



## **Transforming urgent and emergency care services in England**

**Safer, faster, better: good practice in delivering urgent and emergency care**

**A guide for local health and social care communities**

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# **Transforming urgent and emergency care services in England**

## **Safer, faster, better: good practice in delivering urgent and emergency care**

### **A guide for local health and social care communities**

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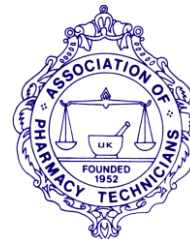
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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

This report has been endorsed by the following partners:



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# 1 Document summary

## 1.1 Transforming urgent and emergency care services in England

The NHS Five Year Forward View (5YFV) explains the need to redesign urgent and emergency care services in England for people of all ages with physical and mental health problems, and sets out the new models of care needed to do so. The urgent and emergency care review (the review) details how these models of care can be achieved through a fundamental shift in the way urgent and emergency care services are provided to all ages, improving out-of-hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions. We need a system that is safe, sustainable and that provides high quality care consistently. The vision of the review is simple:

- For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.
- For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

As part of the review, a number of products are being developed to help create the conditions for new ways of working to take root and when combined, deliver an improved system of urgent and emergency services. The review proposes that five key changes need to take place in order for this to be achieved. These are:

- Providing better support for people and their families to self-care or care for their dependants.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

NHS England is collaborating with patients and partners from across the system to develop a suite of guidance documents and tools to promote best practice and support commissioners and providers in achieving a fundamental shift towards new ways of working and models of care. These guidance documents are being

developed as a suite entitled 'Transforming Urgent and Emergency Care Services in England' and are designed to be read together. The suite comprises the following components:

- Role and establishment of urgent and emergency care networks (UECNs), published June 2015.
- Clinical models for ambulance services.
- Improving referral pathways between urgent and emergency services in England.
- 'Safer, faster better: good practice in delivering urgent and emergency care', published July 2015. This good practice guide focuses on the safe and effective care of people with urgent and emergency health problems who may seek or need specialist hospital based services.
- Urgent and emergency care: financial modelling methodology.

## 1.2 Purpose

This document is designed to help frontline providers and commissioners deliver safer, faster and better urgent and emergency care to patients of all ages, collaborating in UECNs to deliver best practice.

It sets out design principles drawn from good practice, which have been tried, tested and delivered successfully by the NHS in local areas across England. However, the guide should not be taken as a list of instructions or new mandatory requirements. Implementation should be prioritised taking into account financial implications and local context.

This document has been prepared by NHS England in conjunction with the Emergency Care Intensive Support Team (ECIST). Contributions have been sought from the review's delivery group (comprising a wide range of experts in urgent and emergency care services, as well as patient representatives).

## 1.3 Audience

The primary audiences for this document are providers and commissioners of urgent and emergency health and social care services to all patient groups, including children and people with urgent mental health needs.

The secondary audience for this document is the wider membership of UECNs. Suggested membership for these Networks is outlined in the *role and establishment of urgent and emergency care networks*, which forms part of the suite 'Transforming urgent and emergency care services in England'.

## 1.4 Structure

The document begins with an introduction arguing the need for collaboration and consistency in the delivery of best practice in urgent and emergency care. It refers to



the evidence base that underpins the review and goes on to set out design principles for a number of key service areas.

## 1.5 How it will be used

The revised planning guidance for 2015/16 required UECNs to start establishing themselves across England from April 2015, acknowledging that they already exist in some parts of the country. Commissioners and providers should utilise the principles outlined in this document, tailoring them to meet local need as identified by the UECNs across England. The recently published *Five Year Forward View* (See [Five Year Forward View](#)) emphasises the importance of this and how we will increasingly need to manage health care systems through networks of care, not just by, or through, individual organisations.

The planning guidance 2015/16 further outlines that commissioners should take into account their duties as defined by the Equality Act 2010 and, with regard to reducing health inequalities, the Health and the Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities and address health inequalities (see: Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties (See [Equality & Health Inequalities Legal Duties](#))).

Safer, Faster, Better will be updated regularly to reflect emerging practice and the developing evidence base.

## 2 Introduction

This guide has been written for providers and commissioners of urgent and emergency care in England. Our aim is to create a practical summary of the design principles that local health and social care communities need to adopt to deliver safer, faster and better urgent and emergency care for people in all age groups with physical or mental health problems. For ease of reference, we have divided the guide into sections covering major topics. However, delivering safe and effective urgent and emergency care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do.

Everything we discuss has been turned into reality somewhere in the country. All the building blocks are available and have been tested by clinicians and managers and shown to work. However, we know from experience that piecemeal implementation of great care in isolated parts of the pathway only creates disjointed 'islands of improvement'. Critical mass is only developed when good practice is implemented systematically, without unwarranted variation, along the entire pathway.

The challenge is considerable. A social movement, committed to ensuring that urgent and emergency care in England is truly world-class, is needed. This guide is a contribution to making that happen.

### 3 The evidence base

There is a considerable evidence and experience base for ‘what works well’ in urgent and emergency care systems, and the damage caused by poor patient flow<sup>1</sup>. A summary was published by the Review in 2013 and is available at: [Improving Patient Flow](#).

It is important that clinical and managerial leaders across local health communities are aware of the evidence so they can create a compelling narrative of good practice to inspire safer, faster, better care.

Below are some top, evidence-based principles that everyone should know:

- Preventing crowding in emergency departments improves patient outcomes and experience and reduces inpatient length of stay (See [Exit Block Campaign](#))
- Getting patients into the right ward first time reduces mortality, harm and length of stay (See [Impact on Patients, Hospitals and Healthcare Systems](#)).
- Patients on the urgent and emergency care pathway should be seen by a senior clinical decision maker<sup>2</sup> as soon as possible, whether this is in the setting of primary or secondary care. This improves outcomes and reduces length of stay, hospitalisation rates and cost (See [Benefits of Consultant Delivered Care](#)).
- Daily senior review of every patient, in every bed, every day, reduces length of stay and costs of care (See [BMJ Open Access - Cost Benefit Analysis](#)).
- Frail and vulnerable patients, including those with disabilities and mental health problems of all ages, should be managed assertively but holistically (to cover medical, psychological, social and functional domains) and their care transferred back into the community as soon as they are medically fit, to avoid them losing their ability to self-care (See [Acute Care Tool Kit 3](#)). Ambulatory emergency care is clinically safe, reduces unnecessary overnight hospital stays and hospital inpatient bed days ([Acute Care Toolkit 10](#)).
- Acute assessment units enhance patient safety, improve outcomes and reduce length of stay (See [Effectiveness of Acute Medical Units in Hospitals](#)).

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<sup>1</sup> The term ‘flow’ describes the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term denotes the flow of patients between staff, departments and organisations along a pathway of care (See [Improving Patient Flow](#) p7-12).

<sup>2</sup> The term, ‘senior clinical decision maker’, is used throughout this document and should be taken to mean a clinician with the skills and competencies to assess, determine a treatment plan and safely discharge patients under their care. Consultants and general practitioners typically fall within this definition. Doctors in their third year of specialist training (ST3) or above; experienced non-training grade doctors; and nurses, therapists and other clinicians with recognised advanced skills and training may also be considered to be ‘senior clinical decision makers’ within their spheres of competence.

- Mental health problems account for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions. Mortality and morbidity ratios amongst people with mental illness are much higher than amongst the general population (See [Physical Morbidity and Mortality in People with Mental Illness](#)). Well-resourced liaison mental health services provided seven days a week and 24-hour a day are cost effective and an essential part of any urgent and emergency care system (See [Liaison Mental Health Services](#)).
- Continuity of care is a fundamental principle of safe and effective practice within, and between, all settings (See [Continuity of Care for Older Hospital Patients](#) and [Which Features of Primary Care affect Unscheduled Secondary Care use](#)). The sharing of and access to key patient information is essential to this.
- Getting patients to definitive, specialist hospital care can be more important to outcomes than getting them to the nearest hospital for certain conditions, such as stroke, major trauma and STEMI (for examples, See [BMJ Impact of Centralising Acute Stroke Services in English Metropolitan Areas](#), [Effect of Regional Centralisation on Trauma Volume](#) and [RCP Journal - Consultant Delivered MDT](#)).
- Properly resourced intermediate care, linked to general practice and hospital consultants, can prevent admissions, reduce length of stay and enable home based care and assessment, including supporting 'discharge to assess' models (See [National Audit of Intermediate Care - Summary Report 2014](#): and [Avoidable Acute Hospital Admissions in Older People](#)).

## 4 General principles of good patient flow

### 4.1 Balance capacity and demand

- The first essential in maintaining good patient flow is to ensure that there is enough capacity along all parts of the pathway to manage demand.
- Demand should be taken to mean all referrals or presentations to a service, not just its historical activity. Measuring activity can often underestimate demand, as it may exclude referrals or presentations that have been deflected (for example, by refusals to accept a referral due to 'no capacity'; patients leaving without treatment due to long waits; abandoned calls because no one was available to answer the phone, etc.).
- Patterns of urgent and emergency referrals and presentations, while not random, will always exhibit variation hour by hour and day by day (this is 'normal variation'). When calculating demand, it is therefore essential to take into account normal variation and not to plan around averages. Ignoring variation and planning to meet average demand will inevitably mean the service is under regular stress and queues will develop that may be difficult and expensive to manage.

- Variation in demand for a service can be best illustrated using statistical process control (SPC) run charts. The upper control limits on an SPC chart represent the level of demand that, if planned for, will enable to service consistently to manage demand, except in unusual circumstances.
- Capacity relates to a service's ability to treat referrals or presentations to it. In health care, capacity will mean clinicians, support staff, diagnostics, procedures etc. While beds are often referred to as 'capacity', this is really a misnomer. Beds are places where patients wait to be treated. They are not the treatment itself and therefore are not capacity.
- Imbalances between demand and capacity will create bottlenecks and delays along the pathway. These imbalances can be caused by temporary or long-term under-resourcing of services along the pathway or, paradoxically, by over-resourcing (for example where a new surgical service floods diagnostic imaging or intensive care due to poor planning). Smooth flow requires all parts of the pathway to be resourced to meet demand (including normal variation), but not over resourced.

## 4.2 Keep flow going

- Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges. In broad terms, the daily number of discharges will equal the daily number of patients a system has capacity to manage, divided by length of stay.
- For example, if a system has capacity (hospital staff/procedures/intermediate tier support etc.) to manage around 250 acute inpatients each day and hospital average length of stay is five days, we will expect around 50 discharges a day (note there will be some variation in numbers treated and discharged).
- If admissions increase by 10%, it will be necessary to discharge an extra 10% a day to keep the system in balance. This can be achieved either by increasing capacity (doctors/nurses/tests) so that more patients can be treated each day, or by increasing efficiency. In the short term, this can be done by everyone working harder and in the longer term through better processes. If neither capacity nor processes are changed, there is a likelihood that a hospital or service will rapidly reach a tipping point and fill up with patients waiting for capacity to become available to treat them. The ever growing number of patients typically leads managers and staff to see the problem as mainly one of lack of beds, rather than lack of capacity or a need to improve processes.
- Beds are important only insofar as they are places where patients are monitored receive nursing care and spend time recovering. If the number of beds is insufficient, treatment capacity cannot be brought to bear to treat all the patients who could be treated. Queues therefore develop (e.g. trolley waits in A&E) and resources are wasted (e.g. operations not carried out due to lack of beds). Closing beds without either increasing capacity or efficiency is generally a recipe for an overcrowded hospital. However, increasing beds above the number

needed to match available treatment capacity is inefficient and will have no beneficial impact on discharge or treatment rates.

- Having a greater number of patients in beds than capacity to treat them stretches staff, reduces efficiency, creates harm and halts flow. The result is increasing length of stay and a sicker patient population.

### 4.3 Reduce variation

Unwarranted variation is a major obstacle to achieving safe, cost effective patient care and flow. Research has shown there is huge variation in clinical practice between hospitals; between hospital departments; between community teams; and between individual clinicians, even where statistically the patients and facilities are identical. The variation is so large, that it is impossible to say that all patients could be receiving good care.

To reduce variation, it is essential to apply simple rules that set boundaries within which health professionals and managers work. The following, good practice principles, should be considered to improve safety, patient flow and help reduce variation. These principles are outlined more fully in the sections that follow.

- Urgent or emergency care patients in any setting should receive the earliest possible review by a senior clinical decision maker.
- All emergency hospital admissions should be seen and have a thorough clinical assessment by a competent consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
- All adult patients<sup>3</sup> should have a National Early Warning Score (NEWS) established at the time of admission.
- Consultant involvement for patients considered 'high risk' (defined as where the risk of in-hospital mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be within one hour.
- There should be a senior review of the care plan and its delivery, for every patient, in every bed, seven days a week.
- Consider all potential acute admissions for ambulatory emergency care unless their care needs can only be met by an inpatient hospital stay.
- People in mental health crisis presenting at emergency departments should have their mental as well as any physical health needs assessed as rapidly as possible by a liaison mental health service.

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<sup>3</sup> NEWS is not appropriate for people under 16 or pregnant women (See [RCP National Early Warning Score NEWS](#)) page xiii).

- All potential admissions to acute mental health inpatient services should be assessed for intensive home treatment by crisis resolution home treatment teams unless there are significant immediate issues of risk, safety and complexity that warrant assessment under the Mental Health Act.
- Hospitals and local health and social care communities should prioritise activities aimed to achieve the earliest possible discharge of patients. A realistic expected date of discharge, with associated physiological and functional criteria for discharge, should be established as a goal for professionals and patients to work towards.
- Best practice is to establish a time, as well as a date, of discharge. This focusses clinical teams and increases the proportion of morning discharges, which are essential to avoid hospitals and emergency departments becoming overcrowded in the middle of the day.
- Assertively manage frail older people, and younger people with specific vulnerabilities, such as learning disability or those with long term conditions, ensuring they have their needs comprehensively assessed on arrival and are discharged immediately they are clinically ready for transfer home or to on-going care facilities.
- Promptly assess and place patients into the most appropriate care stream to meet their needs.
- All hospitals should promote 'internal professional standards' (IPS) that have been agreed by clinical teams as the basis for response times and relationships between departments (for the theory underpinning IPS, (See [Harvard Business Review - Promise Based Management](#))
- All health services should actively seek to provide continuity of patient care.
- Design the capacity of health services to manage variation in demand, not just average demand.

#### **4.4 Manage interfaces and handovers**

Effective handover of patients between organisations and clinical teams is absolutely essential to patient safety and maintaining flow. It is good practice for all services regularly to review how effectively patients are handed over both internally and externally, and work collaboratively to improve processes along the whole pathway. The following principles should be considered:

- Hospitals and ambulance services must agree handover processes that ensure patients wait safely for assessment and ambulances are released promptly.
- All registered health and social care professionals, following telephone consultation or clinical review of a patient, should be empowered, based on their own assessment, to make direct referrals for patients to mental health crisis services and community mental health teams.

- All teams receiving emergency patients must be informed of the patient's arrival. Best practice is to include an agreed, formal communication method such as situation background assessment recommendation (SBAR) (See [Quality Service and Improvement Tools](#)).
- Good practice is for all patients being referred for admission or assessment to be discussed with the receiving clinical team.
- All patients being admitted from emergency departments should be discussed with the receiving team to agree an appropriate plan of care.
- All patients with additional care complexity should be flagged and have additional needs discussed with receiving teams (e.g. patients with learning disability needing reasonable adjustments to standard care processes).
- All patients leaving hospital must have a completed e-discharge letter for themselves and their general practitioner and relevant associated professionals, including health visitors, school nurses etc. Where discharges are complex, best practice would include a telephone discussion with the GP.

The following sections cover good practice principles that can be applied to the main components that make up local urgent and emergency care systems in England. The sections build on each other and should not be read in isolation. Exemplary practice in one component will not produce good performance in a system. The system is organic, relying on all its parts working together to produce results.

## 5 Governance and whole system partnership

NHS England's guidance document, the 'Role and establishment of urgent and emergency care networks', advises that the planning and delivery of urgent and emergency care improvements is divided between system resilience groups (SRGs) and UECNs, with networks focussed on programmes that cannot easily be delivered at a more local level by SRGs or clinical commissioning groups (CCGs).

To successfully deliver operational scrutiny and oversee strategic developments across the complex, multi-agency emergency care pathway, the following good practice principles should be applied:

- SRGs must have senior level participation and commitment, including chief officers and executive directors. A local lead officer or chief executive should chair the group. Regular participation from senior clinical staff for all age groups, including secondary care consultants and GP clinical leads is necessary. Senior attendance from mental health providers, adult and children's social care, ambulance services and NHS 111 is essential.
- The SRG should 'get things done' through clearly defined works streams and specialist groups that are formally accountable to it. These need to involve a wide group of senior clinical staff from across the system, with clear reporting lines to the SRG.

- Where there are overlapping work programmes (such as those focused on integrating care or managing chronic disease), relationships need to be clear, transparent and formalised to avoid confusion. Shared information about the remit, membership and content of work programmes is important.
- An important role of UECNs is to maintain an oversight of the whole pathway, especially at the interface between organisations. One way of achieving this is to agree standards at key points along the emergency pathway, including response time standards. These should be monitored (ideally using live information 'dashboards') and reviewed to identify pathway bottlenecks that need whole system attention.
- Strong links must be established and clearly articulated between SRGs, UECNs and local Mental Health Crisis Care Concordat steering groups (See [Crisis Care Concordat](#)).
- UECNs and SRGs need to have an agreed strategic vision of what 'good' services and pathways look like for all patient groups, which is meaningful to stakeholders across the system. The vision should be developed with effective patient, carer and public input, as well as that of health and social care professionals and managers. The 2014/15 resilience guidance contains a schematic example (see p23-24 [Operational Resilience & Capacity Planning 2014/15](#)) while some local systems use a set of patient centred principles. The vision needs to be used by members of the UECN/SRG to engage clinicians to develop improvement objectives and milestones, especially at the interface between organisations.
- It is important that UECNs and SRGs develop clear quality and performance frameworks to enable them to hold their systems to account. Well-designed whole system performance dashboards, that include outcome measures and patient and carer experience data, are useful in highlighting system bottlenecks and priority themes for action.
- Local systems should take responsibility for assessing demand and capacity at key points in the pathway for all patient groups. It is important to avoid scaling capacity to meet average demand - it should be designed to manage demand variation of up to two standard deviations from the mean<sup>4</sup>.
- Demand and capacity planning should take into account demand pressure-points, such as those around bank holidays, school holiday weeks, festivals and as a consequence of temperature extremes (for references on weather effects on health, [Met Office - Health Articles and Research Papers](#))
- The UECN should create an expectation that prediction and prevention are as important as escalating to meet demand surges.

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<sup>4</sup> Planning capacity to meet average demand will mean that on 50% of occasions, capacity will be inadequate and queues will form. Fluctuations in demand must therefore be taken into account. Best practice is to use statistical process control (SPC) run charts to plot demand over time and variation. As a rule of thumb, capacity and processes should be planned to manage between 85% and 95% of normal variation in demand at an appropriate level of granularity (e.g. hourly or daily).



- UECNs and SRGs have an important role in establishing effective partnerships between the health, social, voluntary and community care sectors. The growth in demand for non-elective care and the sizeable funding challenges for local authorities and health services creates scope for conflict and tensions. Collective action and risk sharing are essential if these challenges are to be met without damaging patient care.

## 6 Commissioning

- A commissioning strategy for urgent and emergency care should be developed using a collaborative approach with health and social care partners across the whole system. Involvement from the voluntary and community sector, patients and carers is important.
- The strategy needs clearly to define, 'what good looks like', be evidence based, have clear outcome measures and map demand and the capacity needed to manage it.
- SRGs, working in partnership with CCGs, should be responsible for the strategy development process so that the strategy and commissioning intentions are understood by all partners.
- A plan is needed within the strategy to develop extended, seven-day access to all relevant services in the local health and social care system, and take into account the ten clinical standards for seven day services (See [Seven Days a Week Forum](#)).
- Clear plans are required for how the population with frailty, or additional needs due to disabilities, will be managed in all settings, with the aim of enabling people to remain in their own homes as long as possible and ensuring that admissions to hospital are appropriate and as short as possible.
- The rate and trend in potentially preventable admissions of patients with ambulatory care sensitive conditions (ACSC) is an important part of the strategic analysis (See [Focus on Preventable Admissions](#)). A higher than expected rate should trigger a review of the whole system approach to the management of the specific patient groups and conditions that are outliers. These often include frail older people (with urinary tract infections) and people with learning disabilities (with epilepsy, See [Hospital Admissions that Should Not Happen](#)). It is important that every ACSC admission is alerted to the patient's GP, as such admissions are in principle preventable with good quality primary care.
- The strategy should operationalise the principle of 'parity of esteem', incorporating the requirements of the Mental Health Crisis Care Concordat to ensure that services for people experiencing mental health crisis are at all times as accessible, responsive and high quality as other urgent and emergency services (see section 16).

- Commissioning levers can be used to promote collaboration and mutual support between providers. The benefits of continuity of provision and care should be considered before formal procurement exercises are contemplated.
- A strategy is necessary to maximise support for self-management so that carers, individuals and their families feel better able to manage their physical and mental health (or that of those they care for) and can avoid unplanned admissions. This can be achieved through personalised care and support planning for people with long-term conditions and identifying a range of support services to help people build their knowledge, skills and confidence (e.g. through structured education programmes, information resources, peer support, use of technology and connecting people to their local community).

## 7 Demand management

### 7.1 Reducing acute hospital admissions

- The urgent and emergency care review evidence base suggests that schemes designed to reduce hospital admissions or readmissions need to be carefully selected, properly designed and rigorously evaluated.
- Commissioners and providers need first to focus on the relatively small number of interventions that are well-evidenced to be effective in reducing admissions before investing in less well-proven schemes.
- Where the evidence base is limited or absent, rigorous evaluation needs to be built into demand management schemes. Implementation should be programme managed using effective improvement tools (such as plan, do study, act (PDSA) cycles) and appropriate research methodologies. The project should clearly state what the aim is (e.g. 'the aim is to reduce admissions from primary care by 3% within 6 months'). The project should be evaluated against this aim. Due to the risk of optimism bias, any evaluation needs to be independent of staff and organisations that may have a stake in the 'success' of a project (a guide to evaluation is at [Evaluation: What to Consider](#)).
- Purdy et al (2012: See [Interventions to Reduce Unplanned Hospital Admission](#)) carried out a comprehensive systematic literature review to identify interventions that are effective in reducing unplanned hospital admissions. She found good evidence relating to a relatively small number of interventions:
  - Education with self-management reduces unplanned admissions in adults with asthma and in chronic obstructive pulmonary disease (COPD) patients.
  - Pulmonary rehabilitation is a highly effective intervention in patients who have recently suffered an exacerbation of COPD.
  - Exercise-based cardiac rehabilitation for coronary heart disease is effective. Specialist clinics, with ongoing follow-up for heart failure patients, reduce unplanned admissions (but not in asthma patients or older people).
  - Visiting acutely at-risk populations in the community may result in less unplanned admissions. The current programme of individual care planning for the most frail older people, which was implemented after Purdy's study,

has had promising results reported in some areas. There is a strong case to commission randomised control trials to strengthen the evaluation of this and similar programmes.

- It should be borne in mind that while the evidence base suggests that only a small number of the interventions studied reduce unplanned admissions, there have been few studies of the combined effect of multiple linked projects run collaboratively across a locality. Improvement science suggests that improving and smoothing the whole pathway is much more effective than optimising parts of it. This should be considered when evaluating the evidence base and planning future interventions.
- Many studies have shown that up to a quarter of admissions of frail older people could be avoided if there is an early review by a suitably qualified clinical decision maker supported by responsive intermediate care services (See [Avoidable Acute Hospital Admissions in Older People](#)). Early expert intervention with multiagency support to manage older people may be more promising than other interventions that have been attempted (See [Reducing Hospital Bed Use by Frail Older People](#)).

## 7.2 Supporting people to manage long-term conditions

- Proactively managing long-term conditions should involve creating programmes to help people develop the knowledge, skills and confidence to manage their physical and mental health, access the support they need, make any necessary changes and be better prepared for any deterioration or crisis.
- People who are more ‘active’ in relation to their physical and mental health – who understand their role in the care process and have the knowledge, skills and confidence to take on that role – are more likely to choose preventative and healthy behaviours and have better outcomes and lower costs (for a discussion, [What the Evidence Shows about Patient Activation](#)).
- People with long-term conditions or additional vulnerabilities (such as learning disability) who present acutely may often be doing so as a result of inadequate planning and support (including self-management) in the community or lack of confidence in or access to effective services near to home (see Healthcare for All 2008).
- Health and social care professionals need to work collaboratively with individuals and their carers on personalised care and support planning that identifies the outcomes that are important to the individual, what support is needed to achieve these and the actions they can take themselves to self-manage (for more information see: [Personalised Care for LTC](#)).
- There are a range of different interventions, programmes and networks that can help individuals to better manage their health and well-being including peer support, structured education programmes, tailored and accessible information

resources, health coaching, behavioural change programmes, and linking people to voluntary and community resources.

- Children, young people and their families should have the opportunity to become 'expert patients' with access to services that help them to develop the self-confidence and self-management skills needed to deal with the impact of their condition.
- Integrated, multi-agency approaches to the management of long term conditions should be focused around the needs of children, young people, and their families, to enable a coordinated package of care, including a quality assessment, and access to a key worker approach.

### 7.3 Managing seasonal pressures

- Typically, around 50% of adult emergency admissions to acute hospitals have lengths of stay of two days or less, and 80% stay less than seven days. The admission rate of the <7day cohort has no obvious seasonal variation, and therefore does not directly contribute to 'seasonal pressures'. However, the number of these shorter admissions varies randomly by around 25%, which can trigger in-day bed pressures.
- Around 15% of adult emergency admissions remain in hospital for between seven and twenty-one days and utilise more than 40% of bed days. This cohort is distinctive in displaying a drop in bed occupancy just before Christmas followed by a considerable increase after Christmas. Easter can display a similar pattern.
- Trusts need to have sufficient capacity to manage the random variation inherent in the number of shorter stay admissions. Above average admission numbers require increased efficiency and effort (for example, more frequent board rounds<sup>5</sup>, more early morning discharges). Of equal importance is the need to ensure that length of stay does not creep up when, due to normal variation, admission numbers fall and pressure on beds is reduced. To achieve this it is essential that activities associated with expediting straightforward discharges continue to be prioritised.
- Managing the longer stay cohort, many of whom will have complex discharge needs, needs considerable focus from clinical teams and multiagency collaboration. The post-Christmas rise in length of stay is not generally due to admissions being 'sicker'. It is due to a relative fall in whole system discharge capacity over the holiday period, leading to hospitals becoming crowded. Regaining equilibrium can take much longer than expected because processes have been destabilised. This means that even when the discharge capacity returns to normal, it may not be able to cope with the increased demand for discharge services. There will therefore be a period before the system re-stabilises.

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<sup>5</sup> The terms 'ward round' and 'board round' are used throughout this guide. A board round is a rapid, 'desk top' review of the progress of each patient on a ward that does not generally involve seeing patients in person. A ward round involves a clinical team meeting their patients face to face, and typically is a longer and more detailed process than a board round.

- Loss of discharge capacity can rapidly destabilise a hospital and create a downward spiral from which it is difficult to recover. This typically happens after Christmas and Easter, although funding issues may chronically reduce discharge capacity and with it a hospital's resilience.
- It is essential that the need to maintain a relentless focus on straightforward as well as complex discharges, and to maintain whole system discharge capacity, is seen as a priority.

## 7.4 Balancing elective and emergency care

- Best practice is to segregate elective surgery from emergency care entirely through the use of dedicated beds, theatres and staff. This greatly reduces cancellations and improves outcomes and flow.
- It is essential to avoid both surgical and medical outliers due to the associated risks, poor outcomes and increased length of stay.
- Surgeon of the day (or of many days) models, with a surgical team entirely dedicated to managing emergency admissions, is essential (see section 24).
- Day surgery and ambulatory emergency (surgical) care should be maximised to reduce pressure on beds.
- Surgical admissions should be carefully planned based on expected length of stay of individual cases. This is best done centrally through a bed bureau and not left to the discretion of individual surgeons.
- Surgical staffing and theatre capacity should be planned to meet variation in seasonal demand. This is important to manage all cases within the national 18 weeks standard.
- Any backlog of patients who have breached 18 weeks needs to be addressed before the winter, as accelerating elective surgery at a time of high winter demand may be impractical.

## 8 Escalation plans

Year round capacity planning and escalation plans are essential for all health care organisations. The following guidance should be considered in order to achieve this:

- Local integrated health and social care escalation plans need to clearly define trigger levels for escalation across all organisations.
- Linkages between the escalation plans of partners across the local health community are important, so that mutual support is achieved at times of stress.

- The practical and concrete actions that will be taken by individual organisations in the event of escalation being triggered should be clearly described. This must go beyond a communications cascade.
- As most escalations are due to high hospital occupancy levels, escalation plans need to focus on processes to review and rapidly discharge patients who are medically fit but held up in hospital. This should involve the whole local health community working collaboratively, not just acute hospitals.
- Opening additional beds at short notice is a high risk tactic that may worsen, rather than alleviate, pressures by straining staffing resources, increasing length of stay and providing sub-optimal care. Before opening beds at short notice, a trust's executive team should satisfy itself that:
  - Every patient, in every bed, has been reviewed by his/her consultant that day.
  - There has been a rapid review of every patient who has been assessed to no longer require acute inpatient care by a team of clinicians and practitioners from the hospital, general practice, community health and social care services, the voluntary sector and commissioners. The aim must be to discharge safely as many patients as possible.
  - There is a clear de-escalation plan to close the beds as soon as possible.
  - Escalation wards will have dedicated consultant, nursing and therapy staffing, with twice daily consultant ward rounds. The nurse in charge should be senior, experienced and seconded to the ward until it is closed.
  - Escalation wards will not be used to accommodate frail older people moved from other wards to become 'outliers'.
  - The hospital's 'full capacity protocol'<sup>6</sup> has been invoked.
- Timely de-escalation protocols are important.
- There should be sufficient clinical leadership and involvement from primary and secondary care to resolve local issues in relation to escalation.
- It is important systematically to review the effectiveness of system and organisational policies following periods of escalation. The information from this review should be used to inform capacity and demand planning.
- An assessment of how escalation processes are operating should be a standing item on the agenda of both the system resilience group and urgent and emergency care network.
- Any decision to reduce or close a service (including residential and nursing home beds) should be discussed with the executive leads of all areas and organisations that will be affected, and a plan should be made to support the impact of additional activity on other services.

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<sup>6</sup> A 'full capacity protocol' enables patients to be 'boarded' on inpatient wards before a bed has formally been vacated. [Crowding in Emergency Departments](#).

- If a system is very frequently in a state of heightened escalation, it is likely that it is in fact operating within normal process variation. Using extraordinary tactics to manage normal variation is inappropriate. A fundamental review of demand and capacity combined with systematic process changes will be necessary.

## 9 Primary care

### 9.1 General practice

Urgent care in general practice matters. Primary care clinicians have many more interactions with patients than any other part of the NHS. Early diagnosis and treatment in primary care reduces harm and distress for patients. Effective and timely responses can avoid unwell adults and children being driven to use emergency departments. Achieving this is difficult, even in practices that are performing well, due to rising demand and skill shortages. Nevertheless, many practices are managing to deliver high quality urgent care by adopting a small number of good-practice principles:

- Focus particularly on responding to the small number of requests for an urgent home visit. Typically this involves a rapid assessment by a clinician, usually by phone so that, if needed, the home visit can be prioritised. This early response provides greater opportunity to plan an alternative to a hospital admission whilst other community services are able to respond and, if admission is needed, avoids delay with the associated risk of deterioration.
- Define a practice standard for the time from first call/contact to initial assessment, and from first call/contact to clinical intervention or referral for any cases identified as urgent – then audit and monitor performance against this standard.
- Offer a range of options for patients to access same-day care. These may include telephone consultations, e-consultations and walk-in clinics, as well as face-to-face appointments. Channelling patients into a single, rigid process inevitably disadvantages some, can lead to ‘gaming’ of the system and may lead to inappropriate use of emergency departments. The overall aim should be that no patient should have to attend A&E as a walk-in because they have been unable to get an urgent appointment with a GP.
- Provide early morning appointments for children who have deteriorated during the night to avoid parents attending A&E because of anxieties and doubt that they will get an appointment.
- Look at the practice’s operational model to ensure that continuity of care, particularly for the elderly and those with long term conditions or additional vulnerabilities, is provided so far as is practical and that the processes (for example of using the duty doctor to assess and see those looking for an urgent appointment) don’t make this more difficult.
- Establish mechanisms to ensure that the practice takes part in the discharge planning of frail and vulnerable patients. The discharge of clinically vulnerable patients should be reframed as the transfer of care to the general practice-led

community health and social care team so that this team can become more active in the reception and re-settlement of their patients back in the community.

- Practices can play an important role in supporting patients with long-term physical and mental health conditions with personalised care and support planning. They can also help patients to self-manage their condition(s) to reduce the risk of crises.
- Ensure that the practice team has the right skills and competencies in place to deal with paediatrics and develop a training plan in conjunction with local specialist paediatric services where there are skills gaps.

SRGs and CCGs should coordinate local health and social care services to support general practices in the management of patients with urgent care needs:

- GPs and adult and paediatric on-take consultants should consider dedicated telephone numbers to enable rapid discussions to ensure patients enter appropriate clinical pathways.
- Intermediate and social care services should support general practice to manage patients without defaulting to acute hospital admission.
- Ambulance services should have immediate telephone access to general practice to enable discussion of appropriate patient dispositions.
- Practices should use agreed protocols with ambulance services for requesting ambulance transport, which include expected timeframes for responses. This can help optimise the use of ambulance resources.

These types of changes in the environment within which general practice works can be transformative – but practices need to work with others to shape the support that they need.

## **9.2 Out-of-hours primary care**

- Primary care out-of-hours (OOH) services need to have arrangements in place with NHS 111 to enable call-handlers to directly book appointments where appropriate.
- Commissioners and providers should minimise the number of ‘hand-offs’ between different people to avoid unnecessary re-work. Where possible, warm transfers should take place between staff within the integrated NHS 111 service, with early identification of the best person to meet the patient’s needs (e.g. dental nurse, pharmacist, senior clinician).
- Processes need to be in place to minimise delays between NHS 111 receiving a call and a patient being assessed over the telephone by an out of hour’s clinician. It is good practice for commissioners and providers to investigate cases that took longer than an agreed period, from the start of the initial call to the end



of the final call, that results either in reassurance and advice, or in a face-to-face consultation. The aim of the investigation should be to improve processes.

- Providers and commissioners should monitor the percentage of patients referred (or self-referred after an initial call to the service) to hospital, A&E and the ambulance service. This should be measured across both NHS 111 and the primary care out of hours service and be part of an SRG's standard data dashboard.
- Primary care out-of-hours services, NHS 111 and commissioners need to agree how best to implement primary care dispositions indicated by clinical assessment systems (such as NHS Pathways). Such agreements should always put the best interests of patients first, which may require a degree of pragmatism.
- The co-location of primary care out of hours services with emergency departments provides opportunities for collaboration, routine two-way transfer of appropriate patients and can help decongest emergency departments (See [Primary Care Foundation - Reports and Articles](#) for further guidance on primary care supporting emergency departments).
- Co-located services should actively encourage transferred patients to use the service best suited to meet their needs rather than defaulting to attend emergency departments.

### 9.3 Residential care homes

The needs of care home residents require co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care professionals and care home staff. This can reduce unnecessary admissions that are often linked to prolonged hospital stays. Partnerships are essential, built on shared goals, reliable communication and trust. Partners should agree to share joint responsibility for resident's outcomes. The following guidance should be considered for local implementation:

- It is important that patients being considered for admission from care homes are discussed with a senior clinical decision maker in the hospital and with the patient's GP, so that an optimal plan for the individual patient is agreed and understood, taking into account the wishes of the patient and their family.
- Residents should receive comprehensive, multiagency assessment on admission and should agree, with appropriate involvement of relatives/carers, a person-centred care plan that is reviewed at least once every six months.
- The majority of residents of care homes are older people with dementia (although some will be younger with learning disabilities). Acute mental health assessment should be considered where mental and/or physical health problems are expressed with challenging behaviours. Assessments should be multi-disciplinary. Particular care should be taken if antipsychotics are prescribed to people with dementia ([Antipsychotic Drugs](#)).

- Care needs to be planned to include regular medicines reviews and falls risk assessments. A ceiling of care should be established with respect to future health crises and added to the care plan.
- Advance care planning for end of life care should be offered to all residents. This should be based on established good practice, such as the gold standards framework (See [The Gold Standards Framework](#)), and be accompanied by education and training for staff and access to specialist palliative care when required.
- 'Do not attempt active resuscitation' orders (DNAR) are clinical decisions that should be based on a patient's clinical condition and likelihood to benefit. However, a DNAR decision must not be taken to mean that other treatments and interventions should be withheld ([Dilemma: DNAR Orders](#)).
- Where safe and efficient to do so, it is good practice to bring care to the resident in the care home, including GP and specialist reviews and clinical interventions (e.g. intravenous antibiotics and subcutaneous fluids).
- Care home staff at all hours must be aware of each resident's advance care plan and the agreed response to unexpected events.
- All care homes need a falls strategy to avoid inappropriate referrals to the ambulance service and hospital. Staff training to assess risk and manage residents who have fallen is important. They should be supported by community health services, local pharmacies and ambulance professionals trained to manage fallers without defaulting to conveyance to hospital.
- Care home staff should be supported by NHS and social care professionals through training and education, 24/7 access to advice, rapid response teams and encouragement to use clinical tools, protocols and service improvements.
- All local health communities need up to date strategies and commissioned services for the care and management of people in care homes that is based on good practice guidance, such as that from the British Geriatrics Society (See [BGS Commissioning Guidance](#)).

## 9.4 Community pharmacy

Community pharmacies can make valuable contributions to local health communities' urgent care programmes. They can enhance patient safety and reduce pressure on other parts of the local health community, particularly general practice, thus creating headroom for the management of patients with more serious problems. NHS England has published a toolkit to support this (See [Community Pharmacy - Helping Provide Better Quality](#) ).

- Community pharmacies can reduce pressure on general practice and enhance patient safety where they are proactively involved in:
  - medicines reviews

- repeat prescription management
  - supporting hospital discharge ([Hospital Referral to Community Pharmacy](#))
  - medicines reviews of patients in care homes
  - multi-disciplinary community health service reviews of patient with long term conditions
  - supporting patients to optimise medicines use
  - supporting self-care for minor ailments and long term conditions
  - providing urgent access to medicines
  - providing flu vaccination to at risk groups
- NHS 111, general practice receptions and urgent care centres should have protocols to direct patients to community pharmacies where these can appropriately respond to a patient's care needs, including to services locally commissioned from pharmacy by NHS England, CCGs and Local Authorities.
  - The local Directory of Services should reflect services available from community pharmacy and pharmacy opening hours. NHS England has published, '*Urgent Repeat Medication Requests Guide for NHS 111 Services: how to refer directly to pharmacy and optimise use of GP out of hours services*'. (See [Integrated Urgent Care Commissioning Standards](#) ).
  - When providing clinical services, such as minor ailments services and provision of urgent repeat medication, it is helpful if community pharmacies have access to patient care information. The Health and Social Care Information Centre (HSCIC) has been commissioned to support all community pharmacies in England to implement access to the Summary Care Record (See [Summary Care Record Rolled Out to Community Pharmacists](#) ).

Community pharmacy has an important role in promoting health and wellbeing and prevention of disease (e.g. flu vaccination to over 18s in at-risk groups has been commissioned nationally. (See [National Flu Immunisation Programme 2015/2016](#)).

## 10 Community services

### 10.1 Community nursing, rapid response, early supported discharge

It is good practice for commissioners and providers of community health services to work together to turn what is currently urgent care into planned care by developing:

- Support for self-management, including helping to build peer networks and disease or disability support groups.
- Facilitated connection to voluntary support for mental, physical and personal needs and to address social isolation.
- Support for individual carers before they get to crisis point.
- More timely diagnosis of dementia and debilitating impacts of ageing.

- Prevention of falls and other mobility deteriorations.
- Personalised care and support planning, including advance care planning for end of life that can be done by older people themselves or with help from friends and family, advocates, spiritual leaders, solicitors or health and social care professionals. This needs to go beyond the highest risk people who are typically picked up using risk stratification tools. Schemes aimed at earlier intervention to prevent health crises in people lower down the risk stratification pyramid are particularly important.
- Support for nursing and residential homes to prevent admission.
- Education and support to children, young people and their families in community settings to create a 'virtual ward in the community' (for example, in injury management or illness prevention and management).
- Support to key professionals such as health visitors and school nurses in preventing admissions and responding rapidly to the needs of children and young people.
- Crisis care planning to enable direct access to specialist hospital wards for people with specific conditions and symptoms.

To achieve these objectives, it is necessary to:

- Build community capacity to ensure a timely response. Teams need to be able to respond rapidly, seven days a week and into the late evenings, and engage wider personalised community support. Access to equipment and short term care packages is essential.
- Develop person-centred, rather than task-based, care delivery.
- Promote collaboration and integration between nurses in general practice, community based services and voluntary support.
- Develop metrics that measure outcomes as well as activity and processes.
- Simplify processes so that hospitals, general practice, ambulance services and social care can make referrals with a single phone call.

Best practice is for community services to be organised to support 'discharge to assess':

- Wherever possible, frail older people should be transferred from hospital back to their normal place of residence as soon as the treatment of their acute problem is complete.

- Multidisciplinary functional assessments generally should be carried out in a patient's normal place of residence, rather than in a hospital, before decisions are made about higher levels of care (e.g. transfer to a nursing or residential home).
- Integrated health and social care teams should respond rapidly, so that assessment and basic care can be put in place within two hours of a person arriving home.

## 10.2 Community hospitals

Where commissioned, good practice is for community hospitals to provide:

- Step-up care: to prevent inappropriate admission to acute care by taking referrals from the community or care home settings.
- Step-down care: to facilitate a stepped pathway out of hospital by taking referrals from acute hospitals and to facilitate the return of patients to their normal place of residence ('home').

Investment in community hospitals should not be at the expense of domiciliary community health and social care services, which should be the preferred pattern of service provision. An appropriate balance should be struck, with beds being provided for the minority of cases that cannot be reabled in their normal place of residence.

Community hospital beds should be managed in accordance with the good practice principles that apply to acute hospitals:

- All patients need an expected date of discharge (EDD), which should be set by a senior clinician, within 14 hours of admission to a ward. Functional and physiological criteria for discharge should also be established so treatment goals are clear. The EDD should be tailored to the patient's condition and treatment goals and not based on an arbitrary length of stay.
- It is good practice for every day to start with a multidisciplinary board round. Those present need to include a senior clinician (which can be a GP, a senior nurse practitioner or a senior therapist), the nurse in charge, and other representatives from the allied healthcare professional team. This meeting should be short and focussed on checking each patient's progress against their goals, removing any barriers to discharge and managing internal waits.
- As the vast majority of community hospital patients will be frail older people, it is essential that the team understand, apply and deliver comprehensive geriatric assessment.
- Daily senior review, by a competent clinician who may be a doctor, senior therapist, advanced nurse practitioner or consultant, should be normal practice 7 days a week.
- At least one ward round a week should normally include a hospital consultant with expertise in managing frail older people.

- Patients should be accepted for admission based on their ability to benefit from the care provided. There should not be arbitrary exclusion criteria.
- Discharges by midday should be the norm to allow new patients to be admitted early enough in the day for safer and more effective care.
- Care providers, including relatives, must be involved in and made aware of discharge plans. Any required ambulance transport should be confirmed as soon as the timing for discharge is known.
- Processes should be in place to ensure discharges can happen at the weekend if patients have achieved their treatment goals. Ensuring that treatment goal criteria are documented in a way accessible to nursing and therapy teams will support this.

## 11 Urgent care centres (Walk-In & Minor Injuries Units)

- Urgent care centres (UCC) that are co-located with emergency departments provide an opportunity to stream patients with less serious illnesses and injuries to a service that is resourced to meet their needs, while reducing crowding in emergency departments. To preserve flow, UCC staff and cubicles must wherever possible be entirely separated from the majors/admission stream.
- UCCs must aim to manage most of their patients within two hours of presentation. Triage is generally inappropriate in UCCs – best practice is to use a ‘see and treat’ approach, with protocols to ensure that those waiting for treatment are fast tracked where necessary.
- Adults and children should generally be assessed and treated at the first point of NHS contact capable of meeting their immediate needs. Redirection may lead to assessments being duplicated, patients inconvenienced and necessary care delayed.
- Where UCCs are co-located with emergency departments, it is essential that there is appropriate integration, with shared governance arrangements and clearly defined protocols for the two-way transfer of patients. Commissioners must ensure that this requirement is embedded in contracts and effectively delivered where separate providers deliver care within an emergency centre.
- UCCs that are remote from emergency departments should be part of wider clinical network, with clear transfer arrangements and shared clinical governance.
- Procedures must be in place to ensure safeguarding of children and adults occurs to guard against the possibility of repeated presentations with injury.
- Commissioners need to ensure that the aim of UCCs is clear to avoid costly service duplication. Co-located UCCs may have a useful role in managing people with minor illnesses to avoid emergency department crowding. However, it may

be more appropriate for other UCCs to focus on treating less serious *injuries* that would otherwise gravitate to an emergency department, rather than on illnesses that are best managed by in and out-of-hours general practice and community pharmacies.

- Recent good practice guidance on primary care in emergency departments has been produced by ECIST, the Primary Care Foundation and the Royal College of Emergency Medicine (See [Primary Care in Emergency Departments](#)).

## 12 NHS 111

- Commissioners should refer to the NHS 111 Commissioning Standards document for a detailed description of the NHS 111 integrated service (a revised version is due to be issued September 2015).
- Commissioners, SRGs and UECNs should develop a functionally integrated service, incorporating NHS 111 and primary care out-of-hours services, and collaboration with ambulance services. There need to be close links with in-hours primary care and other health and social care partners. The aim is to provide patients with an enhanced urgent care treatment and advice service with a single point of access for all health and social care urgent calls.
- It is important that the local directory of services (DOS) is complete, accurate and continuously updated so that a wide range of agreed dispositions can be made following initial assessment. The DOS must include information regarding services available to support individuals at high risk of, or experiencing, mental health crisis.
- It is essential that a stable and properly resourced and skilled team is in place to ensure that the DOS is maintained and developed.
- NHS 111 must use an evidence based clinical assessment tool to help determine the clinical priority of callers. It must be connected to the DOS to define the service that best meets their needs.
- Call centres should have on-site clinical support so that call handlers have immediate access to professional advice (see also section 9.2, out-of-hours primary care).
- Call handlers require training to meet the needs of those with sensory impairments and disabilities (e.g. deafness, dementia, learning disability).
- Systems should be in place to enable the direct booking of appointments and the electronic sharing of patient information between service providers.
- Calls categorised as 'green calls' to the 999 ambulance service and NHS 111 should, where appropriate, undergo further telephone clinical assessment before an ambulance disposition is made.

- A common clinical advice hub across NHS 111, ambulance services and out-of-hours GPs should be considered to support clinical review and help patients with self-care advice to avoid onward referral.
- NHS 111 should have the ability to auto-dispatch ambulances where a 999 response is required.
- The integrated NHS 111 service should have access to all special patient notes (SPNs) and advanced care plans (ACPs). It is important that these influence how relevant calls are dealt with. Details of the plans should be shared appropriately with receiving organisations in the patient's best interests. SPNs should be regularly updated by the responsible general practitioner.
- The staffing capacity and capability of NHS 111 services must take into account variation in call volumes by hour of day and day of week so that calls can be responded to in a timely manner without queues developing. This applies to call-handlers, supervisors and clinicians. It is also important to ensure that all patient problems can be effectively addressed, including mental health, dental and medication needs.
- If queues of calls form, the NHS 111 service must take appropriate steps to minimise the risk to patients through messaging and clinical oversight of the nature of the caller's condition, escalating calls for immediate intervention where necessary.
- Processes should be established to ensure that the integrated NHS 111 service contributes to the co-ordination of the care of frail and vulnerable patients, developing links with social care and voluntary agencies to support ongoing care.
- Services should provide detailed management information and intelligence to local health systems regarding the demand for and use of emergency and non-emergency healthcare services to enable evidence based planning.
- Continuous improvement needs to be at the heart of integrated NHS 111 services, with providers working in partnership with commissioners and clinical leads to review calls, investigate incidents and look for opportunities to make the services better for patients.

## 13 Emergency ambulance services

Ambulance services play a central role in the provision of urgent and emergency care. Ambulance services and their commissioners should work together to develop a mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital. The following, good practice principles, should be used to inform service development plans:

- Ambulance services should consider maintaining 'clinical hubs' in their control rooms to ensure the appropriateness and timeliness of responses provided to patients. Hubs should be staffed by a range of clinicians, which may include



pharmacists, midwives, palliative care nurses and specialist or advanced trained paramedics and offer 'hear & treat' care to patients, as well as clinical support to paramedics on scene.

- As in other health contexts, care delivered by senior clinical decision makers (such as specialist or advanced paramedics / nurses) produces better clinical outcomes and can reduce demand for an emergency ambulance transport for non-critical 999 calls through 'see & treat', referral to community services or other pathways.
- SRGs should ensure that 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.
- Local health communities, through their SRGs and wider networks, should work collaboratively with ambulance services to develop and evaluate alternatives to conveyance to hospital, including:
  - Pathways to take patients directly to urgent care and walk-in centres in accordance with agreed and clearly documented standardised clinical criteria.
  - Referral direct from competent ambulance professionals to hospital specialties, including direct conveyance to assessment and ambulatory emergency care units, and out-patient appointments (same or next day).
  - Working with community mental health teams to provide triage and/or crisis care at home or in the community, and when necessary, conveyance to a designated health or community-based place of safety rather than to an emergency department or police station.
  - Falls partnership vehicles with advanced, multidisciplinary practitioners, or direct access to falls services.
  - The use of ambulances in alcohol 'hot spots' to provide a field vehicle to treat minor injuries at the scene or care for intoxicated people until they can safely make their own way home.
  - Increasing the scope of practice for more paramedics to provide 'see and treat' and 'hear and treat' care.
  - Paramedic practitioners undertaking acute home visits on behalf of GPs to avoid unnecessary admission and admission surges.
  - 'Call back' schemes for ambulance crews both in-hours and out-of-hours to GPs.
  - Joint planning with GPs and acute trusts for the management of high-volume service users/frequent callers.
  - Direct referral to intermediate care/community rapid response nursing services and direct conveyance to hospices.
- For patients who do need to be taken to hospital, ambulance services can help minimise handover delays by:
  - Reviewing patients' conditions and needs en-route and sending details ahead to the receiving emergency department in the case of any special requirements/circumstances.

- Avoiding the use of ambulance trolleys for patients who are able to walk into the department.
  - Using alternative vehicles to convey patients to the emergency department (e.g. patient transport service vehicles to transport patients, thus keeping paramedic staffed ambulances available.
  - Implementing electronic patient handovers.
  - Sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand rises.
- The local healthcare system should work with ambulance services to enable them to have access in real time to patient care plans to develop a whole systems' approach to patient management and flow.
  - Handover delays should be systematically and jointly reviewed by ambulance operations managers, hospital managers and clinicians. Shared actions can then be developed and agreed to maximise local availability of ambulances to respond to emergency calls.
  - Local health communities must actively cooperate to ensure that ambulance queuing and handover delays are minimised. Where patients experience long waits, their national early warning score (NEWS or, for children, an agreed paediatric equivalent) should be recorded, pain assessed and managed and essential care given. Written guidelines must be agreed between the ambulance service and receiving hospital clarifying specific responsibilities for the care of waiting patients.

## 14 Emergency departments

The following principles of good practice should be considered to improve safety and flow, and to help reduce unwarranted variation and manage demand:

- Emergency departments (EDs) should be resourced to practice an advanced model of care where the focus is on safe and effective assessment, treatment and onward care. While it is essential to manage demand on EDs, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.
- ED crowding adversely affects every measure of quality and safety for patients of all ages, and for staff, and creates a 'negative spiral of inefficiency'. The main causes of ED crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates. These can result in the physical and functional capacity of the ED (especially staffing and numbers of cubicles) and internal processes and responsiveness of other services being exceeded. Performance against the 4-hour standard is a useful proxy measure of crowding.
- The staffing of emergency departments should be planned so that capacity meets variation in demand, rather than average demand, and the variation in demand patterns between different patient groups including children, frail older people and people with mental health problems.
- The majority of emergency departments have 24/7 liaison mental health services to ensure that people of all ages presenting with acute mental health needs receive timely assessment by a skilled mental health professional. All ED staff should receive specific training in working with people with mental health needs.
- Effective clinical staffing models, based on different professional groups, led by senior emergency physicians, are required. If GP referrals are routed via ED, there should be the appropriate workforce to receive the demand. Such staffing models should aim to deliver a capable, sustainable and resilient workforce. The ED nursing and ancillary workforce should be configured to deliver care, and maximise efficiency, using currently accepted best practice.
- The ED shop floor should be well-led with real time 'command and control' achieved through a senior medical, nursing, and administrative team. A good leadership model involves regular board rounds, walk-throughs and active progress chasing.
- There should be a joint plan with the ambulance service to manage ambulance handover safely, with dedicated ED staff to take ambulance handovers and care for waiting patients. Suitable chairs should be available so that where appropriate, patients are not obliged to wait on ambulance trolleys.
- Triage, where used, should be a brief and value adding process aiming to prioritise care, provide first aid and analgesia, and initiate key investigations and

treatments. However, triage may act as a bottleneck at times of high arrival rates and there should be triggers to manage this problem, which may require a senior overview of all patients waiting.

- Co-located urgent/primary care models should be considered. Where there is a co-located urgent care model there should be shared governance and a single front door. (See [Primary Care and Emergency Departments](#) and see Section 11).
- The co-location of GP out-of-hours services with emergency departments provides opportunities for collaboration and the two-way transfer of appropriate patients.
- 'See and treat' for 'minors' is an alternative to processes involving triage. It can free up nurses, thereby increasing the number of staff treating patients and reducing queues. Departments using see and treat take steps to fast track patients with red flag conditions and often use a 'navigator' role to supervise waiting patients.
- Rapid assessment systems can improve safety and efficiency for certain patient groups and reduce length of stay in the ED. They do not significantly improve crowding that is caused by exit block. Rapid assessment systems generally require dedicated space, equipment and staff and wherever possible should be consultant led.
- Separating patients into streams (e.g. 'majors', 'minors', 'resuscitation', children's 'majors' and 'minors') based around similar processes promotes higher quality care and is beneficial. Streams and workforce should be configured, where possible, to work independently so that demand in one area does not impact upon function in another.
- Secure, audio-visually separate facilities and care should be provided for children in accordance with the recommendations of Royal College of Paediatrics and Child Health (See [Standards for Children & Young People in Emergency Care Settings](#)).
- Emergency medicine doctors should focus on those patients who require resuscitation, have undifferentiated conditions and musculoskeletal injuries. There should be clear clinical pathways for the prompt transfer of care from ED to in-patient specialist teams, especially for high volume pathways including acute (internal) medicine, frailty and paediatrics.
- Fast-track processes to bypass the main emergency department patient streams are important for some patient sub-groups with clearly differentiated conditions, such as hip fracture, bleeding in early pregnancy, stroke and STEMI.
- Close attention to reducing waste within the ED can improve effectiveness. Standardising clinical processes and pathways can improve overall quality.

- Using internal professional standards to agree expectations of and between the emergency department and supporting services can greatly improve cooperation between departments and overall effectiveness.
  - ED standards should include all the A&E national care quality indicators, not just the 4-hour standard.
  - Response standards should be agreed with inpatient teams and wards, radiology, and pathology, and should be monitored. Examples include time from referral to being seen, time from decision to admit to reaching the destination ward and time from request to report/result.
  - Within this framework, escalation procedures should be established with clear triggers and meaningful actions, to deal with both surges in demand and crowding.
- Clinical Decision Units are highly effective environments supporting the delivery of modern emergency care. Together with ambulatory care, frailty units, other short stay units (such as paediatric assessment units), and early access to appropriate outpatient clinics, they help reduce overnight admissions and maximise shorter episodes of care. Where there is a CDU, standards for clinical review should be agreed. These units should not be used for time-standard breach avoidance or for patients waiting for a decision to admit.

## 15 Ambulatory emergency care (AEC)

- Each acute site should consider establishing an AEC facility that is resourced to offer emergency care to patients in a non-bedded setting. Models may vary between hospitals, including emergency department (ED) based models and physician-led models outside of the ED.
- The aim of AEC is to manage as many patients as possible who, in the absence of an ambulatory care facility, would need to be admitted to an inpatient ward. Hospitals introducing AEC for the first time should expect to convert 25% of their adult acute medical admissions to ambulatory care episodes.
- The aim should be to consider all patients for AEC management as a first line unless they are clinically unstable. Patients should be streamed to AEC based on fulfilling four simple rules:
  - The patient is sufficiently clinically stable to be managed in AEC.
  - The patient's privacy and dignity will be maintained in the AEC facility.
  - The patient's clinical needs can be met in the AEC facility.
  - The patient requires emergency intervention.
- The AEC facility should have immediate access to a senior doctor who is responsible for agreeing the case management plan for each patient.
- The time frames for initial assessment and medical review in the AEC facility should be similar to those in the main emergency department.
- Patients in the AEC facility should have access to diagnostics within the same timeframe as all other emergency patients.

- The percentage of patients who are transferred from the AEC facility to inpatient wards should be monitored. A low rate may suggest risk aversion, while a high rate may indicate problems with patient selection (around 90% of referrals should be managed without admission to an inpatient ward).
- While this care process is called ‘ambulatory’ care, it is important not to exclude non-ambulant, frail, older people who might benefit, simply because they are unable to walk.

## 16 Mental health

### 16.1 The Mental Health Crisis Care Concordat

- Services for people with urgent or emergency mental health needs should be commissioned and delivered in line with the principles of the [Mental Health Crisis Care Concordat](#).
- An effective local crisis care pathway should be developed, with the following key components:
  1. Good governance, through setting measurable standards of care and outcomes (See [London Mental Health Crisis Commissioning Standards & Recommendations](#)).
  2. Empowerment of people and their families, through the provision of accessible information (See [A Guide to Mental Health Services in England](#)).
  3. Prevention, through identifying and addressing the causes of crisis in local joint strategic needs assessment. (See [Annual Public Health Report 2014](#)).
  4. Improved and timely access to the right care through effective out of hours-of-hospital care (See [Acute Care Locality Service](#) and [Oldham Mental Health Phone Triage](#) and [Easier Access & Better Care](#)).
  5. Seven day a week, 24-hour liaison mental health services in acute hospital settings (for example see [Briefing - With Money in Mind](#)):

### 16.2 Accessing care

- Commissioners, working with mental health providers, should ensure that care pathways are clearly defined in their directory of services for use by NHS 111, GPs, the ambulance service, police and social services to avoid the inappropriate conveyance to emergency departments of adults, children and young people.
- Mental health providers should work in multidisciplinary teams with GPs to risk-stratify patients and identify frequent attenders. These patients can then be case-managed proactively, with support to carers, and offered personalised care planning and support for self-management to help identify how to avoid the need for crisis care.

- Adequate local places of safety should be commissioned so that people of all ages detailed under S136 of the Mental Health Act can be assessed and cared for in an appropriate environment.
- Community mental health services should work collaboratively with police and ambulance services, particularly exploring multidisciplinary street triage models, to provide a joint response that reduces conveyance and admission rates and avoids emergency departments being the default entry point into the system.

### 16.3 Liaison mental health services

- 24/7 liaison mental health services for people of all ages should be commissioned in line with recognised quality standards (see: [Developing Models for Liaison Psychiatry](#)) and be available at all times within one hour of referral by an emergency department to navigate patients swiftly to appropriate physical or mental health services. Liaison mental health services providing senior decision makers at the front of the pathway can reduce repeat attendances, reduce admissions and inpatient length of stay and ensure that the patients get the right National Institute for Health and Care Excellence (NICE)-approved treatment (e.g. for self-harm). Response standards should also be agreed for liaison mental health service assessments on the wards.
- Alcohol intoxication should not automatically be used as an exclusion criterion to delay initial assessment by either ED staff or mental health teams (while noting that any assessment under the Mental Health Act of an intoxicated person has the risk of leading to poorly informed decisions and legal challenge and so must be carefully considered) .
- Where a patient is at high risk and needs to be assessed under the Mental Health Act but does not have an immediate physical health need requiring physical health treatment or admission, a standard for that assessment should be set by commissioners for a response within the 4 hour A&E standard.
- The Mental Health Act requires patients to be assessed by an approved mental health professional (AMHP) and by two S12 assessing medical practitioners, one of whom has previous knowledge of the patient, usually the patient's GP. It is important that the pool of S12 responders is large enough to ensure timely assessment under the Mental Health Act. Local Authorities also need to ensure that they commission sufficient AMHPs to meet local demand.
- Children and young people with mental health needs are especially vulnerable. Commissioners should ensure that emergency department and paediatric emergency department staff have rapid access to paediatric mental health liaison via both telephone consultation and an on-site response from a dedicated pool of children and adult mental health (CAMH) professionals, 24-hours a day, seven days a week.
- In their work to integrate mental health in the local UEC pathway, SRGs should ensure that:

- Senior responsible officers from the whole of the health and social care economy lead the process of improvement, keeping the person at the centre of the service.
- An all-ages approach is taken.
- Training in mental health awareness, brief interventions and signposting becomes a mandatory part of the training of all UEC professionals.
- Mental health NICE guidelines and quality standards are adhered to – e.g. self-harm (See [Self-Harm in Over 8s](#)).

## 17 Paediatrics

Much of the good practice highlighted in this paper for adult services is relevant for paediatric care. However, paediatric standards are generally more demanding as paediatrics is a very short stay specialty service and is increasingly provided on a network (See [Facing the Future](#)). The following good practice principles should be considered by commissioners and providers of children's health services:

- Children and their parents/carers need to be confident that the minimum national standards have been built into agreed care pathways. These are summarised in the Intercollegiate Emergency Care Standards (See [Standards for CYP in Emergency Care Settings](#)).
- All staff should follow the recommendations outlined within the guidance document, *Safeguarding Children and Young People: roles and competences for health care staff* (See [Safeguarding CYP - Roles and Competencies](#)).
- There should be a focus on ensuring that effective primary and community services can be accessed. GP paediatric access must be good, particularly after school hours and into the evening.
- There should be a commissioned, 24-hour children's place of safety service away from the emergency department (ED).
- In hospitals, there should be either a separate paediatric ED or a separate children's stream that includes a specific reception and waiting area, assessment and treatment area and clinical decision unit that meets national standards.
- Dedicated paediatric staffing is important, including paediatric nurses 24/7, a sub-speciality qualified ED consultant or a lead consultant, ENPs or paediatric practitioners. There should also be staff rotations between paediatric and adult EDs and inpatient units.
- Short stay paediatric assessment units should be considered to provide an alternative to both the ED and to admission (See [Short Stay Paediatric Assessment Units](#)).
- Triage systems should be paediatric specific and operated by practitioners with training in paediatrics. This will allow streaming of children and young people to



be seen by the most appropriate health care professional (e.g. GP, paediatric emergency nurse practitioner, ED clinician).

- EDs need 24/7 access to paediatric mental health liaison (PMHL) through telephone consultation and an on-site response from a dedicated pool of CAMH professionals skilled in dealing with psychiatric emergencies and managing the risk of young people who self-harm or attempted suicide.
- A separate primary care stream should be developed if there are substantial numbers of attendances that might appropriately be managed by primary care clinicians.
- Initial assessments should incorporate appropriate treatments such as antipyretics and pain relief.
- Provision should be made for high volume surges to reduce the risk of children waiting more than 15 minutes for assessment. This should include a senior decision maker undertaking rapid overviews of any children waiting.
- A dedicated consultant or middle grade should be present throughout the opening hours of the paediatric service.
- Commissioners should develop, agree and monitor response standards with all relevant providers, to ensure timely access to appropriate community paediatric services.

## **18 Acute medical assessment**

The following good practice principles should be considered to improve safety and patient flow:

### **18.1 Streaming of patients referred to medical specialties**

- All patients referred for emergency assessment should be discussed with a senior clinician who is immediately available to receive the call.
- The senior clinician receiving the call should be able to offer a minimum of four options to the referring clinician:
  - Advice.
  - An appointment in an out-patient clinic.
  - Assessment in an ambulatory emergency care facility.
  - Admission to an acute assessment unit (and access to an acute frailty service where appropriate) or directly to a specialty service.
- The most appropriate options should be determined locally, and should aim to maximise the non-admitted options.

### **18.2 Advice**

- Typically a senior clinician, with good local knowledge of available services, can handle 10-15% of GP referrals over the phone without the need for the patient to attend hospital.
- This senior clinician should be able to refer to rapid response, hospital at home and intermediate care services to be able to offer the best options to the referring clinician to allow patients to be appropriately managed without attendance at the hospital.
- The clinical conversation with the referrer from primary care can be used to pre-plan the patient's care and manage their expectations. This may include informing the patient that their care will be in an outpatient setting; requesting investigations before arrival; or planning their transfer back to primary care.

### 18.3 Appointment in out-patient clinic

- All high volume medical specialties (including paediatrics) should ensure that out-patient capacity is available for patients referred in as emergencies. This should include patients with long term conditions who are experiencing an exacerbation or complication related to treatment. This is especially relevant for patients already attending the service.
- Specialist nurse services are an important option in the patient streaming process, and provide patients with access to expertise in managing exacerbations of their illness.

### 18.4 Acute Medicine Unit (AMU)

- Best practice is to plan the physical and functional capacity of AMUs to meet variations in the number of admissions of at least two standard deviations from the mean. The number of beds / trolleys should be based on turning them over up to twice during each 24-hour period. Inadequate staffing or physical capacity can lead to increased outliers, poor outcomes and prolonged length of stay. It is important to note that patients requiring side rooms on the AMU often wait longer for another side room to become available on an appropriate ward. This should be taken into account when planning physical capacity.
- Patients on the AMU should have face-to-face contact with a senior clinician at least twice daily. The process of providing ward rounds should meet the standards of the RCP/RCN ward round document (See [Ward Rounds in Medicine - Principles for Best Practice](#))
- Senior clinical review on the AMU, usually by a consultant, should commence as early as possible and normally within one hour for sick patients and three hours for all others. AMUs should consider designing rapid assessment models that systematise early senior review.
- Where this standard cannot immediately be met 24/7, workforce plans need to be developed to meet it and as an absolute minimum, first consultant review of clinically stable patients should be commenced within 14 hours.

- Board rounds should be used to co-ordinate a multi-disciplinary approach to patient care, and to maintain the tempo of care.
- The AMU should have pharmacy support to ensure the immediate availability of medications for discharge and medicines reconciliation for patients with polypharmacy.
- An expected date of discharge should be established as part of the care plan and linked to functional and physiological criteria for discharge.
- Specialty in-reach into an AMU should follow an agreed process, which can be based on attendance at board rounds or on request by senior decision makers. The transfer of patient care from the AMU to specialty teams should follow good handover guidance (e.g. using SBAR). Once a patient has been accepted as requiring inpatient specialty care, the patient should be reviewed daily by the specialty, even if remaining on the AMU or transferred to another ward.
- Senior therapy support to the AMU to facilitate the early assessment of patient mobility and functional capacity is important. Ready access to equipment such as walking aids and commodes is required, so that patients assessed as needing these aides will not be delayed unnecessarily.
- Discharge planning should begin on the AMU and include:
  - Anticipated discharge needs.
  - Place of discharge.
  - Discharge date and time.
  - Follow-up arrangements.
- Frail older people should be managed by clinicians competent to deliver comprehensive geriatric assessment. This is best delivered in a discrete area, either on the AMU or in a dedicated facility. Evidence suggests liaison services are neither effective nor cost-effective.

## 19 Short stay medical units

- It is good practice for acute hospitals to provide short stay medical units for patients with an anticipated length of stay of up to 72 hours. These are best co-located with assessment units as part of the AMU.
- Consultants should provide ward cover in blocks of more than one day to provide continuity of care and be present seven days a week and into the late evenings. This will reduce delays and improve outcomes.
- Twice daily, seven day a week face-to-face consultant review is an important feature of a really effective short stay service.

## 20 Planning transfers of care from hospital to community

The following good practice principles should be considered when designing processes for the safe and effective transfer of care of patients from hospital to community settings:

- From the time of admission, all patients (and their carers) need to know four things:
  - *What is going to happen to me today?*
  - *What is going to happen to me tomorrow?*
  - *How well do I need to be before I can go home?*
  - *When can I expect to go home?*
- To answer these questions, every patient must have a medical care plan that contains:
  - Clinical criteria for discharge (functional and physiological),
  - linked with a patient specific expected date of discharge (EDD) and
  - a differential diagnosis.
- EDDs should be set by a consultant. They should represent a reasonable judgement of when a patient will achieve their treatment goals (clinical criteria for discharge) and can leave hospital to recover and rehabilitate in a non-acute setting (usually in their normal place of residence).
- EDDs should be set no longer than 14 hours after admission.
- The progress of every patient towards their EDD should be assessed every day at a board or ward round led by a senior clinical decision maker, who should normally be a consultant. EDDs should only be changed with the agreement of the consultant.
- It is important that patients are actively engaged in the discharge process as this promotes realistic expectations and can improve outcomes, self-care ability and patient experience.
- It is essential that a hospital's discharge profile mirrors its decision-to-admit profile so that beds are available as admission decisions are made. In many cases, changing the discharge profile, so that all patients leave two or three hours earlier each day, will be sufficient. This can be achieved by ensuring that take-out drugs, discharge letters, transport, essential equipment and carers are all prepared. Of equal importance is a 'can-do' attitude amongst clinical staff, who should prioritise activities necessary to achieve prompt discharges.
- Maintaining a steady flow of transfers out of hospital over weekends and bank holidays is essential to avoid very high occupancy levels at the beginning of the week. Routine consultant weekend presence is necessary, supported by diagnostics, a multidisciplinary team and community health and social care services. Priorities should include seeing all potential discharges and patients with a NEWS score of >3.

- Patients should be transferred out of acute hospitals as soon as they cease to benefit from acute care (i.e. have achieved their clinical criteria for discharge). At every board and ward round, the following questions should be considered:
  - If the patient was being seen for the first time as an outpatient or in A&E, would admission to hospital be the only alternative to meet their needs?
  - Considering the balance of risks, would the patient be better off in an acute hospital or in an alternate setting?
  - Is the patient's clinical progress as expected?
  - What needs to be done to help the patient recover as quickly as possible?
  - What are the patient's views on their care and progress?
- Providers should systematically maintain a list of patients who are no longer benefitting from being in an acute hospital. This list may include patients who are officially reported as having a delayed transfer of care (DTC), but should not be limited to them. The term 'medically fit for discharge' should be avoided, as it is too vague to be helpful.
- Run charts (using statistical process control) of officially reported delayed transfers of care should be maintained to identify trends. Collaborative action by health and social care should be triggered where the number of DTCs exceeds an agreed threshold (for example a statistically relevant trend above 3.5% of the permanently established bed base).
- Progress-chasing meetings should take place daily to review all patients who are no longer benefitting from acute inpatient care. Attendees should include NHS community services and social services staff. Attendees must be briefed on relevant patients and able to sign off actions on behalf of their organisations.
- Support services in the hospital, primary and community care setting must be available seven days a week and into the late evenings to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.
- Primary and community care services should have access to appropriate senior clinical expertise (e.g. by phone), and where available an integrated care record, to mitigate the risk of emergency readmission.
- Responsive transport services must be available seven days a week.
- In addition to the above, all prolonged hospital stays above a locally defined level (e.g. 10 days) should be reviewed at least twice weekly. During such reviews, three key questions should be asked:
  - Has the patient ceased to benefit from acute hospital care?
  - What needs to be done now to expedite a safe discharge?
  - What could or should have been done earlier in the patient's stay to prevent or mitigate a long length of stay?
- 'Discharge to assess' is the concept of planning post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This should be the default pathway, with non-acute bedded

alternatives for the very few patients who cannot manage this. Many health communities have committed as a whole system to develop comprehensive pathways based on this principle.

## 21 Bed management

The following, good practice principles, should be considered to improve bed management:

- All acute and community hospitals and acute mental health inpatient wards need to maintain a real-time bed state that is widely and easily available to all staff. Predictive information (taking into account rolling averages and variation) on admissions and discharges throughout the day is needed to inform decision making.
- A dedicated named lead should be assigned for patient flow 24/7. This individual should be responsible for managing a clearly defined escalation process where demand for beds is predicted to exceed capacity.
- Acute hospitals should have agreed 'full capacity protocols' that are triggered when emergency departments (EDs) reach predefined occupancy levels. The protocol may include processes to transfer appropriate patients to inpatient wards to wait for beds to become free; to mobilise additional staff to move patients who have been assigned beds on wards out of the ED; and to trigger additional discharge board rounds.
- Following assessment, patients on acute medical units who require longer stay specialist management should be handed over to specialty teams, which should be responsible for managing them throughout their episode in hospital.
- Best practice is for adult patients with an expected length of stay of less than two midnights to be managed in a short stay unit (ideally co-located with the acute medical unit) and not transferred to a specialty bed unless clinically indicated.
- Handovers between consultants for non-clinical reasons and transferring patients to non-home wards as outliers are associated with poor clinical outcomes and should be avoided. Frail older people should never be transferred to inappropriate wards as outliers due to the high risk of decompensation, harm and extended length of stay.
- Frail older people should be managed assertively with the shortest possible length of stay in a specialist short stay unit for older people or, where a longer length of stay is justified, a ward specialising in acute medicine for older people. Such patients should not be transferred more than once following assessment on an acute medical unit.
- Acute hospitals should ensure that there are enough staff and beds on the AMU for the next 4-hours work (e.g. if the admission rate is between two and four

patients an hour during daytime, then 16 beds and enough staff need to become available during that period to ensure adequate flow and timely assessments).

## 22 Pathways for frail and vulnerable people

The following, good practice principles, should be considered to help improve the safety and effectiveness of pathways for frail and vulnerable people.

- It is essential that frail older people (including those with dementia) receive care by a team of professionals competent to assess and manage their individual needs. Early diagnosis and treatment will minimise time in an acute hospital while maintaining functional status or giving the best chance of restoration of function (See [Quality Care for Older People with UEC Needs](#))
- Best practice is to identify patients with frailty syndromes in the community and provide appropriate support (See [Toolkit for General Practice](#)).
- Comprehensive geriatric assessment is the cornerstone of care. Teams may provide this from a ward base (including acute frailty units) or as a mobile team. Early identification of patients with frailty syndromes at the time of proposed admission is essential so that assessment is not delayed. Best practice is to deploy consultant led acute frailty teams at the front of the hospital pathway to identify patients with frailty. Where this is not possible, a suitable assessment tool may be used to identify patients with frailty (for example see [Clinical Frailty Scale](#))
- Usual functioning should be recorded on admission and used to inform clinical criteria for discharge. There should be goal setting by the multidisciplinary team aiming to attain sufficient functional status to allow the patient to return to their normal place of residence.
- It is essential for teams to ensure there is no further deterioration in physical and mental function while a patient is in hospital.
- There should be an agreed complex discharge planning process with shared responsibility for success between the acute trust, community and social care.
- Restorative care and parallel social care assessment should continue in a place of safe care (ideally the patient's usual place of residence) other than an acute hospital (the 'discharge to assess' model). If there is a wait for community capacity to become available, active re-enablement should start in the acute hospital as soon as the patient has met his/her clinical criteria for discharge. This should include helping patients to dress in their own clothes, to walk and exercise and to avoid unnecessary time in bed.
- Transfer to ongoing re-enablement services should be seamless, with a clear process to ensure that therapeutic goals are clearly communicated.
- Assessment of a patient's suitability for transfer to a community hospital can be done by any competent health care professional based on a patient's ability to

benefit from a longer period of inpatient rehabilitation. It is vital for flow that patients waiting in acute hospitals for rehabilitation beds are pulled into them at the earliest opportunity.

- Other patient groups with vulnerabilities require additional considerations, input and adjustments to standardised care in order that their needs are fully recognised and met. These groups may include people with acquired brain injury and people with physical and learning disabilities. Trusts should develop vulnerable patient group pathways and processes (e.g. most trusts employ learning disability liaison nurses to support development of pathways and train and assist staff around the specific issues that might arise or need addressing).

## 23 General acute wards and specialty teams

- There should be simple rules in place to standardise ward processes and minimise variation between individual clinicians and between clinical teams. Implementation of the SAFER bundle should be considered (See [Breaking the Cycle Safer Flow](#) )
- Ward round check lists should be used routinely (See [Developing a Ward Round Check List](#)).
- Ward rounds should always include an appropriately senior nurse and other members of the multidisciplinary team (for best practice guidance on ward rounds (See [RCN](#))).
- Wherever possible, specialty consultants should work in teams, with at least one member of the team ward-based and responsible for inpatients as ‘consultant of many days’, while the remainder focus on other activities. Separating emergency from elective care enhances continuity and avoids conflicting responsibilities.
- Daily senior medical review (by a person able to make management and discharge decisions) must be normal practice seven days a week. Daily, early morning board rounds enable teams rapidly to assess the progress of every patient in every bed and address any delays and obstacles to treatment or discharge. A second, afternoon board round is best practice. Patients whose condition warrants face to face review should be identified by the nursing team and highlighted on the board round.
- All patients should have a consultant approved care plan containing an expected date of discharge and clinical criteria for discharge, set within 14 hours of admission.
- Morning discharges should be the norm, to reduce emergency department crowding, to allow new patients to be admitted early enough to be properly assessed and for their treatment plan to be established and commenced. The aim should be for 35% of the day’s discharges to have left their wards by midday. This requires teams to prioritise activities associated with discharge.



## 24 Surgery

The following good practice principles should be considered when planning and delivering processes aimed to improve the safety and flow of patients requiring surgical assessment or intervention:

### 24.1 Hospital care

- Surgical resources should be planned to meet the daily demand for elective and emergency admissions. This can vary considerably by day of the week and time of the day. Best practice is to model bed numbers on not less than two standard deviations from the mean demand, not on averages.
- Surgical treatment of acutely ill patients must take priority over planned, elective surgery when necessary. Adequate provision for urgent access to operating theatre time must be available such that it does not impact on elective operating for the efficient management of both patient pathways.
- Emergency centres should consider dedicated surgical assessment units. These may be nurse led, supported by consultant led surgical teams. There should be care pathways for common conditions such as abdominal pain and abscesses.
- A hospital offering emergency surgery should have a consultant of the day/many days model, where the surgical team has 24/7 access to dedicated and staffed emergency theatres and is free from all other commitments.
- A surgeon (at ST3 grade or above or a Trust Doctor with MRCS and ATLS) should be available to see and treat acutely unwell ED referrals at all times within 30 minutes and all routine referrals within 60 minutes. Resident doctors should be supported by consultants who are immediately available by phone and who can attend to provide senior support within 30 minutes of request (see Royal College of Surgeons standards at: (See [Emergency Surgery](#)). Surgery on high risk patients must be carried out by a consultant surgeon supported by a consultant anaesthetist.
- All trusts managing patients requiring emergency laparotomy should consider implementing the Emergency Laparotomy Pathway Quality Improvement Care Bundle (See [Improving Outcomes from Emergency Laparotomy](#))
- All patients considered to be at high risk (>10% mortality) must be reviewed by a consultant in less than four hours (ideally within 60 minutes) if their management plan is undefined and they are not responding to treatment as expected.
- All patients should be reviewed by a consultant within 14 hours of admission and then twice daily while on the surgical assessment unit (SAU) and at least daily on inpatient wards until discharged.
- All patients should be set a consultant approved expected date of discharge as part of the care plan. This should be linked with clinical criteria for discharge.

- Many low risk surgical conditions can be managed through ambulatory emergency care units. These include uncomplicated head injuries, abscesses, kidney stones, urinary retention and early pregnancy bleeding. It is important that bed days are not used where ambulatory care is a viable option.
- Orthopaedic services should be supported by ortho-geriatricians. Hospitals should provide surgical units with proactive 'in-reach' from physicians and geriatricians. This can reduce length of stay significantly.
- Hospitals providing emergency care to children must have comprehensive paediatric facilities, 24/7 paediatric cover and paediatric nursing and anaesthetic support. They must also ensure that on-call surgeons have the training and competency to manage the emergency surgical care of children and young people (for a full discussion of surgical standards for children (See [Standards for Childrens Surgery](#)) and the draft consultation document (See [Standards of Non Specialist Emergency Care of Children](#)))

## 24.2 Surgical networks

- Hospital surgical services should be part of wider operational networks with an identified network lead. This particularly applies to emergency general surgery (See [RCS - Emergency General Surgery](#))
- Adult and paediatric emergency surgical services delivered within a network must have arrangements in place for image transfer, telemedicine and agreed protocols for bypass/transfer.
- Agreed guidelines and protocols for the transfer of critically ill patients must be in place, and regularly audited, to ensure patient safety.

## 25 Care management and the role of social care

- There should be a local agreement between health and social care services that packages of care can be restarted, without an automatic need for reassessment, where a patient's care needs remain largely unchanged. This can be facilitated by implementing a trusted assessor model.
- For the majority of patients, definitive assessment of social care needs should occur outside of hospital (see section 10).
- The multidisciplinary team should have same-day access to social care advice, ideally at the morning board round, or by phone.
- There should be a local agreement between health and adult social care to 'fund without prejudice' while responsibility for funding a patient's care is being established. This will allow assessment to take place outside hospital, ideally at home with support.

- Health and social care communities should work together to reach local agreement that all referral processes are as simple as possible (i.e. simple, short electronic documentation that is quickly and easily completed).
- Trusts in particular should ensure that the legal requirement of Assessment/Discharge Notices from acute trusts to social services - to share patient information (and the required response standards) - are understood and initiated by ward staff (See [Process of Managing Transfers of Care from Hospital](#)). They should seek feedback from social care that notifications are appropriate to avoid wasting social workers' time. Embedding care managers, for the most complex patients, within wards encourages a proactive and co-operative approach.

## 26 Managing Information

Safe and efficient patient care requires effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. This is particularly important in the urgent and emergency care system where, by definition, the patient is accessing care from outside of their routine care providers.

This section should be read in conjunction with the National Informatics Board strategy: *Using Data and Technology to Transform Outcomes for Patients and Citizens, A framework for Action (2014)* (See [Personalised Health and Care 2020](#)).

### 26.1 Principles of information flow in urgent care

#### 26.1.1 Enablers

- The NHS Number must be used as the primary identifier along the patient pathway. All activity within an organisation must be able to be identified using it. It is mandatory to include the NHS number in all clinical correspondence.
- Systems should implement the GS1 standard for unique identification of patients using technology to support identification as patients move around the system. It is essential that access to patient information is auditable.
- Improved information flows and access to systems should be used as an opportunity to improve collaborative working. For example, shared information can allow clinicians in community pharmacies to support NHS 111.
- Ambulance services should develop plans to get access to the NHS Number, through solutions such as Spine mini-services or directly. This is a key building block in enabling information captured by ambulance services to be shared. This will also form the basis for use of electronic messaging of information between ambulance services and other parts of the urgent and emergency care system.

#### 26.1.2 Access to data

- While access to patient information should be governed by appropriate information governance controls, this must be balanced against the need to share information to enable integrated and effective care that is in best interests of patients of all ages, as highlighted by the Caldicott 2 principles.
- Patient consent for sharing information must be sought wherever possible, unless it is an emergency or otherwise in the patient's best interests.
- Access to core general practice information should be made available to all services in urgent and emergency care. This should include special patient notes (including any red flags), medicines and contra-indications, and allergies. In the absence of (or alongside) a local integrated digital patient care record (such as the Hampshire health record), the national summary care record (SCR) should be used, as it offers a low cost, high value solution to summary patient record access (See [Clinical Use of the Summary Care Record](#)). The SCR is available to all clinicians across the NHS in England either through the web based application or suitably enabled clinical applications. The SCR should be used by community pharmacies as it becomes available from autumn 2015.
- As of June 2015, 96% of the English population have an SCR containing key details of their medication history and any known allergies and adverse reactions sourced from their GP record. With patient consent, further additional information can be added to the SCR by their GP practice such as significant past medical history and procedures, anticipatory care information, patient preferences and other relevant information often included in special patient notes. Inclusion of this additional information is encouraged to benefit patients in urgent and emergency care pathways. For more information, visit: [Summary Care Record \(SCR\)](#)
- Patient held information is valuable in empowering choice and increasing patient safety. Simple tools such as 'This Is Me' (from the Alzheimer's society: see [This is Me Tool](#)) should be widely adopted across local health and social care communities.
- Carers are vital to a sustainable health care service and they should also have access to shared digital tools and information (such as access to the NHS Choices website) to support those they look after.

### **26.1.3 Efficient transfer of information**

- The first point of contact must be able to capture enough detail to enable appropriate advice and onward referral.
- Current guidance to NHS 111 is that a 'warm transfer' (i.e. with the call transferred to a person, rather than being added to a queue) must be used wherever possible. The SCR can support this by providing key information to clinical advisors.
- Electronic handover of care using standardised datasets is a key priority. The Academy of Medical Royal College's publication, "*Standards for the clinical*

*structure and content of patient records*” should be followed to ensure that this is achieved safely.

- Electronic discharge summaries must be used to aid safe and effective transfers of care. The Academy of Medical Royal College’s agreed headings should be used to provide consistency in the way that information is displayed.
- The NHS directory of services should be developed as a key source of information on local services and used strategically to support navigation and referral of patients to appropriate settings.
- Wherever possible, systems should be designed so that relevant information arrives at a service ahead of the patient (e.g. ambulance services sharing information electronically prior to their arrival at ED; urgent repeat prescriptions being filled before a patient arrives at a community pharmacy).
- At the end of the episode of care, appropriate transfer of care documents should be relayed to the patient’s GP and other relevant services, such as community pharmacy, to ensure continuity of care. The patient should also receive a copy.
- Data should be used to support the demand management of urgent and emergency care services. For example, repeat users of services can be identified and followed-up to address their specific care needs.

## Reading List

References to the following supporting information are included in this document:

The NHS Five Year Forward View ([Five Year Forward View](#)).

Equality and Health Inequalities Legal Duties [Equality & Health Inequalities Legal Duties](#)

Improving Patient Flow ([Improving Patient Flow](#)).

UECR Phase 1 Report Evidence Base (See [Transforming Urgent & Emergency Care Services in England](#)).

Crowding and Exit Block in Emergency Departments ([Exit Block Campaign](#)).

Boarding – impact on patients, hospitals and healthcare systems ([Impact on Patients, Hospitals and Healthcare Systems](#)).

The benefits of consultant delivered care ([Benefits of Consultant Delivered Care](#)).

A cost-benefit analysis of twice-daily consultant ward rounds and clinical input on investigation and pharmacy costs in a major teaching hospital in the UK ([BMJ Open Access - Cost Benefit Analysis](#)).

Acute care toolkit 3 – acute medical care for frail, older people ([Acute Care Tool Kit 3](#)).

Acute care toolkit 10 – Ambulatory emergency care ([Acute Care Toolkit 10](#)).

Oxford Journal - effectiveness of AMU's in hospitals: a systematic review ([Effectiveness of Acute Medical Units in Hospitals](#))

Physical morbidity and mortality in people with mental illness ([Physical Morbidity and Mortality in People with Mental Illness](#)).

Guidance for commissioners liaison mental health services to acute hospitals ([Liaison Metal Health Services](#))

Continuity of care for older hospital patients ([Continuity of Care for Older Hospital Patients](#))

BMJ Open – Which features of primary care affect unscheduled secondary care use – a systematic review ([Which Features of Primary Care affect Unscheduled Secondary Care use](#))

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RCP Journal – The impact of consultant delivered multidisciplinary inpatient medical care on patient outcomes ([RCP Journal - Consultant Delivered MDT](#))

National audit of intermediate care summary report 2014. ([National Audit of Intermediate Care - Summary Report 2014](#))

Avoidable Acute Hospital Admissions in Older People ([Avoidable Acute Hospital Admissions in Older People](#))

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Crisis Care Concordat – Mental Health ([Crisis Care Concordat](#))

Operational resilience and capacity planning for 2014/2015 ([Operational Resilience & Capacity Planning 2014/15](#)).

Weather effects on health ([Met Office - Health Articles and Research Papers](#)).

NHS Services seven days a week forum clinical standards [Seven Days a Week Forum](#)).

Quality Watch – focus on preventable admissions ([Focus on Preventable Admissions](#))

Improving Health and Lives: Learning Disabilities Observatory – Hospital admissions that should not happen ([Hospital Admissions that Should Not Happen](#)).

The Health Foundation – Evaluation: What to consider ([Evaluation: What to Consider](#)).

Interventions to reduce unplanned hospital admissions: a series of systematic reviews (Final Report) - ([Interventions to Reduce Unplanned Hospital Admission](#)).

NCBI - Effect of telehealth on quality of life and psychological outcomes over 12 months (<http://tinyurl.com/o5tralq>).

BMJ - Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community (<http://tinyurl.com/opyog4w>).

British Journal of Healthcare Management – avoidable acute hospital admissions in older people ([Avoidable Acute Hospital Admissions in Older People](#)).

International Journal of integrated care – reducing hospital bed use by frail older people: results from a systematic review of the literature ([Reducing Hospital Bed Use by Frail Older People](#)).

Researchgate article – What the evidence shows about patient activation ([What the Evidence Shows about Patient Activation](#)).

NHS outcomes framework – personalised care for long term conditions ([Personalised Care for LTC](#)).

Primary Care Foundation – urgent care in general practice ([Primary Care Foundation - Reports and Articles](#)).

Alzheimers.org.uk factsheet: Changes in behaviour (See [Changes in Behaviour](#)).

Gold Standards Framework in end of life care ([The Gold Standards Framework](#)).

MPS – Dilemma: DNR orders ([Dilemma: DNAR Orders](#)).

BGS Commissioning Guidance – high quality healthcare for older care home residents ([BGS Commissioning Guidance](#)).

NHS England: Community Pharmacy – helping provide better quality and resilient urgent care ([Community Pharmacy - Helping Provide Better Quality](#)).

RPS – Hospital referral to community pharmacy: an innovators' toolkit to support the NHS in England ([Hospital Referral to Community Pharmacy](#)).

Urgent Repeat Medication Requests Guide for NHS 111 Services: how to refer directly to pharmacy and optimise use of GP out of hours services (see [Integrated Urgent Care Commissioning Standards](#)).

HSCIC – summary care record rolled out to community pharmacists ([Summary Care Record Rolled Out to Community Pharmacists](#)).

NHS Interim Management and support – Primary Care in Emergency Departments: a guide to good practice ([Primary Care in Emergency Departments](#)).

Primary Care and Emergency Departments – Report from the Primary Care Foundation March 2010 ([Primary Care and Emergency Departments](#)).

Standards for children and young people in emergency care settings ([Standards for Children & Young People in Emergency Care Settings](#)).

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NHS Choices: a guide to mental health services in England ([A Guide to Mental Health Services in England](#)).

Annual Public Health Report 2014: Mental health and wellbeing in Kingston ([Annual Public Health Report 2014](#)).

Bradford District Care Trust: Our acute care services ([Acute Care Locality Service](#)).

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Hertfordshire Partnership University NHS Foundation Trust: Easier access, better care – single point of access success ([Easier Access & Better Care](#)).

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Mental Health Partnerships: Developing models for liaison psychiatry services - Guidance ([Developing Models for Liaison Psychiatry](#)).

NICE Self Harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care ([Self-Harm in Over 8s](#)).

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Short Stay Paediatric Assessment Units: Advice for Commissioners and Providers – January 2009 ([Short Stay Paediatric Assessment Units](#)).

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Quality care for older people with urgent and emergency care needs ([Quality Care for Older People with UEC Needs](#)).

Toolkit for General Practice in supporting older people with frailty and achieving the requirements of the unplanned admissions enhanced service ([Toolkit for General Practice](#)).

Dalhousie University Clinical Frailty Scale ([Clinical Frailty Scale](#)).

Safer patient flow bundle ([Patient Flow](#)).

Quality and safety at the point of care: how long should a ward round take? ([Developing a Ward Round Check List](#)) and [RCN](#)

Emergency Surgery – Standards for unscheduled surgical care: Guidance for providers, commissioners and service planners ([Emergency Surgery](#)).

The Health Foundation Shine 2012 final report: improving outcomes from emergency laparotomy ([Improving Outcomes from Emergency Laparotomy](#)).

Children's Surgical Forum – Standards for Children's Surgery ([Standards for Childrens Surgery](#)).

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RCS England – Emergency General Surgery ([RCS - Emergency General Surgery](#)).

Care and support statutory guidance: Annex G the process for managing transfers of care from hospital ([Process of Managing Transfers of Care from Hospital](#)).

National Informatics Board strategy: Using Data and Technology to Transform Outcomes for Patients and Citizens, A framework for Action (2014) ([Personalised Health and Care 2020](#)).

HSCIC – Clinical use of the summary care record ([Clinical Use of the Summary Care Record](#)).

HSCIC - Summary Care Records ([Summary Care Record \(SCR\)](#)).

Alzheimers.org.uk factsheet: This is me ([This is Me Tool](#))