NHS Improvement

National priorities for acute hospitals 2017

Case studies: Focus on improving patient flow

July 2017

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Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

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Ambulance handovers: early senior clinical decision making to release ambulance staff to respond to the next emergency

The Royal London Hospital, Barts Health NHS Trust

What was the problem?

The Royal London Hospital is a major teaching hospital with a large emergency department (ED) which includes a regional trauma centre. It is also the home of London's air ambulance, the London Helicopter Emergency Medical Service (HEMS), which responds to serious trauma emergencies in and around London. Space in the ED is at a premium and at times the ED is crowded, in part due to ongoing challenges with the internal flow of patients, with the result that the ED has little space to assess or accommodate more patients. However, ED staff also recognise that if ambulance staff are not freed quickly to respond to further 999 calls, patients in the community could be put at increased risk.

What was the solution?

- The decision was taken to accept timely ambulance handover whatever the level of ED crowding. ED staff take responsibility for finding space for these new patients.
- Where possible and appropriate, patients are transferred from the ambulance trolley to a chair, which is more comfortable for them and also helps promote an ambulatory approach to their subsequent care.
- Any necessary cohorting of patients because of ED crowding happens after ambulance handover and ED staff supervise these patients, not paramedics.
- ED leadership reinforces timely ambulance handover as the normal way of working. There is never an excuse for ambulance handover to be delayed.

What were the results?

- The number of ambulance crew hours lost from ambulance handovers taking over 30 minutes is consistently one of the lowest across London.
- Senior clinical decision-makers take the ambulance handovers which has increased patient safety in the ED.

- Promoting an ambulatory care approach early in the ED pathway has provided benefits to patients while facilitating early release of ambulance crews.

What were the learning points?

- Ambulance handover delays can be minimised by developing and maintaining a strong leadership culture in the ED that focuses on reducing clinical risk across the system as a whole.
- Timely ambulance handovers can be achieved and maintained even in crowded EDs.

Find out more

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Primary care streaming: appropriate patient direction on first emergency department contact

Luton and Dunstable University NHS Foundation Trust

What was the problem?

Luton and Dunstable University Hospital is an average-sized district general hospital with specialist stroke, bariatric and ENT services. It is also a dedicated trauma centre. The hospital serves a mixed urban and rural population which is ethnically diverse. The emergency department (ED) receives approximately 101,000 patients per year, 25% of whom are children. Primary care access in the area is challenging and patients with primary care needs often present to the ED instead. This practice was putting strain on an already busy ED with limited space. With all patients being processed through the ED the department was often crowded and patient experience was poor as a result.

What was the solution?

- A co-located primary care service.
- Pathways that stream patients away from the ED. Patients are placed in the most appropriate care stream for them at the first point of contact. Streams include ambulatory emergency care, ENT, gynaecology, surgical and medical assessment units following GP referral and open access pathways in addition to the co-located primary care service.
- Early senior assessment by an experienced ED streaming nurse from 8am to 11pm seven days a week.
- Written protocols and guidance for staff to support decision-making.
- Regular review of protocols and an understanding of the capabilities and capacity of each of the services patients can be streamed to.
- Clear professional standards and service expectations.

What were the results?

- More than 30% of patients streamed away from the ED to the co-located primary care urgent GP clinic.
- An increase in the number of patients presenting to the ED to access primary care.
- Improved patient satisfaction as a result of the provision of more appropriate environments to meet patients' care needs.

- Decongestion of the ED to enable emergency staff to focus on real emergencies.
- Consistent delivery of the emergency four-hour standard. Ownership of this standard is now shared across all departments within the acute trust and the system as a whole.

What were the learning points?

- Keep it simple: streaming is not triage. It is the rapid assessment of patients by an experienced ED clinician to allow them to direct the patient to the most appropriate clinical service to meet the patient's care needs.
- The more experienced the streamer, the greater the number of patients streamed away from the ED.
- Secondary triage may be necessary for some patients.
- Regular review of what did and did not work well allows frequent adjustment of service hours and criteria to ensure demand and capacity are matched.
- Clear escalation processes enable each service to draw attention to any issues. If the urgent GP clinic considers a patient should be sent back to the ED, clinicians in each service need to discuss this first.
- If patients streamed to the co-located primary care urgent GP clinic require a specialist opinion, they should be referred directly to the relevant specialty.
- Collaborative working and trust between services are essential. Regular audit and review enables discussion and a shared understanding of each service's capability and capacity, and develops trust between services.

Find out more

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Emergency departments: streaming of ambulances on arrival

Royal Berkshire NHS Foundation Trust Emergency Department

What was the problem?

Royal Berkshire is a large district general hospital with cancer, eye and renal specialist services serving a mixed urban and rural population of over one million. It receives 125,000 emergency department (ED) attendances a year, 25% of whom are children. The ED was built over 10 years ago with a capacity of around 65,000 attendances per year. During 2016 the trust started to see a decline in its ambulance handover response time, which had been one of the best in the South Central region.

What was the solution?

- To improve capacity and to meet national clinical quality indicators the trust embarked on a journey to implement senior triage and treatment (STATing) in a new dedicated eight-trolley area.
- A senior clinical decision-maker was placed at the ED front door between 8am and 10pm to ensure all patients are streamed to the most appropriate area to meet their needs: assessment unit; ambulatory care; emergency nurse practitioner (ENP) led minors area or into the main ED for further assessment and treatment.
- Senior cover: an ST4 doctor or above is on duty 24/7 and there is consultant cover 16 hours a day, seven days a week. Consultant-led board rounds are conducted three times a day.
- Safety huddles involving the consultant in charge, nursing co-ordinator and site manager are held every two hours alongside clinical validation of breaches when these occur.
- ED clinical quality indicators are visible on the shop floor and staff are more aware of these. Performance against the ED clinical quality indicators is also discussed at the monthly clinical governance meetings.
- A daily predictor of activity model has been developed to help plan for staffing and variation in demand.

What were the results?

- Improved patient and staff experience due to reduced crowding in the ED.
- Sepsis screening standards have been met and exceeded.
- Ambulance handover delays have reduced and the trust is once again a high performer across the South Central region.
- Both time to assessment and time to treatment have seen an improvement against the previous winter.

What were the learning points?

- Dedicated administration staff need to be allocated to the STAT area to support seamless patient registration.
- Nursing, portering and healthcare assistant staffing levels need to be adequate to support the high turnover acute workload and patient moves.
- A standard operating protocol can be used to reduce inter-clinician variability in the STAT process.
- Alternative pathways to which patients can be streamed need to be resilient, robust and accessible.
- The main ED (majors/resuscitation) must actively 'pull' the patients through after initial rapid assessment and treatment. This requires dynamic senior nursing and medical leadership.

Find out more

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Mental health: providing earlier access to services

Cambridgeshire and Peterborough NHS Foundation Trust mental health crisis first response service (FRS) and sanctuaries

What was the problem?

Before this service was launched there was no capacity to see people in need of mental healthcare out of hours except via A&E, and no self-referral route, meaning many sought help direct from A&E. Service users told us that it was very difficult and stressful trying to get help when in a mental health crisis and they found the emergency department (ED) a stressful environment.

What was the solution?

- A new community-based mental health crisis first response service (FRS) provides timely access to safe, effective, high quality care for people in mental health crisis.
- FRS provides assertive and responsive support and triage for anyone experiencing mental health crisis, including face-to-face assessment if needed.
- Open 24/7 for people of all ages throughout Cambridgeshire and Peterborough.
- Welcomes self-referrals as well as urgent referrals from carers, GPs, ambulance crews, police (anyone!) and the ED.

What were the results?

- A 20% decline in the use of ED for mental healthcare, reversing the local trend over many years of rapidly increasing numbers doing so.
- A 26% reduction in number of people with mental health needs being admitted to acute hospitals from ED.
- Reduced ambulance call outs, assessments and conveyances to ED for people with mental ill health.
- Reduced need for out-of-hours GPs to see people in mental health crisis.
- We predict the above impacts on the urgent and emergency system will increase once the FRS becomes more established.

- Implementation of FRS and the sanctuary has forced the system to change and this transformation has been achieved with a relatively small amount of money. We have done this with:
  - greater integration of the drug and alcohol treatment team, local authority and mental health services
  - pooled budget arrangements with the police to further solidify our commitments to ensuring safer, faster, better services for our communities
  - statutory and third-sector services working more cohesively to allow improvements in the wider mental health pathways.

What were the learning points?

- All partner agency staff need to be aware of the FRS and what it does if individuals experiencing mental health crisis and acute hospitals are to fully benefit from this alternative to presentation at EDs. For example, better engagement of paramedics could further reduce the number of ambulance conveyances to EDs.
- Directory of services: an up-to-date and comprehensive directory of all mental health, local authority and third sector services is required to enable effective and supported signposting. This needs to be easily accessible – for example, via a mobile app (MiDOS, MyHealth) and a 'one stop' mental health website.

Find out more

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Clinical decision units: providing a short stay area outside the emergency department

University Hospitals Bristol NHS Foundation Trust

What was the problem?

Bristol Royal Infirmary, one of nine sites that make up University Hospitals Bristol NHS Foundation Trust, is a large teaching hospital with specialist services covering a mixed urban and rural population of over 350,000.

While it is appropriate to admit some patients into the acute hospital for specialist review and management, a cohort of patients was identified that could be managed under the care of the emergency department (ED). These patients could be investigated, treated and discharged within 24 hours.

Appropriate patients to remain under ED care include patients with: suspected renal colic and suspected pulmonary emboli; frail older patients requiring further assessment before discharge; and moderate risk patients requiring psychiatric assessment.

What was the solution?

- An eight-trolley clinical decision unit (CDU) was opened which was co-located with the ED and operational 24/7.
- Patients are selected for CDU care according to standard operating protocol criteria and entry to the CDU is signed off by a consultant (up until 10.30pm).
- Patients are reviewed and discussed twice a day in consultant-led ward rounds and handovers.
- An internal standard has been set so that no more than two patients with specialty needs are managed within the CDU at any one time to ensure that the CDU offer is maintained.

What were the results?

- Patient turnover is rapid due to appropriate patient selection for CDU care and a low admission rate from CDU. Length of stay is usually under 24 hours, with the exception of adult and child mental health service users.

- Two to three patients per day will routinely be investigated, managed and discharged per CDU bed, highlighting the efficiency of the unit.
- Few clinical incidents have been reported.
- Patients consistently describe their experience as being ‘good’ in feedback surveys.

What were the learning points?

- Inadequate therapy cover for the CDU at weekends still means that some patients are unnecessarily admitted to an inpatient bed. Extending therapy services out of hours would further improve the efficiency of the CDU.
- Extended psychiatric liaison hours would allow a more rapid turnover of patients. Currently any patient who arrives on the CDU after 8pm who requires these services will not be assessed until 7am the next morning.
- Mental health patients who require admission to a psychiatric bed, subsequent to their assessment in CDU, may remain in the CDU for days awaiting their bed. This results in a poorer experience for the patient and a loss of capacity and throughput in the CDU. Close liaison with bed managers and psychiatry colleagues is essential to positively manage hospital transfers.
- CDU patients who subsequently require admission to inpatient specialties, following initial investigation, can experience delays in admission to general wards. Early senior review of potential CDU patients is essential to mitigate this risk.

Find out more

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Ambulatory emergency care: keeping it truly ambulatory improves flow

Mid Cheshire NHS Foundation Trust

What was the problem?

The hospital adopted ambulatory emergency care (AEC) in 2013 in an area close to the emergency department (ED). But a Care Quality Commission visit in 2014 drew attention to the area often being fully bedded with patients overnight awaiting a bed. This was to the detriment of patient experience and the system's ability to maximise ambulatory care. Jonathan O'Brien, Director of Operations, explains: "In Winter 2015/16 it was clear our assessment units were not performing: the ED was blocked, patients were being bedded in an unsuitable area and we were seeing large numbers of GP referred patients who needed rapid diagnostics not ED services. We needed to get our ambulatory care functioning properly to improve patient flow."

What was the solution?

- Doug Robertson, Associate Medical Director, suggested siting the AEC service where it could not practically bed patients. In May 2016 it moved to a former renal unit adjacent to the acute medical unit (AMU) but self-contained with its own entrance and not equipped as a ward.
- At first, long ED waits and high numbers of late admissions persisted because GPs continued to send their patients to the ED. The acute medical team trialled broadening the admission criteria to include all non-bedbound GP referrals direct to the unit, including those coming in by ambulance but excluding potential stroke patients and those with unresolved chest pain or sepsis. The service was relaunched to primary care to reinforce this new approach and its benefits.
- The team now encourages the ambulance services to bring patients direct to AEC, with on-trolley assessment. Nurse co-ordinators have been trained to triage and stream all GP referrals on arrival. The ED is encouraged to accept sick arrivals from AEC and to refer directly from its triage area to AEC. Acute consultant and advanced nurse practitioner (ANP) sessions are held on AEC.
- To ensure smooth transfer of patients requiring admission, the AEC and AMU work together, cross-covering consultants, advanced nurse practitioner (ANP) rotas and nursing off-duty.

What were the results?

- With its new approach and in its new location, the AEC unit quickly started seeing 40% of the medical take and was able to send 60% of presenting patients home on the same day.
- The trust's four-hour standard performance improved by 5% within a month, an improvement maintained into winter. The trust is now in the top 10% nationally for performance against this target.
- A 32-bedded medical ward could be closed and only 15 beds needed to be opened for six weeks during winter.

What were the learning points?

- Inspiration can be gained from visiting AEC units at other trusts.
- Support from the ambulatory emergency care network secured executive buy-in.
- Strong clinical leadership – a matron was seconded to lead the project – and empowered staff were important in this 'success story'.
- Agreed key performance indicators allowed staff to measure and monitor progress as the service evolved, and a PDSA (plan do study act) approach allowed them to perform controlled tests of change during implementation.
- Weekly catch-up meetings chaired by the project lead and attended by the associate medical director, senior managers, acute physicians, bed managers and staff from ambulatory care, ED and the wider team facilitated the rapid development of AEC processes.
- Effective data sharing with a new dashboard showing performance in one meaningful graph meant staff could see what was going well and the impact of their new way of working.

Find out more

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Acute medical units: developing an emergency village

Salford Royal NHS Foundation Trust

What was the problem?

Salford Royal NHS Foundation Trust provides services to a population of 246,000, averaging 1,100 admissions per month. The trust wanted to bring together its medical assessment services into an 'emergency village', to ensure that patients' needs were assessed as early as possible in their journey.

What was the solution?

A consultant-delivered acute medicine service was developed, with 14 whole time equivalent (WTE) acute physicians providing an on-site presence in the acute medicine unit (AMU) seven days per week.

- These doctors are part of a multidisciplinary team (MDT) that includes physiotherapists, occupational therapists, pharmacists, social workers, the voluntary sector and nurses (working on a 1:6 nurse-to-patient ratio).
- A dedicated frailty zone within the AMU has its own MDT.
- Dedicated nurse in charge and co-ordinator roles 24/7 facilitate flow, discharge and pull from the ED.
- Acute physicians in-reach to ED to pull appropriate patients from the ED and provide a dedicated phone line for referrals, advice and admission avoidance, including same or next-day appointments or admission to a 'virtual ward'.
- Access to diagnostics and investigations is prioritised over routine work, supported by internal professional standards.
- Specialty consultants and other teams in-reach to ED on a daily basis.
- Board rounds and huddles are held routinely and regularly throughout the day.
- The MDT is encouraged to trial new ways of working using an agreed improvement methodology.

What were the results?

- Patient transfer times improved from an average of 20 minutes to an average of two minutes, which meant ED staff were freed up and able to spend more time in the main department increasing the number of ED staff available.
- Better collaboration between the ED and the emergency assessment unit (EAU) within the newly created ‘emergency village’ led to the development of joint pathways and the creation of an ambulatory emergency care (AEC) unit in the EAU; this allowed for the admission of identified medical patients direct from the ED.
- The improved medical in-reach to the ED supported surge management at times of peak demand.
- Better quality care for patients with a smoother transition from ED to acute medicine.

What were the learning points?

- Effective recruitment and retention of clinical staff is vital.
- Good patient flow to specialty beds is needed to keep the AMU functioning well.
- The function of ambulatory areas and the AMU must be protected when the system is under pressure.

Find out more

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Frailty: an ambulatory emergency care unit dedicated to older people

Poole Hospital NHS Foundation Trust Acute Frailty Service

What was the problem?

Poole has an ageing population with 20% aged 65+ and 3.3% 85+ in 2011.To support acutely unwell frail patients both within the acute setting and in the community, and to alleviate pressure on A&E from this patient group, the Rapid Access and Consultant Evaluation unit (RACE) was opened in 2010. The aim was to promptly admit frail patients and then directly discharge them home when appropriate. But despite this unit receiving about 400 attendances per month, older patient admissions to the trust were up 4% in 2015 compared to the previous year. The trust was also in the top five in England for a disproportionate amount of emergency compared to elective work and the ED was not meeting the four-hour standard, compounded by significant delays in discharge of medically stable inpatients. Arrivals at the RACE unit peaked at 5pm, leading to unnecessary overnight stays on the unit and a large number of outliers.

What was the solution?

- An ambulatory emergency care (AEC) pathway was developed for frail older people that is nurse led and supported by consultants in older people's medicine.
- A chair-based area within the RACE unit was developed into an AEC unit for older people with the loss of four beds.
- Advanced nurse practitioners (ANPs) undertake comprehensive geriatric assessment (CGA), diagnosis and treatment, and arrange follow-up if required, supported by a consultant/registrar.
- Interprofessional services – physiotherapy, occupational therapy, social services, pharmacy and intermediate care – are all accessible within the AEC unit.

What were the results?

- Of the 81 people attending the AEC in its first month, 80% were discharged home direct from the unit and 41 (51%) admissions were avoided. Plan-do-study-act (PDSA) cycles indicated the AEC was capable of seeing more patients and even more admissions would be avoided if it did.

- We estimate the AEC unit has saved 292 bed days in its first six months of operation.
- Feedback from patients and their carers is excellent.

What were the learning points?

- The operational worth of the new AEC unit needed to be demonstrated to prevent the clinic being blocked with escalation beds at times of pressure.
- Confidence in the expanding ANP role needed to be earned.
- A formal frailty assessment tool would help identify patients presenting to ED who could benefit from the dedicated older person's AEC unit, before they are referred to other specialties.

Find out more

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Specialties: adopting a patient-centred continuous improvement approach

Western Sussex Hospitals NHS Foundation Trust

What was the problem?

Western Sussex Hospitals NHS Foundation Trust was formed from a merger in 2009 and operates across three sites in Chichester, Worthing and Shoreham-by-Sea. In 2013 the organisation achieved foundation trust status, having made improvements in the quality and safety of care provided. However, like acute trusts all over the country, it was confronted with ever-growing demand, increasing financial constraints and significant recruitment issues. The trust's leadership believed a new approach and strategy were required to ensure that the organisation continued to improve in the midst of these challenges.

What was the solution?

The trust's Patient First Improvement Programme was launched in September 2014 and is its long-term approach to transforming hospital services for the better. Patient First is based on proven improvement methodologies, most notably the principles of 'kaizen' (or 'continuous improvement') and the Lean approach to management developed by the Toyota Motor Company and adapted successfully for use in healthcare by organisations such as the Virginia Mason Medical Center.

The trust evolved these further for the specific needs of its hospitals and community to create its own Patient First Improvement Programme as a framework for service development through:

- redesigning systems to take out waste and to reduce the possibility of error, and
- standardising practices to make sure that every patient gets a great service each and every time.

This new Western Sussex approach is driven by six key principles:

- the patient at the heart of every element of change
- cultural change across the organisation
- continuous improvement of services through small steps of incremental change
- constant testing of the patient pathway to find new opportunities to develop
- encouraging frontline staff to lead the redesign processes
- equal voices for all.

The trust has trained hundreds of staff in Lean working methods and Lean awareness training is now included in induction and annual update sessions to make sure that everyone understands the principles behind it before it is rolled out into their area of work. Front-line staff learn new ways to approach problem solving and root cause analysis from a different, ceaselessly inquisitive perspective.

From ward to board, estates to corporate teams, the shared True North and Breakthrough Objectives with the patient at the heart are used to ensure all priorities, investments, improvements and projects are aligned to the shared vision of the organisation.

The trust's comprehensive Patient First Improvement Programme drives the implementation of Patient First throughout the organisation. The Lean improvement methodology has shaped the implementation of measures to improve patient flow, which include:

- The discharge profile of every patient is managed with clear plans in place.
- Board round processes have been improved and designed not according to ward areas but following core principles, for example twice daily in assessment areas.
- Senior review of every patient every day – job plans have been amended accordingly. This supports clinicians to set estimated dates of discharge for every patient and for patients and carers to be involved in early decision-making.
- New care models have been introduced in, for example, orthogeriatrics and cardiology.
- Reconfiguration of the emergency floors has led to a consistent, centralised approach for specialties.
- Focus on the application of effective site management principles with investment to support operational delivery through standardised structures across all sites alongside agreed minimum staffing levels with a particular focus on overnight staffing. Escalation processes are also aligned across all sites.
- Implementation of the SAFER patient flow bundle with senior nursing review of patients who have a length of stay of seven days or more (stranded patients) undertaken once or twice a week. Delays are routinely escalated with consistent adherence to thresholds.

What were the results?

- A&E performance: the four-hour standard has been consistently achieved.
- The Patient First Improvement Programme played a key role in the Care Quality Commission awarding the trust an overall Outstanding rating in April 2016.

- Best organisation: the trust won the award for Best Organisation at the 2017 Patient Safety Awards in July 2017 as a result of demonstrable improvements resulting from the Patient First approach.
- Staff survey: the trust showed improvement against every single question 4,000 staff members answered in the last staff survey.
- Quality improvement: the Patient First Improvement Programme focus on quality improvement sees the organisation's hospital standardised mortality ratio figures consistently within the best performing 20% of trusts in the country and the Patient Safety Thermometer is 1% higher than national average, just below 99%.

What were the learning points?

- The continuous improvement approach allowed the trust to identify areas of best practice and from this to apply a consistent approach of best practice across all sites.
- The Patient First Improvement Programme enabled the trust and staff to focus on the most important areas for improvement.
- The opportunity to learn from mistakes needs to be supported in the improvement approach.
- Engagement is an area of continued focus and this can be variable at times.
- The improvement journey never ends - no single change provides a 'magic bullet'.
- Strategic patience is important when implementing a major transformational programme that affects the entire organisation and its workforce.

Find out more

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Discharge: integrating services to meet the care needs of older people for earlier discharge

South Warwickshire NHS Foundation Trust

What was the problem?

South Warwickshire NHS Foundation Trust provides acute and community services to a population of 548,000. Older patients account for 80% of admissions and their increasing lengths of stay was adding pressure to the availability of traditional hospital beds, leading to gridlock in the system and a poor performance against emergency department (ED) targets and rising mortality.

What was the solution?

Different care needs of older people were integrated to allow earlier, appropriate discharge of this group.

- Reablement services and community emergency response teams were developed.
- Health and social care assessments were combined into a single assessment by trusted assessors before discharge. An electronic trusted assessment was developed by practitioners in the field.
- Clear discharge to access (D2A) pathways were established and resourced to discharge 65 patients per week with different levels of need when fit to be discharged:
  - **Home with support** (40 patients per week): the patient's needs are assessed using an electronic tool and they are then referred to reablement or the Community Emergency Response Team (CERT) for care that meets identified reablement and rehabilitation needs at home for up to six weeks.
  - **Reablement and rehabilitation in a bedded facility** (20): rehabilitation or reablement support is provided in community hospitals/residential care homes for up to six weeks (most return home within four weeks).
  - **Requiring (but not inevitably) ongoing care in a residential setting** (5): case managed care in a local authority-commissioned nursing home bed and local GP-commissioned medical care for up to six weeks, with care co-ordinated and rehabilitation provided by the trust.

What were the results?

- A&E target consistently met over the winter 2015/16 for the first time since 2009-10.
- Community capacity increased from 25 to 71 patients discharged per week with the reinvestment of savings from closing 18 acute and 26 community hospital beds.
- Older patients' length of stay is three days shorter in the acute setting and 17 days shorter in the community setting.

What were the learning points?

- It is important for all organisations to agree to the shared common purpose.
- Getting to an agreement can take a long time. Persistence and perseverance are the key.

Find out more

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 Publication code: IG 32/17