GIRFT online tool supports emergency departments in managing capacity and patient flow

Insightful metrics and tools to give trusts more accurate information on how best to meet demand for emergency care have been developed as part of the Getting It Right First Time (GIRFT) programme's national review of emergency medicine.

The new GIRFT report offers a unique and comprehensive picture of emergency department (ED) attendance and capacity in English trusts. It introduces the Summary ED Indicator Table (SEDIT) as a tool to enable EDs and their trusts to understand the relationship between the demand and capacity profile of their ED and the patient flow and outcomes.

It also makes a key recommendation for a six-hour threshold for patients waiting to be admitted from EDs, after finding that a six-hour waiting time is more consistent with current case mix and outcome data than the current four-hour operational standard.

The report's authors, emergency medicine consultants Dr Chris Moulton and the late Dr Cliff Mann, reviewed 90 of England's type 1 emergency departments – those that provide a consultant-led 24-hour service with full resuscitation facilities. As part of their review, they introduced new metrics to examine patient waiting times for discharge or admission from ED, or transfer to another service. They found that changes in patient case mix and in the practice of primary care over recent years have brought an increase in the numbers of patients attending EDs who either require admission to hospital or significant investigation, including imaging. Such investigations take more time and, in their view, weaken the case for a single waiting time standard across all patients at all sites. This aligns with the recent consultation by NHS England to replace the current four-hour operational standard with a new set of measures and time standards for when a patient is clinically ready to proceed to the next stage of their care.

However, the GIRFT leads found compelling evidence for a six-hour waiting time threshold for patients requiring admission to a hospital bed. Analysis of GIRFT emergency medicine data shows a quantifiable increase in patient mortality where there are delays in excess of six hours.

New GIRFT metrics were used to understand the patterns in ED patient flow. The admitted patient breach rate (APBR) helped to better analyse the percentage of patients who missed the current four-hour and 12-hour waiting time standards, and the aggregated patient delay (APD) metric uses the total wait time beyond a given threshold to demonstrate unwarranted delays in care.

For admitted ED patients, the report proposes a six-hour threshold. The authors consider there to be no clinical reason for a patient to be in the ED beyond six hours after time of arrival. There is also evidence showing that patients who remain in the ED for longer than six hours has an associated increased 30-day mortality risk.

The GIRFT emergency medicine leads also developed the Summary ED Indicator Table (SEDIT), which provides data for each ED site with monthly updates. Each SEDIT contains several key charts including a quadrant chart with a view of the interplay between the four GIRFT-EM domains of demand, capacity, flow and outcomes. This enables ED teams to evaluate the causes and consequences of their current GIRFT-EM quadrant position and identify options for improvement.

The SEDIT and the new GIRFT-EM metrics will help deliver the recommendation made in the NHSE 2020 report *Transformation of Urgent and Emergency Care*, for trusts to monitor the average time admitted patients spend in their EDs and the time lapsed once admitted patients are 'ready to proceed', It is hoped is that the new GIRFT metrics will improve the understanding of underlying systems, behaviours and the patterns of ED patient flow.

On average, there are 15.5 million ED attendances each year. The nature of emergency medicine means that no appointment is required to access care. As such, EDs have increasingly become a first point of contact for many patients with conditions that could and should be managed by other services. The report advocates the provision of co-located primary care services at hospitals with high ED attendance rates. It recommends that trusts increase the proportion of patients taken directly to same-day emergency care (SDEC) units and also improve access to urgent outpatient clinics. This allows patients to be diagnosed and treated on the same day without being admitted to a hospital ward. The report notes that the feasibility of these services was clearly demonstrated during the COVID-19 pandemic and recommends that these improvements should be maintained.

The report also highlights the variation in resources available to EDs and presents recommendations to reduce avoidable costs. These include: addressing poor IT systems and processes that reduce ED productivity by adding to the clerical burden; staffing issues and high ED agency and locum costs; and litigation liabilities, often due to delays in diagnosis because of difficulties in access to 24-hour imaging.

The report makes 17 recommendations to help match capacity to local demand, improve patient flow, and reduce avoidable costs, including:

- Trusts to ensure all admissions occur within one hour of completing necessary ED investigations and treatment and within **six hours** of arrival.
- Commissioners to work with trusts to support a targeted expansion in the provision of hospital bed capacity to manage and meet local demand.
- Trusts to monitor and report APD at six and 12 hours and to use the SEDIT to understand the factors impacting on their ED demand and capacity, patient flow and outcomes.
- Trusts to work with their commissioners to optimise the provision of same-day emergency care (SDEC) and urgent clinic access, including the supporting imaging, as outlined in the NHS Long Term Plan and NHS Planning Guidance (2019 and 2020).

- The Royal College of Emergency Medicine to benchmark the usability of IT systems to enable trusts to make informed choices prior to procurement.
- Trusts to review their ED-attributed litigation, and to work with commissioners to address the need for 24-hour availability of urgent imaging (both CT and MRI scanning), with rapid reporting to reduce patient harms.

Report recommendations

Match emergency care capacity to local demand

1. Trusts, working with commissioners, to determine and fully understand their local demand and ensure that both the hospital and ED capacities match that demand.

2. Trusts, along with commissioners, to identify the ED burden arising from both new and existing services in primary, secondary and tertiary care, and to put measures in place to mitigate that burden.

3. Commissioners to work with trusts to enable a targeted expansion in the provision of hospital bed capacity to manage local demand.

4. Trusts to benchmark the number and adequacy of their ED cubicles, isolation facilities, resuscitation areas, x-ray and computed tomography (CT) capacity and staffing to ensure that overall capacity at least meets the current national mean.

5a. Trusts to work with their commissioners to optimise the provision of SDEC and urgent clinic access, including the supporting imaging, as outlined in the NHS Long Term Plan and NHS Planning Guidance (2019 and 2020).

5b. Trusts to ensure timely access to urgent care services and specialist opinions such that patients only attend ED when it adds value to their care.

Improve ED patient flow using solutions based on GIRFT-EM metrics

6a. Trusts to ensure that all admissions occur:

- within one hour of completing the necessary ED investigations and treatment;
- and within six hours of arrival.

6b. Trusts to assess their number of six-hour breaches, review ED flow and take action to improve hospital capacity and systems accordingly.

7. Trusts to produce a monthly report of the ED case mix variation and use this data to monitor and improve services.

8a. Trusts to measure all event and flow times from the patient's time of arrival.

8b. EDs to report all breaches of 12 hours from time of arrival.

8c. Care Quality Commission to review 12-hour breach records as part of their routine inspection.

9a. Trusts to monitor and report the Aggregated Patient Delay (APD) at 6 and 12 hours as key metrics for measuring ED performance.

9b. NHS England and NHS Improvement and the CQC to use the Aggregated Patient Delay (APD) metric in their reviews.

10a. Trusts to use their Summary Emergency Department Indicator Table (SEDIT) to understand their demand, capacity, flow and outcome rankings, and take action accordingly.

10b. Trusts to evaluate the causes and consequences of their current GIRFT-EM quadrant position and take appropriate action.

Reduce unwarranted variation in the resources available to EDs

11a. Commissioners' funding systems to reflect accurate and actual costs incurred and reported nationally in the provision of efficient and effective emergency care.

11b. Trusts and commissioners to ensure high-quality coding and costing of clinical activity.

11c. The Care Quality Commission to review and report on Emergency Care Data Set data quality as part of all their ED inspections.

12a. Trusts to invest in the facilities and opportunities for staff by adopting the priorities and values of the NHS People Plan.

12b. Health Education England, NHS England and NHS Improvement, and NHS Employers to collaboratively address the underlying human resource issues and the unacceptable consequences of inequitably and inadequately staffed EDs.

13. National bodies and commissioners to provide capital funding to ensure that every trust has an ED(s) with an appropriate physical environment to enable the provision of high-quality patient care and to allow a good working environment for staff.

14. All EDs to be configured to comply with infection and prevention control requirements.

15a. Trusts to ensure that ED hardware and software is purchased, developed and revised to enable clinical staff to work efficiently and effectively, without loss of productivity.

15b. The Royal College of Emergency Medicine to benchmark the usability of IT systems to enable trusts to make informed choices prior to procurement.

16. GIRFT to work with NHS England and NHS Improvement and the Royal College of Emergency Medicine to develop and publish a list of standard drugs to be automatically

available to ED teams without the need for local applications. (This has already been achieved with the list of required antidotes.)

17a. Trusts to review their ED-attributed litigation; identify recurrent themes and take appropriate action.

17b. Commissioners and providers to ensure 24-hour availability of urgent cross-sectional imaging (both computed tomography and magnetic resonance scanning), rapid reporting of imaging and senior clinical advice to reduce patient harms.