

What makes a top hospital?

Accident and emergency care

August 2015

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About CHKS

CHKS has worked with healthcare organisations across the UK to inform and support improvement for more than 25 years. This report highlights examples of best practice in emergency departments, which we aim to share throughout the NHS.

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Produced for **CHKS** by **InHealth Communications Ltd.**

FOREWORD

CHKS celebrates and shares success across the health service with its annual Top Hospitals awards. As a result we have come across many examples of excellence in the delivery of healthcare within acute sector organisations. The idea behind this series of reports is simply to share these examples of success in the hope that other organisations can take something from each of them.

In 2015 CHKS added a new category to the awards programme, for excellence in accident and emergency care. This award identifies outstanding practice in A&E and is based on an analysis of publicly available data divided into domains for outcomes and patient experience. Outcomes included Department of Health indicators for A&E departments (for example, waiting times for treatment and patients leaving without treatment) as well as results from clinical audits of sepsis and trauma. Patient experience included results of the CQC patient experience survey (for A&E departments) and the NHS Friends and Family Test.

Six shortlisted trusts were invited to submit a detailed entry, with three being chosen to be visited by a panel of expert judges who then decided on a winner. The judges were: Dr Clifford Mann, president, Royal College of Emergency Medicine; Professor Keith Willett, director for acute care, NHS England; Janet Davies, executive director, Royal College of Nursing; and Moyra Amess, associate director, CHKS Assurance and Accreditation.

The winner of the award was Derby Hospitals NHS Foundation Trust (see case study, page 18). This report highlights best practice, not only at the winning trust but at other trusts throughout the country. It looks at what makes a top A&E department and focuses on the areas of good practice and innovation that enable them to provide a good patient experience while avoiding gridlock and crowding, which can be detrimental to patients' health and recovery times.

Please note that, as many departments are now referring to themselves as emergency departments, we have used this term throughout the report. ●

EXECUTIVE SUMMARY

According to Hospital Episode Statistics, in 2013/14 there were 18.5 million attendances recorded at major emergency departments, single-specialty emergency departments, walk-in centres and minor-injury units in England, a one percentage point increase on 2012/13 figures. With attendances on the rise, the proportion of patients waiting longer than four hours to be treated, admitted or discharged has also been increasing.

In 2014, the NHS struggled to meet the government target of 95 per cent of patients waiting no longer than four hours. The number of trusts breaching the target increased towards the end of the year, with waiting times reaching their highest levels for a decade in the winter of 2014.

Going into hospital is an anxious time for any patient, but particularly those who may be in need of emergency care. Our perception of emergency departments is that they are places of long waits, patients queuing in corridors, and stressed and overworked staff.

This doesn't have to be the case. Across the NHS, staff are working hard to ensure patients are treated in the best way by the most appropriate clinician. However, even though there are areas of excellence in most trusts, there is still too much variation across the country.

Staffing has also become an issue, with many trusts facing seasonal fluctuations, hard-to-fill nursing vacancies and, more recently, a focus on the amount of money being spent on agency staff.

However, there are many examples of trusts coming to terms with these challenges. A focus on short-stay wards, speedy discharge and care of frail elderly patients, as well as better links with community providers, are just some of the ways in which the best-performing emergency departments are beginning to improve patient flow. With staff retention in mind, others are allowing senior clinicians time away from the frontline to develop clinical practice, or to mentor others. There is no one-size-fits-all approach, but this report highlights areas where improvements can and have been made. ●

“Getting patients better quickly and safely requires the systematic implementation of known good practice, a consistent approach by all clinicians, collaboration within and between organisations and great leadership along the pathway.¹”

Russell Emeny, director, emergency care intensive support team, NHS IMAS

IMPROVING PATIENT EXPERIENCE

Hospitals and patients want the experience of urgent and emergency care to be as good as possible, but increasing demand and pressure on resources mean there is a difficult balance to be achieved.

Figures show the proportion of patients waiting longer than four hours to be treated, admitted or discharged has increased, as has the number of people attending emergency departments. They are more unwell and also more likely to require admission – an extra 4,000 people a week are being admitted from emergency departments compared with last year.²

With more people attending year on year, and more people being admitted, how do trusts cope and what does good look like? How do emergency departments ensure the experience is one that patients and their families would praise?

Dr Ian Higginson is a consultant in emergency medicine at Plymouth Hospitals NHS Trust, and heads the Royal College of Emergency Medicine's service design and delivery committee. He says: "A good emergency department is one where you would want yourself or your family to be treated and one where you are proud to work.

"It should be calm; if you ask people what they would expect, they might think about stressed staff and long waits but it doesn't need to be like that. There should be resources in place to ensure short waits. If you do things right at the front door it is not only best for the patient, it is good for the hospital as well."

Dr Higginson believes good practice starts as soon as a patient arrives. "We should do as much as we can as early in the journey as possible and only admit patients that we know need admitting."

In 2013 NHS medical director Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. NHS England engaged with patients, the public, NHS staff and organisations to develop a set of principles for a change to the current system. A steering group led by NHS England's director for acute care, Professor Keith Willett, has taken this work forward.

Key elements for change include helping people with urgent care needs to get the right advice in the right place first time, as well as providing urgent care services in the community so people can avoid attending the emergency department. The system design objectives include improving care, experience and outcome.³ There is also a recognition that although there cannot be a one-size-fits-all approach, there is a need to create a standard vision of what good looks like.

So, in terms of patient experience, what does good look like? The experience is inevitably linked with good outcomes and this starts with a focus on the patient pathway. Having ready access to healthcare records, including those in primary care, offering an early diagnosis from a senior doctor and access to a specialist frail elderly assessment team and short-stay wards are all ways to help patients flow through the hospital and ultimately provide them with the best possible care.

However, it is not just the clinical aspects of care that are under scrutiny; customer service is an important part of the overall experience. Patricia Miller, chief executive of Dorset County Hospital NHS Foundation Trust, sums up a good experience as one where patients are greeted by a friendly face, experience empathy, are involved in their own care and then are able to leave with a good clinical outcome.





→ IMPROVING PATIENT EXPERIENCE

She says many of the complaints received at the trust arise from dissatisfaction with customer service and communication. "We are teaching staff a different type of customer service now. The flow of patients is now so quick it's about teaching people about a more 'retail' type of customer service.

"Patients are no longer in hospital long enough for the staff to build a strong relationship with them – it has to be immediate to work."

Even a relatively modest improvement can be a huge comfort to patients. At Derby Teaching Hospitals NHS Foundation Trust, a sitting room with a fireplace has been created to help calm people who are confused. Chief

executive, Sue James, says: "By encouraging our staff to act more as companions, we can stop elderly confused people walking up and down the corridor. Reassurance is such a big part of what we do."

Technology can also help to promote a good patient experience. For staff, awareness of a patient's previous illnesses or treatments is essential but patients may not always be in a position to provide that information. Professor Willett says: "Staff should have access to the electronic patient record for those previously hospitalised, as well as to GP records. This makes a difference to the large percentage of patients who present with multiple conditions." ●

IMPROVING STAFF EXPERIENCE

The relationship between staff and patient experience is well understood. We know that when nurses and other emergency department staff are demoralised it has a negative impact on patient experience.

One issue that continues to provoke debate is staffing levels. Initiatives that allow trusts to match staff numbers and skills with patient demand are helping ensure patients get the right treatment and to create a calm atmosphere in the department. Staffing levels are often high on the news agenda, particularly following the Francis report.⁴ Yet a perception shared by professionals and the public is that there are too few staff and those who are there are working long shifts under a tremendous amount of pressure.

It is not only nursing that is affected. For the past three years, only around half of higher specialist emergency medicine training posts have been filled, resulting in a lost cohort of about 200 potential consultants. Unsociable hours and relentless workload are among the factors causing trainees to turn away from emergency medicine.² Lower staff numbers inevitably have an impact on those already in post, which creates a self-fulfilling prophecy of overwork and low morale, thereby perpetuating recruitment difficulties.

Recruitment and retention of the right staff and the ability of medical professionals to develop their careers are key to ensuring a smooth-running emergency department and contributing to a positive patient experience. When staff feel valued they are more likely to stay and be dedicated to the job. Plymouth Hospitals NHS Trust has experienced the benefits of ensuring the staff experience is a good one. For this reason, many staff who have left have subsequently returned, and others

are prepared to travel considerable distances to work at the trust.

Executive director of the Royal College of Nursing, Janet Davies, believes good practice involves making staff feel valued as well as working to develop their skills. Encouraging strong links with the rest of the hospital and with the community not only makes for a better patient experience but also helps to develop staff.

She says: "There is lots of scope in A&E for staff development. There are lots of new roles and plenty of opportunities to create strong links with the rest of the hospital and other professionals. At the same time, managers need to make sure A&E has the right staff with specific skills in specific areas, such as specialist nurses. Not everyone can do everything. What makes a good department is where these things are in place. Where we are getting good results we see there is a really strong commitment to staff development."

She acknowledges there is some truth behind the widely held perception that emergency departments are stressful, pressurised places to work but insists this does not always have to be the case. "If you have the right resources, the right staff and the right skills it can work and be a fulfilling job."

She says investing in staff and helping to develop their skills is crucial to maintaining a good patient experience and keeping busy departments functioning well. It is now generally accepted that clinicians need time away from the frontline to develop skills; constantly working long hours and treating patients without the time to develop or to carry out research or audits can lead to demoralisation.

Clifford Mann, president of the Royal College of Emergency Medicine, believes low staff morale also has →



→ IMPROVING STAFF EXPERIENCE

an impact on clinical performance. He says: "There is evidence that if you don't allow people to develop their service they will become demoralised and ultimately see fewer patients."

He places greater emphasis on professional development than on financial reward. "You don't always need to pay people more money. They may feel the system they work in doesn't allow them to practise emergency medicine in a sustainable way because they spend too much time being overloaded. Just because you can get away with having an understaffed department doesn't mean to say you should.

"There are examples of best practice where trusts have decided that if consultants work overnight, or a

high proportion of weekend shifts, they have amended terms and conditions locally so the consultants can have more time off at other times."

At Derby Teaching Hospitals NHS Foundation Trust, the board has recognised the importance of staff experience. The trust has recruited staff to training programmes and appointed 14 senior doctors who were trainees at the trust in the past and had been working as locums but getting limited career satisfaction. It has also taken on more PAs so consultants can get out into the hospital where they are needed.

The trust also celebrates the great work that staff do and has introduced Christmas awards for its emergency department team. ●

ENSURING GOOD PATIENT FLOW

Getting patient flow right is critical for a top performing emergency department – but good patient flow is not just about those who work in the department getting the job right; it is about a number of factors working together to avoid patients staying in hospital too long or for the wrong reasons. Poor patient flow is bad for a hospital and it can also have a negative effect on patients' recovery.

Integration is the foundation of good patient flow and the best systems have integrated services between emergency departments and co-located primary care services. In the absence of good integration services become fragmented and the outcome for patients suffers.⁵

Although it is accepted that community service providers and hospitals need to work together, it is also agreed that good practice begins at the front door of the emergency department. Early diagnosis by a senior doctor – and early discharge where appropriate – are key. An early diagnosis by a senior clinician can prevent a build-up of patients waiting several hours for treatment and avoid unnecessary hospital stays. This is why initiatives such as early senior review of patients and frail elderly care are working well.

Russell Emeny, director of emergency care intensive support at NHS IMAS, says: "One way to avoid admissions is to get the earliest possible review by a senior clinician, as close as possible to when the patient arrives." His study also advises that those who are admitted must have a consultant-approved care plan in place within 12 hours of admission, which should include an expected date of discharge.¹ Also important is empowering multidisciplinary teams to discharge when the discharge criteria are met, especially at

weekends, rather than having to wait for senior medical confirmation. A focus on discharging as many patients as possible during the morning is also important, as by the afternoon demand for beds is on the rise.

Dr Ros Tolcher, chief executive of Harrogate and District NHS Foundation Trust, agrees that early involvement of a senior decision maker at these key stages of the patient pathway is vital to improve outcomes.

She says: "Staffing needs to be proportionate to the level of demand. We need to be able to treat walking wounded and those who are seriously ill at the same time. At Harrogate we are involving specialty doctors in A&E earlier. Every department in the trust must take responsibility for getting patients where they need to be quickly. Everyone is asked to take responsibility for this."

Trusts that perform well will have board rounds instead of the traditional ward rounds and early discharge to free as many beds as possible. Avoiding workload spikes is important when it comes to the momentum of care. Consultant-approved care plans with expected discharge dates, in place within a few hours of ward admission, and one-stop ward rounds, where tasks such as take-out medication and request forms are dealt with before moving on to the next patient, can prevent work building up and minimise delays in discharge.

Early discharge ensures good patient flow and the best trusts focus on short-stay and discharge wards as a way of addressing the issue. Derby Hospital has set up a medical emergencies short-stay ward for acutely unwell patients who have the drugs they need and don't need to be on a hospital ward. These wards have twice-daily senior doctor rounds and patients are then discharged as soon as is appropriate. →



→ ENSURING GOOD PATIENT FLOW

Discharge-to-assess wards are especially useful in the care of frail elderly people and Dorset County Hospital has shown how this can work. Often there are internal reasons why discharge is delayed and assessments for discharge tend to only take place once an acute patient is well again, meaning the hospital stay can be longer than necessary.

However, now a health and social care team begins this process on admission to the hospital. Once acute care has been given, the patient can then be moved to their usual place of residence complete with a package of care. It may mean community care is needed but avoids patients being placed in a higher level of care than they need. For example, a patient may end up in a nursing home because an extended stay in hospital has had an adverse effect on their ability to cope at home. This, in turn, can be detrimental to their long-term health.

Dorset chief executive Patricia Miller says the trust

did recent a study with the county council and found that 50 per cent of patients in residential care came from the hospital. She says: "Twelve months later their needs had changed. It showed that the initial assessments were being done in the wrong place.

"Now our systems have changed and as soon as a patient is medically fit they go home and have a two-week assessment process with wraparound care. In this way we have reduced the number of patients going into residential care by 75 per cent and a similar approach has worked well in other trusts. This really helps to maintain patient flow in the hospital. It means the emergency department does not get gridlocked because there are not enough cubicles to take patients from ambulances or you can't move people on through the hospital."

Frail elderly care has a major impact on how well emergency departments function, especially as around 8 per cent of patients who attend are over 85 years

old. Good units have rapid-response frailty services, with teams including occupational therapists and social workers, which can quickly address care needs.

At Derby, any patients above the age of 85 with comorbidities are automatically seen in the medical assessment unit by a frail elderly assessment team. Being able to fast-track patients to the correct wards and departments is also important; correctly streaming patients is imperative to ensure they are treated quickly by the right person. This can either begin at the hospital front door or out in the community.

Emergency care centres and ambulatory care centres can help stream patients while giving them the care they require, without the need to admit them to a ward. Good emergency departments also fast-track patients where indicated, such as in the case of chest pain, abdominal pain or hip fracture.

Measures to improve patient flow mean emergency

departments can minimise crowding. This is vital, as once crowding happens, it is hard to regain momentum and less serious cases may start being admitted inappropriately as staff become stretched and decision making suffers. This in turn can affect patient outcomes.

Ipswich Hospital NHS Trust has used data in an innovative way to devise a unique trigger tool to alert them that the emergency department is likely to breach its waiting time target within a few hours. This allows time to improve patient flow throughout the hospital to avoid gridlock (see box, page 17).

Chief executive Nick Hulme says: “We can see if we are going to breach targets three hours in advance rather than 10 minutes. That gives us time to make decisions and put in place a series of actions throughout the hospital to improve the situation. Everyone collects this data, it’s just that we put it together in a certain way. We have had 37 organisations visit us so far to find out more about it.” ●

THE URGENT CARE CHALLENGE: FIVE THINGS TO KNOW

The most successful improvement projects combine world-class analytics with leadership development and lean implementation. A tried-and-tested approach follows a three-stage process: first, using analytics and leadership development to align the leadership around the ambition and route map; second, building the required capability within the delivery teams in order to execute; and finally supporting delivery and monitoring progress. When planning this process, there are five areas to consider:

1. Tackling urgent care and A&E is not just about the hospital

The challenge goes beyond the four walls of the hospital and requires a focus on the broader care chain and the value this brings to patients. In practice, it is difficult for chief operating officers and urgent care leads to find the time to take a system-wide approach when the focus is on achieving A&E performance targets, which is why this is one area where top hospitals set themselves apart.

2. Building a detailed picture of demand

The best trusts have a detailed picture of demand, covering the type of demand, the volume and the timing. Understanding demand is critical in order to build the required workforce to meet patient demand safely while giving value for money. A top hospital has a good understanding of demand and then builds its workforce to match the need.

3. Identify failure demand

Top hospitals understand current demand and the difference between 'value demand' – the demand that is appropriate to a hospital and 'failure demand' – the demand caused by a failure to do something, or do something right for the patient earlier in the care chain. A top hospital will work across the system to identify and eliminate failure demand at the earliest point in the care chain.

4. Focus on flow

Flow, like most things, can be measured by looking at effectiveness (having a clear plan to do the right things) and reliability (how frequently the right things are done according to plan). A top hospital works to eliminate variation working across the health and social care system in order to achieve good flow. It recognises that optimum patient flow is owned across the hospital and not just by the emergency department. Beyond the hospital the whole system works together to enable patients to arrive safely and swiftly where they need to be.

5. System change isn't simply about a technical solution

System change starts with aligned leadership built on trust. Each senior leader must have the same desire to serve the patients they care for and be able to work through cross-organisational challenges. Top hospitals invest in building this senior leadership team and they also ensure they have the support of regulators to pursue the sustainable change.

These five areas of focus are not new but they are often hard to piece together in a coherent and aligned action plan.

David Baker is a director at Capita Health Partners

WORKING WITH PRIMARY AND COMMUNITY CARE TEAMS

Emergency departments cannot operate in isolation. They are affected by what is happening in departments throughout the hospital and also out in the community. Patient flow is critical but if there is nowhere for patients to go, the system starts backing up and patients can be inappropriately placed in hospital beds.

It is not just about having more beds. Extra beds will not necessarily mean better care if patients are in the wrong wards or there is no accompanying extra capacity to carry out the tests they need.

Community care and support for patients is one way to ensure the emergency department can cope with demand and make sure patients are discharged promptly. A survey conducted for the Royal College of Emergency Medicine found that 15 per cent of patients could have been treated in the community.

However, hospitals and community providers need to work together. Derby Hospital has transformed patient care by setting up an urgent care board. Such boards demonstrate joint working with the community and bring together social services, GPs and hospital doctors from the emergency department and emergency medicine.

Chief executive Sue James says: "We created an urgent care board 12 months before anyone else was

doing it. We have a well-developed transformation team and had a clear project plan. The crucial thing that made the difference is that it was a whole-system approach. The medical workforce here is excellent and they had ideas that they had been talking about for a while.

"But it was like lighting a fire when we started to see these things working. The board has been in place for two years now and we are continuing to develop services. We have transformed the care we provide."

Good contacts within the community, such as with social care, nursing homes, GPs and pharmacies, can also help to fast-track patients to where they need to be. Giving staff the chance to foster those relationships also helps their development, giving them a more specialist insight into certain areas.

It is essential that emergency departments and hospitals actually drive care rather than just being the default place for all patients to go. Professor Keith Willett says: "We should be looking at how they offer consultant advice 24/7 to GPs, community nurses or paramedics. GPs are often in a position where they say: 'But for the want for more expert advice I could have made a better decision for the patient here and now'. You might argue it is up to the hospital to provide that support so that GPs can manage the patients close to or in their homes." ●

LEADERSHIP, TEAM ETHOS AND BOARD SUPPORT

Good emergency departments are run by teams that function well and are managed by leaders who understand how to get the most from their staff. These leaders know that if they want change to happen in a high-pressure environment, they need to take their teams with them. This leadership must go all the way up to board level.

Top emergency departments are generally found in NHS trusts where boards listen to staff and understand the problems they are facing. They also know what is required of the leadership team. Rather than leaving the department to run itself and deal with its own challenges, the leadership team will offer support from the top to encourage collaborative working and ensure that all staff in the hospital are contributing to smooth patient flow.

High-performing trusts know not to view an emergency department in isolation but will be able to commission services from the rest of the hospital. This ensures that specialty medicine is on hand, which improves the patient experience.

A good leader builds a strong team and puts an emphasis on teamwork. If staff start working on their own in silos, the system starts to break down. Dr Ros Tolcher believes her management team in Harrogate is very supportive. She says: "There has been a big culture change, with a focus on working collaboratively and meeting the four-hour target as an organisation. There is a much wider focus on the issue of crowding."

Having leaders with experience in an emergency department is also an advantage. They will be able to see

the whole picture and have a clearer knowledge of the requirements. College of Emergency Medicine president Clifford Mann refers to the example of the national accelerated leadership programme, which has several emergency department consultants participating. He says some of those with an appetite for good leadership have stepped up; one has been asked to be medical director and sent by the trust to Harvard Business School. This was a significant investment but the trust will reap rewards by having a senior leader with an emergency-department background.

Dr Ruth Brown, vice-president of the College of Emergency Medicine and also emergency medicine consultant at Imperial College Healthcare NHS Trust, says leadership skills are crucial in this high-pressure, high-risk environment. With the NHS's current emphasis on outcomes and efficiency, she counts leadership as an increasingly important part of the emergency clinician's skillset.

She says: "Our clinical leaders must be able to respond to the variation in demand and capacity, support and comply with performance standards, both clinical and operational, and importantly work with the team to maximise the efficient delivery of safe care.

"Developing leadership skills in our trainees is an important part of the curriculum delivery in emergency medicine and relies on consultant presence, supervision and role modelling. Trainees must be able to hone their leadership skills in supervised shifts but also have the chance to reflect on their performance with their consultant supervisors."⁶

WHAT DOES THE CQC THINK OUTSTANDING LOOKS LIKE?

Ipswich Hospital NHS Trust's emergency department was rated outstanding by the CQC following an inspection in January 2015. Mid-winter is one of the busiest times for any hospital, yet the trust still managed to impress. Chief executive Nick Hulme knows he has a good department but realises it can only be outstanding if the whole hospital is working together.

He says: "The best bit of our department is actually the rest of the hospital because the rest of the hospital makes it look outstanding. We have made improvements but our real success has come from the work that has happened on the wards, such as reducing length of stay and having senior staff on at weekends."

The hospital has also embraced technology. Whether Nick is sitting in his office or on a train, he is able to call up information instantly about how many people are waiting in the emergency department, how long they have been there and who are the most in need.

The hospital's trigger tool has also been praised and is the focus of much interest from other trusts. Developed by one of the trust's junior IT analysts, the programme looks at months of data and what happens over the course of 24 hours. It looks at how long patients waited and why. The data enable the emergency department to see much sooner if it is likely to breach the waiting-time target.

Delayed discharges are also dealt with in a simple but effective way. Each patient is assessed as having a red or green day. A green day means something will have happened that day to help move them towards discharge; for example, the patient may have had the CT scan they have been waiting for. If nothing has happened that day to bring discharge closer, that is known as a red day.

Nick says: "Instead of all the nurses coming together to discuss how many beds they have, we talk about the people and who is going to have a red day. We decide how we can make that red day a green day tomorrow. We held a 'red to green week'; whatever block was in the way we moved it. If there is pressure in the organisation, we look at how we can move those blocks out of the way."

The trust is also improving its emergency department from a recruitment perspective. Nick admits that, like the rest of the country, there are some issues with having enough consultants. But he says: "We are managing that risk by employing more former doctors and nurses and investing heavily in training. Also our emergency nurse practitioner roles are attracting staff to come here."

The hospital is also working to attract consultants by linking up with the East Anglian Air Ambulance to allow consultants to spend time with the helicopter team to help treat patients at the scene of an accident.

→ LEADERSHIP, TEAM ETHOS AND BOARD SUPPORT

CASE STUDY
1

Managing patient flow at Derby Teaching Hospitals NHS Foundation Trust

Derby Teaching Hospitals NHS Foundation Trust provides both acute hospital and community-based health services, serving a population of more than 600,000 people in and around southern Derbyshire. It runs two hospitals: the Royal Derby Hospital, which incorporates the Derbyshire Children's Hospital, is a busy acute teaching hospital; London Road is the Trust's community hospital. Its community services are based in health centres and GP practices across the region, providing care to patients in their own homes.

The Royal Derby Hospital is the newest hospital in the East Midlands. The trust treats a million patients each year and has the only rooftop helipad in the region. Its busy emergency department sees around 320 patients each day.

According to chief executive Sue James, the winter of 2012/13 was a bad time in the emergency department. She says: "We were not hitting our targets and consultants were critical of the fact that the hospital was awash with

emergency department patients. At the time, safety and the patient experience was the concern.

"Everyone was blaming each other for the situation and it was clear that something needed to change. We decided to hold a no-blame summit, inviting all the key players to be present, including social services, GPs and doctors from our department and from emergency medicine.

"An urgent care board was set up, which has transformed the way we work and, in some respects, was ahead of its time. It was clear everyone needed to work together – in the hospital and the community. The board focused on four major work streams: keeping patients out of hospital; working in the emergency department itself; managing flow through the hospital; and discharging patients.

"The crucial thing we did was to ensure that each work stream was led by a consultant or doctor. The urgent care board is chaired by a GP. It's evident

that the whole hospital needs to work together to ensure patient flow is continuous."

Among the initiatives was the development of a range of systems around daily board rounds. Everything that has happened to the patient is recorded on electronic whiteboards. Consultant and teams spend half an hour on this each morning. Lots of training has been done to ensure a consistent approach.

For the judges of the CHKS excellence in A&E award, the trust was a worthy winner as it showed a clear focus on the patient experience, demonstrating compassionate care and good outcomes. Crucially it has established strong links throughout the system, within the hospital and in the community. The judges felt excellent in-hospital front-door support was combined with a solution-focused approach, with innovations such as virtual hospital wards. The trust also demonstrated strong leadership, which is essential for a smooth-running department.

Harrogate and District NHS Foundation Trust cares for the population of North Yorkshire and York and North East Leeds. It has strong links with the other health and care providers across the county to ensure the needs of people who use its services are met before, during and after their treatment.

For chief executive Dr Ros Tolcher, strong leadership and making sure the whole hospital takes responsibility for patient flow is key to a smooth-running emergency department. It's also fundamental to delivering high-quality care consistently. She says: "High-performing organisations don't happen by accident and they don't happen overnight. They require leaders with the right sense of purpose and values, and attention to things that really matter. This means the things that really matter to staff as well as to people using the services.

"That means giving staff clarity on what is required – for a small- to medium-sized hospital, we rely heavily on staff across the organisation being flexible and all hands on deck when the going gets tough."

Like all emergency departments, Harrogate has surges in demand where there needs to be flex in the whole hospital in order to avoid crowding. Ros says: "We

have worked hard to ensure that the whole hospital owns the target of moving people through the department by creating the conditions for success. We ask ourselves: 'What does good look like in terms of safety, patient experience and clinical outcomes? Now you tell me how we are going to get there'. It helps staff take responsibility and own the decisions."

An internal summit was recently held to bring together a wide range of staff, from clinicians to managers. Ros says: "Instead of sitting down and saying performance is slipping, we used an appreciative enquiry approach, bringing doctors, nurses and managers from all directorates. The aim was to create the conditions for success. We asked: 'What are the current arrangements and behaviours that allow us to deliver compassionate care in a timely manner and what are the things that get in the way of this?'"

In line with evidence that shows that a person with acute needs has a better outcome the earlier they are seen by a decision maker, specialty doctors are brought down to the department as soon as possible.

Ros says: "The staffing needs to be proportionate to the level of demand – when you

have walking wounded coming through one door and seriously ill on trolleys, you need to have a system where lower-risk, high-volume patients are treated at the same time as the seriously ill are handled.

"I'm a great believer in giving the problem back to the people who are in the department to solve because they are the ones who live with the outcome of that decision. Instead of telling people what to do, we need to give them permission to problem solve by giving the issue back to the team, perhaps rephrasing it, so that they offer up realistic solutions. They will make it work when they have designed the solution."

At Harrogate good protocols are not just about the ability to respond but also about goodwill, trust and the recognition that everyone wants to do the right thing for the patient. Ros says: "These are some of the softer things around organisational culture. In a small organisation, it just wouldn't work if people said that's not my job, or I'm not rostered to work there.

"There has to be a lot of give and take between clinical teams. We have to look at specific needs of patients on a ward each day and there has to be willingness for flexing on a continuous basis."

→ LEADERSHIP, TEAM ETHOS AND BOARD SUPPORT

CASE STUDY
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Reaching out into the community from Dorset County Hospital NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust is the main provider of acute hospital services to around 210,000 people living in Weymouth and Portland, West Dorset, North Dorset and Purbeck.

Its emergency department sees around 45,000 patients each year, even though the department was only built to accommodate 23,000. This presents the trust with one of its main challenges, although chief executive Patricia Miller prefers to see it as a strength of the team, given that it is able to deal with the numbers and still meet the four-hour target.

As well as putting in procedures to ensure a good front-door presence, with consultants available until about 9pm as well as at weekends, the hospital has built strong links with the community.

It is widely recognised that good community care ensures busy emergency departments keep flowing and don't get gridlocked. By creating good links with the county council, the trust has created Hospital-

at-Home care. Patients are assessed in the department or emergency assessment unit, but if the trust thinks their condition can be managed at home, a comprehensive care plan is put in place with regular visits from the Hospital-at-Home team. This team is based in the hospital but operates in the community.

The care includes a daily, consultant-led, multidisciplinary review of the care plan. The team also has a wifi-enabled system to update details of that day's visit onto a tablet for review by clinicians.

Evidence shows that in a good emergency department staff feel supported and there is investment in their development; there is a focus on staff engagement and development across the trust. Staff are empowered to make their own decisions. The trust now has a flattened management structure to avoid the need to go through layers of committees for every decision.

Feedback is also considered very important – whether it is from

patients or staff. Patricia says: "By welcoming feedback you can see when you've done a good job but also when things need to improve. That's when you're really able to introduce change to the system."

The hospital has been using patient feedback to help improve patient experience. Patricia says: "I want my personal care needs to be addressed as well as the clinical. I want my care package to be put together with me rather than around me and to be treated with dignity and respect. If I choose, I want my relatives to be kept informed. I would also want to leave with a good clinical outcome and knowing that my expectations have been met."

Patricia says it is rare that complaints to the trust are based around clinical care. Often, complaints are linked to customer service and communication. She says staff are having to change the way they relate to patients as they no longer stay in hospital long enough to build a relationship as before.

CONCLUSION

It is clear emergency departments are under pressure. Many patients still gravitate toward them by default if they can't access the services they need in the community, or don't know where else to go.

Patient numbers are increasing year on year, patients are sicker, and children and the elderly make up a significant proportion of them. Around 20 per cent of the workload is made up of people aged over 65.

To avoid crowding and gridlock within the emergency department, good trusts are looking at the issue as a hospital-wide challenge: freeing up ward space with early discharge and short-stay wards, and making sure patients are seen as early as possible by a senior clinician to avoid unnecessary admission.

A good patient experience has to be the ultimate focus, with the patient feeling as though they have been given the most appropriate care. They want to feel that they have been treated with empathy and involved in their care package rather than it being put in place around them.

Most patients would rather be treated and sent home where possible, so top trusts are creating short-stay wards and discharge wards to facilitate this. An early consultation from a senior clinician can establish where a patient needs to be treated and by whom.

Daily, rather than weekly, ward rounds can prevent delayed discharge, and discharging as many people as is appropriate during the morning can ensure beds are free as demand builds during the day.

Integrated systems are crucial and it is widely accepted that emergency departments cannot stand alone. The hospitals that are leading the way are building good links with the community, finding ways to discharge patients back to their own homes with the help of health and social care teams, rather than to a residential home. This brings better long-term outcomes for patients and prevents residential homes reaching capacity and patients backing up at hospitals because there is nowhere to go after their acute needs have been met.

Good trusts are working with social care teams and GPs to create urgent care boards to improve patient flow in the hospital and provide the right care for discharged patients.

Top emergency departments are not only creating a good patient experience, but they are focusing on their staff and providing ways for them to develop, giving them time away from the frontline. Emergency nurse practitioners are seen as a good way to develop staff and ensure faster care for patients. The top trusts recognise that showing staff operating in a high-pressure environment that they are valued will help them improve the patient experience; empathy has to work both ways.

Therefore, good leadership from the top down is vital for a good hospital. Boards that understand the needs of emergency departments know that bringing the whole hospital and the community into the equation is the best way to optimise patient flow, and that investing in staff is an important way to enhance the patient experience. ●

REFERENCES

1. NHS Interim Management and Support. *Effective approaches in urgent and emergency care, paper 1: priorities with acute hospitals*. 2011. tinyurl.com/NHSE-emergencycare1
2. The King's Fund. *What's going on in A & E? The key questions answered*. 2015. tinyurl.com/KingsFund-AandE
3. NHS England. *High quality care for all, now and for future generations: transforming urgent and emergency care services in England. Emerging principles from the urgent and emergency care review*. 2013. tinyurl.com/NHSE-urgentcare
- 4 Francis, R. *Report of the Mid-Saffordshire NHS Foundation Trust public enquiry*. 2013. tinyurl.com/francis-midstaffs
5. Royal College of Emergency Medicine. *The drive for quality: how to achieve safe, sustainable care in our emergency departments*. 2013. tinyurl.com/RCEM-drive4quality
6. Brown, R, Faculty of Medical Leadership and Management. *The role of effective leadership in securing a positive future for emergency medicine*. 2013. tinyurl.com/Brown-effectiveleadership

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