This advice pack is produced by the Getting It Right First Time (GIRFT) programme in collaboration with the Emergency Care Intensive Support Team (ECIST). It is aimed at encouraging the implementation of known good practice.
Foreword

The unprecedented pressures seen by the NHS are well documented and analysed. These pressures have forced NHS clinicians and managers to take the difficult decision to cancel elective procedures, knowing that these procedures are not trivial or cosmetic, but would prevent or alleviate serious suffering for their patients. Delivering high quality healthcare during a period of rising demand means the contribution of every healthcare professional is crucial in maintaining patient flow.

This advice pack has been developed to set out examples of interventions that NHS trusts can take to improve patient flow and help to manage these pressures. Improvements to patient flow in some areas have mitigated the worst of these pressures, enabling trusts to keep providing elective procedures whilst maintaining good A&E performance.

Improving A&E performance requires a whole system approach. This guide focuses attention on the improvements that are within a trust’s ability to control. In this respect it is important that we do not focus solely at the front door of the A&E department, but instead remember that maintaining good patient flow requires action across the whole trust. We therefore urge NHS providers to adopt a ‘whole trust’ ownership of the four hour operational standard.

Our GIRFT Clinical Leads have now completed over 1,300 deep dive trust visits and across the specialties patient flow has been a key discussion point. Our GIRFT visits have identified many examples of good practice and there is a great opportunity to learn from these. For example, South Warwickshire NHS Foundation Trust met the A&E target last winter and maintained strong finances thanks to continuing their elective work right through the period. At Gloucestershire Hospitals NHS Foundation Trust, reorganising trauma and orthopaedic services has allowed them not only to continue but to increase their elective activity while also meeting the A&E target in November 2017 for the first time in seven years.

These ways of working do not need to be reinvented: we can learn from the places where they have already been demonstrated and shown to work. Working together, flexibly and swiftly, clinicians and managers can implement these proven examples and have a significant impact on performance and quality of care across the NHS. GIRFT stands ready to help trusts achieve this in any way we can.

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Professor Tim Evans
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What trusts should do and how GIRFT can help

This advice pack contains useful guidance along with good practice examples identified by GIRFT Clinical Leads and Regional Hub teams on trust visits to date for:

- acute surgical attendances - with examples of where this has achieved reduced admissions of up to 30%;
- acute medical attendances – with examples of where length of stay reduction of up to 3 days have been achieved;
- attendances to emergency departments by frail patients;
- trauma and orthopaedic attendances, utilising a 'hot and cold' split site model, which demonstrates how a trust can significantly improve A&E performance and elective throughput including through placing dedicated trauma senior decision makers at the front door - which has reduced trauma admissions by over 20% in Gloucestershire Hospitals NHS Foundation Trust.

Implementation of these pathways will strengthen the front door by:

- reducing admissions or improve flow to enable faster admissions and transfers;
- accelerating time to decision to discharge, admit or transfer.

Trusts should consider which of these approaches best fits with their requirements and work with their nearest GIRFT Regional Hub over the coming months to implement them urgently. The contacts page (p17) provides detail on where to go for more information and support.

Trusts should also press on with implementing existing GIRFT recommendations which make a significant contribution to improving the operation of the front door (Emergency Departments, Surgical Assessment Units and Acute Medical Units), and releasing bed capacity.

We estimate the existing GIRFT surgical recommendations* alone offer a collective national opportunity of:

- 1,500 beds a year for stays under 7 days
- 2,100 beds a year for stays from 8 to 21 days

Further GIRFT support

In addition to supporting trusts in implementing GIRFT recommendations and the examples in this pack, GIRFT will also:

Keep adding to these examples and advice as GIRFT conducts more visits and expands into the medical and clinical support service workstreams – look out for future editions of this pack.

Co-ordinate with other NHS national programmes, such as the NHSE/ NHSI Urgent and Emergency Care Programme, to support winter planning, including initiatives such as the long stay reduction programme.

Help trusts with more than one site to implement a trauma and orthopaedics hot and cold site reorganisation where requested. GIRFT is currently supporting five trusts to deliver this change. It has already delivered improvement in A&E performance, elective performance and bed capacity at Gloucestershire Hospitals NHS Foundation Trust (see p15). Interested trusts are asked to contact their local GIRFT hub (see p17) to progress.

Work with a pilot trust this year to flex elective activity, scaling up from March to November and scaling down from November to March, with the intent that this annualised activity planning will increase overall activity while releasing capacity in winter to meet acute demand. If successful, the findings will be circulated nationally, and GIRFT support made available to trusts keen to emulate it in 2019.

The Emergency Care Intensive Support Team (ECIST)

ECIST provides support to NHS organisations across England to improve safety and outcomes by focusing on patient flow. ECIST’s tools, techniques and guidance are widely used and many are referenced in this document.

*Methodology: The bed estimates from 2016 would not account for elective activity growth subsequently and should not be compared to GIRFT’s financial opportunities. The 1500 bed calculation is based on a bed day opportunity of 663,731 and assumes a 365 day year, and bed occupancy of 85%. The bed day opportunity is calculated by subtracting the 75th percentile performance for 2016 from the length of stay for spells under 7 days, thus a length of stay of 6 days where 75th percentile performance is 4 days, would give an opportunity of 2 days.
Here we showcase measures already being practiced in trusts visited by GIRFT clinical leads which can help to improve patient flow.

For specific support, please contact the hub listed alongside the relevant example. (See page 17 for hub contact details).
Improving patient flow

GIRFT and ECIST strongly recommend implementing the measures outlined in NHSI’s Patient Flow Guidance.


NHS Improvement’s Patient Flow Guidance contains case studies on:
(see link above)

- Ambulance handovers (Barts Health NHS Trust)
- Primary care streaming (Luton and Dunstable University NHS Foundation Trust)
- Emergency departments (Royal Berkshire NHS Foundation Trust)
- Mental health (Cambridgeshire and Peterborough NHS Foundation Trust)
- Clinical decision units (University Hospitals Bristol NHS Foundation Trust)
- Ambulatory emergency care (Mid Cheshire NHS Foundation Trust)
- Acute medical units (Salford Royal NHS Foundation Trust)
- Frailty (Poole Hospital NHS Foundation Trust)
- Specialties (Western Sussex Hospitals NHS Foundation Trust)
- Discharge (South Warwickshire NHS Foundation Trust)

In addition, GIRFT clinical leads advise:

- Seeking to ensure that all patients awaiting admission in A&E departments are moved by 9pm, before the night shift begins.
- Planning to secure empty beds within Acute Medical Units (AMU) and Surgical Assessment Units (SAU) by 9pm each day. This ensures patients are not moved to outlier wards without a comprehensive treatment plan in place, and prevents overnight trolley waits in A&E departments. This is accomplished by a better mind-set on earlier decision making, earlier discharge and better IT flagging of potential available beds.
- Reviewing bed occupancy levels and the absolute number of acute hospital beds; also the flexibility of this bed stock.
Improving patient flow: decongesting emergency departments

Studies have consistently shown that at least a third of A&E attendances can and should be managed by clinicians other than emergency physicians. Co-located primary care, community pharmacy, and mental health teams can provide rapid expertise for up to 5 million A&E attendances per year.

Triaging all patients who present to the A&E department to the most appropriate stream, including mental health, primary care, dentistry and community pharmacy. This can include colocation of frailty services for older people with multidisciplinary teams supporting flow to avoid unnecessary admissions.

Examples: Luton and Dunstable Hospital (EMEE); Rotherham (NENCY), Taunton and Somerset (SW).

Such multidisciplinary teams (geriatric nurse specialists, physiotherapists and occupational therapists) should support the A&E department and acute medical units on a 12 hour per day, seven days a week basis. Example: Taunton and Somerset (SW).
Improving patient flow: admission of frail patients

Improving patient flow for elderly admissions
GIRFT and ECIST recommend consideration of the Sheffield Teaching Hospital NHS Trust’s experience of the Health Foundation’s Flow Cost Quality Improvement Programme:

The case demonstrates Sheffield achieved a 37% increase in discharge within 48 hours of admission, without increased re-admission, alongside reduced bed occupancy and decreased in-hospital mortality. Shortening time from presentation to assessment was central to achieving this, and the key actions taken were:

- Matching geriatric capacity to demand more effectively, and extending on call consultant cover in particular.
- Implementing a frailty unit.
- Adopting discharge to assess.

The actions taken were identified based on data analysis, multidisciplinary discussion and process mapping.

Example: Sheffield Teaching Hospital NHS Trust (NENCY)

Specialist staff for elderly admissions and assessment

Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies to which they are alerted within the community at care homes, A&E and through GP surgeries, and handle those which could be dealt with through treatment at home or through short-term residential care. Over a two-and-a-half-year period, over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET).

Example: Greenwich (L)
Improving patient flow: admissions

Assessment and ambulatory emergency care
All Acute Medical Units should be developed on an ‘assess to admit’ basis and not ‘admit to assess’. The design of AMUs with chaired areas help to suggest it is an assessment unit and not necessarily a prelude to admission. This can manifest in two ways according to the patient need, and to maximise the speed with which patients are seen and reviewed. There may be a central assessment area within the AMU to identify the severity of illness in referred patients and thus their correct disposition. This may be to an enhanced care area in the AMU which facilitates step up/down of patients and gets treatment in fast. There should also be an ambulatory care area. This area can take patients from the assessment area, from A&E, and directly from community practitioners. Up to 30% of acute medical referrals can be managed via ambulatory care. This is often preferable for patients and reduces the pressures on in-patient beds. There are consequent reductions in bed occupancy rates that assist in the delivery of the A&E four-hour standard.

ECIST recommends that all acute hospitals develop effective ambulatory emergency care services and strongly advises that these are never used for patients waiting for admission. Trusts considering implementing or enhancing their service should study the excellent Director of Ambulatory Emergency Care for Adults.

Example: South Tees Hospitals (NENCY) and Mid Cheshire Hospitals (NW).

Maximised access and rapid assessment
South Devon and Torbay already has well-coordinated or integrated health and social care but now plans to offer people joined-up care across the whole spectrum of services, by including mental health and GP services. They are looking at ways to move towards seven-day services so that care on a Sunday is as good as care on a Monday – and patients are always in the place that is best for them. Having integrated health and social care teams has meant patients having faster access to services; previously, getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In addition, patients needing physiotherapy only need to wait 48 hours for an appointment – an improvement from an eight-week waiting time.

Example: South Devon and Torbay (SW)
Improving patient flow: effective discharge

Proactive rehabilitation
A proactive rehabilitation package promotes independence, rehabilitation and more rapid recovery. Health outcomes have improved and dependency is reduced as patients are returned to the appropriate place of care more rapidly. ECIST recommends the involvement of relevant allied health professionals (AHP) in the assessment of patients as close to the time of their arrival (rather than admission) as possible. In Stoke a weekly AHP MDT is held to discuss all patients within the 16-bedded Respiratory High Dependency Unit. Moving forward into 2018 this should be discussed at the morning board round to target therapies input. Additionally a more in-depth discussion for complex patients with protracted length of stay should occur in all higher dependency areas to facilitate discharge planning as occurs in the 20-bedded Royal Stoke NIV / weaning unit, a system that is more broadly applicable. Example: University Hospitals of the North Midlands (WM)

Acute care hub, hospital and primary/intermediate care integration
The use of a ‘Acute Care Hub’, a suitably equipped and located physical space within which all those responsible for the delivery of inpatient care (ACH) assemble twice per day, 7 days per week to ensure safe and effective hand over, interact with community services, ensure the rapid availability of specialist advice within and outside the hospital, identify deteriorating patients (as judged by universal use of the National Early Warning Score, (NEWS) and those ready and fit for transfer out of hospital). Example: Rotherham (NENCY).

An ambitious project has been undertaken at Rotherham. In 2011, community services were transferred to the acute hospital trust, and developed into a community Transformation Plan (2014) and in 2015 to a ‘integrated locality vision’. This has involved the identification of 7 healthcare localities, a new out-of-hours model to provide 24 hour cover via a multi-disciplinary team, a Care Coordination Centre (single point of referral), new supported discharge pathways and the investment in and launch of a novel mobile IT solution. Metrics for success include numbers of A&E attendances, admissions and length of stay in the acute sector, number of placements into long term residential care, number of assessments undertaken at home, number of patients still at home 91 days after hospital discharge, and patient and staff satisfaction. Example: Rotherham (NENCY).

Virtual integrated clinics
Virtual integrated clinics can be utilised, in a similar way to the virtual fracture clinic in orthopaedic trauma, to facilitate getting results / reports back to GPs to try and reduce length of stay. Sometimes patients don’t need to be seen in clinic but need a quick specialty opinion. The use of a baton phone that the specialist has when they are covering emergency admissions can facilitate a quick clinic response and expedite discharge. Example: Gastro teams – Wirral University Teaching Hospitals (NW).

Hot clinics and early follow up of discharged patients
Hot clinics and ambulatory care services should be available as an alternative to admission for stable patients, to allow discharge from A&E with a date to come back to an appropriate ‘ology clinic. Access to hot slots for investigation also facilitates this e.g. radiology, next day ambulatory endoscopy for very low risk GI bleeds. Hot returns clinic slots should be used to reduce length of stay, by allowing earlier discharge of inpatients with the safety net of an early clinic review e.g. in acute medicine, acute surgery, or appropriate ‘ology). These can be run by consultants, trainees or AHPs, with appropriate supervision/support.

Respiratory rapid access/hot clinic
A respiratory ‘hot’ clinic avoids unnecessary admissions by allowing rapid access to respiratory physicians and specialist nurses, to enable stable patients to be managed in the community. Telephone advice may be given to primary care teams, referrals are accepted to see patients the same or next day, and links with community services assist with management in the community.

In Bristol the service is available to GPs and community matrons to refer patients they feel meet the referral criteria. The clinic runs Monday to Friday 10am to 5pm and is staffed by a respiratory consultant, supported by a respiratory nurse specialist and a specialist registrar. It is intended to prevent the admission of patients with acute respiratory problems and is suitable for referral of adult patients threatening admission with a respiratory problem. Patients are discharged from the clinic with a management plan drawn up by a respiratory consultant.

A recent audit of the effectiveness of this clinic showed that 72% of our referrals were successfully treated in the community following attendance at the clinic and avoided the need for hospitalisation. (Thorax 2008; 63: supplement VII A13).
This service is NOT for suspected lung cancer in well patients - these must still be referred via the ‘2 week wait fast track’ service.

*Source: [https://www.nbt.nhs.uk/our-services/a-z-services/respiratory-medicine/respiratory-hot-clinic](https://www.nbt.nhs.uk/our-services/a-z-services/respiratory-medicine/respiratory-hot-clinic)*

**Example: North Bristol (SW)**

- **Geriatric Hot Clinic**

Camden CCG - Royal Free Hospital: The Triage and Rapid Elderly Assessment Team (TREAT) at the Royal Free assesses older patients’ needs quickly, including a specialist elderly medical component, within a multidisciplinary structure. TREAT includes consultant geriatricians, registrars, occupational therapists, clinical nurse specialists and pharmacists. The aim is to link with community teams to ensure appropriate care provision is in place to enable a patient’s safe return home without the need for hospital admission. HOT clinic is a one-stop clinic that is part of TREAT and is run five days a week at the Royal Free on the lower ground floor next to the Emergency department.

Eligibility criteria: patients with complex needs who require quick, comprehensive, geriatric assessment and intervention; patients who are expected to need admission within 48 to 72 hours, if no intervention were provided; patients with exacerbation of chronic conditions who require rapid investigation and treatment; patients with high risk of further falls or syncope; patients off baseline mobility; patients with infections unresponsive to oral antibiotics who could remain at home during intravenous treatment; patients under PACE/RAPID who require medical review or practical procedures.

*Source: [https://gps.camdenccg.nhs.uk](https://gps.camdenccg.nhs.uk)*

**Example: Camden CCG - Royal Free Hospital (L).**

- **Scaling Up Hip Fracture Service**

Early medical assessment and optimisation as well as early surgery and mobilisation are paramount in getting patients fit for discharge. At Great Western Hospital, Swindon the NOF service has developed and instigated the Scaling Up Hip Fracture project. This involves:

- 80% of patients get a nerve block in A&E or ward prior to surgery. This is twice the national average.
- Number of patients receiving an extra meal per day has risen to 60% with appointment of nutrition assistant.
- 97.5% of patients now get a point of care test for Hb in recovery allowing early transfusion if required.
- Once patients were are mobilised early over 70% of their NOF patients are fit for transfer of care within one week.

*Example: Great Western Hospital, Swindon (SW)*
Discharge planning processes
The timing of discharge planning, the destination of discharge, and the availability of community services also impact upon length of stay. Interventions that have been introduced include:

- **Timeliness of discharge**
  When patients are discharged late, a cohort of morning patients for admission develops with no empty beds. The University Hospital of the North Midlands developed and led a ‘Home for lunch’ campaign to alert patients and their carers that they would go home early. The introduction and use of a discharge lounge assisted this process.

  **Example: University Hospitals of the North Midlands (WM)**

- **‘Discharge to assess’**
  ‘Discharge to assess’ and similar schemes can facilitate discharge of more complex patients. In Medway, a small cash injection from the CCG allowed the creation of a ‘Discharge to assess’ model in just 8 weeks, with a single point of access for all discharge coordination. Used the existing team and directed all care via that route, removing historical ‘territories’. Created one single point of access for all coordination of the patients’ discharge. Created a communications and marketing plan for roll out using ‘Home First’ branding for banners and posters across the hospital. Positive experience reported by patients and staff.

  **Result:** delayed transfer of care (DTOC) rates dropped 25% in 3 months. Discharge to Assess is strongly supported by ECIST. Other good examples are The Royal Sussex County Hospital and Warwick Hospital.


  **Example:** Medway (SE)

- **Home First**
  A community-wide project to help patients go home sooner from hospital was named as a regional winner in the NHS70 Parliamentary Awards. The innovative scheme was launched by the Royal United Hospitals Bath NHS Foundation Trust in 2017. It aims to reduce the length of stay for patients who are clinically well enough to leave hospital, but who might need extra support to return to their usual place of residence. Home First is a team effort, a system-wide project requiring health, social care and charity colleagues to work together to improve patient discharge, focusing on individual patient and their families’ needs, to get more patients home, on their feet and regaining their independence. By working closely with colleagues in the community they are providing real continuity of care for patients, helping speed their recovery and maintain their independence. Home First is a partnership of organisations that includes the RUH Bath NHS Foundation Trust, Wiltshire Council, Wiltshire Health & Care, Medvivo, Virgin Care, Age UK Bath, Somerset Partnership NHS Foundation Trust and Somerset County Council.

  **Example:** Royal United Hospitals Bath NHS Foundation Trust (SW)
Workforce measures

Effective staffing models will contribute to providing capacity at times of increased workload and maintaining patient flow.

The introduction of an innovative consultant job plan, replacing twice-weekly with twice-daily ward rounds in the Royal Liverpool University Hospital’s medical wards resulted in the number of daily average discharges increasing and lengths of stay decreasing, whilst readmission rates and mortality remained unchanged over the ensuing 12 months. **Example: Royal Liverpool University Hospital (NW); Derby Hospitals (WM).**

Three staffing models are required, one for A&E, one for AMU and one for the wards. Ambulatory care needs staffing 7/7 with therapists as well as pharmacists, as do the wards, to ensure effective timely discharge. Junior doctors are also imperative on the wards 7/7 to facilitate some of the discharges. This will make effective use of all the beds and represents an investment to save. **Examples: University Hospitals of the North Midlands (WM), Chelsea and Westminster (L).**
Senior medical cover
The functioning of any Acute Medical Unit will be compromised by the intake of patients whose primary need is from a specialty other than medicine. However, in some hospitals such as Royal Stoke University Hospital, with good clinical leadership it is possible to provide 12-hour cover of AMU during the weekend and 14 hours during the day with daily input into the short stay ward. **Example: University Hospitals of the North Midlands (WM)**

Specialist staff
Patients in AMU may initially be seen by an acute or a general physician and for many their complete hospital stay may be managed without the need for more specialist input. There is a need, however, to ensure that patients with specialty needs are seen promptly by the relevant specialty. The clinicians from the relevant acute specialty should have the competencies of a senior decision maker in their specialty to facilitate relevant patient management with an emphasis on rapid treatment and discharge whenever possible. Endoscopic investigations must be available within 24 hours for specific conditions in particular for patients with GI bleeding.

Senior nursing staff
The availability of senior nursing staff is often diminished at weekends in assessment units. These individuals are key to ensuring that patient flow occurs. The benefit has been demonstrated in units which have this consistent presence, and emphasises the necessity of a team approach to patient management in the acute pathways. As part of the senior role, medical and nursing handover should be made more robust and time-saving. All patients transferred from AMU or SAU into main hospital beds must have a named consultant responsible for their care until discharge. Within AMU all patients must be aware of the name of their responsible consultant and rotas must be designed to minimise the number of consultant handovers that occur. With a ‘Physician of the Week’ model, the benefits of having daily or twice-daily review outweigh the negatives of having to handover once a week to a new physician of the week. **Examples: County Durham and Darlington (NENCY), Chelsea and Westminster (L).**

Multidisciplinary teams
In Greenwich, teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies to which they are alerted within the community at care homes, A&E and through GP surgeries, and handle those which could be dealt with through treatment at home or through short-term residential care. Over a two-and-a-half-year period, over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET).

For elderly patient admissions it is vital that they should be screened by therapies staff in A&E. This should be a 7/7 acute therapies service who are able to see people in downstream wards not just AMU. Where possible there should be direct support from a geriatrician in all medical wards. The physiotherapy and occupational therapy services can mobilise patients and assess their care needs on discharge. The link between these in-hospital services and community services must be robust to ensure that no patient waits in hospital for a package of care. **Example: Greenwich Borough (L).**

The use of physiotherapists and occupational therapists working alongside geriatric nurse specialists, especially in the care of older people, can reduce admission rates and length of stay for this key cohort of patients. **Examples: Taunton and Somerset (SW); Wirral University Teaching Hospitals (NW).**

Multidisciplinary teams (geriatric nurse specialists, physiotherapists and occupational therapists) should be integrated within the A&E department and acute medical units on a 12 hour per day, seven days a week basis. **Example: Taunton and Somerset (SW).**
The roles of physician associates and advanced nurse practitioners should be defined and maximised over an extended day and at weekends to facilitate rapid assessment of patients, to allow contact with GP practices and social services, and to manage communications.

**Example: South Devon and Torbay (SW)**

**Pharmacists**

Pharmacists should be used more effectively to ensure the prompt supply of, and instruction in the use of, discharge medications.

**Examples:** Nottingham University Hospitals (EMEE); North Bristol (SW); Lancashire Teaching Hospitals (NW); Royal Cornwall Hospitals (SW); and Kettering General Hospital (EMEE).

Other GIRFT clinical lead suggestions for enhanced use of pharmacists include:

- Pharmacist prescribers should be present in admissions units and wards.
- Pharmacists or pharmacist prescribers should be writing discharge prescriptions. This can be done on one stop ward rounds to prevent batching (see SAFER patient care bundle).
- Pharmacists’ jobs should be planned to work in AMU matching work demands and patient flow into and out of acute units.
- Use of near patient pharmacy discharge teams.
- Pharmacy technicians/dispensing assistants to be embedded in ward teams to improve communication, counselling & supply.
- Pharmacy staff should be included on ward rounds.
- Pharmacy workforce hours should reflect decision making times on the ward e.g. start at 8am if the ward round starts at 8.30
- Pharmacy pre-admission clinics should be in place.
- Seven day clinical pharmacy services to high admission/discharge areas to reduce delays to discharges on weekend/ Mondays
- All patients admitted with delirium should have a defined and streamlined acute pathway so that they are managed in an appropriate ward environment that is compatible with their needs. This should include the extended use of pharmacists.
Surgical Assessment/Acute Surgical Units

A minority of patients presenting to the acute general surgical service requires operative treatment. Flow depends upon effective triage, early access to senior decision makers, diagnostics, emergency theatre capacity, perioperative care and social support.

Traditionally the acute general surgery take has been run by a trainee led team taking referrals from A&E and admitting patients directly to the ward from primary care. A common problem is for the surgical team to be involved with prolonged emergency operations and thus being unavailable to assess new attendances.

ECIST recommends both surgical assessment units and the development of surgical ambulatory emergency care services.

A number of trusts have introduced surgical assessment units (SAU, also referred to as Acute Surgical Units) with variable resources allocated to them for the assessment of patients referred from primary care. These units are self-contained and separate from the main A&E. They are staffed by the surgical team and therefore do not draw upon the resources of the emergency department. Relatively few hospitals have put a consultant at the front of the process i.e. the point of contact for primary care and other referrals. The General Surgery GIRFT report (August 2017) highlighted that the availability of senior decision makers in the A&E department reviewing surgical patients reduced the admission rates by 30% in some units.

Examples: Royal United Hospitals Bath (SW), Royal Blackburn Teaching Hospital (NW), Derby Hospitals (WM), Nottingham University Hospitals (EMEE).

New models of working: hot and cold split site model

Opportunities exist to physically separate elective and non-elective surgical activity provided operational plans allow for the management of variation in urgent trauma flows. Delivering patient care in this way has the potential to improve the quality and efficiency of trauma and orthopaedics in sites where the geography, estate and human resources can be optimised accordingly.

Gloucestershire Hospitals NHS Foundation Trust was formed in 2005 by the merger of Gloucester and Cheltenham Hospitals, nine miles (30 minutes) apart by road. Since 2017 GIRFT has supported the trust to split trauma and orthopaedic services across the two sites, with Cheltenham designated the main cold (elective orthopaedic) site and Gloucester the hot (trauma) site. Prior to this separation of services the A&E department across the two hospital sites was falling all constitutional standards.

Over 10% of A&E attendances at both Cheltenham and Gloucester hospitals were for musculoskeletal issues.

Trauma services were upgraded and improved at Gloucester and senior decision makers now review all trauma admissions on a daily basis, and are available within 30 minutes of being called to see or offer guidance to trauma patients.

Since its inception the breaches in A&E attributable to trauma and orthopaedics have fallen from over eight per week to one or two.

This has resulted in a significant reduction in trauma admission and overall usage of trauma beds, whilst ensuring that patients requiring admission are seen quickly and admitted.

Elective paediatric surgery and some day-case elective work still continues at Gloucester. This elective work continues to be affected by winter pressures but there is significant improvement in elective performance at Cheltenham, such that the trust significantly outperformed its contract in the final quarter of the financial year. It performed 19% more lower limb joint replacement surgery after reconfiguration and when on a block contract as compared to the final quarter of the previous year when it was on a variable contract.

Similarly in the final quarter the trust had a planned inpatient activity of 2,102 cases but actual activity delivered was 2,758 cases.

Example: Gloucestershire Hospitals NHS Foundation Trust (SW)
New models of working: hot and cold split site model

Gloucestershire Hospitals NHS Foundation Trust: Results

- 14% increase in the volume of elective activity (Winter, block contract and Financial Recovery Plan impact)
- In same timeframe 2016/17 - 155 elective cases; in 2017/18 - 558 elective cases performed
- 50% reduction in the number of patients cancelled in the week prior and on the day (90% of cancellations that occurred attributable to unfit patients and only one to lack of beds)
- Trauma cancellations down from an average of eight per week to three (six of the nine weeks in the period had zero cancellations)
- 15% reduction in fracture clinic appointments since trauma triage has been introduced.
- Average wait for upper limb trauma surgery (from injury) reduced from an average of 16.2 days to 8.1
- Length of stay reductions for all hip arthroplasty (5.2 to 4.49 days) and all knee arthroplasty (4.7 to 4.4 days)
- Number of A&E breaches, attributable to T&O, down from an average of eight per week to one
- Placing a senior T&O decision maker at the A&E front door reduced trauma admissions by 20.7%

These improvements in patient flows have been maintained over the six months of the trial up to May 2018. This has resulted in better care for patients, reduced cancellations, shorter average bed days per patient (4.48 vs 4.74), improved efficiency and improved performance in the A&E department.

Outcomes in T&O performance following implementation of new model in October 2017:

- 100%
- 95%
- 90%
- 85%
- 80%
- 75%
- 70%
- 65%


Gloucestershire Hospitals NHS Foundation Trust

The South
## Contacts

For enquiries about the good practice examples:

### GIRFT Regional Hubs

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<tr>
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For enquiries about the rest of the pack:

### GIRFT National Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Contact Details</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

### The Emergency Care Intensive Support Team (ECIST)

ECIST works with health and social care systems helping to implement best practice. ECIST is centrally funded and its help may be requested by contacting NHS Improvement or NHS England Regional Offices or by emailing NHS.ECIP@nhs.net
Best Practice Models

Model pathways

NHS Improvement’s Patient Flow Good Practice Guide has already identified the need for embedded frailty pathways within emergency departments and assessment units, and well-functioning acute medical (and other) assessment units. The GIRFT General Surgery report identified that consultant led-triage within surgical assessment units may reduce acute surgical admissions by 30%. Given the importance of these pathways and units to A&E flow, and our GIRFT Emergency Medicine leads’ prioritisation of the frailty pathway, GIRFT has focused attention in these key areas for patient flow.

GIRFT is producing a series of model pathways, designed with our GIRFT Clinical Leads which explicitly define a hypothesised best practice operation for each pathway.

Over the next few months, GIRFT will work with pilot trusts to:

- Test and refine these pathways and interventions.
- Model demand and capacity.
- Compare the trust’s practice to best practice.
- Identify resulting improvements required and help to implement them.
- Produce an evaluation of the results to support replication across the acute sector as appropriate.
- Disseminate the resulting model pathways in the second edition of this pack.

These are hypothesised pathways that require local customisation to be fully useful. Our network of GIRFT regional hubs will stand ready to help trusts who would like to compare their current operations to these optimal pathways, and quantify the changes and resources required to emulate them.
In addition to NHS England and NHS Improvement plans developed for winter resilience ([https://www.england.nhs.uk/winter/](https://www.england.nhs.uk/winter/)) GIRFT recommends consideration of the following:

### Broad measures to support acute patient flow

### Enhanced Recovery and Rehabilitation
- NHSI Online library of Quality, Service Improvement and Redesign tools: Enhanced recovery
- NHSI Good Practice Guide on patient flow should be considered for rehabilitation planning before discharge
- NICE (2017) Intermediate Care Including Reablement overviews intermediate care options available: [https://www.nice.org.uk/guidance/ng74](https://www.nice.org.uk/guidance/ng74)

### System Wide improvements to support emergency care systems

### Quick Guide: planning for increased seasonal demand in respiratory illness
NHSI/NHSE December 2017 guide endorsed by British Thoracic Society sets out steps for improving care, reducing admissions and supporting early discharge: [https://improvement.nhs.uk/resources/planning-increased-seasonal-respiratory-illness/](https://improvement.nhs.uk/resources/planning-increased-seasonal-respiratory-illness/)

### SAFER principles to maximise patient flow:
Further guidance

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

RCEM initial assessment of A&E patients guidance:
www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

Safer, faster, better: good practice in delivering urgent and emergency care sections 14,16 & 18:

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/resources/rapid-improvement-guide-making-internal-professional-standards-work/

Using safety checklists in emergency departments:

Fast track pathways: Laparotomy bundle:

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

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

www.rcem.ac.uk/docs/Policy/The%20Way%20Ahead_Final%20Dec%202011.pdf

Ambulatory emergency care guide: same day emergency care — clinical definition, patient selection and metrics

Ambulatory emergency care guide: same day acute frailty services
https://improvement.nhs.uk/resources/ambulatory-emergency-care-guide-same-day-acute-frailty-services/

Managing increased demand from winter illness
https://improvement.nhs.uk/resources/managing-increased-demand-winter-illness/

The directory of ambulatory emergency care for adults

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:
https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-10-ambulatory-emergency-care

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

Seven-day services clinical standards:

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

Standards for short stay paediatric assessment units:
Further guidance

Standards for unscheduled surgical care (see section 1.6.3 surgical assessment units)

www.bgs.org.uk/silverbook/campaigns/silverbook

https://www.rcplondon.ac.uk/projects/outputs/ward-rounds-medicine-principles-best-practice

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/

Emergency surgery: standards for unscheduled care

Quick guides: discharge to assess

Quick guide: supporting patients’ choices to avoid long hospital stays

ECIST videos on patient flow:
https://www.youtube.com/watch?v=pFhAzveLcZo&list=PL6rrXMWFEqXLSNsTFy7zyIDbYsAlZWui1

Allied Health Professionals Supporting Patient Flow:
For more information about GIRFT, visit our website: www.GettingItRightFirstTime.co.uk or email us on info@GettingItRightFirstTime.co.uk

You can also follow us on Twitter @NHSGIRFT and LinkedIn: www.linkedin.com/company/getting-it-right-first-time-girft

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement