering change to improve patient flow is challenging and complex but of vital importance.

Six principles underpin good non-elective patient flow:

1. **Flow is a team sport** – patients often visit many different health and social care professionals and departments before, during and after their hospital stay. All organisations, departments and staff groups in and outside hospitals need to collaborate and act together – for example, through shared assessments and interventions to deliver effective and responsive patient care.

2. **Flow needs focus from the top** – there should be senior clinical and executive leads for flow who use live data to track flow across the hospital, identify unnecessary variation and troubleshoot where there are bottlenecks.

3. **Flow is seven days a week** – attendances and admissions occur relatively consistently through the week and so should reviews, transitions and discharges.

4. **Flow is about case mix** – use analytical tools to understand the acuity of patients attending the ED and how this varies across the day and the week. Use this information to match resources to demand.

5. **Flow needs patient input** – pathways and individual patient journeys should be regularly reviewed with patients to appreciate where flow is being blocked, see things from their perspective and improve processes and systems.

6. **Flow needs to be maintained at times of pressure** – systems will come under significant stress. Tried and tested escalation processes should be implemented when they do, to protect assessment and short stay wards, clinical decision units, ambulatory emergency care and acute assessment services. Escalation should be meaningful and the whole system needs to act to relieve pressure where it occurs.

The 10 areas for focus

Mental health

Ambulance handovers

Primary care streaming

Clinical decision units

Ambulatory emergency care

Emergency departments

Acute Medical Units and other assessment services

Specialties (medicine, surgery, paediatrics)

Frailty

Admission, transfer, discharge

Ambulance handovers

Outcome

Patients arriving by ambulance enjoy a seamless handover to an ED without delay, supported by the transfer of patient information from the ambulance service to the hospital.

Core principles

- EDs should accept handover of patients within 15 minutes of an ambulance arriving. Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel is unacceptable.

- On arrival or at the time of initial assessment, patients on trolleys should be assessed for their suitability to be transferred to wait in a chair. 'Fit to sit' assessments help release ambulances to respond to the next call.

- The clinical assessment of patients arriving by ambulance should start within 30 minutes of their arrival at an ED.

- Clinically stable patients referred to an ED by a GP should go directly to an assessment service to be assessed by the clinical team within 30 minutes of arrival.

- Escalation plans must be triggered when objective measures indicate the system is under significant pressure. Plans may include:

  - **Cohorting**, where patients are placed in an area of the ED not usually used for assessment or waiting, should be used as a temporary measure with a clear plan for de-escalation. Cohorting is safest when applied after assessment to ensure departments are fully aware of the patients and their risks. Areas used for cohorting must have appropriate equipment and facilities to maintain patients' privacy and dignity at all times. Escalation plans should include how the extra nurse staffing required for any cohort area will be met.

  - **A full capacity protocol (FCP)**, as recommended by the Royal College of Emergency Medicine (RCEM),[6] should be used to balance the risk to patients when EDs are crowded and there is no available space in which to assess patients. Patients requiring inpatient care are moved out of the

[6] RCEM (2015) *Tackling emergency department crowding*, p20
www.rcem.ac.uk/docs/College%20Guidelines/5z23.%20ED%20crowding%20overview%20and%20toolkit%20(Dec%202015).pdf

ED or assessment units to an inpatient ward area. This is achieved by, for example, a ward caring for one extra patient until a bed becomes available elsewhere for that person following discharge of another patient. The FCP should be de-escalated as soon as practically possible. Repeated use of the FCP should prompt a thorough review to ensure that all escalation steps are effective. Protocols should include appropriate safeguards, based on patient acuity and condition – for example, frail older patients and those with a national early warning score (NEWS) of >3 should be excluded.

– Deploying **ambulance managers** (sometimes termed 'HALOs') or additional acute resources to help manage the hospital–ambulance interface and release ambulances quicker to respond to the next emergency. This is essential to reduce the risk faced by unassessed patients waiting 'at scene' for an ambulance.

To learn more

- ECIP guide to reducing ambulance handover delays
  https://improvement.nhs.uk/resources/reducing-ambulance-handover-delays/

- RCEM initial assessment of ED patients guidance
  www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

- Papers on the FCP:

  – www.sciencedirect.com/science/article/pii/S0196064409002388

  – http://altarum.org/health-policy-blog/full-capacity-protocol-simple-changes-can-transform-a-hospital

  – http://info.medicalreimbursementinc.com/ef1/files/2128/ED_Overcrowding%20(Full%20Capacity%20Protocol).pdf

  – www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12012015320

Primary care streaming

Outcome

Patients attending EDs with conditions more suited to assessment and treatment in primary care are streamed to a co-located primary care service.

Core principles

- Hospitals should set clear criteria to support patient streaming to primary care services.

- Redirecting patients to other sites requires specific safeguards to ensure it is both appropriate and safe, and that the off-site service has accepted the patient.

- Clinical streaming should always be performed by a trained ED clinician (usually a nurse).

- Streaming should be performed as soon as possible and always within 15 minutes of the patient's arrival. For this to be achieved, capacity must be planned to meet variation in demand on an hour-by-hour and day-by-day basis, not based on average demand.

- Demand and capacity should be analysed to determine the staffing profile, model and opening hours of the primary care service (in local circumstances where primary care attendances are very low, a primary care stream may be inappropriate or be integrated into the 'minors' stream).

- Clinical liaison between the ED and the primary care service must be regular and effective. Joint governance is a fundamental requirement. Monthly governance meetings should consider the operational effectiveness of the streaming process and primary care service together with all risk reports and incidents.

- A clear process must exist for patients requiring ED assessment to be transferred back promptly to the ED from the primary care service. These cases should be discussed at monthly governance meetings and protocols modified where appropriate.

- The four-hour A&E standard applies to all patients streamed to a co-located primary care service.

Emergency departments

Outcome

All patients receive timely assessment and clinically appropriate, high quality care in the ED.

Core principles

- All patients attending an ED should be streamed at the front door by a trained ED clinician (usually a nurse) to the most appropriate area and clinician.

- Streaming involves taking a brief history and performing basic observations if appropriate. This information may also be used to support triage prioritisation within streams if required.

- Streaming should include calculation of an early warning score (for example, the national early warning score (NEWS) for adults or paediatric equivalent for appropriate patients). Early warning scores should form part of the assessment of acuity but streaming decisions should not be based on them alone.

- The ED should prioritise the assessment and treatment of the sickest patients including:

  – those presenting with time-critical and potentially life-threatening conditions

  – frail older people at risk of admission

  – vulnerable patients including children, people with learning disabilities and those at risk of self-harm.

- The ED further streams patients to:

  – resuscitation

  – majors

  – low acuity/less serious injuries ('minors')

  – co-located primary care

  – fast track pathways (eg fractured neck of femur, acute abdomen)

  – other services in the hospital including ambulatory emergency care (AEC), assessment services and rapid access outpatient services.

- – normal place of residence, following risk assessment and with appropriate follow-up care and liaison and information sharing with primary and community care services.

- ED staffing should be planned so that capacity meets hourly, daily and seasonal variations in demand, rather than average demand, including that from specific patient groups such as children, frail older people and people with mental healthcare needs. There should be routine analysis of demand at a detailed level to support workforce planning.

- A senior doctor of ST4 grade (or equivalent) or higher should be present 24/7. Best practice is to deploy consultants to manage each of the functions of the ED, including overall command and control; resuscitation; rapid assessment and treatment (RAT); and the clinical decision unit (CDU).

- The deployment of advanced clinical practitioners in emergency departments is strongly encouraged (they may come from a range of professional backgrounds including nurses and allied health professionals – for example, paramedics and physiotherapists), together with pharmacists and clinicians from other specialties where appropriate.

- ED layout should be reviewed regularly to ensure that it supports flow.

- GP referred patients should go direct to the relevant assessment service, and not the ED, unless they are clinically unstable.

- Internal professional standards[7] or local agreements should be made with specialty departments across the wider hospital to provide rapid assessment, treatment and decision-making in the ED when requested.

- Acutely unwell people with frailty should be identified at the front door and appropriately assessed by clinicians competent to identify the most appropriate care pathway for these patients. The use of well-evidenced frailty assessment tools is encouraged (for example, the Rockwood Clinical Frailty Scale).

- Patients should only be admitted if their needs cannot be met by AEC or other pathways (for example, primary care).

- Close liaison with, and the direct support of, emergency medicine by in-taking specialties is essential. Site-specific rules should be agreed that set timescales, expectations and processes for how EDs can access specialist services, particularly during periods of escalation.

---

[7] https://improvement.nhs.uk/uploads/documents/internal-professional-standards-RIG.pdf

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 14
  /www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- Guidance on initial assessment in ED:
  www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

- Guide to internal professional standards:
  https://improvement.nhs.uk/uploads/documents/internal-professional-standards-RIG.pdf

- Using safety checklists in emergency departments:
  www.health.org.uk/sites/health/files/Bristol%20final%20report_website%20version_0.pdf

- Fast track pathways: Laparotomy bundle:
  http://onlinelibrary.wiley.com/doi/10.1002/bjs.9658/full

Mental health

Outcome

Patients presenting to EDs or on inpatient wards with mental health and related physical conditions receive compassionate care from all staff. Skilled assessments and interventions by an all-age liaison mental health team (including alcohol specialists) are available seven days a week to maximise safety, optimise patient experience, and reduce avoidable admissions and procedures and inpatient length of stay.

Core principles

- People presenting with a mental health crisis need to be assessed in an environment that is quiet, safe and supportive. While waiting for assessment and treatment, to reduce their distress and during the assessment itself, patients should have access to a bespoke mental health assessment room.[8]

- People thought to have a mental health condition should be triaged by compassionate staff trained in line with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2017 recommendations, as adverse attitudes increase the risk of repeat self-harm and suicide. Particular attention should be given to providing a compassionate response to those groups who report poorer experiences of ED and are at much higher risk of suicide, including those diagnosed with personality disorders and those who self-harm. Care should be provided in line with NICE guidance CG16 for the short-term management and prevention of recurrence of self-harm.[9]

- The initial priority is to assess any significant physical health needs, including delirium; overdose; self-harm injuries or self-injuries incurred by people with dementia or alcohol-related conditions; cardiovascular disease, diabetes, chronic obstructive pulmonary disease, liver and other conditions common in people with psychoses. ED staff should refer to the liaison mental health team as soon as they believe its involvement is necessary. As these teams include the necessary expertise in caring for people with co-morbid mental and physical health problems and they work in parallel with medical teams, they should be proactively involved in the person's treatment and be ready to provide mental health input within 60 minutes or less of the person being able to be seen. If undue delays in the pathway are to be avoided, this should be more than a request to be notified when the person is declared 'medically cleared'.

[8] www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf
[9] www.nice.org.uk/guidance/cg16

- A multidisciplinary liaison mental health team that includes a consultant liaison psychiatrist should be available 24/7.

- The liaison team identifies those at risk of suicide or self-harm or who may have mental health co-morbidities, including people with long-term physical conditions and the large population of older people in acute hospitals among whom a high prevalence of undetected dementia, delirium and depression is likely.

- People who are intoxicated and experiencing mental health problems:

  - should be assessed and given appropriate support. All hospitals should have access to a drug and alcohol liaison service, which is either part of a liaison mental health team or provided through another model, such as an alcohol care team

  - should be kept safe physically and assessed clinically as having sufficient mental capacity to receive mental healthcare

  - should be assessed for transient suicidality or psychosis, in which cases the liaison mental health team should provide interventions

- ED and liaison staff must understand and comply with the Mental Health Act and the Mental Health Act Code of Practice to reduce delays. Protocols are needed for access to rapid Mental Health Act assessments by s12 doctors and social care teams if required and liaison teams should include psychiatrists approved under s12 of the Act. This includes protocols with police services for escort of patients detained under s136 of the Act or for those not detained to EDs.

- An appropriate area should be provided for patients to wait in while transport for admission to a psychiatric service or other follow-up action is arranged.

- Acute hospital staff should have access to an up-to-date NHS111 Directory of Services (DoS) and primary care social prescribing directory, to enable faster onward referral to appropriate community services.

- By the time of discharge, those having experienced a crisis should have been appropriately assessed, an urgent and emergency mental health (UEMH) care plan or follow-up care accepted and scheduled, or advice/signposting provided.

- For people with mental health needs and dementia on acute hospital inpatient wards, early involvement of liaison teams including embedded social care and housing expertise will improve discharge planning and co-ordination, resulting in shorter lengths of stay and reduced general hospital readmissions for adults and particularly older adults.

- People who are known to mental health services and also frequent attenders should have a co-produced care plan in place, including an advance decision crisis plan of the actions to take to manage a crisis, as well as arrangements to support the patient to share that plan safely with ambulance, ED and other staff.

To learn more

- *Achieving better access to 24/7 urgent and emergency mental health care – part 2: Implementing the evidence-based treatment pathway for urgent and emergency liaison mental health services for adults and older adults – guidance*
  www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 16
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- The College of Emergency Medicine (2013) *Mental health in emergency departments*
  www.rcem.ac.uk/docs/RCEM%20Guidance/CEM6883-Mental%20Health%20in%20ED_Toolkit.pdf

Clinical decision units

Outcome

Patients who can be discharged following a short period of observation, investigation or treatment are managed in an appropriate short stay area outside the ED.

Core principles

- All hospitals should have a facility that enables same-day emergency care in a non-inpatient setting. Clinical decision units (CDUs) and ambulatory emergency care (AEC) services are both effective models. Hospitals may decide to have both depending on the model of emergency care, but this is not essential.

- CDUs should be supervised and led by a consultant and staffed by multidisciplinary teams including clerical staff and allied health professionals.

- Open 24 hours a day or to match the known demand profile.

- Co-located with or close to the ED, with access 24/7 to key diagnostic services, such as pathology and radiology.

- Governance should include medical, nursing and allied health disciplines.

- Decisions should be made as soon as a patient's results become available and should not be contingent on a ward round process.

- CDUs must not be used for patients waiting for admission as part of 'escalation' when the hospital is under pressure.

- CDU criteria should be balanced and co-ordinated with those of AEC and acute frailty services to avoid unnecessary duplication.

To learn more

- The College of Emergency Medicine (2011) *Emergency medicine operational handbook: The way ahead*, pp32-33
  www.rcem.ac.uk/docs/Policy/The%20Way%20Ahead_Final%20Dec%202011.pdf

Ambulatory emergency care

Outcome

Patients being considered for emergency admission are rapidly assessed and, where appropriate, streamed to AEC, where they are diagnosed and treated on the same day, without overnight admission where possible. Hospitals introducing AEC should aim to convert a third of their adult acute medical admissions to ambulatory care episodes.

Core principles

- All patients other than those who are clinically unstable should be considered for AEC as the preferred option.

- AEC should be available at least 14 hours a day, seven days a week to receive patients directly from the ED and primary care.

- Where possible, the AEC facility should be close to the ED. AEC should be available for patients with medical, surgical or gynaecological problems.

- Selection of patients for AEC should be maximised by:

  - AEC clinicians undertaking regular board rounds with ED staff to identify patients

  - displaying a list of common AEC conditions in the ED to help identify appropriate patients for AEC

  - giving the AEC team access to the ED board to spot patients

  - allowing automatic referral from ED for appropriate patients.

- There should be immediate access to a senior doctor who is responsible for agreeing the case management plan for each patient.

- The timeframes for initial assessment and medical review in AEC should be similar to those in the main ED.

- Patients should have access to diagnostics within the same timeframe as other emergency patients.

- The AEC facility should have a combination of consulting rooms, treatment trolleys and chairs for patient assessment. Patients should be kept ambulant as the default.

- AEC must not be used for patients waiting for admission as part of 'escalation' when the hospital is under pressure.

There should be agreed and shared clinical governance of AEC between the ED and other relevant departments in the hospital, particularly the CDU and assessment services. This should set out the roles and responsibilities of the different functions and seek to ensure that assessments and other processes can be shared.

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency care,* section 15
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- *The directory of ambulatory emergency care for adults*
  www.ambulatoryemergencycare.org.uk/uploads/files/1/BAAEC/AEC%20Directory%202016%205th%20edition.pdf.pdf

- Providers can refer to the Royal College of Physicians *Acute care toolkit 10: ambulatory emergency care* to assess what proportion of admissions could be converted from inpatient to AEC: www.rcplondon.ac.uk/projects/acute-care-toolkits

- www.ambulatoryemergencycare.org.uk/

Acute assessment

Acute Medical Units (AMU)

Outcome

Patients with acute medical conditions are assessed and their treatment begun by a multi-professional acute medical team. Patients are referred from the ED or primary care. Following initial assessment and treatment, patients are either discharged from the acute medical unit (AMU), or transferred to a specialty ward appropriate for their condition, usually within 72 hours of arrival.

Core principles

- AMUs must be consultant-led, with a core team of acute physicians supported by specialty physicians.[10] They must be available 24/7.

- AMUs should aim to receive clinically stable GP referred patients directly, not via the ED.

- AMUs should have a dedicated multidisciplinary team that includes nurses (with appropriate nurse-to-patient ratios), allied health professionals (for example, physiotherapists and occupational therapists) pharmacists and discharge co-ordinators as appropriate.

- AMUs should have ready access to in-reach services to support patient care and early discharge, including inpatient specialist doctors, specialist nurses, social workers and allied health professionals, for example, speech and language therapists and dieticians.

- AMUs should include dedicated assessment wards and ring-fenced short stay beds. Service design should conform to the recommendations of the Royal College of Physicians 2007 Acute Care Taskforce.

- AMUs should have direct access to the hospital executive team to foster collaborative working, especially during periods of peak demand.

- Communication and handover rotas should be used to promote continuity of care. There should be regular 'board rounds' and core acute assessment service multidisciplinary team 'huddles'.

[10]

https://cdn.shopify.com/s/files/1/0924/4392/files/acute_medical_care_final_for_web.pdf?1709961806511712341

- Patient discharge processes, including establishing an expected discharge time and date, should start as soon as the patient arrives on AMU as part of the initial assessment process.

- As a quality marker of acute medical assessment services, specific pathways should have standardised processes (for example, a sepsis pathway, an acute kidney injury pathway).

- There must be close working between clinicians and managers to optimise flow through the AMU, for example avoiding delays in discharges and transfers to wards. To efficiently admit patients from ED to AMU, the AMU should run at between 85% to 90% bed occupancy.

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency* care section 18.4
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- Royal College of Physicians (2007) *Acute medical care*,
  https://cdn.shopify.com/s/files/1/0924/4392/files/acute_medical_care_final_for_web.pdf?1709961806511712341

- *Acute care tool kits:* www.rcplondon.ac.uk/projects/acute-care-toolkits

- *Seven-day services clinical standards:*
  https://improvement.nhs.uk/documents/768/Clinical_standards_revised_Feb_2017_FINAL_for_publication_QvpPj1X.pdf

- Effectiveness of acute medical units in hospitals: a systematic review:
  https://academic.oup.com/intqhc/article/21/6/397/1797926

Acute surgical and specialty assessment

Outcome

Patients are rapidly assessed and their treatment begun by acute assessment services following referral from the ED or primary care, and either discharged or admitted to a ward that is appropriate for their condition.

Models may vary but all assessment services adhere to similar principles. AMUs may be co-located with surgical and non-medical specialities in combined assessment units or 'emergency floors'.

Core principles

- Acute assessment services are consultant led and available in accordance with demand patterns, ideally 24/7 where patient volumes justify it.

- As a minimum, a specialty trainee (ST3 or above) or a trust doctor with equivalent ability, is available to see/treat acutely unwell patients at all times within 30 minutes and is able to escalate concerns to a consultant.

- An initial patient assessment should start within 15 minutes of arrival.

- Acute assessment services should aim to receive clinically stable GP referred patients directly, not via the ED.

- Acute assessment services should have a dedicated multidisciplinary team that includes qualified nurses (with appropriate nurse-to-patient ratios), allied health professionals (for example, physiotherapists and occupational therapists), pharmacists and discharge co-ordinators as appropriate.

- Acute assessment services should have ready access to diagnostics and in-reach services to support patient care and early discharge.

- Patient discharge processes, including establishing an expected discharge time and date, should start as soon as the patient arrives on an acute assessment ward.

To learn more

- Standards for short stay paediatric assessment units: www.rcpch.ac.uk/system/files/protected/news/SSPAU%20College%20Standards%2021.03.2017%20final.pdf

- Standards for unscheduled surgical care (see section 1.6.3 surgical assessment units) www.rcseng.ac.uk/-/media/files/rcs/about-rcs/regional/rcs_emergency_surgery_2011_web.pdf

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 18.4
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

Frailty

Outcome

Frail patients are identified as soon as they present to the ED or directly to assessment services, and receive specialist, high quality, person-centred care on the non-elective pathway. They are discharged without delay when their acute care is complete, with the right level of support to continue their recovery and rehabilitation in their own home.

Core principles

- Frailty should be identified and measured at the front door using an evidence-based assessment tool (for example, the Rockwood Clinical Frailty Scale).

- There should be a multidisciplinary team that is competent to deliver holistic assessment and management of older people (through comprehensive geriatric assessment).

- The frailty pathway should be embedded in processes in the ED, AEC, CDUs, AMUs and on specialty wards.

- Patients with frailty should be actively involved in their care and the provider able to demonstrate shared decision-making/patient-centred care. Patients should be routinely asked what is most important to them and their responses clearly documented.

- Hospitals should be aware of what happens to patients with frailty who leave their service. This is a central part of providing care to these patients.

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency care*, section 22
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- British Geriatrics Society (2012) *Silver Book*
  www.bgs.org.uk/silverbook/campaigns/silverbook

- The Health Foundation (2013) *Improving the flow of older people*
  www.health.org.uk/sites/health/files/ImprovingTheFlowOfOlderPeople_casestudy_1.pdf

Specialties

Outcome

Patients on hospital inpatient wards receive person-centred, compassionate and skilled care. They are admitted promptly to, and remain on, the right ward to meet their needs. They, and where appropriate their families, are involved in decisions about their consultant-led care and achieve outcomes that are personally relevant to them without exposure to avoidable delays or harm. They are discharged without delay when their acute care is complete, with the right level of support to continue their recovery and rehabilitation.

Core principles

- Specialties should use simple rules to standardise ward processes and minimise variation between individual clinicians and between clinical teams. This may include implementing the SAFER patient flow bundle and Red2Green days (see Appendix 1) and routinely using ward round checklists.

- Daily senior medical review should be normal practice seven days a week. A senior doctor should assess the progress of every patient, in every bed, every day on a board or ward round. Delays and obstacles to treatment or discharge should be discussed and addressed. A second, afternoon board round or huddle is considered best practice to progress care plans, particularly in the first 48 hours after a patient's admission.

- Ward rounds should always include an appropriately senior nurse and other members of the multidisciplinary team.

- Actions should be undertaken in real time whenever possible (requesting tests, writing discharge prescriptions, etc) not at the end of ward rounds.

- Continuity of care is essential. The Royal College of Physicians' *Future Hospital Commission* report (2013)[11] states that continuity of care for patients should be co-ordinated and delivered by a single consultant-led clinical team. As far as possible, the provision of care to any single acutely ill patient should be confined to a single ward or adjacent wards to facilitate continuity of care by the same team on successive days. Once the patient has left the hospital, continuity of care from a single team should be the case for successive clinical contacts with hospital-based services for the same

---

[11] www.rcplondon.ac.uk/projects/outputs/future-hospital-commission

index clinical problem (for example, follow-up in the community, outpatient department or AEC centre).

- All patients should have a consultant-approved care plan containing clinical criteria (both physiological and functional) for discharge and an expected date of discharge, set within 14 hours of admission.

- Patients considered at high risk (eg patients with a predicted mortality of ≥10% using an appropriate specialty risk-scoring mechanism) must be discussed with the consultant and be reviewed by a consultant within four hours if the management plan remains undefined and/or the patient is not responding as expected.

- Morning discharges should be maximised to reduce ED crowding, to allow new patients to be admitted early enough to be fully assessed and for their treatment plan to be established and started. Of a day's discharges, 35% should leave wards by midday. Activities associated with discharge should be prioritised by specialty teams.

- From the time of admission, all patients should know:

  – What is going to happen to them today?

  – What is going to happen to them tomorrow?

  – How well do they need to be before they can leave hospital?

  – When can they expect to leave hospital?

- Hospitals should ensure that patients are admitted to the right ward to meet their needs and are only transferred to another ward for sound clinical reasons. This is particularly important for frail patients.

- Requests for diagnostic tests and specialty review should routinely be completed on the same day and always within 24 hours.

- All patients with a length of stay over six days ('stranded patients') should be reviewed by the multidisciplinary team to determine the reason for any delays and to ensure that an appropriate discharge plan has been developed.

To learn more

- Royal College of Physicians (2015) *Ward rounds in medicine: principles for best practice*
  www.rcplondon.ac.uk/projects/outputs/ward-rounds-medicine-principles-best-practice

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 24
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- The Royal College of Physicians (2013) *Future Hospital Commission*
  www.rcplondon.ac.uk/projects/outputs/future-hospital-commission

- ECIP rapid improvement guide to setting expected dates of discharge and clinical criteria for discharge
  https://improvement.nhs.uk/resources/rapid-improvement-guide-expected-date-discharge-and-clinical-criteria-discharge/

- Seven-day services standards www.england.nhs.uk/wp-content/uploads/2017/02/clinical-standards-feb17.pdf

- Emergency surgery: standards for unscheduled care www.rcseng.ac.uk/-/media/files/rcs/about-rcs/regional/rcs_emergency_surgery_2011_web.pdf

- Health Foundation (2013) *Improving patient flow: How two trusts focused on flow to improve the quality of care and use available capacity effectively*
  www.health.org.uk/sites/health/files/ImprovingPatientFlow_fullversion.pdf

Admission, transfer, discharge

Outcome

Patients are discharged as soon as they no longer benefit from acute hospital care. In most cases, discharge is to a person's usual place of residence.

Core principles

- Therapy and social work teams should work at the front of the acute care pathway, routinely collecting information on how patients have been managing at home before becoming acutely unwell.

- On admission, the expectation should be that people will be discharged to their usual place of residence, with additional support if required, and assessment of their longer term needs undertaken there rather than in hospital.

- A clear clinical care plan must be set for all patients within 14 hours of admission, which includes an expected date and time of discharge that are linked to functional and physiological criteria for discharge.

- There should be a strong focus on 'simple' discharges. The SAFER patient flow bundle and 'Red2Green days' tools should be used routinely to ensure the most appropriate care for patients on all hospital wards (see Appendix 1).

- Board rounds should take place on all hospital wards each morning. The multidisciplinary team should review the clinical plan (including the discharge elements) on the board rounds and any decisions communicated to the patient.

- Duplication of assessment should be minimised using trusted assessors, building on the functional information collected on admission (see below).

- There should be a single point of access for health and social care to support 'discharge to assess'. Integrated discharge teams should be linked to an integrated intermediate tier of local services.

To learn more

- *Quick guides: discharge to assess*
  www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

- *Quick guide: supporting patients' choices to avoid long hospital stays*
  www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 20
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- *Utilising the 8 high impact interventions to assess our local system: Improvement in discharge management & planning*
  http://londonadass.org.uk/wp-content/uploads/2016/04/Utilising-the-8-high-impact-interventions-to-assess-our-local-system-.pdf

Appendix 1: The SAFER patient flow bundle and Red2Green days

The SAFER patient flow bundle

SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity).

The SAFER bundle blends five elements of best practice. It is important to implement all five elements together to achieve cumulative benefits. It works particularly well when it is used in conjunction with the **Red2Green** days approach.

When followed consistently, length of stay reduces and patient flow and safety improve.

The SAFER patient flow bundle rapid improvement guide
https://improvement.nhs.uk/resources/safer-patient-flow-bundle/

Red2Green bed days

Red2Green bed days are a visual management system to assist in the identification of wasted time in a patient's journey and reduce length of stay. It is applicable to inpatient wards in both acute and community settings.

The approach is used to reduce internal and external delays in conjunction with the SAFER patient flow bundle.

It is not appropriate for high turnover areas such as EDs, assessment units, CDUs/observation units and short stay units where using Red and Green on an hours/minutes basis may be more appropriate.

The Red2Green rapid improvement guide
https://improvement.nhs.uk/resources/rapid-improvement-guide-red-and-green-bed-days

Red2Green video
www.youtube.com/watch?v=Dc-b6GclTq4

Appendix 2: Trusted assessment

'Trusted assessment' simplifies assessment processes and increases the speed of patient discharge from hospital.

- Many local health systems have introduced 'trusted assessment' or 'generic assessment' where one person or team is appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

- Trusted assessment should be carried out by a trusted assessor who is authorised to undertake defined assessments for a range of different health and care provider organisations (normally care homes, home care services, NHS trusts and local authorities) through a single process.

- Organisations intending to carry out trusted assessments and those that will provide the care (for example, private-sector residential provision) must co-design and agree a streamlined and simple assessment process for trusted assessors to follow. Some local organisations may not agree to the use of trusted assessment.

- Patient experience and feedback should be used in the design of the trusted assessment process. Feedback from patients going through the process should be regularly collected to review and improve the process.

- There must be a clear and rapid route for challenge and escalation of problems/issues by any organisation for placements that are unsuitable for a person's needs. The aim should be to resolve any disputes on the day they arise.

- A competency profile for the trusted assessor must be agreed by all organisations.

- The costs and funding of the trusted assessment model should be agreed by all local partners. In some models, offering trusted assessments does not add to cost because existing staff are supported to carry them out. Often these are staff who are already collecting the necessary information, or much of it, as part of their routine work.

- There should be a clear analysis of the number and types of assessments that may be suitable for a trusted assessment model, the impact this should have on reducing length of stay and delayed transfers of care (DToCs), and an agreed ambition for the system. Metrics tracking the number of assessments done by trusted assessors, the number of satisfactory transfers and the locations patients are transferred to should be collected on a

monthly basis and the impact on length of stay and DToCs regularly reviewed.

- Arrangements should be captured in a memorandum of understanding between the relevant organisations that have signed up to the trusted assessment model, likely to include local authorities, clinical commissioning groups, NHS trusts and NHS foundation trusts, care home and home care providers, that explains the agreed trusted assessment model in a local system.

To learn more

- *Rapid Improvement guide to trusted assessors* https://improvement.nhs.uk/uploads/documents/ECIP_RIG_Trusted_assessors_March2017.pdf

- South Warwickshire's trusted assessment form has enabled direct referral to reablement without the hospital social work team's involvement: www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/18-south-warwickshire-trusted-assessment-form.pdf

- East and North Hertfordshire Care Home Vanguard is piloting a trusted assessor model and has developed the 'complex care premium' which is paid to the care home for residents who have 'complex needs' www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/19-en-herts-trusted-assessment.pptx

Appendix 3: Coming soon

The **emergency flow improvement tool** is an online resource that presents a range of indicators illustrating flow through a trust from arrival to discharge.

This flow tool is provided as an improvement aid rather than a performance tool, allowing trusts and their stakeholders to visualise their data and prompt questions about where demand, pinch points and blocks are occurring in their system.

Each time series graph has been processed against six statistical process control (SPC) rules to highlight common cause (expected) and special cause (unexpected) variation. A benchmarking feature shows how a trust compares to all others.

The tool will be made available to trusts in September 2017 through the Model Hospital portal.