Under pressure

Safely managing increased demand in emergency departments

May 2018

Contents

Foreword

England's health care and adult social care services face a formidable challenge. Demand is increasing inexorably not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. The total number of years people can expect to live in poorer health is steadily growing. This rising demand is manifested as pressure on emergency departments that is increasing year on year, further exacerbated by spikes in activity driven by seasonally-related conditions.

Our inspections have shown that many individual providers have improved in the face of these pressures. However, the overall picture remains precarious as the system struggles with increasing demand, access and cost. In many hospitals the people at greatest risk are seen in the emergency department. As a result, how well hospitals, in particular emergency departments, are managing this rise in pressure in periods of peak activity is hugely important.

Throughout the winter months we have focused on inspecting emergency services under pressure. We know that all emergency departments face many of the same problems, regardless of whether the trust overall is performing well or poorly. And what we have found supports the concerns about the service widely expressed by staff in the service.

We have found committed staff working in difficult circumstances, often going above and beyond what could reasonably be expected of them. The dedication of emergency staff has enabled the service to deliver safe care to many patients. However, we have also found exceptions to this. In some of our inspection reports we have highlighted how increasing pressure on emergency departments has led to patients receiving care that is wholly unsatisfactory and in some cases unacceptable. Where we have found this, we have acted to protect people and make sure that services take the necessary immediate steps to improve.

So that we can understand the issues and what needs to change, over the last few months we have worked closely with and listened to more than 70 frontline emergency department clinicians – a new way of working to prompt new ways of thinking. Starting with a workshop in September 2017, we asked clinicians from leading emergency departments in a range of trusts across England to discuss the key challenges they are facing right now, to share practical solutions to tackling these problems and to consider preparation strategies for future surges in demand. From these discussions, we produced our report 'Sharing best practice from clinical leaders in emergency departments' in November 2017.[1] Building on the experience that the clinicians shared with us, we highlighted the eight key areas emerging from these discussions and emphasised the importance of focusing on measures that protect the safety of patients in the face of severe operational pressures. It is these areas we have focused on as we have inspected these services over the winter months.

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[1] Care Quality Commission. *Sharing best practice from clinical leaders in emergency departments*. November 2017.

We held a further workshop with frontline clinicians in March 2018 to look at these eight areas through the lens of their experiences over winter, with the aim of building on the best practice guidance.

It is clear that while the actions emerging from our clinical workshops are necessary to improve the care of patients in emergency departments, they are not enough to address the wider problem. The problems in urgent and emergency care are a symptom of much wider capacity problems across health and social care. If we are to reduce the burden on emergency care we must not only learn the lessons from this winter to improve our planning for next winter, we must as a matter of urgency address the underlying system issues.

During winter, it is not the just number of people attending emergency departments that creates increased demand on the service, but the fact that those attending hospital often have more complex needs and require more medical attention. It cannot be accepted that each winter will be worse than the one before – we are already seeing the effect of this on both patients and staff and action need to be taken now to address these pressures. It is clear that what used to work doesn't work anymore – while a long-term plan is developed and implemented to make system-wide and sustainable changes, we need to immediately introduce new ways of collaborating and planning for surges in demand to make sure that next winter is different.

This report aims to contribute to the discussion about how those working in health and social care can come together in a more systemised way to encourage early and effective planning for not only winter pressures but for all periods of peak demand. All need to develop a shared understanding of what an effective escalation strategy looks like – and longer-term, how health and care providers and commissioners collaborate to meet the needs of their local populations, with a stronger focus on keeping people well and helping them stay out of hospital.

Professor Ted Baker
Chief Inspector of Hospitals

Summary

Every year we are seeing more and more people in need of health and care support, with emergency departments bearing the brunt of this. It is well known that the pressure on emergency departments and the system is greatest during the winter months, with more people with complex needs requiring admission to hospital. A report from the Health Foundation, published in May 2018, shows that in 2015/16 one in three emergency patients admitted for an overnight stay had five or more health conditions, up from one in 10 in 2005/06.[2] This pattern of rising demand was seen over winter 2017/18, which saw an unprecedented demand on services.

While our inspections have seen good practice, we have also found too much variation in the way that hospitals and wider health and social care systems have planned for and managed this increase in demand, both during winter and throughout the rest of the year.

Looking at our local system reviews, it is evident that the problems we are seeing in urgent and emergency care are symptomatic of a much wider problem of capacity in the health and social care system. The demand for emergency care has steadily increased year-on-year and there is no reason to expect that this trend will change. The situation will only get worse unless there is a whole system approach to planning for, and managing heightened demand.

To better understand the issues faced by emergency departments, and identify areas where people could be at risk, we have worked with more than 70 frontline clinicians across two workshops to identify best practice on addressing these risks to make sure that patients are kept safe despite the operational pressures. Our workshop in March 2018 focused specifically on the key challenges emergency departments face during winter pressures, and identified practical solutions that trusts and the wider health and care system can put into action immediately to address these issues (see section 3).

There are no simple solutions to this problem. Our discussions with frontline clinicians working in emergency medicine have highlighted that new ways of collaborating and planning for surges in demand that need to happen immediately to ensure that next winter is different. This means looking at how we can keep people well and reduce emergency department attendances, better manage the flow of patients attending emergency departments and avoid unnecessary admissions and ensure early discharge.

However, hospitals cannot work alone to address this ever increasing demand on services. There needs to be transformation across the health and care system as whole, but planning for long-term change is not enough, we also need to act in the immediate future to make sure that the system can safely manage current pressures.

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[2] The Health Foundation. *Emergency hospital admissions in England: which may be avoidable and how?* May 2018

1. Increasing demand and the effect on emergency departments during winter

Winter 2017/18 saw an unprecedented demand on services. This follows an ongoing pattern of rising demand over the last few years, with the number of emergency admissions growing by 42% over the last 12 years.[3] Figure 1 also illustrates this long-term trend, showing that annual attendances at type 1 emergency departments have increased by 9.1% between 2011/12 and 2017/18.[4] The rise in attendances particularly has an effect during winter as more people attend with complex needs that need admission to hospital. This trend is likely to continue if we do not take immediate and effective action.

Figure 1 – Total monthly attendances to emergency departments (type 1)[5]
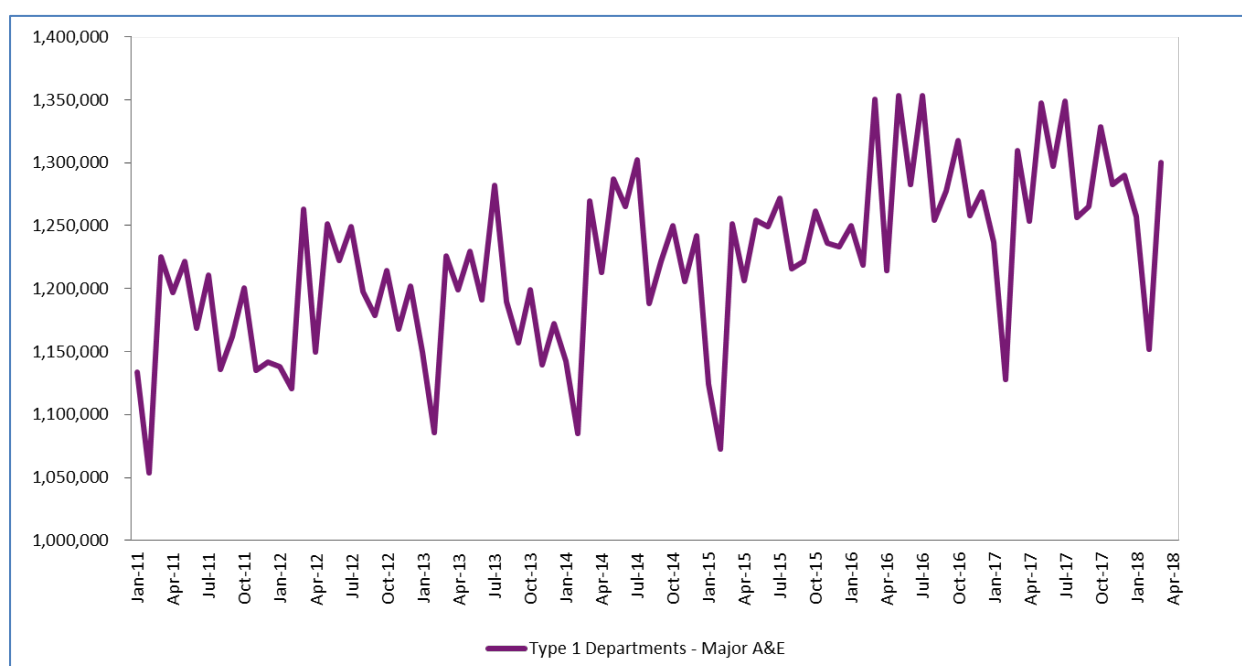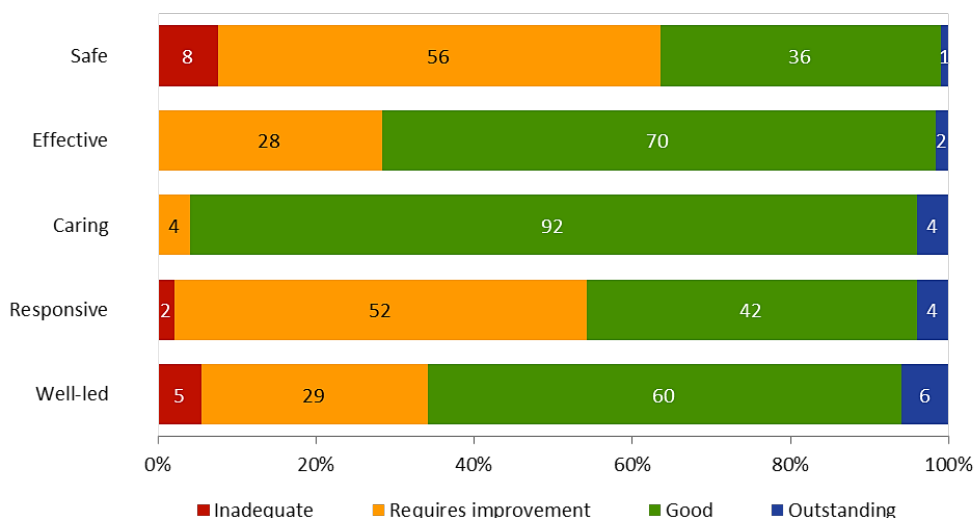

Source: NHS England

Our inspection programme has shown that many trusts are improving many of their services despite the operational pressures they face. However, we have found that urgent and emergency care services are an exception to this. As at April 2018, 4% of urgent and emergency care services were rated as inadequate and 46% were rated as requires improvement overall. Safety remains a key area of concern with 8% rated as inadequate for safety, raising serious concerns about the risk to patients that the pressures on the system are creating (figure 2).

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[3] The Health Foundation. *Emergency hospital admissions in England: which may be avoidable and how?* May 2018

[4] Type 1 departments are consultant-led 24-hour services, with full resuscitation facilities and designated accommodation for receiving accident and emergency patients.

[5] Data from NHS England – A&E attendances and Emergency Admissions (up to March 18).

Figure 2 – NHS acute hospital A&E ratings by key question[6]

(Horizontal stacked bar chart showing percentage ratings)

Key question	Inadequate	Requires improvement	Good	Outstanding
Safe	8	56	36	1
Effective		28	70	2
Caring		4	92	4
Responsive	2	52	42	4
Well-led	5	29	60	6

Source: CQC ratings data, April 2018

In this section we look in more detail at the areas where emergency departments are showing the strain of this year-on-year increase in demand. Importantly, we have found that these issues are not just limited to emergency departments during winter, but are of concern across the system all year round.

To understand more fully the issues faced by emergency departments, and the risks faced by patients, we held a workshop with emergency department clinicians in September 2017. We asked attendees to identify best practice on addressing these risks to make sure that patients are kept safe despite the operational pressures. They identified eight broad areas:

1. **Ambulance arrivals** – delays in patient handovers from ambulance into hospital.
2. **First clinical assessment** – delays in early assessment of patients.
3. **Deterioration** – monitoring of patients and identification of people at risk of deterioration.
4. **Escalation** – strategies for managing surges in demand.
5. **Specialist referrals** – delays in referrals and the working relationships between the emergency department and specialty teams.
6. **Use of inappropriate physical spaces** – this includes, for example, corridors for the care and treatment of patients.
7. **Staffing** – the wellbeing of staff and staff shortages.
8. **Patient outcomes** – the importance of all services monitoring the outcomes of their treatment and taking action if they are not within the expected range.

Over the winter months we have focused on these key areas in our inspections and a further workshop in March 2018 concentrated on the key challenges emergency departments face during winter pressures, and at other times of peak demand, and

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[6] CQC ratings data from April 2018, based on ratings of 201 emergency departments.

identified practical solutions to these challenges (see section 3). Following on from these workshops, we have reviewed historical performance data from 2010/11 to 2017/18 and analysed our inspection reports from the three last winters (2015/16 to 2017/18) where the urgent and emergency core services had been inspected.

Ambulance arrivals

Over winter 2017/18, data from NHS England for ambulance handovers shows that the proportion of ambulance handovers delayed over 60 minutes was highest for the weeks starting 25 December 2017 and 1 January 2018. During this period, 4.9% (4,734 of a total 97,706 arrivals by ambulance) and 5.2% (5,082 of a total 97,072 arrivals by ambulance) of handovers respectively were delayed more than 60 minutes (figure 3). Our inspection reports of hospitals and ambulance trusts showed some unacceptably long delays in ambulance handover and a significant number of handovers delayed by more than 60 minutes, known as "black breaches".

Figure 3 – ambulance handover[7]
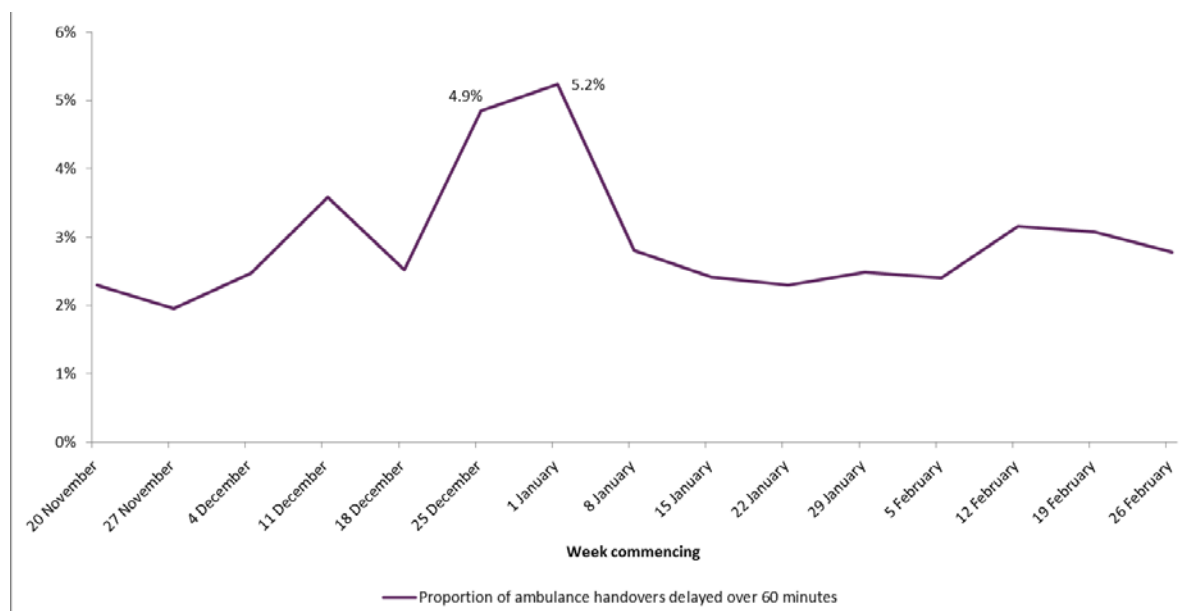
Source: NHS England

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[7] NHS England, Winter Daily SitRep 2017-18 Data, May 2018.

Ambulance delays as a sign of winter pressures

We used the last four years of data to investigate the factors that influence or explain the pressure on emergency departments in the winter period. We have looked at a range of emergency department data, using ambulance minutes lost beyond 30 minutes per ambulance journey as a measure of the pressure on the departments.[8] Our initial analysis of the data suggests that turnaround delays were:

- Longer at emergency departments in areas with smaller population centres, rather than in large cities. However, over the four years of our study, longer delays were starting to affect larger cities as well.

- Longer at emergency departments where the numbers of attendances were high relative to the total number of people registered with GPs in the local area. This finding may reflect difficulties in people accessing GP care.

- Longer at emergency departments where the nearby availability of care home beds was low relative to the numbers of older people admitted in key diagnosis groups, such as strokes, head injuries and seasonal influenza, which are among the most common in emergency departments.

- Longer at hospitals with lower ratios of senior to junior emergency department staff, and with lower proportions of all staff in clinical support roles.

- Longer at hospitals with longer lengths of stay for people in diagnosis groups that are among the most common in emergency departments.

Delays in patient handovers from ambulance into hospital puts the patients at risk, but also puts other people who are waiting for ambulances at risk as they have to wait longer for an ambulance to become available. Some of our inspection reports showed that employing Hospital Ambulance Liaison Officers (HALOs) in emergency departments can help improve handover times and patient flow. This was also found in our inspections of NHS ambulance trusts. HALOs can play key a role in building relationships between paramedics and the emergency department, by encouraging collaborative working and provide an on-site presence to support crews in handover.

However, introducing HALOs only addresses the issue of handover into the hospital, and ensuring people are not waiting in ambulances. Trusts need to make sure that there is a holistic approach to managing surges in demand and making sure that people are not waiting to be seen in inappropriate or unsafe environments, either in ambulances or in the hospital building itself.

These delays in ambulance handovers mirror the trend for an increase in the number of patients spending unacceptably long periods in emergency departments. This is reported as delays of more than 12 hours from decision to admit to admission for all types of emergency department and is higher in the winter months (figure 4). (The reported delay after the decision to admit does not represent the total waiting period for many patients in emergency departments, as the decision to admit is often itself

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[8] Ambulance minutes lost beyond 30 minutes is the amount of time the ambulance spends at the emergency department, after 30 minutes, while handing over a patient.

delayed long after the patient's arrival.) The very marked increase in reported delays in early January is a recurrent and predictable finding year-on-year. While the January increase has been well recognised for several years, advance planning has not effectively mitigated the problem.

Figure 4 – Number of patients spending more than 12 hours from decision to admit to admission (all types)[9]
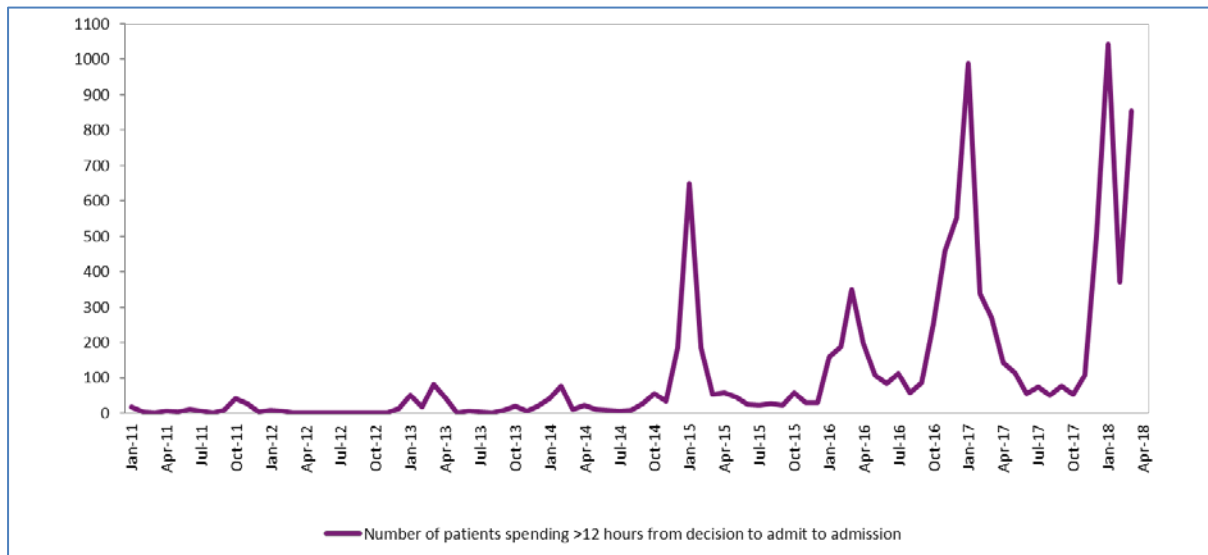
Source: NHS England

First clinical assessment and the deteriorating patient

In our guidance to trusts we have stressed the importance of early clinical assessments of every patient. Our inspection reports for the last three winters showed that patients in most emergency departments were not having a first clinical assessment (for example by a nurse) within 15 minutes of arriving.[10] We also found that there were some occasions where hospitals were not being appropriately alerted before the person arrived, which was leading to delays. Where emergency departments were working well, there was a suitably clinically-qualified member of staff, working in an allocated space, who prioritised people according to clinical need.

Early warning scores were not being used correctly or often enough, and ongoing monitoring of patients was not happening consistently. This meant that departments were not able to identify people at risk of deterioration. In some trusts, we saw that that delays in people receiving their first clinical assessment meant that those at risk of deteriorating were not being recognised quickly enough.

[9] Data from NHS England – A&E attendances and Emergency Admissions (up to March 18).
[10] The Royal College of Emergency Medicine. *Initial Assessment of Emergency Department Patients*. February 2017.

There were also occasions where it was unclear who was responsible for managing patients waiting for an initial assessment in the emergency department. In some situations we found that there were no policies or formal arrangements in place that made it clear who was accountable for people when they were in an ambulance that was on site at a trust. Despite a trained paramedic staying with the patient at all times, it was not always clear how they would communicate any deterioration in the patient's condition to the emergency department. Clinicians at the workshops were clear that when a patient arrives on site, the hospital becomes responsible for their care, and trusts need to have systems in place to make sure that they are aware of their arrival and that they are being cared for appropriately.

Escalation

Effective whole hospital escalation protocols are essential for managing surges in demand. Our inspection teams found that escalation policies and procedures were generally in place, but these were not always followed, or were not effective in coping with the increased demand. This finding is supported by data on performance against the emergency department four-hour target.[11] This shows that there has been a long-term trend of deterioration with a year-on-year decrease in performance. Over winter 2017/18 it dropped to its lowest level in the last seven years for type 1 departments (figure 5).

Figure 5 – Performance against the A&E four hour target (type 1)[12]
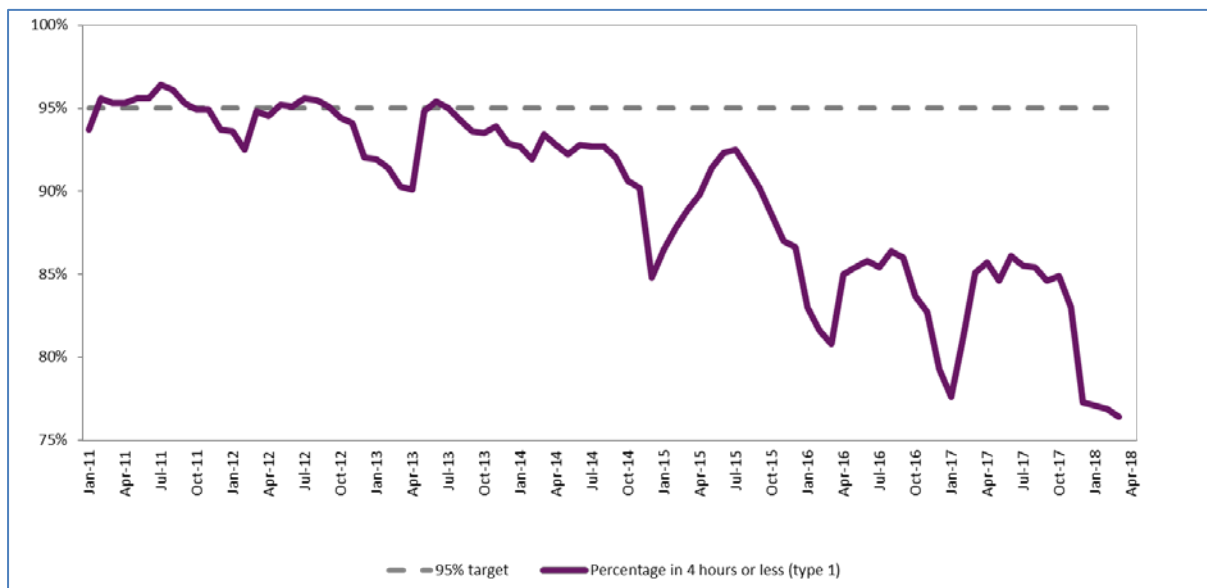
Source: NHS England

Specialist referrals

Our inspections highlighted some examples of good joint working with mental health specialists, including psychiatric liaison services. However, this varied between

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[11] Four-hour target refers to the percentage of patients spending less than four hours in the emergency department from arrival to admission, discharge or transfer.
[12] Data from NHS England – A&E attendances and Emergency Admissions (up to March 18). `

trusts. Inspection reports also showed many examples of poor working relationships with mental health specialty teams, leading to long referral wait times. There were also occasions where processes for referring patients to medical and surgical specialities were not good enough and were causing unnecessary delays, with patients waiting for unacceptably long periods in the emergency department for specialist assessment.

Use of inappropriate physical spaces

A key area identified in the best practice guide was the use of inappropriate physical spaces – such as corridors – for the care and treatment of patients, whether this was in the emergency department itself or elsewhere in the hospital.[13] We have made it clear in our guidance to trusts that the use of inappropriate spaces is not acceptable; however we found that many hospitals were using such spaces routinely, with no plans in place for alternative, safer accommodation.

Figure 6 shows that between December 2017 and February 2018, the percentage of attendances to type 1 emergency departments that led to admission to hospital was the highest recorded over the last seven years. In response to the increase in demand, trusts had to open additional clinical areas to care for patients. These escalation areas were inevitably varied in nature, but our inspections team found some were not a safe environment to care for patients and that often they did not protect patient privacy, dignity or confidentiality. They often also did not cater to the needs of children or patients in need of mental health support.

Figure 6 – Emergency admissions (type 1)[14]
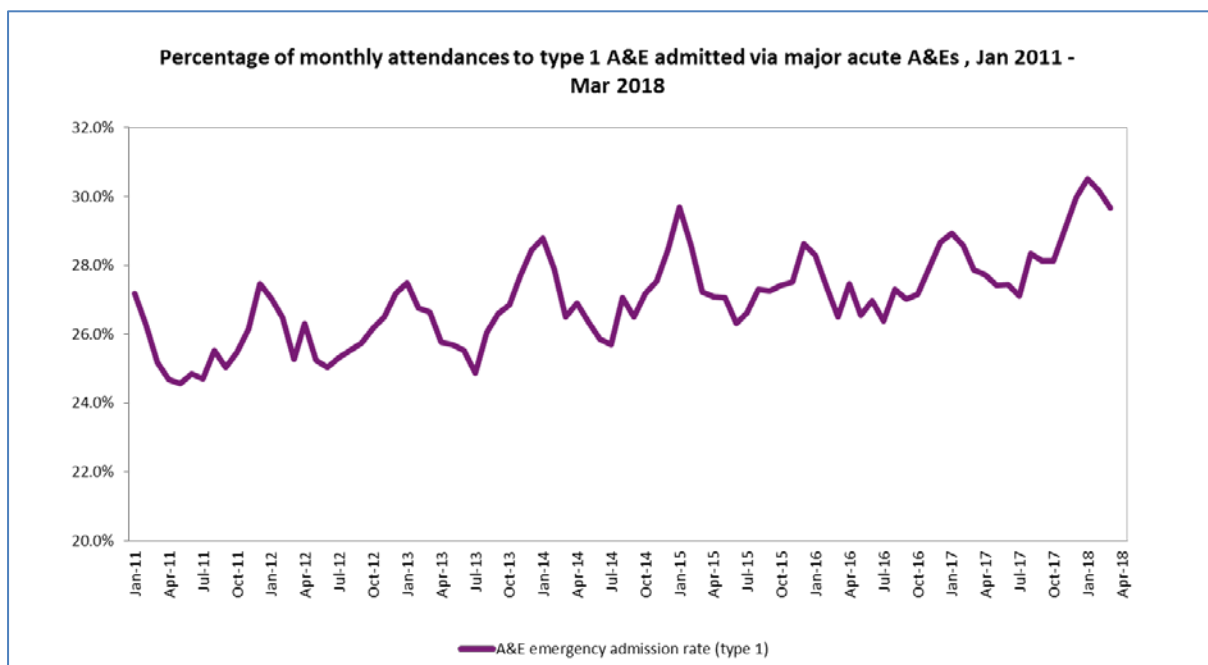
Source: NHS England

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[13] Care Quality Commission. *Sharing best practice from clinical leaders in emergency departments*. November 2017.
[14] Data from NHS England – A&E attendances and Emergency Admissions (up to March 18).

Staffing

Staffing was a particular area of concern. We remain concerned about the wellbeing of staff working under considerable pressure in clinically high-risk environments. This is made worse by shortages of key staff in many departments. A number of inspections found that many emergency departments were failing to meet the recommended 16 hours a day consultant cover.[15] Some trusts used staff modelling tools to look at nursing staff numbers. For example, we found the 'safer nursing care' tool had been adapted for emergency departments to establish the number of permanent nurses and healthcare assistants employed. This led to an increase in nursing staff numbers, following a successful recruitment programme.

However, nursing staff levels remained a challenge and many trusts continued to use a high level of bank and agency staff to maintain planned staffing levels both in the emergency department and also in inpatient escalation areas. Often there were not enough suitably qualified, skilled and experienced nursing staff in these areas.

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[15] The Royal College of Emergency Medicine. *Emergency Medicine Consultants – Workforce Recommendations.* April 2010.

2. Setting the challenges of emergency departments in the context of local health and care systems

From our workshops and reviews of inspection reports, it is clear that the problems in urgent and emergency care are a symptom of a much wider capacity problem across the whole health and social care system. Planning for surges in demand needs to be addressed at a system-wide level, not just in emergency departments. However, our review of how 20 health and social care systems are working together has shown that there is no shared understanding of what is meant by a "system". Through these reviews, which began in September 2017 following a request from the the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government, we have found that where things are working well, it is often down to individuals and organisations working together for the good of their local communities.[16] A national report on the findings of our review will be published in July 2018.

We have seen local health and social care organisations under pressure and struggling to cope with demand. People we spoke to who work in the health and social care sector told us that while preparing for winter pressures was vital, there needs to be systems in place that are resilient enough to respond to surges in demand throughout the year. In particular, urgent care services were operating under significant pressure. Some areas were frequently in escalation, to the point where this had become normalised; some systems leaders and operational staff told us that it was "always winter" in terms of the scale and frequency of pressures.

In some areas we found that improved information and oversight of activity is helping them better plan for, and respond to, surges in demand. There were some examples of local organisations working together to plan for winter pressures; led by local health partners, plans were submitted to NHS England with delivery overseen by the A&E delivery board or urgent care board. Some systems had brought their plans into line with wider regional plans and were linked to the sustainability and transformation partnership (STP) via the A&E delivery board. Some winter plans were submitted and signed off at health and wellbeing boards. However, the role of health and wellbeing boards in providing scrutiny and challenge to resilience planning varied significantly across the areas reviewed.

However, timeliness of planning was an issue in several of the areas we looked at; many initiatives designed to ease pressure on urgent care services were in the early stages and would not be embedded in time for winter. In some areas, stakeholders expressed concerns that winter planning had not begun early enough, and they lacked confidence in the system's ability to cope with winter pressures.

We also found issues with the extent to which wider partners were involved in the planning process. There could be confusion about the process for developing the winter plan across different stakeholder groups, and a lack of clarity about the role of different partner organisations in winter planning.

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[16] More information about our local system reviews and the interim report are available at: www.cqc.org.uk/localsystemreviews

At an operational level, it was typical for frontline staff and service managers to be aware of their own organisational plans for winter, but not to be sighted on system-wide planning. Individual plans were sought from organisations and fed into system-wide planning, but system plans were not always fed back down to individual organisations.

While winter planning involved a range of health and local authority partners, independent social care providers and the voluntary, community and social enterprise (VCSE) organisations were generally not well engaged, even though these sectors have much to contribute to winter resilience plans. These sectors play an important role in keeping people well at home, monitoring wellbeing and providing information and support. In some areas we saw excellent uses of the VCSE sector, and many VCSE sector representatives told us that there was more they could do with the support of commissioners.

Understanding the needs of the local population is key to successful cross-organisational planning. In some areas, we saw long-term strategies for increasing capacity in the adult social care market. A priority in several areas was to increase the amount of provision for people with complex needs, including dementia. There was also a move to increase the provision of housing with support and extra care facilities that help people to stay well at home. But as many of these were longer-term initiatives, they would not have an effect before winter.

In the more immediate term, some areas had put in place arrangements that would allow social care capacity to be flexed in response to spikes in demand; money from the Better Care Fund had been used to support this.[17] Short-term measures included additional block purchasing and opening interim facilities, but we found that there needs to be caution in how these are used so there is not over-reliance on out-of-hospital interim beds.

Our local system reviews support the findings of our workshops and inspection reports, showing that "winter pressures" are not just a winter issue. In some cases escalation has become normalised. Building resilience to manage the additional demands placed on the urgent and emergency care services needs input and buy-in from health and social care organisations across a local area. Understanding the needs of the local population, and having the right workforce in place, particularly in the primary care and home care workforce, is key to having the resilience to respond to surges in demand.

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[17] NHS England. Better Care Fund

3. Identifying solutions to the challenges of increasing demand in emergency departments

While it is clear that system reform is necessary to tackle the problems associated with increasing demand, there are still steps that emergency departments can, and need, to take immediately to prevent the issues we have seen during winter 2017/18 happening every year. Many systems have taken some of the steps we outline here. Clinicians at our workshops have told us that they are keen to share information and learn from each other to make sure that they are effectively implementing all the steps they can to manage the pressures they face.

At our workshop in March 2018, we asked emergency department clinical leads and matrons from 24 hospitals to build on the eight areas identified in September 2017, looking at the issues through the lens of winter pressures. Discussions were structured around four key themes:

1. ambulance handover, crowding and safety in emergency departments
2. emergency department medical and nursing workforce
3. patient flow, escalation and winter planning
4. condition-related issues during winter: flu and respiratory illnesses; frailty; paediatrics and mental health.

These discussions generated a number of practical steps, which are outlined in this section. For clarity, these have been grouped into those that address:

- **Demand** – actions that can be taken outside of the hospital that have been found to reduce the number of attendances to emergency departments.
- **Capacity** – actions that emergency departments and hospitals can take to improve patient flow through the hospital.
- **Output** – actions that can be taken to help to get people home more quickly and avoid admission to hospital.

While the suggestions from the workshop come from the perspective of, and are primarily relevant to emergency departments, they need to be considered in the context of our assessments in our local system reviews.

The consensus from the workshop was that making multiple small changes, using elements of each of the demand, capacity and output suggestions, can have a big overall effect. The suggestions are supported with some short examples how they have been used in practice. Full details of these examples are provided in section 4.

Steps to address demand

Reducing the number of people who go to emergency departments is an essential element of easing the pressure on the service. This section identifies what potential steps, including in the wider system, could be taken to reduce demand.

1. **Extended access to community services** during the week and at weekends to reduce unscheduled attendance at emergency departments. Continuity of care improves people's experience, person-centred care of complex conditions, and could reduce unnecessary hospital admissions.

2. **Care plans for adults** with social care needs and at risk of being admitted to hospital. Improving clinical support to nursing homes and residential homes and making sure people have a care plan for long-term conditions, has been shown to reduce or avoid unnecessary admissions to hospital. Review of medications and assessment of the risk of polypharmacy for people with long-term conditions is an important part of this.

3. **End of life care plans** should be in place where necessary to address all of the needs of patients and prevent inappropriate referrals to hospital for patients approaching the end of their lives.

4. **GP referrals** for hospital care should go straight to an appropriate assessment area for specialty review. They should not be channelled through the emergency department.

5. **Processes and pathways out of hospital for frequent attenders** to emergency departments (high impact group) need to be in place, such as community falls teams and a mental health service. At Bristol Royal Infirmary, the multidisciplinary group have shown an 80% reduction in emergency department attendances and hospital admissions in the high-impact group with this approach. See page 23.

6. **Frailty pathways for the elderly should be established** so that frail patients can bypass the emergency department. Ipswich Hospital and Homerton University Hospital have addressed this, for example with the Frailty Assessment Base at Ipswich Hospital. This has led to fewer patients over 75 being admitted into hospital since its introduction. See page 24 and page 25.

7. **Early follow-up clinics following discharge** after medical or surgical procedures, to make sure that patients receive appropriate follow-up care, can help preventing people defaulting to attending the emergency department if they are experiencing problems.

8. **Extra specialist outpatient clinics,** such as rapid access, hot clinics and ambulatory care appointments, can help to prevent avoidable admission to emergency departments.

9. **Integrated patient information systems** that link primary medical services, community services and acute hospital services, and that have the capacity to support clinical decision making, are essential. This includes, for example, managing cognitive impairment, polypharmacy, people with complex care needs, and recognising a patient's preferred place of death in palliative care.

Steps to address capacity and capability

When people have to attend the emergency department, the following initiatives were identified by clinicians at our workshop as ways to smooth the transition of patients through the department, and in turn reduce the need for admission to hospital.

1. **Effective streaming on arrival,** triage or clinical assessment to identify critically ill patients and those at risk of deterioration. To support this, there also needs to be an efficient ambulance handover at the front door. Frimley Park Hospital uses the Emergency Severity Index tool, and Bristol Royal Infirmary uses the queue nurse model, to assist effective streaming. Since the queue nurse model was implemented at Bristol, there have been no undetected deteriorated patients. See page 26 and page 27.

2. **A trained and skilled clinical team** in place at the front door to make sure that the clinician in charge of the department is aware of the status of all patients in the ambulance queue, and in the emergency department itself. The clinician in charge should have the authority to admit patients directly to inpatient wards where necessary.

3. **Defined professional standards** for emergency departments and the specialty services that support them, supported by open, resilient and collaborative leadership with effective staff engagement. Having a defined set of standards for staff, which is agreed by all stakeholders, is the foundation for a good emergency department.

Example of defined professional standards from a leading trust

"The emergency department will…"

1. The emergency department will initiate all appropriate emergency investigations (for example bloods, ECGs, relevant imaging) before admission.
2. The emergency department will initiate all time-critical emergency treatment (for example resuscitation, IV fluids, IV antibiotics, relevant procedures) before admission.
3. All patients in pain will be given appropriate analgesia and their pain score will be re-assessed within 30 minutes (IV analgesia) or 60 minutes (oral analgesia) of being administered.
4. Patients presenting with sepsis will be treated in accordance with national guidelines – Sepsis Six.
5. The following time-based standards will be adopted:
   a. Ambulance handover within 15 minutes.
   b. Patients will be seen by a decision-making clinician (F2 or above) within 60 minutes of arrival.
   c. All resus patients will be seen by a consultant or bleep holder within 60 minutes of arrival.
   d. Referral to a specialty or a decision to admit or discharge will be within 150

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minutes of arrival.

    e. Patients to be admitted will be transferred out of the emergency department within 30 minutes of the bed being declared by the receiving assessment unit/ward.

6. All patients requiring admission will be reviewed by, or discussed with, an emergency department consultant or bleep holder.

7. No patient will be admitted to a specialty ward without a formal handover to the specialty team concerned.

8. All patients requiring handover to another emergency medicine colleague for their ongoing care will be recorded in the notes using the SBAR tool.[18]

"All non-emergency department specialties will…."

1. Patients seen and/or referred by a GP should be directed to an appropriate assessment area (not the emergency department) for specialty review.

2. All patients who are referred back to hospital by a GP within seven days of discharge will be directed to an appropriate assessment area (not the emergency department) for specialty review.

3. Specialty clinical assessment in the emergency department will be carried out within 30 minutes of referral from the emergency department. (If this is not achieved the patient will be transferred to an appropriate assessment area/ward for their ongoing care – see below.)

4. Specialty clinical assessment in the emergency department will be at ST3 level or above.

5. The emergency department consultant (or 'bleep holder' out-of-hours) has the authority to determine which specialty a patient's 'transfer of care' from the emergency department should go to.

6. An assessment area/ward bed/space will be declared within 30 minutes of the decision to admit a patient.

7. When a decision to admit has been made, patients will not be kept in the emergency department for further review or assessment or for the availability of results that do not contribute to the decision to admit or transfer.

8. If it is subsequently deemed appropriate for another specialty to provide care for a patient, it is the responsibility of the first receiving specialty (not the emergency department) to arrange transfer of care.

4. **Agreed clinical standards** and recognised clinical pathways for critically ill patients, for example STEMI (ST-Elevation Myocardial Infarction), sepsis, stroke and major trauma with timely laboratory and radiology support. Luton and Dunstable University Hospital has agreed a one-way referral policy for specialty consultations, with a target of 30 minutes from first call to review. See page 27.

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[18] The SBAR communication tool - situation, background, assessment, recommendation is an easy to use, structured form of communication that enables information to be transferred accurately between individuals.

5. **Improved patient flow**, supported by a system that makes sure that staff are always aware of:

- how many patients are currently being cared for
- how many critically ill patients there are in the department
- what services they need and when
- how the service capacity matches the patient demand and how many patients are spending more than four hours in the emergency department
- what each patient needs next
- which patients need to be admitted and how they are identified early in their care.

6. **Reviews by specialty teams** should take place within 30 minutes of referral, with an incident reporting system that records lapses against this standard. The specialty team responsible for acute admissions should be free of elective and outpatient commitments. If a patient needs a specialty review after being seen in the emergency department, this should be by an experienced doctor (grade ST3 or above).

7. **Review of workforce and skill mix.** Planning for staffing for the whole emergency pathway should take into account variation in demand and not be purely based on the average demand**.**

Staffing plans to cope with surges in demand need to take into account the resource in the hospital as a whole. Staffing support from each clinical service can reduce the risk in the emergency department or elsewhere in the emergency pathway at times of high demand. To do this, each service could highlight, at the beginning of shifts, members of staff that could be deployed to ease the pressure in the emergency pathway.

To improve staffing capacity in emergency departments, trusts should consider the following:

- Employing advanced/extended scope physiotherapists to diagnose and treat musculoskeletal conditions.

- Investing in advanced nurse practitioners and healthcare assistants, and giving them the opportunity of a promotion by investing in training and development.

- Employing phlebotomists to support point of care testing.

- Employing band 5 paramedics (joint advertised with band 5 nurses) and paramedic practitioners.

- Offering CESR (Certificate of Eligibility for Specialist Registration) fellowships.[19]

- Employing dedicated pharmacists to support medicines management and help reduce medicine errors.

Derby Teaching Hospitals NHS Foundation Trust has taken a three-step approach to tackling their issues around staffing, focusing on recruitment, retention and matching capacity with demand. See page 28.

8. **The trust must manage crowding in the emergency department as a high-risk.** Crowding in emergency departments causes a high clinical risk affecting the safety of patients, overall quality of care and staff wellbeing. Trusts need to make a trust-wide assessment of where the safest place to care for any patient is, taking into account the physical environment but also the staffing available. Patients should not be cared for in unsuitable spaces such as emergency department corridors, or in ambulances on the hospital forecourt. Trusts also need to have agreed metrics for measuring capacity in the emergency department, which can then be used to manage crowding and monitor against hospital resources, for example bed capacity.

9. **Escalation policies needs to involve** all specialties across acute and emergency care in the trust. The whole hospital needs to be aware of the full capacity protocol, which has predetermined criteria. These criteria should be monitored and reported as a system failure if not actioned. Ipswich Hospital's trigger tool, for example, which was designed with IT support, raises awareness across the whole organisation of how busy the emergency department is on an hourly basis. See page 29.

10. **Trusts should monitor the total length of stay of all patients in the emergency department** and set and manage appropriate internal targets rather than focusing purely on delays after a decision to admit.

In section 4 we have included additional good practice case studies from Cambridge University Hospital and Frimley Park Hospital, which cross over a number of the steps suggested in this section. In early 2017, after a period of crowding due to exit block and poor performance against the four-hour standard, Cambridge University Hospital took action to "reset" the acute care pathway. Frimley Park Hospital has had a 52% reduction in admission of frail patients through their new Frailty Liaison Team. Read more about these in our case study section on page 29 and page 30.

Steps to address output

Once the patient is ready to leave the emergency department, the following measures were identified as measures that can help to get people home more quickly and avoid admission to hospital.

1. **Effective patient flow through ambulatory care.**[20] This is currently influenced by local policies and opening times (for example at weekends). Ambulatory units need to adopt a new mind set, and have a clear agreement with the emergency department about what patients they will accept, to have the maximum impact.

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[20] Ambulatory care units look after patients who can be seen and discharged on the same day, and don't require admissions to hospital.

2. **Closer multi-specialty team working.** How emergency departments and specialty teams work together is key to improving patient flow and avoiding admission. This includes, for example, the use of validated risk stratification tools to inform clinical decisions about hospital admissions for patients with medical emergencies.

3. **Early discharge planning** that starts at the moment the decision to admit the patient is made, particularly for medical patients.

4. **Provision of sufficient specialty beds** for patients with more complex needs – for example, mental health, isolation, end of life care, respiratory, monitored and critical care.

5. **Improved bed management/inpatient capacity.** Make sure that patients are not placed in any bed, but are given an appropriate bed for their needs and that they are available when patients need them. The goal of bed management is to move patients efficiently throughout the system. The practical steps that help to improve bed management are:
   - a bed coordinator
   - an electronic board that visually displays bed status
   - patient flow information throughout the hospital
   - the patient transport team.

   Monitoring facilities will help to understand acute hospital bed occupancy, capacity, flow and outcomes in real time, taking into account changes in a 24-hour period and the occupancy levels and needs of specific wards and units.

   Luton and Dunstable University Hospital has developed a proactive approach to the use of contingency beds that involves dual purpose planning. See page 31.

6. **Earlier discharge of patients** during the day, not late in the afternoon. This requires taking a proactive approach to discharge. This includes regular ward rounds by the consultants, discharge checklists that identify which patients can be discharged, and making decisions about discharge the night before. These steps can help to make beds available earlier in the day (before midday), and in turn help to improve patient flow through the hospital.

7. **Management of hospital bed occupancy.** Hospitals running at over 95% bed occupancy cannot manage patient flow effectively. There needs to be an effective and proactive system response when hospital bed-occupancy is higher that the recommended level.

8. **Multidisciplinary team approach to reviewing patients in hospital** to reduce the length of stay, including on weekends and bank holidays. This is especially important in extended holiday periods such as the Christmas and New Year break, since a surge in demand is to be expected immediately after.

4. Examples of good practice in action

Through our reviews and workshops we have seen how an increasing demand for health and care services is putting more and more pressure on health and care services, in particular emergency departments. This in turn is creating greater challenges for staff on the front line. However, these challenges are not insurmountable.

This section gives real life examples from trusts that have made small but significant changes to address their local challenges, putting patients first and creating a better service.

For ease of reference, these have been grouped under the same headings as in .

Examples of addressing demand

Bristol Royal Infirmary – High Impact User Group

The multidisciplinary group at Bristol Royal Infirmary (BRI) works with patients who are frequent attenders to the emergency department, or who are "high impact" for other reasons, such as violence and aggression. BRI emergency department has approximately 800 frequent attending patients each year, and the High Impact User Group (HIU) aim to manage the top 100 of these. Attendance rates in this "super user group" vary from 20 to 70 times per year. The team is made up of the emergency department matron, consultant, psychiatry liaison nurse, homeless health team, drug and alcohol nurse, and primary care, with regular input from police, ambulance and other specialties. Support plans and behavioural contracts are made for individuals, and people are signposted to other services to support them.

The group have shown an 80% reduction in emergency department attendances and hospital admissions in the super-user group. The team leads a regional network for frequent attenders to support other emergency departments in the area. Many sites are now setting up a service in a similar model, and the BRI have produced an online toolkit with the Academic Health Science Network to support other sites.

Ipswich Hospital – The Frailty Assessment Base

The Frailty Assessment Base (FAB) at Ipswich Hospital is a multidisciplinary, geriatrician-led, admission prevention service. The service is for older people living with frailty who are experiencing a crisis situation, for example changes in health needs, carer breakdown or risk to safety, which without support would result in an acute hospital admission or emergency department attendance. The key intervention of FAB is in providing these individuals rapid access to a comprehensive geriatric assessment via a multidisciplinary team. This specialised intervention primarily aims to empower the individual to manage their health and wellbeing and prevent avoidable admissions of frail elderly individuals from the emergency department and/or the community or GP. In turn this reduces reliance on acute hospital beds for this cohort of individuals.

FAB is also integrated with the community crisis team and the local intermediate care beds, offering alternative methods of support, care and management. The service runs 8am to 6pm, Monday to Friday, with direct access to consultant geriatrician by phone. Referrals are from GPs, community teams, and the emergency department. Referrals are seen within 48 hours or on the same day if clinically-indicated. FAB consistently scores 98% or higher on the friends and family test recommendation for its service.

The frailty interface nurse, who started in September 2016, is the central point for the management and safe discharge of older people living with frailty at Ipswich Hospital's emergency department. Clinically, the frailty interface nurse practices at an advanced level, proactively instigating early recognition of frailty and frailty syndromes, and arranges early supportive diagnostic care that promotes and makes safe discharges easier. The nurse also works in conjunction with FAB in identifying suitable individuals that need same day or next day assessment. This role also has strong links into the community providing people who are discharged from hospital with ongoing functional and enabling care if needed. The service runs 8am to 6pm Sunday to Friday.

The effect of this integrated and focused way of working is evident in a number of ways. FAB and the emergency department share an emergency medicine speciality doctor in their workforce, offering unique insight to both areas of speciality in care delivery. The frailty interface nurse provides frailty education sessions to both emergency department nurses and junior doctors. The orientation of all new emergency department staff includes time with FAB and the frailty interface nurse. Operationally, the trust has seen fewer individuals over the age of 75 being admitted into hospital against an increase in emergency department attendees. For example, there were 12,286 admissions in 2017/18 compared with 12,840 in 2016/17, showing a decrease of 4.3% across the full year.

Homerton University Hospital – care of the elderly at the front door

Homerton University Hospital's emergency department was involved in the previous City and Hackney Urgent Care Board where the priority was the patient's pathway through the urgent care system. Knowledge of their patient groups allowed the hospital to identify potential areas for improvement, and then trial these with support of the board. Urgent care pathways need to be adaptable to changes in patient population, and while frailty is not currently a significant proportion of their emergency department attendances, it is one that is changing as has the potential to be a significant challenge if not managed.

Before hospital

If people with complex needs are seen at home or in their own environment, a more holistic approach can be taken. Paradoc is a GP and Paramedic combined service that provides an alternative pathway for these people instead of 999. This aims to see and treat people in their own home, with the aim of avoiding both hospital attendance and admission. The combination of a paramedic and GP provide a good skill set, which includes manual handling, injury and illness assessment, excellent knowledge of the particular person's chronic conditions as well as the ability to treat the acute issues that have been identified. Paradoc links with the person's own GP, providing follow-up directly themselves, or through the GP out-of-hours service.

Emergency department

The Integrated Independence Team (IIT) is a team that includes physiotherapists, occupational therapists and social workers. There are also links with geriatricians especially in the community.

This team provide a rapid response to both the emergency department and the acute admissions ward where the aim is to discharge patients with complex needs safely and to provide ongoing support in the home. This includes, for example, people who fall and may or may not have an injury as a result. The team in the emergency department are the same as in the community, so there is continuity of care.

To maximise this service, the emergency department have a dedicated referral pathway via the Observational Medicine Unit (OMU) – emergency department short admissions ward. This is pathway driven to make sure that the correct patients are captured and as many patients as possible are referred to the service to avoid hospital admissions wherever possible. Pathways provide inclusion and exclusion criteria that support the junior or rotating staff and equity of decision making, both in and out-of-hours. With a common understanding of all speciality teams this also provides improved cross team working.

To support this further, there is a geriatrician at the front door every weekday. The consultant is allocated to emergency department where they liaise with the emergency department OMU consultant and team. They will review anyone who may benefit from being seen by a geriatrician. This is not limited by age but by needs and links well with the IIT and care of the elderly outpatient clinics. This aims to reduce hospital admissions, reduce hospital future attendances by engaging the correct services, and linking hospital and community inputs. It also provides a supporting and educational service to the emergency department.

Examples of addressing capacity and capability

Frimley Park Hospital – the Emergency Severity Index tool

Frimley Park Hospital introduced the Emergency Severity Index (ESI) tool in March 2016 as the Manchester triage tool proved difficult to use in conjunction with the four hour performance target and the need to do timely assessments of patients. The ESI tool is a validated tool used nationally and internationally. Training handbooks and DVDs provided with the tool were reviewed by the clinical director and matron. This was invaluable helping to put a comprehensive ESI educational programme in place.

Senior nursing staff and practice development nurse delivered training to medical and nursing staff. The IT system used was configured to enable to ESI as part of nurse assessment. Different colours were used for the five ESI categories to help the nursing and medical staff to identify the acuity of patients in all areas at a glance on the department tracking grid. The tool proved user friendly and efficient in times to triage. The nursing feedback was positive and they felt empowered when using the tool in appropriately streaming patients.

The tool supports the team in rapidly identifying patients in need of immediate attention, which helps them to deliver high-quality care in time critical conditions. This enabled the department to introduce a reception nurse to focus on making sure that patients categorised as ESI 1 and ESI 2 are streamed directly into majors and the resuscitation area. ESI 3 patients are streamed to the assessment area for differential diagnosis to be made. ESI 4 are streamed to the minor injuries unit and ESI 5 are streamed to their GP surgery. The tool has been shared with clinical commissioning group colleagues who support the use of the tool to stream patients back to primary care.

ESI assists effective streaming, ensuring patients are treated in the correct area with the correct resources available. The department has a five-bed assessment area. This is registrar and nursing led to make sure that ESI 3 patients are seen by a senior decision maker, which prevents unnecessary diagnostics and inappropriate treatments.

From the data collected from using ESI, the emergency department were able identify that ESI 3 accounted for almost 50% of the patient workload. Further data analysis identified that 49% of ESI 3 patients could be managed in the assessment area rather than in majors. This had a significant positive effect in emergency care. This model of streaming improved patient flow and experience. It also improved four-hour performance, staff morale, collaborative working with specialities teams and effective use of ambulatory care pathways.

The tool identifies those patients who could safely and more efficiently be seen in our assessment area rather than the main emergency department, which prevents overcrowding in the majors area.

Bristol Royal Infirmary – managing the queue

Bristol Royal Infirmary has put in place the queue nurse model to manage the flow of patients through the emergency department. In this model, the emergency department supports the first three patients in the queue, after which ward staff are called on to support patients. Divisions have devised a timetable for queue support, with each ward covering two hour blocks. This makes sure that the clinical site management teams, duty matrons and wards in each division are aware which ward will be called on to support the queue and when. Over the winter, the emergency department has a band 6 nurse employed in the afternoons and nights to coordinate and support the queue. This registered nurse is peripatetic and makes sure that ward nurses supporting the emergency department queue are able to care for their patients. The nurse also makes sure that equipment is available. All patients are managed using the emergency department safety checklist to maintain their safety and there have been no serious incidents associated with the queue or undetected deteriorating patients since this was implemented.

Luton and Dunstable University Hospital – professional standards

Luton and Dunstable University Hospital identified that response times for a specialist consult varied between specialties, and that if the specialty doctor identified that the patient needed to see a different specialist team they would refer the patient back to the emergency department to make that second referral, leading to more delays.

Following consultation with colleagues, including matrons and clinical directors, and with support of the medical director, the hospital set a target of 30 minutes from first call to review. If this review did not happen within an hour, it was agreed that the emergency department consultant would take responsibility for referring the case to the relevant specialty consultant, both during the day and at night.

The hospital formalised this in the form of a "one-way referral" policy. This policy states that if a specialty finds that the pathology in question is relevant to another specialty, it should be referred directly to that specialty rather than being referred back to the emergency department. This is in line with the General Medical Council's advice on communicating with colleagues, and creates the best means of handover.

Where there is crossover between specialties, for example when do hand injuries go to plastics or orthopaedics, a policy of "who owns what" was agreed by the clinical directors and put into writing.

The policy is visible in the emergency department, is discussed at induction, and reliably followed. There is buy-in from all clinical directors and the medical director will intervene when required.

Derby Teaching Hospitals NHS Foundation Trust – workforce strategy

Ensuring that emergency departments are staffed appropriately is one of the biggest challenges for emergency medicine. To tackle this issue, Derby Teaching Hospitals NHS Foundation Trust has taken a three-step approach, focusing on recruitment, retention and matching capacity with demand.

Recruitment

- The trust has a multifaceted approach to recruitment, and seeks to recruit a breadth of roles including trainees, specialty and associate specialist (SAS) doctors, F3s/junior clinical fellows, advanced practitioners, emergency nurse practitioners, physician associates and GPs.

- It uses innovative adverts and job descriptions, as well as secondments in key specialties including anaesthetics, intensive care units, acute medicine and paediatrics.

- As part of the recruitment process, the trust telephones all applicants to find out the reason for their application, as well ask key questions, for example about their career aspirations. This approach has proven highly successful at converting applications into uptake of posts.

Retention

The trust's retention strategy is based around valuing individuals, and includes:

- Bespoke teaching programmes for SAS doctors – mapping and matched to the Royal College of Emergency Medicine (FRCEM) curriculum

- £1,000 study leave budget

- Protected time for SPA (0.5PA's per week)

- Workplace-based assessment clinics

- Sustainable rotas:

  o 10-week rolling rota with 1:10 night shifts.

  o Bespoke rotas for individuals

  o Recent development to self-rostering with annualisation of hours.

Matching capacity and demand

Over the last two years, the trust has started to match capacity with demand in an evidence-based way. The model used has been based on a time to be seen (TTBS) of 60 minutes with a view 'flattening out' this metric. This model is now electronic and takes into account the following variables:

- Individual clinician productivity

- Predicted peaks in demand

- Clinicians self-rostering (including annualisation)

- Recommendations to use our clinical time more effectively (including clinical assistants and note dictation).

Ipswich Hospital – The Ipswich Trigger Tool

The Ipswich Hospital emergency department trigger tool was designed with IT support in the trust to standardise awareness across the whole organisation of how busy the emergency department is on an hourly basis. An application was developed that weighted a number of different indicators of activity to calculate an overall score. This score could then be communicated across the whole organisation and allowed the hospital to direct operational support to the emergency department when required.

The indicators chosen were tested and the total score was compared with how busy the floor coordinating nurse and the coordinating consultant felt the department was on an hourly basis for a trial period. The weighting scores were then adjusted accordingly.

Current indicators measured include:

- The numbers of patients in each area of the department.
- The number of empty cubicles available, the number of inbound ambulances.
- Any staff deficits (divided into clinical decision makers, nursing roles, and clinical support staff roles).
- The number of patients waiting for an inpatient bed longer than 30 minutes.

The overall score is given a colour rating (green, amber, red, black) and the overall score and colour is sent via a text message system to all relevant operational staff (including the chief operating officer) hourly throughout the day (until 10pm). An escalation tool with specific tasks for each individual was written to complement the scoring tool. These tasks include the hospital coordinator informing all the relevant on-call specialties requesting review of capacity and ability to "fast track" patients and the executive on call supporting requests to divert resource to the emergency department.

This whole system awareness and response allows and expects support to be activated to the whole organisation.

Cambridge University Hospitals – patient flow

Cambridge University Hospitals' emergency department and trauma centre sees 112,000 patients a year. The emergency department has a single front door (no assessment units) and attached to the emergency department is an acute care hub (clinical decision unit, ambulatory care and medical short stay wards).

In early 2017, after a period of crowding due to exit block and poor performance against the four-hour standard, the trust took action to "reset" the acute care pathway. To do this the hospital:

a) protected 10 beds in the acute care ward from midnight. This enabled the hospital to flow patients out of the emergency department next morning seamlessly.

b) increased overnight staffing for the emergency department from five to seven doctors.

c) enforced their internal professional standards with the help of speciality teams.

d) employed acute paediatricians and increased their cover in the department until 10pm at night.

e) started a stakeholders meeting every day at 1pm, chaired by the chief operating officer to iron out previous day issues.

All of the above actions improved flow through the department, achieving the 95% standard and improved experience for patients.

Frimley Park Hospital – frailty pathway

Frimley Park Hospital launched a new Integrated Frailty Liaison Team in April 2018. The team consists if a consultant nurse, two frailty practitioners (nurse and occupational therapist), a junior doctor, in-reach GPs and is led by a consultant geriatrician. The team was designed with the hospital's community partners and some members have been seconded in from community roles. The team is based in emergency department and also supports inpatients on the wards that are not under the care of a geriatrician. Initial funding was obtained from an NHS England Urgent and Emergency Care bid.

Frimley Park has mandatory, electronic frailty identification for all people over the age of 75 on admission. The emergency department nurses ask the "FRAIL" criteria on admission (Falls, Reduced mobility, Incontinence, Altered cognition and Lots of medicines). If a person has one or more of these frailty syndromes, then they will be given an electronic frailty flag.

The team currently works Monday to Friday, 8.30 to 5pm, but have plans to expand and work towards a seven-day service.

The team will see any patient with a frailty flag who presents with a frailty syndrome. They take referrals directly from the emergency department team, and one team member holds the frailty coordinator phone, which is the single point of access. Every patient receives comprehensive geriatric assessment (an evidence-based intervention) using a multidisciplinary proforma.

The team takes a home first, patient-centred approach. If the patient can be cared for safely in the community, they liaise closely with local community teams and social care to make sure that the patient has the support they need at home. If necessary, the team can arrange for the patient to be followed up in a rapid access slot in clinic, or at a daily clinic at the community hospital in Farnham. Frimley Park frailty practitioners can also provide a follow up phone call or visit to the patient the day after discharge.

If a patient does need to be admitted, the team make sure that they are admitted to the most appropriate bed, for example the Older Persons Short Stay Unit, which is an acute frailty unit. The frailty team can follow these patients during their admission to make sure that they are discharged once medically stable with the appropriate community support and minimise delays in the process and issues with multiple handovers.

Outcome:

In the first month, 48 new referrals were seen by the team in the emergency department. Twenty-five patients who would otherwise have been admitted were discharged to their normal place of residence (52%), and 23 patients were admitted for further assessment (48%). All of these patients were followed up by the inpatient frailty team.

Of the patients admitted, 74% were appropriate admissions for acute medical problems. Of those patients admitted for non-medical reasons, 13.5% were due to community beds not being available, 9% needed social care assessments and there was no intermediate care available for 4.5%.

The time spent by older people in the emergency department, number of stranded patients, outliers and occupied bed days on the older persons short stay unit all reduced in April. The team will also monitor the three-day and 30-day readmission rate.

Examples of addressing output

Luton and Dunstable University Hospital – escalation wards and contingency beds

Patient flow through a hospital is key to preventing a backlog of patients, and the efficient use of beds helps to achieve this. Luton and Dunstable University Hospital developed a new proactive approach to the use of contingency beds over several years, and now have a constantly evolving strategy, with an improved approach to contingency beds year-on-year.

One of the first principles involves dual purpose planning. Whenever an area of the hospital was being updated or modernised, the hospital considered what other functions the area in question could perform. For example, an area used from 9am to 5pm on weekdays for the recovery of planned minor procedures was built to be able to accommodate patients overnight in times of surge. This included ensuring there were adequate shower and toilet facilities, storage areas and IT provision. These areas are well described and contained in the escalation plan. The hospital is able to flex bed capacity up and down as needed, and once opened the escalation ward should be closed as quickly as possible.

Luton and Dunstable also look closely at staffing for escalation wards. Every day the chief nurse and operational matron assess the bed state, and with the use of prediction tools plan extra staff to cover any contingency areas that may be needed over the next 24 hours. The hospital never staff these areas with agency nurses, instead substantive staff are moved into these areas and backfill the base wards with an agency or bank nurse to maintain the numbers. Anticipating the need and identifying in advance the staff who will go is key.

These areas often have a higher nurse to patient ratio than base wards, but identifying suitable patients to go there can be challenging. At times of peak demand, matrons liaise with ward managers and consultants during working hours to provide a list of patient who may be suitable to move if required.

Conclusion

The ongoing trend of increasing demand on health and social care services is not abating and it is clear that action is needed now to address the pressures on emergency departments, and in turn keep patients safe. There are no simple solutions to this problem, but through our discussions with frontline clinicians working in emergency medicine we have identified examples of good practice and potential immediate steps to take to manage these issues.

However, hospitals cannot work alone to address this ever increasing demand on services, transformation is needed across the health and care system as whole. This report is the beginning of the conversation about how those working in health and social care can come together in a more systemised way to encourage early and effective planning for not only winter pressures, but for all periods of peak demand. This work needs to start now to make sure that next winter patients receive consistently high quality and safe care.