SHARING BEST PRACTICE IN 24/7 CARE

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CHKS

Insight for better healthcare

CONTENTS

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ABOUT CHKS

CHKS, part of Capita Health Partners, is a provider of healthcare intelligence and quality improvement services to the NHS and independent healthcare sector. It has worked with healthcare organisations across the UK to inform and support improvement for more than 25 years. This report highlights examples of best practice in emergency departments, which we aim to share throughout the NHS.

CHKS would like to thank the following contributors:
Cliff Mann, president, Royal College of Emergency Medicine
Chris Hopson, chief executive, NHS providers
Professor Simon Brake, director of primary care, Coventry & Rugby CCG
Suraj Bassi, principal consultant, Capita Health Partners

1. INTRODUCTION

Current debate about how best to deliver 24/7 care often centres around flow methodology and ways to address congestion in emergency departments. For the past 10 years a great deal of attention has been paid to patient flow, with the assumption that if the system could work harder, faster or smarter all would be well. However, almost every permutation of harder, faster and smarter has been played out in UK hospitals, as summarised by NHS England in 2015 in *Transforming urgent and emergency care services in England*.[1]

NHS England's medical director Professor Sir Bruce Keogh's Urgent and Emergency Care Review[2] recognised the limitations of the flow approach and strove to tackle the problem by reducing demand on A&E services by creating alternatives – NHS 111, community pharmacy, extended role paramedics, urgent care centres and enhanced access to primary care.

The Royal College of Emergency Medicine (RCEM) conducted a nationwide audit in 2014, which demonstrated that 37 per cent of A&E attendances did not require the services of an emergency medicine doctor. Importantly, though, the audit did *not* say that these people did not need to attend an A&E department.

A&E attendance is triggered by many factors: perceived urgency, convenience, expectation of imaging, blood tests and so on, as well as the lack of availability of alternatives. Another RCEM study, co-authored with the Patients Association, highlighted the power of the A&E "brand".[3]

However, this does not mean we believe patients can or should be redirected elsewhere. We are convinced that redirection is a failed strategy; more than 20 years of attempts to reduce attendance or subsequent admission have been largely futile – and sometimes counterproductive.

As a consequence, A&E has come to signify "Anything and Everything", especially out of hours. We should not rail against this trend but recognise it and configure services to meet patients' needs. A&E should act as a hub rather than a department. Within this hub, the emergency department itself would be one component, albeit a key one.

An A&E hub model would see urgent primary care outside normal GP opening hours co-located with every emergency department, together with community pharmacy, liaison psychiatry/crisis mental health, and even urgent dentistry. The hub model emphasises the specific skillsets of each team while providing a service properly focused on patients rather than on organisations. Also vital would be in-reach services from frailty teams to minimise avoidable admissions among this key patient group.

As things stand though, 60 per cent of emergency departments have no co-located services at all. Thus the terms 'emergency department' and 'A&E' are often erroneously seen as synonymous, leading to misaligned expectations. Provision of A&E hubs would ensure services are aligned with patient needs and expectations. It is not a complex model – its power lies in its simplicity. No mass education programmes (repeatedly shown to fail), no signposting away from where patients want to go (doomed), no expectation that emergency medicine can be anything and everything (absurd), instead, proper recognition of the key role other disciplines have to play in an urgent and emergency care system that is fit for purpose in the UK in the 21st century. ■

Clifford Mann

President of the Royal College of Emergency Medicine

2. EXECUTIVE SUMMARY

Ensuring services are available around the clock to meet the 24/7 aspiration is a significant challenge for every trust even before finances are taken into account. With NHS trusts forecasting a combined end-of-year net deficit of around £2.3 billion for 2016/17, many are focusing their efforts on cost reduction.

Although there is some debate about what 24/7 care looks like, the 10 clinical standards set out by Sir Bruce Keogh are considered a useful yardstick. These standards take an overview of care to ensure that all elements involved in the patient journey are available as and when needed.

Trusts seeking to meet the 24/7 challenge often start by trying to reduce demand on emergency departments as way to smooth the patient journey and ensure resources are available to all patients throughout the week, day and night.

Successful trusts are challenging traditional ways of working, ensuring that not only is the emergency department co-located with other services, such as community pharmacy, but that services offered are patient-centred. They recognise that the department is part of the whole system and work with primary and community care providers. Improved access to primary care and mental health services is one of the benefits of this joint working and an important aspect of delivering 24/7 care.

The best trusts also ensure they understand patterns of activity and are able to match the skillsets of staff with patient demand. They fast-track patients with certain conditions to help to enhance patient flow and improve the overall experience. This can involve setting up ambulatory emergency care, medical assessment units or frail elderly wards to help reduce the bottlenecks that lead to long waits and delayed treatment.

The aim of this report is to share best practice in 24/7 care; it highlights practical ways that trusts are overcoming the challenge by looking at three trusts in particular. These trusts were shortlisted for the CHKS Excellence in Delivering 24/7 Emergency Care Award 2016 and were identified by an analysis of relevant indicators before being asked to submit award entries. Our expert panel of judges included Royal College of Emergency Medicine president Cliff Mann, Royal College of Nursing head of nursing practice JP Nolan, and head of transformation at NHS Improving Quality, Hannah Wall. ■

3. THE CHALLENGE OF PROVIDING 24/7 CARE

It is widely accepted that we now live in a 24/7 society, but some argue the NHS has not kept pace with this, despite the inevitable fact that people will become ill at all hours of the night and day. The aim of round-the-clock, seven-day working is to improve patient care and to make sure that all services are available to all patients whenever they get ill.

A report by the NHS Services, Seven Days a Week Forum[4] highlighted deficiencies in many areas of care and found patients admitted at the weekend had a greater risk of dying within 30 days of admission than those admitted on a weekday. It said many factors could contribute to this, such as: variable staffing levels in hospitals at the weekend; the absence of senior decision makers of consultant-level skill and experience; inconsistent availability of specialist services such as diagnostic and scientific functions; and a lack of availability of specialist community and primary care services to support patients on an end-of-life care pathway to die at home.

The forum also found that an absence of senior decision makers at weekends and evenings can lead to a longer length of stay, which increases the risk of acquiring a hospital-based infection and the degree of lost mobility from time spent in bed.

The guidance developed by the forum aims to standardise care and spread best practice to ensure good-quality care and patient experience is available 24/7 for everyone. However, it recognises there can be no one-size-fits-all approach for trusts and that local solutions are needed. However, finances also need to be taken into consideration. NHS England's *The NHS belongs to the people: a call to action*[5] points out that the NHS is facing an unprecedented challenge in terms of finances and quality of provision. The move towards 24/7 services is just one of a number of financial considerations for trusts when setting policy or implementing strategic change programmes.

Following publication of the Seven Days a Week Forum guidance, Sir Bruce Keogh outlined 10 clinical standards (see page 13), offering an overview of care to ensure all elements of the patient journey are available as and when needed.

NHS Providers chief executive Chris Hopson is supportive of the standards. He says: "Given there is still ongoing discussion about the working definition of 24/7 care, having clear clinical standards is very helpful so we know what we need to meet the gold standard."

The best trusts are endeavouring to ensure that services at weekends resemble those on weekdays as far as possible, not simply by having consultants on site. Pharmacy, therapists and diagnostic and scientific services are crucial to this model. Administrative, clerical, facilities and ancillary services are also being adapted according to local circumstances. In some trusts, management teams are now rostered to ensure they have a presence at weekends to improve continuity and to ensure operational quality is consistent, particularly in areas such as single-sex accommodation.

Chris Hopson points out that leadership plays a vital role in moving organisations to 24/7 working. He says: "As I go around the country, my observation is that the people who are making the most advances are those who are clear about their strategy. More often than not this involves having someone on the executive board who has been nominated to oversee the process and has developed a sensibly paced strategy to get there.

"This means, for example, knowing what you are going to deliver over the next four years and having a management change strategy which clinicians have bought into, having been involved in establishing what progress looks like." ■

SIR BRUCE KEOGH'S TEN CLINICAL STANDARDS

1. PATIENT EXPERIENCE

Consistently involving patients, families and carers in shared decision making, supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and any ongoing care. This should be available seven days a week.

2. TIME TO FIRST CONSULTANT REVIEW

Emergency admissions seen, with a thorough clinical assessment by a consultant as soon as possible but within 14 hours of arrival.

3. MULTIDISCIPLINARY TEAM REVIEW:

Prompt assessment for all emergency patients by a multiprofessional team to identify any complex or ongoing needs, overseen by a competent decision maker. The assessment should be undertaken within 14 hours and have an integrated management plan with an estimated discharge date along with a completed medicines reconciliation within 24 hours.

4. SHIFT HANDOVERS

Senior decision makers must lead handovers. There must be participation with a multiprofessional team from the relevant incoming and outgoing shifts. Handover processes should be standardised across seven days of the week.

5. DIAGNOSTICS

Seven-day access to diagnostic services such as X-ray, ultrasound, CT, MRO echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and their reporting must also be available.

6. TIMELY 24-HOUR ACCESS

Seven days a week for key inpatient services and to consultant-directed interventions including critical care, interventional radiology, interventional endoscopy and emergency general surgery.

7. MENTAL HEALTH

Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales, 24 hours a day, seven days a week.

8. ONGOING REVIEW

All patients on the AMU, SAU, ICU and other high-dependency areas must be seen and reviewed by a consultant twice daily. Once transferred onto a general ward, patients should be reviewed by a consultant-delivered ward round at least once every 24 hours, seven days a week.

9. TRANSFER TO COMMUNITY, PRIMARY AND SOCIAL CARE SUPPORT SERVICES

Whether in primary, community or mental health settings, this should be available seven days a week.

10. QUALITY IMPROVEMENT

All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

4. OVERCOMING THE CHALLENGE

EMERGENCY DEPARTMENTS AND THE WHOLE SYSTEM

Emergency departments are often the focus of media and political attention, and recent performance by the NHS in England has fuelled debate. The NHS recently recorded its worst yearly results for four-hour A&E waits since the target was introduced in 2000. The original target was to treat 98 per cent of patients within four hours, but this was amended to 95 per cent in 2010. Data released by NHS England[6] found that performance against the four-hour target dropped to 87.9 per cent in 2015/16. According to the Kings Fund, attendances rose by a quarter that year, from 12 million to 15 million, while admissions rose from 2.5 million to 4.1 million.

The causes of problems in the emergency department are complex. It is often assumed that the deterioration in performance results from an increase in attendances, sometimes by people who are in the wrong place, or who are attending unnecessarily.[7] While there are no data available on unnecessary attendances in emergency department, the closest proxy used is the percentage of people who are discharged without requiring treatment, which is around 13 per cent. This, however, does not mean those patients attended unnecessarily.

An audit by the RECM[8] found that while patients are often aware of alternatives to the emergency department, they end up there because they couldn't access timely help elsewhere. The college found patients attend emergency departments because they have been advised to by other healthcare providers.

The availability of community services and social services outside hospitals can cause pressure in emergency department. Hospitals have reported difficulty in discharging frail and elderly patients because there is no support for them in the community, particularly in parts of the country with a shortfall in services. The Care Quality Commission has found clear regional variation in the provision of council-funded adult social care services.[9]

A report by the Parliamentary and Health Service Ombudsman[10] shows poor planning, co-ordination and communication between hospital staff and health and social care services are failing patients and compromising their dignity. The report

➜ highlights the issue of patients being discharged with no home care plan in place, or having to stay in hospital due to poor co-ordination across services.

The King's Fund's *Quarterly Monitoring Report* showed that, in 2015, more than 5,000 patients experienced a delayed discharge – the highest level since 2007. Nearly a third of such delays were caused by problems accessing social care services, a 21 per cent rise on the previous year.

The best trusts, recognising that delayed discharge can have a major impact on patient flow, focus on early discharge by using short stay and discharge wards. They also know that frail elderly care is critical to how well emergency departments function, especially as around 8 per cent of people who attend the emergency department are over 85 years of age.[11]

There is a clear link between increases in occupancy within emergency department units and a rise in breaches of the four-hour target. Crowded departments take longer to process patients and slower treatment inevitably means greater occupancy. Increased length of time spent in the emergency department can result in harm, with multimorbid older patients more likely to be at risk. Research has shown a 43 per cent increase in mortality at 10 days after admission through an overcrowded emergency department.[12]

Where improvements are being made measures have been taken to ensure that the emergency department is not the default place for patients to attend and also that those who do attend are seen promptly and referred to the right departments. These units often have rapid-response frailty services, with teams including occupational therapy workers and social care teams that can quickly address care needs.

Emergency care centres can give patients the care they need without having to admit them to a ward. The best emergency departments also fast-track patients where indicated, such as in the case of abdominal pain, chest pain or hip fracture.[13]

Some trusts are setting up ambulatory care units to deal with common presentations that can be treated without admission. Frail elderly wards are also often seen within top emergency departments, where specialist care teams, often involving early intervention from a consultant, can ensure that patients are not

admitted if they don't need to be. Social care and community teams can also put the right care package in place once the patient returns home.

Central Manchester University Hospitals NHS Foundation Trust has an ambulatory care unit linked to the emergency department, with distinct clinical pathways designed to avoid admission. At the Dudley Group NHS Foundation Trust, the ambulatory emergency care unit has a large throughput of more than 200 patients a day – almost as many as the emergency department itself.

Good emergency departments work with community services and social care to find ways to improve the whole system. Joint working with primary and community care is essential to help improve patient flow. Urgent care boards bring together the hospital (including emergency department doctors and consultants), social care and GPs to optimise care for patients, and good contacts within the community, such as in social care, pharmacy, care homes and general practice, can also help fast-track patients to where they need to be.

Good work and innovation is already taking place in successful trusts around the UK and it is essential that this best practice is shared; organisations need to take the lead in looking to see what is working elsewhere.

IMPROVING PRIMARY CARE ACCESS

General practice plays an important part in urgent care; early diagnosis and effective treatment in the community can avoid patients being driven to use emergency departments.

Initiatives to improve early diagnosis and effective treatment include early response. A rapid assessment (usually by phone) when an urgent home visit is requested leads to faster treatment and the ability to plan an alternative to hospital admission. Hotlines between GPs and consultants can ensure that patients enter the appropriate clinical pathway as quickly as possible. In addition leading trusts use a range of well signposted options – telephone consultations, e-consultations, walk-in clinics and face-to-face appointments. Choices need to be clear to avoid people attending the emergency department as a walk-in simply because they have been unable to get a GP appointment.

Other initiatives include discharge planning, involving GPs and community health and social care teams for frail and vulnerable patients. GPs can also help patients with self-management of long-term conditions to reduce the risk of crises and the need for emergency care.

In some parts of the country ambulance services collaborate closely with GPs to ensure they have telephone access to a GP if needed. This working relationship is based on agreed protocols between the ambulance service and GP practices, with an expected time frame for a GP response.

Residential homes, community hospitals and community nursing supporting the discharge to assess schemes are other examples of best practice. This involves a rapid assessment of integrated health and social care teams so that assessment and basic care can be put in place within two hours of a person arriving home. Community hospitals can also help to prevent inappropriate admissions to the acute setting by taking referrals from community providers or care homes.

IMPROVING MENTAL HEALTH ACCESS

A recent CQC report[14] into gaps in mental health care highlighted a clear need for better 24-hour support for people experiencing a mental health crisis. It showed those who need help out of hours often find the only options they have to ensure their own safety are an emergency department or a police cell. The report found most people reported that they came into contact with at least three different services when they had a crisis, while one in 12 said that they had contact with between six and 10 services' This clearly points to a need for these services to work more closely together in areas.

People with mental health problems often find themselves in the emergency department because there is nowhere else for them to go. The CQC report also found such people often reported an unfavourable response from staff.

NHS England says 24/7 mental health liaison services for people of all ages should be available at all times within one hour of referral by an emergency department. It recommends these services should provide senior decision makers as soon as possible to reduce admissions, repeat attendances and length of stay.

The best trusts ensure patients in need have access to mental health professionals during their visit to the emergency department. Mental health is integrated within the urgent care pathway and system resilience groups (SRGs) ensure that senior officers from across health and social care lead a process of involvement that keeps the person at the centre of the service.

At Dudley Group NHS Foundation Trust (see case study, page 36) there is a 24/7 onsite psychiatrist liaison service that provides integrated care for mental health patients, with access to both community and inpatient services. The mental health liaison at Central Manchester is based in the emergency department 24/7, which provides daily access into assessment units.

However, many organisations struggle to implement and sustain recommended best practice to reduce pressure in the emergency department, such as rapid senior-level assessment and improved discharge planning.

ENSURING APPROPRIATE LEVELS OF STAFFING

Matching capacity to demand means being able to adapt staffing levels quickly, which in turn relies on the ability to make accurate predictions. The challenge is that unpredicted spikes in activity can occur with little notice. The Dudley Group has been able to determine a pattern in activity; it found there was an increase in ambulance admissions and GP referral admissions between 12pm and 2pm and between 5pm and 7pm. It has been able to put in place measures to ensure resources are available to meet these increases in demand.

However, levels of staffing are not the only factor. Good emergency departments will ensure they have the right staff with the right skills in the right place to match patient demand. Innovative trusts are creating new roles, investing in and developing their staff to provide strong links with the rest of the hospital and with community providers. There has been a particular focus on training emergency nurse practitioners and emergency care practitioners.

➜ Matching patient demand does not mean simply looking at average demand over a given time period. This means having access to data that monitors variation in demand which helps identify peaks and troughs as they appear. E-rostering software can ensure trusts have the right staff in the right place at the right time.

Central Manchester (see case study, page 34) underwent a major programme to change staffing levels, beginning with mapping activity and profiling patients to see which skillsets are necessary to meet a patient's needs at a particular time of day. Consultants, doctors, nurses and advanced practitioners were all involved in the challenge to improve patient experience.

CO-LOCATION – IMPROVING THE PATIENT JOURNEY

Urgent care vanguards are pioneering the co-location and coordination of services provided by hospital trusts, GPs and community services, pharmacists, ambulance services, NHS 111, social care and self-management and support. The eight vanguards are benefiting from a programme of support and investment from a £200m transformation fund.[15]

The vanguards are tasked with providing more joined-up care to improve the patient experience throughout their treatment and recovery. As well as the services mentioned above, mental health care services have also been included in a bid to remove the boundary between physical care and mental health care.

Alongside the vanguards, some trusts are leading initiatives to bring services together so patients can more easily be directed to where they need to be. This includes an A&E hub model, which sees the co-location of GPs and out-of-hours services with others such as an urgent care centre, ambulatory emergency care, pharmacy and a clinical observation unit. Top-performing trusts ensure effective signposting to direct patients to the services they should be using.

With this level of co-location, patients who choose to attend the emergency department can be redirected to appropriate services on the same site without any inconvenience.

At Central Manchester there is a GP- and nurse-led walk-in clinic within the emergency department, which is open seven days a week. There is also a GP booking clerk who will make follow-up appointments for patients to see their own GP for continuing treatment.

The out-of-hours GP provider offers booked appointments and telephone consultations but also supports urgent care by accepting streamed patients when capacity is available. Mental health liaison services are also based in the emergency department 24/7.

SRGs have a significant part to play in bringing services together. Barking and Dagenham and Havering and Redbridge SRG is aiming to create a simplified, streamlined urgent care system to prevent patients becoming confused by the different services available to them. It has just three points of access supported by a smart digital platform that will recognise patients and personalise the help they get as soon as they get in contact. Patients can use an online or telephone service. If they go to the emergency department, its entrance is now fronted by an ambulatory care centre.

One trust that has taken the decision to repurpose the front door of its emergency department in this way is the University Hospitals of Leicester NHS Trust. This new approach will include providing an assessment team with the ability to refer patients to ambulatory clinics, assessment beds, urgent care centres or primary and community care.

Collaborating with ambulance services can also help to ease the urgent care burden. SRGs should ensure paramedics have routine access to community health and social care services to enable them safely to manage more patients at scene, either treating and discharging or referring onward to other appropriate services.

Alternatives to taking patients to emergency departments should include:

- Creating clearly documented and standardised criteria for taking patients directly to urgent care or walk-in centres.
- Direct referral from ambulance professionals to hospital specialties.
- Working with community mental health teams to provide crisis care in the community and, where necessary, taking patients to a designated health or community based place of safety.

- Direct access to falls services.
- Ambulances stationed at 'hotspots' to treat minor injuries at the scene or care for intoxicated people until they can get safely home.
- Paramedic practitioners undertaking acute home visits on behalf of GPs to avoid unnecessary admissions and admission surges.
- Working with GPs and acute trusts to manage high-volume service users.
- Direct referral to intermediate care/community rapid-response nursing.

FAST-TRACK PATHWAYS AND RAPID ASSESSMENT

Fast-tracking and rapid assessment of patients can help to enhance patient flow and experience. Some trusts are using ambulatory emergency care, medical assessment units or frail elderly wards to help reduce the bottlenecks that can lead to long waits and delayed treatment.

Fast-tracking patients with less severe symptoms has also been shown to improve waiting times and lengths of stay, along with rates of people leaving without being treated after a long wait.[16] Best practice sees top-performing trusts separating minors and majors through the "see and treat" option. Avoiding triage for those presenting with minor injuries or treatable illnesses means they are treated more quickly, thereby reducing waiting times.

Some conditions automatically require admission or specialist treatment. Rapid assessment means those with clearly differentiated conditions such as chest pain, hip fracture, bleeding in early pregnancy or stroke can bypass the main emergency departments, reducing bottlenecks.

Fast-tracking patients with certain conditions has also shown to reduce the length of stay, which is better for the patient's recovery and also more efficient for the trust in terms of bed space and cost efficiency.[17]

The Dudley Group has introduced a number of fast-track pathways, including those for urology and gynaecology. A rapid-assessment initiative has also been introduced during the winter season to help support falls and fracture patients, who can be given speedy assessment and treatment by an orthopaedic practitioner. Emergency care centres and ambulatory wards can help stream

patients, giving them the care they require without the need to admit them for treatment.

Rapid-assessment units are a good replacement for triage and initial junior medical assessment in the emergency department pathway. One way to improve early assessment is with the involvement of a senior clinician early in the pathway, thereby eliminating unnecessary tests and investigations. As well as improving the patient experience it saves time and money.

This model has also been shown to improve patient safety and satisfaction. However, it can be a challenge in poorly staffed departments, creating an intense workload for senior clinicians, so trusts need to take this into account when organising rotas.

Running rapid-assessment clinics at core times rather than all the time can be effective, but they must also be aimed at walk-in patients as well as those brought in by ambulance. Successful clinics prevent unnecessary admissions and can also ensure immediate referral to a specialty for admission, ahead of any tests being carried out. Alternatively it can result in transfer to a more appropriate provider.

However, there also needs to be a focus on fast-tracking patients from a primary care setting. By working with GPs, community and social care, good trusts nurture a relationship that enables patients to go straight to the correct consultant or department, avoiding any added pressure on emergency departments from GP referrals.

Some SRGs coordinating care in the community are also setting up hotlines between GPs and consultants to ensure patients are immediately placed on the right pathway. GPs can also refer directly to ambulatory care units.

Case Study 1.

Improving access to 24/7 care in Coventry and Rugby

In Coventry and Rugby a GP alliance was set up to provide an integrated solution to improve primary care access and to ensure continuity of care through locally integrated pathways. This included a new shared technology platform which can be accessed by patients and clinicians.

Coventry and Rugby's GP Access Fund Programme "Best Care, Anywhere", which was successfully launched in 2015, consists of three high-profile workstreams that integrate into existing services. These pilot schemes, which cover 64 GP practices with a patient population of more than 350,000 include:

- GP in ED: providing a GP and practice nurse based in the A&E department to treat patients presenting with problems better suited to primary care.
- Primary care frailty team: focusing on the older patient population, with Coventry and Rugby's first GP-led multidisciplinary team of primary care specialists who provide discharge and care planning for frail patients and manage their care with a proactive, community-based focus.
- Extended hours: offering extended weekday urgent appointments and weekend routine appointments to complement and support existing primary care services. The service is based at a single hub at City of Coventry Health Care Centre.

Director of primary care at Coventry and Rugby CCG, Professor Simon Brake, says: "The primary complexity around 24/7 and seven-day care is generally the contractual and physical base issues. For example, buildings may not be designed for 24/7 care and the challenge is how to reconcile that with patient demand."

Professor Brake highlights the importance of looking at the system as whole and bringing about change that counters traditional ways of working. He cites the example of the local "GP in ED" scheme. "We have negotiated admission and discharge rights. This means that once the GP sees a patient they are able to say this patient needs to be admitted and likewise they will work with consultants to agree when a patient is ready to go home."

The schemes have been shown to make a difference to patient care and are helping to drive system-wide improvement within urgent care and frailty. The primary care

frailty team is already breaking down some of the barriers that result in delays in discharging frail elderly patients from the hospital, and is pre-empting and managing situations that could lead to crisis and readmission.

There are direct links between the GP access schemes, especially extended hours and out-of-hours services, and expanded primary care provision within the region will cut emergency department attendance and support patients closer to home.

The key benefits of the Best Care, Anywhere programme include:

- Improved efficiency and management of primary care cases presenting in the emergency department.
- Significantly reduced time for patients to be seen and treated by GPs and discharged if appropriate, contributing to the achievement of the acute trust's four-hour target.
- Additional appointments in primary care on evenings and at weekends, which reduce pressure on existing GP and hospital services.
- Improved identification of frail elderly cases as they present at the hospital door and their subsequent management. More than 30 per cent of patients seen by the primary care frailty team are being discharged on the same day, contributing to a reduction in average length of stay for the acute trust.
- Integration of community and hospital services in discharge planning through a multidisciplinary team approach, resulting in quicker discharges from the acute trust and releasing capacity within the system, including bed space and staff time.

Feedback from a patient's daughter

"It's now been a week since my mum was taken into A&E and then discharged back home on the same day. We were concerned that she would not be able to cope but thanks to the combined efforts of the teams involved she has gone from strength to strength.

My mum was feeling very vulnerable after her fall in hospital but the nursing help in the morning and the extra aids supplied have helped to give her much more confidence. She is also going to be supplied with a panic button so that she feels safe while she is alone in the house. Her appetite has improved and so has her mood. In all, the swift response to her hospital visit has been both surprising and very welcome. I do not know how we could have coped without it."

5. USING DATA TO SUPPORT 24/7 CARE

MEASURING GOOD EMERGENCY DEPARTMENT CARE

The starting point when measuring the quality of care in emergency departments is to acknowledge that it is not just about the numbers and waiting times. Feedback from patients and their families and carers is key to pinpointing areas for improvement.

The best trusts are triangulating this feedback with good data and there is a number of standard indicators that are measured to gauge performance. However, this relies on trusts' ability to collect and monitor the data.

The current indicators take into account ambulatory care, unplanned readmission, the total time spent in the emergency department, how many people leave without being seen, time to initial assessment, service experience (patient and family/carer), time to treatment and consultant sign-off.

These indicators are all vital in building up a picture of how a department is performing.[18]

The best trusts have in place adequate IT systems that are able to track the patient pathway seamlessly to collect and monitor data. Indicators they use cover ambulatory care because the ambulatory care process is vital to success. Patients with certain high-volume, low-risk conditions should be treated in a way that avoids admission unless absolutely necessary. This helps to provide consistency of practice for other conditions.

Another indicator used is unplanned readmission within seven days of original attendance. The data suggest there are two different cohorts being monitored: those who reattend frequently and single reattendance. Nearly 50 per cent of patients who are readmitted, do so within seven days of discharge, potentially costing trusts £300m in lost annual income. Readmission within a short time frame can be indicative of issues related to hospital care or shortcomings in the process of discharging patients to the appropriate level of care.[19]

Total time spent in the emergency department reflects the benefits that have accrued from the four-hour emergency care standard while minimising the consequences of a single time-related measure of care. Experience during the past

10 years has established a body of evidence indicating that in a properly staffed department, supported by prompt access to diagnostics and well-managed flow into inpatient beds, more than 95 per cent of patients will complete their care within four hours. If the department is under-resourced or in-hospital bed capacity is inadequate, then compliance with the target becomes difficult.

CHKS has been working with the RCEM to analyse emergency department treatment times in English hospitals. This analysis has focused on variation in treatment times within the four-hour target and beyond. It was carried out using hospital episode statistics data from all English acute hospital trusts for the 12 months to July 2015.

When CHKS researchers looked at the number of patients treated within two hours, they found a significant variation. The best trust treated 71 per cent of its patients within two hours, whereas at the worst only 12 per cent of patients were treated within this time.

The analysis also looked at treatment times across all acute trusts according to the number of minutes patients spent in the emergency department. The results showed a significant spike at 240 minutes, which coincides with the four-hour target. This suggests the four-hour target, rather than need, may be determining many treatment times.

SERVICE EXPERIENCE

This is not simply a patient satisfaction indicator, but an indicator of overall service experience reflecting the 24-hour nature of emergency and urgent care. It requires data on service experience to be gathered and analysed on a regular basis; the minimum requirement is for quarterly review. The indicator also requires clear evidence of action taken in response to the findings of the review.

This service experience indicator is not restricted to patients, but may also include carers, staff or others' perceptions of the service. Its aim is not to derive satisfaction ratings but to explore more broadly how the service is experienced and therefore how it might be improved. Unlike the other indicators, there is no comparison between sites. It is intended to support local quality improvement.

The indicator is used because it is essential to understand how a service is experienced if it is to be responsive to the needs of users. Emergency and urgent care services address a wide range of human need beyond the purely clinical, including compassionate care for the bereaved, comfort for the dying and alleviation of anxiety for all. Overall experience of emergency and urgent care services is therefore as important as clinical outcomes.

TIME TO INITIAL ASSESSMENT

This quality indicator records the time from arrival in the emergency department to full initial assessment, for patients arriving by ambulance. Initial assessment includes a pain score and physiological early warning score for all these patients. By monitoring this indicator, trusts aim to reduce the time the patient spends without assessment by staff. Serious untoward events have been noted where there have been significant delays in formal assessment.

TIME TO TREATMENT

This quality indicator records the time between arrival and the time when the patient is seen by a decision-making clinician; in practical terms such a clinician is somebody able to discharge the patient from the emergency department, such as a suitably experienced doctor or emergency nurse practitioner. Arrival time is well defined and is measured in two ways: either the time of initial assessment/triage or initial registration, whichever is sooner, or by ambulance handover time or 15 minutes after ambulance arrival, whichever is sooner. The time that the patient is seen by a decision-making clinician is already routinely recorded and reported in many emergency departments.

CONSULTANT SIGN-OFF

This quality indicator is adapted from the recently released RCEM standard for consultant sign-off. It identifies three high-risk presentations that should be reviewed by a consultant prior to discharge: non-traumatic chest pain in adults (over 17 years of age); febrile illness in children (less than one year old); and unscheduled

- reattendances (with the same complaint) within 72 hours. If a consultant is not immediately available then review may be undertaken by an experienced trainee in emergency medicine (ST4 or above) or a staff grade or similar substantively appointed doctor who has been designated to undertake this role by the emergency medicine consultant staff.

WHAT OTHER INDICATORS CAN BE USED?

These indicators all track the patient experience from arrival at the front door of the emergency department, how long they have to wait until they are seen and who they see during their time there. However, many trusts use additional measures to provide greater insight and lead to greater improvement.

Using trolley waits as an indicator can also provide a better picture of patient experience than just the four-hour wait. Trolley waits can be distressing for the patient and their family and can also contribute to crowding. This indicator can highlight challenges with patient flow across the hospital.

Monitoring when crowding occurs, handover delays and also ambulance diverts can all help build a clearer picture of a trust's performance and help to pinpoint where changes can be made and burdens eased. Common causes of crowding include non-urgent visits, inadequate staffing and bed shortages; effects of crowding include patient mortality, transport and treatment delays, ambulance diversion, patients walking out untreated and increased costs.[20]

THE ROLE OF DATA IN MOVING TO A 24/7 SERVICE

Trusts leading the move towards 24/7 care use data to measure the impact of any changes on performance and patient experience. Data can be used to identify the pressures occurring in emergency departments, and what external factors are causing them. This enables trusts to create more efficient staffing programmes, ensuring the right types of staff are in place to meet demand.

The use of real-time data can help to improve patient care as it is delivered rather just recording past events. Handheld devices can be used for better compliance in

patient observations. If patients are checked and action taken then they are less likely to deteriorate. In addition they are less likely to need frequent observations, which reduces the workload of nursing staff. Uploading this information wirelessly to the hospital system ensures all ward staff are aware of the condition of all patients. Handheld devices can also be programmed to flag up when a patient is at risk of an infection.[21]

There are always peaks and troughs within an emergency department, depending on the day or the time of day, and good trusts use such data to identify where their challenges lie. But to standardise the quality of care, it does not just fall to the emergency department to gather data. Ensuring smooth patient flow always means looking at what is happening within the wider hospital and beyond.

It is essential that primary, secondary, community and social care are involved and that data are used to monitor and understand the patient journey – where the gaps and bottlenecks occur and how they can be resolved.[22] The best systems are using data to build up a detailed picture of demand, looking at the type of demand, the volume and the timing. Understanding demand is critical in order to build the required workforce to meet patient demand safely while also giving value for money.

In the acute sector there is a variety of data available to help trusts measure patient experience. Good trusts don't just look at quantitative data such as waiting times. They also triangulate this with qualitative data such as from complaints, compliments and the Friends and Family Test (FFT). Leeds Teaching Hospitals NHS Trust (see case study, page 37) is using data to create a health check for its emergency department. The trust uses the Picker Institute to carry out a survey of A&E patients every two years and also gathers feedback from the FFT. It also uses Healthwatch Leeds to gather patient opinion about performance. The data are reviewed along with complaints, compliments and incidents to triangulate and evaluate care and experience. The trust also records and measures falls and pressure ulcers, and audits the documentation against agreed standards every month.

Top-performing trusts also use data from staff surveys, mock CQC inspections, specialty deep-dives, nurse care indicator audits and matron audits to help them understand where change and improvement can be made.

HOW SHOULD TRUSTS USE DATA?

The best trusts use data to build up a detailed picture of demand, looking at the type of demand alongside the volume and the timing. Understanding demand is critical in order to build the workforce necessary to meet patient demand safely while delivering value for money. Top trusts use data to understand the difference between value demand and failure demand, where a failure to do something has led to increased demand.

Successful trusts have diversified their staff, training up a number of ANPs and ENPs as well as physician assistants, who can manage the minors with the help of a doctor or consultant if needed. Data revealing patient acuity can also help trusts to ensure the right staff numbers per patient. Discussing such data at daily meetings and highlighting those patients who have the greatest need can provide hospitals with the information they need to be objective, moving staff to areas that may be experiencing the greatest pressure.

Trusts that are leading the way with management of 24/7 emergency care also focus on good handovers. At Central Manchester (see case study, page 34) data are reviewed to change staffing profiles of doctors and nurses to match patient presentation and the likely demands on particular skills.

Some data can also show trusts ways in which patients can be directed from the emergency department to a more suitable department. Over the past few years data have shown the departments are seeing more older people than ever before, with rates of attendance among older people growing disproportionately.

Patient feedback sources (PALs, FFT, complaints, compliments and staff surveys) are all a rich source of information. At The Dudley Group, a database of each PALS interaction is kept in the emergency department. While each issue is addressed by a single consultant, the database can reveal any overall themes among the complaints or issues. A summary of complaints is presented at departmental governance meetings and any issues arising are discussed and highlighted. ■

6. WHAT DOES GOOD 24/7 CARE LOOK LIKE?

Case Study 2.

Central Manchester University Hospitals NHS Foundation Trust

How understanding urgent care has improved the 24/7 service

Central Manchester University Hospitals NHS Foundation Trust is a large teaching hospital group made up of six hospitals, each with its own specialist areas and provision for urgent care services. Although there are pockets of affluence within the area it serves, the population is predominantly of a lower socio-economic group, with higher rates of deprivation, alcohol misuse and poor health.

The trust operates Manchester Royal Infirmary, Royal Manchester Children's Hospital, The Royal Eye Hospital and St Mary's Hospital, all on one main site. Trafford and Manchester Dental Hospital sit outside the main campus, but shares values and beliefs based on the Keogh clinical standards. Each hospital is accountable through board assurance and a range of quality indicators to ensure the same standard of quality services is delivered on each site.

To be able to support delivery of 24/7 care, a number of changes have been made in urgent care first contacts. The trust has taken into account the different types of patient need and matched the staffing profiles and skills of doctors and nurses accordingly.

The sickest patients are noted at a handover taking place twice daily in A&E, with regular reviews throughout the day involving both doctors and nurses. At nurse handover, skills are discussed to ensure the right skill level is based in a particular area or to support any deficits in skills, particularly related to agency nurses. A 'supernumerary' senior nurse is available on each shift to provide additional support in whichever area requires senior skill levels to manage patient acuity or demand.

As well as access to diagnostic services seven days a week, there are also mental health liaison teams based in A&E seven days a week, with an alcohol nursing service five days a week which follows up all weekend discharges. Community services are also available, with social services on hand for five days a week, with intermediate care assessment and rapid response teams working across seven days to support patient discharge home at weekends.

As with many other A&E departments, CCGs were sympathetic to the demands of primary care pathways on the department. The trust's clinical director Rosemary Morton requested direct access to GP appointments for same-day assessment or follow-up, to reduce hospital attendance rates. Commissioners have supported the department by funding a GP booking clerk from Monday to Friday. Patients can now be triaged to a same- or next-day GP appointment with their own practice. As a result hospital attendance has fallen to less than 2 per cent of those offered an appointment.

All the actions taken to improve quality and reduce waiting times were introduced and implemented through an A&E improvement programme. The original project has taken 18 months to complete, and is revised every three months to sustain the momentum and energy, particularly through the difficult winter months.

Marie Rowland, associate director performance, says: "Our approach was based on working with the teams, and 'moving the focus away from what you can't do or influence, to working on what we

can do'. We have been on a journey, with an expectation that everyone contributed to how we would make things better for patients and develop a great place to work for staff. We mapped activity, profiling patients coming in and seeing what skills were needed to meet that patient's needs at that time of day. Workforce engagement was heavily influenced by illustrating the waiting times of patients, and how changes to work patterns and skill mix could reduce those waits."

Marie adds: "We are just the same as every other hospital in terms of our capacity challenges. You can be consumed in your own bubble, blaming everyone else for a crowded department. This change process has been uplifting. We have invested in the teams, tried to reduce stress levels by making sure skillsets are in the right place and also have a resident on-call consultant seven days a week."

A major challenge was to highlight the need to change the profile and skills of the workforce across the 24-hour period. Marie says introducing an additional senior registrar overnight, seven nights a week, had an immediate benefit in terms of breaches of the four-hour target and of reducing the time to see a clinician. This meant that even with several trauma cases overnight, the morning teams rarely came into a department full of patients waiting to be seen. Building on the benefits of early decision making, an advanced nurse practitioner (ANP) service was introduced to cover the A&E ward, seven days a week. Meeting the needs of observational medicine, Steve Jones, associate clinical director for urgent care, and Cath Barlett, lead nurse urgent care, introduced a seven-day ANP rota that included rotation with A&E to maintain a broad range of skills for all the ANPs. This has had a significant impact on weekend discharge and early patient reviews.

Matching workforce with demand included consultant-level change. A 16-hour consultant presence has been implemented by allowing the consultant to self-roster onto shifts and having a consultant onsite for major trauma 24/7. "We have various ages of consultant, some with younger children who prefer to work the evening and others who like to teach, but so far the rota has worked out well for the department and service provision," says Marie.

The trust has also funded a GP based in the walk-in centre. Changing the frontage of the centre has encouraged patients to choose this as an alternative to A&E, which has eased the pressure on the department, and the trust has seen a 10 per cent reduction in A&E minors and a 20 per cent increase in walk-in centre demand. The team took the decision to replace the emergency department sign with an accident & emergency sign, which is clearer to the public. The team asked Healthwatch Manchester to walk through A&E and the walk-in centre before and after the change of signage and increased visibility of the walk-in centre with user group representatives. The feedback and effect on flow has been very positive, and fits with the trust's aim of including patients in how we provide the most appropriate service for their needs.

Bed capacity is an ongoing challenge as the trust balances the demands of planned and urgent care, but the key success of A&E is to keep the focus on reduced waits to see a clinician. "Maintaining this is important, and leadership is essential as we move to our next improvement programme review," says Marie.

Case Study 3.

The Dudley Group NHS Foundation Trust

Diversifying workforce is key to easing the burden

The Dudley Group NHS Foundation Trust serves a population of some 450,000 at three hospital sites. Its hospitals are among the most technologically advanced in the country, with state-of-the-art equipment and purpose-built buildings combining to create the highest standards of patient care.

Each year around 100,000 patients are treated in the emergency department. A number of community services are co-located in the department, including a 24/7 urgent care centre (which has extra provision to run the GP out-of-hours service), a seven-day ambulatory emergency care centre that takes direct referrals from the ED, a seven-day pharmacy, and community teams and therapist supporting rapid discharge. There is also a clinical observation unit.

The hospital has introduced a number of fast-track pathways including urology and gynaecology to help with patient flow and early treatment. During last winter a new initiative called HIP Aid was introduced with rapid assessment and treatment by an orthopaedic practitioner for fracture patients.

Due to an increasing demand on the ED and a shortage of medical staff, the trust looked to diversifying its workforce. ENPs manage the minor workstream and have also trialed physiotherapists working alongside them. The trust also has physician assistants/associates and successful trials have prompted the introduction of emergency care practitioners from paramedic and nursing backgrounds to supplement the junior doctors with a 24/7 rota.

Johanne Newens is director of operations for medicine. She says the trust is trying to capture the qualitative elements of care and boost patient experience by making changes within the department.

As a result, the trust can deal with spikes in demand. Johanne says: "It's inevitable that ambulances and patients referred from their GP arrive at the same time; 12 to 2pm and 5 to 7pm are peaks and the question then is how we cope with spikes in activity and get back to normal, which is what we are good at."

The trust's ambulatory emergency care (AEC) and emergency admissions unit (EAU) work well together. The AEC opens from 8am until 10pm and pulls in patients from the EAU who need treatment and would have otherwise been admitted.

The unit also has recall clinics with highly skilled staff. Acute physician teams cover EAU and the short-stay unit as well as AEC. Johanne says: "The AEC set-up here is much bigger and better used than in previous places I have worked. Here we are getting patients out and back home. For people like the frail elderly, it is stopping them coming to be admitted."

The frailty assessment unit is also a focus, with an impact team consisting of community workers, social workers and therapists. Physiotherapy is accessible seven days a week and an onsite psychiatric liaison service provides integrated mental health care 24/7, giving access to both community and inpatient services.

To ensure it continues to offer a good patient experience, the trust uses the Friends and Family Test and also canvasses patient opinion working on a "You said – we did" basis. There is also a number that people can use to text immediate feedback. The executive team has just launched "customer care" – a new strategic trustwide initiative to think about how to improve patient experience. Johanne says: "We have done quite well on national patient and staff surveys. Some people would argue staff experience is just as important."

Case Study 4.

Leeds Teaching Hospitals NHS Trust

How a new compact has improved patient flow

Leeds Teaching Hospitals NHS Trust cares for around 1.5 million patients a year with around 15,000 staff across six sites and seven hospitals. It has an international reputation for excellence in specialist care, research and academic training. It is one of the largest healthcare providers in the UK and has two emergency departments in the city, which see around 200,000 patients a year. It is also one the largest urgent care vanguards looking at developing a sustainable and integrated approach to urgent care, working closely with the local CCG and emergency partners.

There is a consultant based at Leeds General Infirmary 24/7. This site provides all the paediatric emergency care and hosts the major trauma centre cardiac and vascular services, while the other emergency department hosts general medical, elderly, surgical and cancer services. This department has a much higher proportion of frail and elderly patients and people with chronic conditions.

The trust is signed up as an early implementer of 24/7 services and a comprehensive review of consultant cover has been undertaken. In most areas consultant staffing and ward rounds have been shown to be compliant with the seven-day service standard.

Other initiatives to ensure the successful delivery of 24/7 care include:

- Development of an electronic handover system to ensure accurate handover between shifts.
- Access to diagnostic services, including imaging, echocardiography, endoscopy, pathology, radiology and haemotology.
- A comprehensive consultant-directed critical care service, supporting all specialties within the hospitals.
- Seven-day cover in all core areas such as respiratory, orthopaedics and stroke services, with cover extended in medicine and respiratory to support weekend discharge planning and referrals.
- Collaborative working with support services to reduce delays, including: hospital social workers, collaborative early discharge and assessment team, Hospital to Home discharge support service, extended ward-based pharmacy cover, electronic referral processes, weekly working group to review delays, monthly meetings with mental health care trust to address concerns and delays with a shared escalation process, and acute liaison psychiatry in both EDs.

Stephen Bush is a consultant in emergency medicine and clinical director, acute medicine. He links the delivery of care to workforce and flow."I am specifically proud of the fact that we have a consultant here 24/7 covering both sites at any time of the day or night and have had that in place since September 2012," he says.

The trust is currently undertaking a 100-day review where everyone within the clinical service unit has the chance to come up with ideas for improvement. Suggestion boxes are placed around the trusts. There are also change champions, a group of nurses, doctors and admin people who feed their opinions back to the trust.

In order to manage demand and patient flow through the units, the trust has set up 10 principles by which all staff have to abide to ensure a good patient experience (see box, right). Stephen says: "Patients don't fall into neat groups. The agreement is a compact. Non-elective patients are everyone's responsibility, it's not just about the clinical outcomes."

THE LEEDS 10 PRINCIPLES OF EMERGENCY CARE

1. A decision-making clinician will see new patients on, or as close to, arrival as possible in the emergency department.

2. The department team will not admit a patient likely to be able to go home just to avoid a breach of the Emergency Care Standard.

3. Specialties will have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and must not insist on emergency department-based investigations that do not contribute to the immediate management of the patient.

4. Patients referred from primary care (or any other clinical service) should be routed directly for specialty assessment via the operations centre. If this does not occur and the patient attends the emergency department, the patient will be transferred to the specialty considered most appropriate by the department team unless immediate medical intervention is required.

5. Patients will only be sent to the emergency department as a result of advice by specialty teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. In this situation, the department team will continue to provide clinical support to patients within the resuscitation area, and then refer on to the most appropriate specialty for ongoing management of the current clinical problem.

6. Decanted patients from critical care will take priority in inpatient bed allocation over and above any other calls for that available bed.

7. No specialty doctor will refuse a request to assess any emergency department patient. If subsequently it is considered that an alternative specialty would provide more appropriate care, it is the responsibility of the first specialty (not the emergency department team) to arrange the transfer. The emergency team will continue to provide clinical support to patients within the resuscitation area.

8. The emergency department team will highlight any patient recently discharged from an inpatient admission or under current investigation or treatment for assessment by the suitable specialty. This should help the specialty team to avoid unnecessary admissions.

9. Except for specific agreed clinical pathways – for example, ruptured abdominal aortic aneurysm – patients requiring clinical review in another Leeds trust site will not be transferred to the other emergency department.

10. If there is a failure among different specialties to agree on accepting a patient, the emergency department consultants have the authority to admit any patient to any level one bed in the specialty that they consider best able to meet that patient's clinical needs.

7. CONCLUSION

While there is continuing debate about what effective 24/7 services look like, the 10 clinical standards set out by Sir Bruce Keogh are a useful starting point for any health economy looking to meet the challenge. The journey for each NHS provider or commissioner will of course be different, but sharing best practice will be valuable in overcoming the stumbling blocks that are common to all, such as the inevitable financial constraints.

Whether the initiative starts with a compact between a trust's specialty departments, or with commissioners taking the lead to improve access to primary care, a number of approaches that have been successful.

Many providers and commissioners have begun their journey with the emergency department, putting in place measures to reduce pressure on the front door of the hospital. Some trusts have set up ambulatory care units linked to the department, with distinct clinical pathways designed to avoid unnecessary admission.

Others have looked at improving patient flow once the patient is seen. Fast-track pathways for certain specialties, such as urology and gynaecology, help to enhance the flow and promote early treatment. At the same time, good emergency departments are working externally with community services and social care to find ways to improve the wider system. Joint working with primary and community care is essential to help address patient flow.

Culture and attitude to change is fundamental to the success of these initiatives. This means challenging deep-rooted views about the way services should be delivered. Developing new models of care that include roles such as physician assistants/associates and emergency nurse practitioners has led to success for some trusts. Changing roles in primary care so GPs work in emergency care has also been shown to work well.

Regardless of how providers and commissioners approach the challenge, the patient experience must be central to the process. This means bringing together the hospital (including emergency department doctors and nurses), social care and GPs to ensure a focus on what works for patients. Ideas for improvement will come from patients and their families, and also from staff at the frontline. Using this feedback in an continuous review of services will be essential if success is to be achieved and sustained. ■

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FIND OUT MORE:
+ 44 (0)1789 761600
INFO@CHKS.CO.UK
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