

This media release will be issued by the national team later today.

FUNDING FOR NHS COMMUNITY SERVICES WILL REDUCE LONG STAYS IN HOSPITALS

A new scheme to reduce unnecessary long hospital stays is set to be rolled out across the NHS.

Under new national guidance, health leaders in different parts of the country will be expected to allocate extra funding to community services like district nursing teams and outreach clinics to help them care for more patients, freeing up hospital beds and staff.

As well as being better for those patients who could otherwise get stuck on wards, the initiative will create more capacity for patients requiring routine operations such as hip and knee replacements, reduce waiting lists and help hospital bosses to manage periods of extra pressure on emergency care services.

Nearly 350,000 patients spend more than three weeks in a hospital each year. That is around a fifth of beds, or the equivalent of 36 hospitals.

Some patients need to be there for medical reasons but many could go home or may never have needed to be admitted if alternative services were more readily available.

The new Excess bed days initiative, confirmed today by NHS England, is part of a series of measures the health service is taking to reduce the number of long-staying patients by 25%.

The one quarter reduction ambition was announced by the Chief Executives of NHS England and NHS Improvement earlier this year.

Pauline Philip, national director for urgent and emergency care for NHS England, said:

“Reducing unnecessarily long stays in hospital is good for patients and makes better use of NHS resources.

“Anyone over 80 who is in hospital for longer than ten days risks ten years of muscle ageing, so where it’s safe to do so, the health service and councils should work together to get people care closer to home.

“Redirecting more funding to community services will unlock vital extra resources

for patient care. By integrating health services more effectively, as well as joining up the links between the NHS, councils and other services our patients will get better care and we'll get more value from taxpayers' funding."

Currently, hospital stays of 21 days and longer account for one in five of all beds across the health service in England.

Although some patients in hospitals for an extended period of time need to be there for medical reasons, others do not. In June, NHS England's Simon Stevens and NHS Improvement's Ian Dalton confirmed that organisations across the health service had committed to reducing long stays to free up 4,000 beds in time for an anticipated rise in demand over winter.

Background notes

Under the Excess bed day scheme community health services, CCGs and acute hospitals will agree a plan to reduce the number of excess bed days, to transfer patients to a more appropriate place for care.

As the number of excess bed days in hospitals falls as part of the initiative, the savings will be transferred by the CCG to community services. Local organisations also will be permitted to share any savings and to reinvest it in services needed in their own area.

By freeing up bed space, acute hospitals will be able to deliver more elective surgery including hip, knee and cataract operations, which will reduce waiting times for these patients and allow acute trusts to gain income by performing more operations.

Currently, in some areas due to high demand and long waiting lists, some patients end up having their operation performed by a private care provider. Under this scheme, better integration of care, safe and efficient transfers of patients and investment in more operations will reduce the need for NHS procedures to be performed privately.

Thank you

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03/08/2018

To: Community provider Chief Executives
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Publications Gateway Reference: 08330

Dear colleague

Excess bed day incentive scheme

We are writing to set out the key recommended features of voluntary local incentive schemes to reduce excess bed days, through collaboration between CCGs, acute and community providers. Local areas are expected to adopt an excess bed day incentive scheme to improve patient experience and improve efficiency across the local health economy. This is particularly important for the CCGs with the highest excess bed day spend per head of weighted population.

There is clear evidence that staying in hospital for longer than required drives adverse outcomes for patients. It is also costly to keep patients in hospital for longer than is necessary. Local areas should seek to reduce lengths of stay across the inpatient setting by following best practice guidance on discharging patients. NHS Improvement has published the “*Good practice guide: Focus on improving patient flow*”¹ which may be used as the starting point for a best practice discussion.

Whilst for some patients an extended length of stay will be clinically appropriate, there is significant variation across the country – the highest quartile of CCGs have almost three times the rate of excess bed days compared to those in the lowest quartile. This indicates that there are opportunities to reduce length of stay by transferring these patients to a more appropriate setting, including in the community. If all CCGs had an excess bed day rate per head of weighted population equal to the average of the upper quartile of performers, around 1 million bed days would be freed up from acute hospitals, equating to £0.2bn.

The onward transfer of patients to a more appropriate setting requires acute and community providers to work together with their local CCG. To encourage this further,

¹ <https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow>

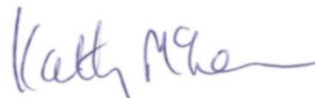
we have developed the attached document on local incentive schemes to reduce excess bed days. It recommends that community and acute providers agree a baseline level of excess bed days with their local CCG and a plan to reduce them below that level. All the savings to the CCG from this reduction should be transferred to the community provider, unless the local partners agree to share the savings in a different way. This will ensure that the funding follows optimal patient flows.

We are aware that some health systems have already implemented a scheme of this nature; where this has happened we are not seeking changes to the existing arrangements. However, where there is not a scheme in place for excess bed days and community investment, we encourage STP and ICS leaders to support this being rolled out in every system.

Yours sincerely



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Excess bed day incentive scheme

Summary

1. This document sets out the key recommended features of voluntary local incentive schemes to reduce excess bed days, which will in turn:
 - Improve patient flow and efficiency in acute hospitals to improve patient outcomes and experience
 - Help acute hospitals reduce super-stranded patients by 25% to reduce the patient harm that comes from excessive stays in hospitals and create the extra capacity needed for elective and emergency care
 - Recognise that community providers need to be appropriately reimbursed if they are to care for more patients
 - Share the benefits across participating organisations
 - Encourage more integrated working on delayed discharges, 'stranded' patients and reducing length of stay
2. **Annex 1** provides background information.
3. Local areas are expected to adopt an excess bed day incentive scheme to improve patient experience and improve efficiency across the local health economy. This is particularly important for the CCGs with the highest excess bed day spend per head of weighted population. The CCGs which lie in the highest quartile of CCGs ranked by excess bed days per head of weighted population, are shown in Annex 2.

Proposed key features of local incentive schemes

4. Community and acute providers should agree with the CCG a baseline level of excess bed days that the CCG will have to fund if the status quo remains and a target for the reduction of this number in the local acute provider that will result from focused management and investment in community services. The community provider, CCG and acute provider should then agree a plan to reduce the number of excess bed days and transfer patients to the most appropriate setting.
5. If the total number of excess bed day payments by the CCG to the acute provider falls, then all the savings to the CCG should be transferred to the community provider, unless the local partners agree to share the savings in a different way. If the CCG and/or acute provider agree to invest in community services in advance to share the upfront risk with the community provider, they should expect to recover their investment and a share of any additional savings if the programme is successful.
6. Most of the service changes necessary to deliver the reduction in excess bed days should be achievable through targeted management within the community services, with any additional investment in staff and services funded by the resulting reduction in excess bed days and a monthly transfer of resources from the CCG.

7. The CCG, acute provider and community provider should agree a series of KPIs for any investment in community services, such as:
 - a. A specified number of community beds and community teams available
 - b. The planned growth in beds or non-inpatient staff
 - c. Community bed occupancy to remain below a set percentage and domiciliary productivity to go up through more efficiency work
 - d. Community discharge planning team available 7 days per week
 - e. Admissions are accepted by the community provider 7 days per week
8. Where there are multiple community providers supporting the same acute provider, local agreement will be required on how funds will be distributed and how risk will be shared.
9. The reduction in excess bed days should contribute to freeing up capacity in the acute setting and continued improvements in patient flow through the hospital. Most parts of the country are currently not meeting waiting time standards or reducing their emergency bed occupancy to the required levels to confidently prepare for winter. As a result, it may be possible to use this freed up capacity to provide elective activity that is covered by existing contracts without an adverse impact on CCG finances.
10. Where acute providers are able to over-perform their elective contract, the provider and commissioner should discuss the affordability of using any freed capacity to further increase levels of activity.
11. It is likely that in taking targeted action to reduce excess bed days, there will also be some reductions in length of stay for some patients who are current long stayers but below the excess bed day trim point. This will help to offset the loss of income for the acute provider and improve patient flow to help meet the 4-hour A&E standard.

Local and national monitoring

12. Local areas should set clear and specific targets for the reductions in excess bed days that they are seeking to achieve from targeted action – with clarity about the specialties (some or all) to which these targets apply.
13. Routine monitoring of these metrics, along with regular local performance reviews, should identify early on where actions are having the desired effect and where they are not. Discussions about any remedial action to return to plan should happen regularly and with reference to performance in peer organisations.
14. Nationally, we will regularly publish statistics of excess bed days by CCG and provider.

National tariff payment system

15. Where local areas have agreed contracts using national prices as specified in the National Tariff Payment System (NTPS), the commissioner will need to submit a

local variation to NHS England and NHS Improvement to confirm any new arrangements. To help reduce burden locally, NHS England and NHS Improvement will produce some exemplar templates that can be used to submit this information.

16. Areas of the country that have already agreed local variations to prices specified in the national tariff should still agree a local incentive scheme if it is likely to reduce length of stay in the acute provider by an amount greater than planned. Where areas are operating with some form of block or fixed payment, the published national prices for excess bed days could be used as a starting point for local negotiation.

Annex 1 - Background

1. Some patients stay in hospital longer than others, even if they have similar characteristics and receive similar treatment. In order to fairly reimburse hospitals when patients remain in hospital longer than expected, the national tariff payment system requires that CCGs pay an additional amount to the provider per day after a pre-determined length of stay¹, which varies by HRG – an excess bed day payment. In 2017/18 commissioners paid providers £0.6bn² in excess bed day payments. However, the number of excess bed days varies across the country, and the highest quartile of CCGs pay for almost three times the rate of excess bed days compared to the ones in the lowest quartile. This is after controlling for each CCG's weighted population and so cannot be explained by casemix alone.
2. If all CCGs had an excess bed day rate per head of weighted population equal to the average of the upper quartile of performers, around 1 million bed days would be freed up from acute hospitals, offering better patient experience and improved patient flow across the hospital. This offers the potential to free up around £0.2bn of the £0.6bn paid in excess bed days to be invested in community services to provide care closer to home for tens of thousands of patients.

Patients with long lengths of stay

3. There are likely to be three main reasons that patients stay in hospital for a longer than expected period triggering these excess bed day payments:
 - Even within the same HRG, the complexity of patients' needs varies. Some patients will stay in hospital for good medical reasons, probably within specialist centres.
 - In some cases, patients could be discharged sooner with more consistent clinical practice and organisation within the hospital.
 - Some patients will be medically fit for discharge but cannot be discharged because of delays in setting up the health and care support packages needed to support them at home.
4. Some stranded patients (patients with a length of stay of 7 days or more) and super stranded patients (patients with a length of stay of 21 days or more) could be discharged from hospital earlier with better service integration between acute and community organisations. Some of these stranded and super stranded patients will have stayed in hospital for a period of time which triggers excess bed day payments.

¹ This 'trimpoint' is calculated for each HRG as the upper quartile plus 1.5 times the interquartile range. Each trimpoint is published in the national tariff payment system document.

² Providers reported they incurred £1.4bn of excess bed day costs in 2016/17 reference costs (£1.2bn relating to non-elective admissions). For payment purposes, the tariff is calculated on a spell basis rather than an episode basis (as in reference costs) and a floor of 5 days is introduced which prevents an incentive to keep very short staying patients in one extra day to trigger an excess bed day payment, which may be a relatively high amount compared to the cost of the spell. Taken together, the payment system explicitly reimburses around half of the provider self-reported excess bed day costs in reference costs through excess bed day payments.

New local incentive schemes

5. By creating a local incentive scheme which aims to reduce the number of stranded and super stranded patients, resources which were being used by commissioners to pay for long staying patients in hospital (the excess bed day payments) can be redeployed to other parts of the health system to provide more opportunities to discharge patients in a more timely manner, when medically fit to do so.
6. Local areas should seek to reduce lengths of stay across the inpatient setting by following best practice guidance on discharging patients and with regard to levels in peer organisations. NHS Improvement has published the “Good practice guide: Focus on improving patient flow³” which may be used as the starting point for a best practice discussion.
7. The guide sets out:

“The outcome of following best practice is that patients are discharged as soon as they no longer benefit from acute hospital care and in most cases, discharge is to a person’s usual place of residence. The core principles to follow to achieve such an outcome are:

- *Therapy and social work teams should work at the front of the acute care pathway, routinely collecting information on how patients have been managing at home before becoming acutely unwell.*
 - *On admission, the expectation should be that people will be discharged to their usual place of residence, with additional support if required, and assessment of their longer term needs undertaken there rather than in hospital.*
 - *A clear clinical care plan must be set for all patients within 14 hours of admission, which includes an expected date and time of discharge that are linked to functional and physiological criteria for discharge.*
 - *There should be a strong focus on ‘simple’ discharges. The SAFER patient flow bundle and ‘Red2Green days’ tools should be used routinely to ensure the most appropriate care for patients on all hospital wards.*
 - *Board rounds should take place on all hospital wards each morning. The multidisciplinary team should review the clinical plan (including the discharge elements) on the board rounds and any decisions communicated to the patient.*
 - *Duplication of assessment should be minimised using trusted assessors, building on the functional information collected on admission (see below).*
 - *There should be a single point of access for health and social care to support ‘discharge to assess’. Integrated discharge teams should be linked to an integrated intermediate tier of local services.”*
8. Local areas should focus on how better use of community and out of hospital services can improve patient flow in the hospital. This may require investment in additional community capacity or redesigning how existing community services interact with patients who are in hospital.

³ <https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow>

Variations in levels of excess bed days

9. CCG commissioned activity data shows that there were around 2.3m excess bed days in 2017/18, around 38 excess bed days per 1,000 population, but this hides variation at CCG level. The lowest quartile CCGs had on average 21 excess bed days per 1,000 weighted population, compared to 57 in the highest quartile. Table 2 shows the summary by quartile, ranking CCGs from highest to lowest number of excess bed days per head of weighted population.
10. Annex 2 shows each CCG ranked by excess bed days per 1,000 weighted population.
11. Specialty level data also shows variation, with paediatric specialities incurring the highest proportions of bed days classed as excess bed days. In raw numbers, nervous system, digestive system and respiratory system accounted for around 0.8 million excess bed days, around one third of the total number of bed days including non-CCG commissioned activity. Annex 3 shows the differences between specialties.

Table 2 – summary excess bed days by CCG quartile and reduction opportunity

Quartile	Excess bed days	Weighted Population	Excess bed days per head of weighted population	Reduction if everyone at the lowest quartile rate
1	921,041	16,126,731	57.1	575,363
2	630,676	16,794,551	37.6	270,683
3	395,553	13,067,381	30.3	115,452
4	272,896	12,731,257	21.4	-
All	2,220,166	58,719,921	37.8	961,498

12. Local incentive schemes could be targeted at the specialties with the largest number of excess bed days and/or specialties where the number of excess bed days appears to be a significant problem compared to peer organisations.

Annex 2 – Variation in the number of excess bed days January-December 2017

CCG Name	Excess Bed Days	Weighted Population	Excess bed days per 1000 weighted population
NHS City and Hackney CCG	26,517	217,080	122.2
NHS Trafford CCG	23,002	255,599	90.0
NHS Manchester CCG	46,861	570,358	82.2
NHS Lewisham CCG	19,781	250,728	78.9
NHS Portsmouth CCG	15,174	203,159	74.7
NHS South Sefton CCG	13,620	189,449	71.9
NHS Dorset CCG	62,622	897,136	69.8
NHS Bath and North East Somerset CCG	13,850	198,603	69.7
NHS Cumbria CCG	26,023	381,336	68.2
NHS West Hampshire CCG	40,777	602,187	67.7
NHS Nene CCG	42,067	651,154	64.6
NHS Lancashire North CCG	28,491	443,878	64.2
NHS Southampton CCG	15,743	264,745	59.5
NHS East Lancashire CCG	25,974	442,508	58.7
NHS Fareham and Gosport CCG	12,521	214,680	58.3
NHS Leeds CCG	47,638	841,070	56.6
NHS Dartford, Gravesham and Swanley CCG	13,854	253,318	54.7
NHS South Eastern Hampshire CCG	12,342	226,776	54.4
NHS North Hampshire CCG	11,913	219,566	54.3
NHS North East Hampshire and Farnham CCG	11,873	219,039	54.2
NHS Oxfordshire CCG	34,264	635,244	53.9
NHS Buckinghamshire CCG	26,687	496,338	53.8
NHS Sutton CCG	9,286	178,215	52.1
NHS Cannock Chase CCG	8,093	155,613	52.0
NHS Corby CCG	3,961	76,311	51.9
NHS Surrey Heath CCG	4,900	95,014	51.6
NHS Doncaster CCG	18,298	361,467	50.6
NHS Stockport CCG	18,131	359,726	50.4
NHS Fylde & Wyre CCG	9,703	196,564	49.4
NHS Swindon CCG	10,431	212,607	49.1
NHS Norwich CCG	10,624	219,904	48.3
NHS Somerset CCG	31,515	652,509	48.3
NHS Tameside and Glossop CCG	13,772	285,253	48.3
NHS Wiltshire CCG	25,080	521,815	48.1
NHS Bexley CCG	10,783	231,344	46.6
NHS Greenwich CCG	11,064	238,883	46.3
NHS Blackburn with Darwen CCG	8,780	190,599	46.1
NHS Herefordshire CCG	9,244	202,417	45.7
NHS North Norfolk CCG	9,653	211,415	45.7
NHS West Leicestershire CCG	17,059	373,722	45.6
NHS West Kent CCG	21,099	466,097	45.3
NHS East Surrey CCG	8,031	177,628	45.2
NHS Eastbourne, Hailsham and Seaford CCG	10,297	229,883	44.8
NHS Surrey Downs CCG	12,813	287,086	44.6
NHS Lambeth CCG	12,333	279,652	44.1
NHS Ealing CCG	14,725	335,225	43.9
NHS Sheffield CCG	25,691	588,192	43.7
NHS Bromley CCG	14,081	325,636	43.2
NHS Newcastle Gateshead CCG	24,591	573,862	42.9
NHS Southport and Formby CCG	6,699	158,608	42.2
NHS Blackpool CCG	9,155	217,079	42.2

NHS High Weald Lewes Havens CCG	7,465	177,500	42.1
NHS Liverpool CCG	24,663	586,438	42.1
NHS Berkshire East CCG	15,704	378,345	41.5
NHS Stafford and Surrounds CCG	6,846	167,613	40.8
NHS Bristol, North Somerset and South Gloucestershire CCG	38,730	953,317	40.6
NHS Greater Preston CCG	9,308	230,302	40.4
NHS Hillingdon CCG	10,943	273,940	39.9
NHS Stoke on Trent CCG	12,475	313,471	39.8
NHS Wandsworth CCG	10,204	256,506	39.8
NHS Southwark CCG	9,295	234,166	39.7
NHS Milton Keynes CCG	10,054	254,054	39.6
NHS North Tyneside CCG	10,563	270,230	39.1
NHS Brighton & Hove CCG	10,028	258,192	38.8
NHS Kernow CCG	27,017	697,744	38.7
NHS Scarborough and Ryedale CCG	5,358	138,940	38.6
NHS Walsall CCG	11,800	306,479	38.5
NHS Merton CCG	6,515	169,756	38.4
NHS Harrogate and Rural District CCG	6,469	169,512	38.2
NHS Lincolnshire East CCG	11,767	308,392	38.2
NHS Birmingham and Solihull CCG	48,050	1,266,141	37.9
NHS West Lancashire CCG	5,004	133,970	37.4
NHS Great Yarmouth & Waveney CCG	10,639	287,302	37.0
NHS South Norfolk CCG	8,857	240,043	36.9
NHS Haringey CCG	8,833	240,267	36.8
NHS Guildford and Waverley CCG	7,218	198,026	36.4
NHS West Norfolk CCG	8,090	223,153	36.3
NHS Horsham and Mid Sussex CCG	8,223	228,204	36.0
NHS Coventry and Rugby CCG	17,274	479,962	36.0
NHS Lincolnshire West CCG	8,660	243,831	35.5
NHS Herts Valleys CCG	20,601	580,985	35.5
NHS South East Staffs and Seisdon Peninsular CCG	8,594	242,721	35.4
NHS Northumberland CCG	14,485	409,423	35.4
NHS East Leicestershire and Rutland CCG	11,731	332,164	35.3
NHS North Staffordshire CCG	8,582	243,080	35.3
NHS Gloucestershire CCG	22,916	650,153	35.2
NHS North East Lincolnshire CCG	6,444	183,472	35.1
NHS Enfield CCG	9,976	285,730	34.9
NHS West Cheshire CCG	10,372	297,504	34.9
NHS North, East, West Devon CCG	35,991	1,038,992	34.6
NHS Thurrock CCG	5,473	158,695	34.5
NHS North Durham CCG	10,004	290,923	34.4
NHS South Tyneside CCG	6,948	203,511	34.1
NHS Hounslow CCG	7,974	234,920	33.9
NHS Tower Hamlets CCG	6,915	203,725	33.9
NHS Berkshire West CCG	14,641	431,535	33.9
NHS Durham Dales, Easington and Sedgfield CCG	12,532	371,673	33.7
NHS Cambridgeshire and Peterborough CCG	28,784	857,008	33.6
NHS Croydon CCG	11,593	345,575	33.5
NHS Harrow CCG	7,354	220,364	33.4
NHS Hastings & Rother CCG	7,095	212,725	33.4
NHS Waltham Forest CCG	8,052	242,212	33.2
NHS Airedale, Wharfedale and Craven CCG	6,069	184,522	32.9
NHS Coastal West Sussex CCG	19,690	601,829	32.7
NHS Eastern Cheshire CCG	7,334	225,743	32.5
NHS Halton CCG	5,136	158,601	32.4
NHS Thanet CCG	5,370	166,617	32.2
NHS Crawley CCG	3,888	121,615	32.0

NHS Central London (Westminster) CCG	4,640	146,412	31.7
NHS South West Lincolnshire CCG	4,572	144,550	31.6
NHS Wirral CCG	13,473	426,931	31.6
NHS Calderdale CCG	6,950	220,868	31.5
NHS Ipswich and East Suffolk CCG	13,290	424,469	31.3
NHS Hartlepool and Stockton-on-Tees CCG	10,887	347,891	31.3
NHS Isle of Wight CCG	5,103	163,266	31.3
NHS Wakefield CCG	13,217	424,899	31.1
NHS Brent CCG	8,820	283,808	31.1
NHS Leicester City CCG	10,273	331,199	31.0
NHS South Lincolnshire CCG	5,728	185,709	30.8
NHS Basildon and Brentwood CCG	8,317	271,765	30.6
NHS Bradford City CCG	3,320	109,441	30.3
NHS North Derbyshire CCG	10,190	336,867	30.2
NHS East Staffordshire CCG	4,423	146,462	30.2
NHS North Lincolnshire CCG	5,804	192,201	30.2
NHS Knowsley CCG	6,361	213,757	29.8
NHS Warrington CCG	7,128	241,459	29.5
NHS Redditch and Bromsgrove CCG	5,322	183,574	29.0
NHS Bradford Districts CCG	10,444	360,291	29.0
NHS Luton CCG	5,879	203,911	28.8
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	5,172	181,041	28.6
NHS Redbridge CCG	7,142	250,020	28.6
NHS Richmond CCG	4,537	159,232	28.5
NHS Hammersmith and Fulham CCG	4,484	157,434	28.5
NHS Sandwell and West Birmingham CCG	15,232	536,637	28.4
NHS Ashford CCG	3,511	123,723	28.4
NHS South Worcestershire CCG	9,240	326,281	28.3
NHS Islington CCG	5,488	195,959	28.0
NHS Salford CCG	8,016	290,402	27.6
NHS Bedfordshire CCG	12,597	458,656	27.5
NHS Chorley and South Ribble CCG	5,717	209,310	27.3
NHS Bury CCG	5,939	218,292	27.2
NHS Warwickshire North CCG	5,528	204,482	27.0
NHS South Kent Coast CCG	6,163	228,072	27.0
NHS West Essex CCG	8,189	304,993	26.8
NHS Vale of York CCG	9,300	346,418	26.8
NHS Barking & Dagenham CCG	4,792	179,892	26.6
NHS Darlington CCG	3,288	123,586	26.6
NHS Bolton CCG	8,688	328,539	26.4
NHS Dudley CCG	9,790	371,654	26.3
NHS South Devon and Torbay CCG	9,255	351,400	26.3
NHS Sunderland CCG	8,617	329,794	26.1
NHS North Kirklees CCG	5,058	196,381	25.8
NHS Havering CCG	7,299	283,904	25.7
NHS Swale CCG	2,926	114,915	25.5
NHS Greater Huddersfield CCG	6,051	239,249	25.3
NHS East and North Hertfordshire CCG	13,982	558,094	25.1
NHS South Warwickshire CCG	7,405	296,467	25.0
NHS Oldham CCG	6,401	260,361	24.6
NHS Hambleton, Richmondshire and Whitby CCG	3,907	161,553	24.2
NHS Nottingham City CCG	8,059	333,680	24.2
NHS Barnet CCG	8,155	338,916	24.1
NHS Heywood, Middleton & Rochdale CCG	6,182	262,159	23.6
NHS Shropshire CCG	8,182	358,388	22.8
NHS Camden CCG	4,453	195,156	22.8
NHS Medway CCG	6,642	292,570	22.7

NHS Barnsley CCG	6,917	307,646	22.5
NHS Newham CCG	5,925	264,411	22.4
NHS Erewash CCG	2,412	108,765	22.2
NHS Telford & Wrekin CCG	4,158	188,294	22.1
NHS Wolverhampton CCG	6,538	297,820	22.0
NHS Rushcliffe CCG	2,772	128,065	21.6
NHS Hardwick CCG	2,737	127,828	21.4
NHS North East Essex CCG	8,273	388,378	21.3
NHS Wyre Forest CCG	2,769	130,900	21.2
NHS East Riding of Yorkshire CCG	7,485	356,864	21.0
NHS Southern Derbyshire CCG	11,560	555,118	20.8
NHS Canterbury and Coastal CCG	4,574	223,349	20.5
NHS St Helens CCG	5,102	251,202	20.3
NHS Nottingham North & East CCG	3,369	169,926	19.8
NHS South Cheshire CCG	4,109	207,657	19.8
NHS Kingston CCG	3,080	155,975	19.7
NHS Wigan Borough CCG	7,668	391,934	19.6
NHS Mansfield & Ashfield CCG	4,374	224,984	19.4
NHS Rotherham CCG	5,525	290,655	19.0
NHS Nottingham West CCG	1,890	102,169	18.5
NHS Vale Royal CCG	2,193	118,826	18.5
NHS North West Surrey CCG	5,889	344,291	17.1
NHS South Tees CCG	5,893	347,079	17.0
NHS Newark & Sherwood CCG	2,579	153,507	16.8
NHS Bassetlaw CCG	2,272	135,283	16.8
NHS Southend CCG	2,917	193,739	15.1
NHS Mid Essex CCG	5,413	381,847	14.2
NHS Castle Point and Rochford CCG	2,791	198,962	14.0
NHS Hull CCG	4,020	315,368	12.7
NHS West Suffolk CCG	3,352	273,650	12.2
All CCG commissioned	2,220,166	58,719,921	37.8

Annex 3 – Variation in the number of excess bed days by specialty (including CCG and specialised commissioned activity)

HRG Subchapter	Total bed days	Excess bed days	Excess bed days as a proportion of all inpatient bed days
Paediatric Immune System Disorders	1,731	1,106	64%
Eyes and Periorbita Procedures and Disorders	96,841	23,429	24%
Pain Management	1,371	274	20%
Paediatric Nervous System Disorders	70,126	13,035	19%
Paediatric Non-Malignant Haematological Disorders	21,982	3,795	17%
Paediatric Rheumatology Disorders	23,642	4,049	17%
Paediatric Gastroenterology Disorders	119,025	19,854	17%
Skin Procedures	60,807	10,112	17%
Ear, Nose, Mouth, Throat and Neck Disorders	346,181	57,235	17%
Paediatric Diabetology, Endocrinology and Metabolic Disorders	26,071	4,200	16%
Paediatric Hepatobiliary Disorders	6,623	937	14%
Spinal Procedures and Disorders	683,256	95,454	14%
Poisoning, Toxic Effects, Special Examinations, Screening and Other Healthcare Contacts	956,443	129,901	14%
Paediatric Cardiology Disorders	26,991	3,478	13%
Paediatric Haematological-Oncology Disorders	67,756	8,104	12%
Musculoskeletal and Rheumatological Disorders	688,994	80,579	12%
Diabetic Medicine	209,172	24,189	12%
Neurological Imaging Interventions	36,156	4,157	11%
Paediatric Medicine	139,142	15,918	11%
Haematological Procedures and Disorders	608,126	61,917	10%
Nervous System Procedures and Disorders	2,991,163	302,863	10%
Paediatric Ear Nose and Throat Disorders	50,630	5,084	10%
Orthopaedic Disorders	833,615	83,338	10%
Ear, Nose, Mouth, Throat and Neck Procedures	176,954	17,354	10%
Paediatric Renal Disorders	24,532	2,392	10%
Multiple Trauma	623,473	57,529	9%
Renal Procedures and Disorders	1,730,942	159,258	9%
Endocrine System Disorders	70,829	6,493	9%
Paediatric Dermatology Disorders	14,528	1,330	9%
Paediatric Trauma Medicine	34,270	3,135	9%
Skin Disorders	699,627	61,183	9%
Metabolic Disorders	280,312	23,838	9%
Vascular Imaging Interventions	170,515	14,095	8%
Breast Procedures and Disorders	105,453	8,661	8%
Urological and Male Reproductive System Procedures and Disorders	752,575	61,741	8%
Paediatric Respiratory Disorders	233,874	19,038	8%
Infectious Diseases and Immune System Disorders	1,970,442	158,291	8%
Digestive System Procedures and Disorders	3,582,366	287,780	8%
Musculoskeletal Imaging Interventions	11,005	875	8%
Cardiac Disorders	1,865,677	145,736	8%
Open and Interventional Procedures for Congenital Heart Disease	60,733	4,678	8%
Vascular Open Procedures and Disorders	524,473	39,186	7%
Orthopaedic Non-Trauma Procedures	1,213,890	77,436	6%
Interventional Cardiology for Acquired Conditions	776,441	48,485	6%
Female Reproductive System Disorders	146,553	8,919	6%
Paediatric Infectious Diseases	200,595	11,159	6%
Respiratory System Procedures and Disorders	4,722,526	249,535	5%
Hepatobiliary and Pancreatic System Disorders	749,115	37,558	5%
Hepatobiliary and Pancreatic System Endoscopic Procedures	205,721	10,228	5%
Hepatobiliary and Pancreatic System Open Procedures	204,133	9,940	5%
Orthopaedic Trauma Procedures	1,335,230	62,952	5%
Neonatal Disorders	475,117	22,196	5%
Thoracic Imaging Interventions	3,706	155	4%
Gastrointestinal Imaging Interventions	46,727	1,801	4%
Hepatobiliary and Pancreatic Imaging Interventions	40,962	1,383	3%
Female Reproductive System Procedures	231,193	7,796	3%
Obstetric Medicine	1,444,971	47,356	3%
Paediatric Ophthalmic Disorders	8,346	250	3%
Open Cardiac Procedures for Acquired Conditions	218,727	4,370	2%
Urological Imaging Interventions	5,498	64	1%
Dental and Orthodontic Procedures	4,315	-	0%
Breast Imaging Interventions	2,128	-	0%

Guide to reducing long hospital stays

June 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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1. Introduction

Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare-associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning).

Tackling long stays in hospital will reduce risks of patient harm, disability and unwarranted cost, particularly for those who are intrinsically vulnerable because they have mild or moderate frailty and/or cognitive disorder, and for whom a different, more positive outcome can be achieved if the right steps are taken very early in their admission.

Hospital-related functional decline in older patients and the subsequent harm has dreadful consequences for many patients, and is something we should not tolerate.

- A stay in hospital over 10 days leads to 10 years of muscle ageing for some people who are most at risk (see Section 12 for the evidence).
- 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%.
- Extensive use of audit tools has shown 20% to 25% of admissions and 50% of bed days do not require an 'acute' hospital bed as these patients' medical needs could be met at a more appropriate, usually lower, level of care.
- 39% of people delayed in hospital could have been discharged using different, usually lower dependency, pathways and services more suited to meeting their assessed needs.
- Typically these audits show that up to half the reasons why patients are not discharged earlier are under the direct control of the hospital itself and often relate to ineffective internal assessment processes, lack of decision-making and poor organisation of care management.

Congested hospitals struggle to deliver best care. They are too full to treat 95% of A&E patients within four hours and to provide the kind of patient and staff

experience that they should. Reducing bed occupancy to improve flow through the system greatly improves the working and care environment, reduces A&E crowding and enables patients consistently to be treated in the right bed by clinical teams with the right skills.

Nearly 350,000 patients currently spend over three weeks in an acute hospital each year. Many of these are older people with reduced functional ability (frailty) and/or cognitive impairment (delirium or dementia). Long-stay patients account for about 8% of overnight admissions, have an average length of stay (LoS) of about 40 days. Around one-fifth of beds are occupied by patients who have already been in hospital for three weeks.

Every day in hospital is a precious day away from home. We want to embed a 'home first' mindset across our health and social care systems and do everything we can so our patients, particularly older people, can enjoy their lives in their own home environments or, for the few who cannot go straight home from hospital, in a care location most suited to meeting their needs.

The benefits of reducing the time a patient occupies a hospital bed are clear, but achieving it has proven difficult, particularly during winter. This guide explains what can be done to implement the approaches proven to reduce LoS (see Figure 1). We go beyond principles, describing the practical steps and suggesting tactics to employ. This is a 'how to' guide, not high-level guidance. It is primarily aimed at acute and community trusts, but refers to how system partners, social services, the voluntary/third sector, independent care providers and unpaid carers can play a supporting role.

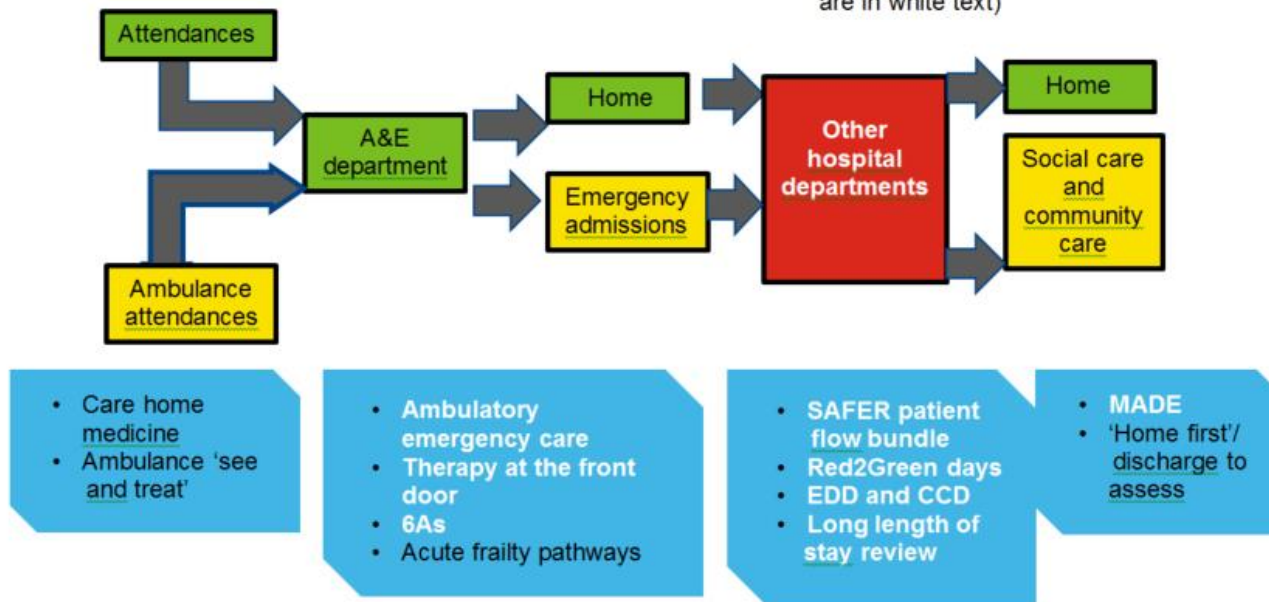
These tactics must of course be carefully considered and implemented with an eye to local circumstances. One size does not fit all. We stress the need to use effective improvement approaches and in particular plan, do, study, act (PDSA) cycles to ensure that new approaches are implemented in a way that works locally.

Figure 1: Where to focus for maximum impact on reducing length of stay*

Reducing length of stay

Numerous studies have shown that effective action by hospitals to improve patient flow beyond emergency departments has the greatest impact on length of stay. Whole-system collaboration to expedite discharges is also important.

- Minor or no impact on length of stay
- Moderate impact on length of stay
- Considerable impact on length of stay
- Approaches/tactics to reduce length of stay (those covered in this guide are in white text)

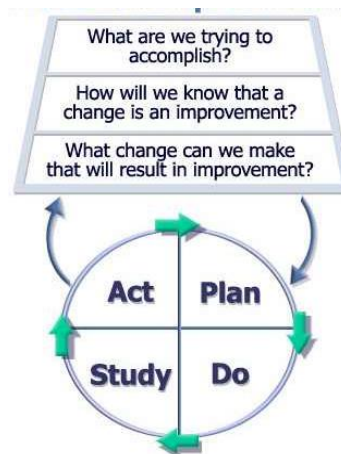


* We will publish detailed guidance on preventing deconditioning in frail older people later this month. See Section 12 for links to guidance on medicines in care homes, see and treat, and home first/discharge to assess.

2. How to approach improvement: a primer

All improvement is change, but not all change is improvement! Too often the mantra is ‘something must be done’ at ‘pace and scale’. But do not be tempted to implement a solution too quickly or without fully understanding the problem and the local context.

The [Institute for Healthcare Improvement’s model for improvement](#) is a simple, systematic and effective approach to problem identification and bringing about effective change.



1. **What do you want to achieve?** Define the issue you are trying to solve and the required outcomes. Identify the main internal and external stakeholders. Consider the context. Use tools such as [affinity diagrams](#), [fishbone diagrams](#), [Pareto](#) and the [five whys](#) to gain clarity.
2. **How will you know that a change is an improvement?** Decide what metrics to use to monitor progress (process metrics), to demonstrate you have achieved the desired outcome (outcome metrics) and to spot any unintended consequences (balancing metrics).

For example – dieting:

- outcome metrics: weight and waist measurement
- process metrics: number of calories eaten each day and minutes of exercise

- balancing metric: level of happiness.

Real-time data for these metrics need to be plotted on statistical process control (SPC) charts to show trends and normal variation in any process. 'Before and after' data on their own can be very misleading (see [Making data count](#)).

3. **What change(s) will result in improvement?** Once the problem is clearly defined and metrics identified, you can work on ideas for changes that will result in the desired improvements. Pull as many ideas as possible from everyone involved before creating a shortlist. If you are struggling to generate new ideas, tools such as [brainstorming](#), [simple rules](#) and [six thinking hats](#) may help.

Use [plan, do, study, act \(PDSA\) cycles](#) to test the shortlisted changes. The intended outputs of a PDSA cycle are learning and informed action. Multiple PDSAs are usually needed to refine and localise changes. Although a simple method, PDSA mirrors the steps of scientific inquiry. The amount you can learn from PDSA cycles depends on the rigour with which you complete each step and the consistency of purpose in iterative cycles of change.

Connecting this guide to the model for improvement

Some of the tools and approaches in this guide help you with question 1 of the model for improvement: What do you want to achieve? For example, if you need to understand why patients are staying in hospital for seven days or more, you will have a large number of patients to review. Tools such as Pareto analysis can help break down the problem into smaller components.

Other tools allow you to focus on the delays and constraints that increase length of stay. The [Red2Green days approach](#), for example, provides real-time data highlighting local constraints. Using simple tools such as fishbone diagrams and the five whys, frontline teams and wards can work to eliminate waits specific to their area. The Red2Green days approach is best implemented through multiple PDSA cycles to iron out implementation issues and fully localise it.

A comprehensive and free collection of proven service quality improvement and redesign tools, theories and techniques that can be applied to a wide variety of situations is provided on the [NHS Improvement website](#) as well as more information about [building improvement capability in your organisation](#).

3. 6As for managing emergency admissions

What is it?

The [6As for managing emergency admissions](#) is a tool which enables review of the main options that could have been selected at the point the emergency department (ED), primary care or another service requested an admission. It identifies service gaps that may have led to patients being admitted on suboptimal pathways.

Impact

Learning from the review may stimulate initiatives to improve the management of patients being considered for admission at the start of the acute pathway. Senior decision-makers receive a report summarising findings to inform their actions. This can reduce inappropriate admissions or the LoS of those admitted. Also, the learning within the review group on the day can result in swift improvements.

Works best with

Using the 6As approach works best when there is system-wide multidisciplinary representation, including from external partners in social care, the voluntary and independent sectors, and primary and community services, and the results are shared widely. The 6As approach should inform wider plans to improve care across the system.

Ease of implementation

The process is straightforward. A six-week lead-in time is necessary to ensure a good attendance. The team required and processes involved are described below. Following up the findings and configuring new pathways is more challenging as it requires the involvement of commissioners and system-wide working.

Typical time to implement

At least 40 sets of notes should be audited. About four to six hours should be allowed for the exercise. One member of the facilitating team should be responsible for keeping conversations on track and timely.

Team needed to implement

A multidisciplinary, system-wide team is required to undertake the review. Collectively it should have a thorough understanding of service provision across the whole system. It may include ED consultants and senior nurses, acute medical consultants and senior nurses, a GP with good local knowledge, community matrons, the ambulance service, integrated discharge team members, and representatives from social services, the voluntary sector, the independent sector and clinical commissioning groups (CCGs; preferably someone currently working on the urgent and emergency care pathway). This list is not exhaustive. The key point is whole-system representation.

Best way to implement

The main options that could be selected from when a request for admission is made from the ED, primary care or another service are:

- **advice:** to develop a clinical management plan that allows the patient to be managed in primary care
- **appointment – manage as an outpatient:** for people who need urgent but non-emergency specialist assessment
- **ambulatory emergency care (AEC):** for clinically stable patients who can be assessed and treated with same-day discharge
- **acute frailty:** for frail, older people, with or without cognitive impairment, who would benefit from a comprehensive geriatric assessment
- **acute assessment units:** for acutely unwell people requiring inpatient care for diagnosis and stabilisation
- **admission directly to specialty ward:** for patients who can be managed on agreed clinical pathways.

In practical terms, the following approach may be used:

- **Pre-review:** An individual from the system (usually the acute trust) needs to be identified as co-ordinator. Sufficient notice of the review will ensure good attendance on the day. Six weeks is ideal. The co-ordinator should plan to have 60 sets of notes available in the room where the review will be undertaken. The request should be, '60 sets of notes of adult patients admitted through the ED for more than one midnight'. More notes should be requested than required as some will be inappropriate (eg the person was not admitted).

The review requires the whole team to be in the room as each patient is discussed to ensure there is no gap in local knowledge. Refreshments should be provided.

- **Introduction:** The review requires a minimum of two facilitators, one to take notes (the person who will ultimately write up the report) and one to provoke discussion, challenge and keep discussions on track. Once all team members are present, the review should be introduced and the running order for the day explained.

Having two clinicians in the team helps with the flow of cases as one can present a set of notes while the other prepares the next.

- **Review:** The review identifies, for each patient, whether an alternative to admission through the ED existed using the 6As classification. For GP-referred patients, you need to establish whether the GP and a senior acute consultant were in contact; if they were, this may have been an opportunity for the consultant to avoid admission by providing advice or for the patient to have been directly admitted to an assessment unit or ward, attend AEC or be diverted to an outpatient appointment.

As each set of notes is discussed, the team should decide (using a [pro forma](#) – see Figure 2) whether admission through the ED was appropriate or whether there was a better alternative. The alternative solution could be something already in place in the system or known good practice. This should be captured by the facilitator and added to the final report.

- **Report:** The report should be brief and clear, highlighting the key themes from the review. Although the report will contain some quantitative data, the review is an ideal opportunity also to gather one or two patient stories that illustrate its key themes.

4. Ambulatory emergency care

What is it?

Ambulatory emergency care (AEC, or emergency day care) is same-day emergency care for patients being considered for emergency admission. The approach reduces inpatient admissions by providing early senior assessment and intervention. It is safe, well-accepted by patients and analysis by NHS England shows it to be highly cost-effective (see Section 12).

Impact

AEC has considerable impact. A properly resourced and implemented service can reduce inpatient admissions by up to 30%. But AEC units must not be used during escalation for inpatient admissions as doing so will exacerbate hospital crowding rather than reduce it.

Works best with

AEC works best with effective streaming in the ED. Any patient who requires admission and is clinically stable should first be considered for AEC. Best practice involves a clinical discussion between an ED clinical decision-maker or the patient's GP and the AEC team ahead of referral. Some hospitals have arrangements with ambulance services to convey patients directly to the AEC unit.

Ease of implementation

Most hospitals now have AEC units and most have found their implementation moderately easy. Trusts tend to prioritise their implementation to help manage workforce and estate constraints. Protecting units from being bedded during periods of escalation is a challenge for some hospitals, but it is vital as their benefit is greatest at these times. Gaining buy-in from commissioners is important to avoid misunderstandings about the purpose of the unit and its cost structure. Most units use the inpatient short-stay tariff for new presentations and the outpatient tariff for follow-ups.

Typical time to implement

Six weeks to six months. After bedding in, units may develop the expertise to manage a wide medical and surgical casemix. Units should be consultant-led but make maximum use of experienced nurses for care delivery.

Team needed to implement

AEC units are typically set up and led by acute or emergency physicians depending on the local model. Proactive executive and senior management support is needed to maximise the potential of the model and to protect units from inappropriate use for inpatients. An expert and effective senior clinical nurse is needed to run the unit efficiently. A wide range of stakeholders must be involved, including therapies, ED teams, acute assessment teams, diagnostic services, GPs, social care and commissioners.

Best way to implement

A small improvement team drawn from the stakeholders is needed to enable rapid implementation using effective improvement techniques (eg PDSA cycles). Many hospitals have joined the national [Ambulatory Emergency Care Network](#) either to support the initial development or to refresh and relaunch their offer to maximise the focus on alternatives to emergency admission. Executive sponsorship is vital to recognise and endorse the importance of the service in the hospital.

Hospitals introducing AEC should aim to convert a third of their adult acute medical admissions to ambulatory care episodes. AEC should be considered as the preferred option for all potential emergency admissions, other than those who are clinically unstable (with a national early warning score (NEWS) >4).

Patient selection for AEC rests on four considerations:

- **Is the patient clinically stable enough to be managed without inpatient admission?** Generally patients with a NEWS ≤ 4 are candidates if the care environment, location of the unit, access to critical care and staffing model are suitable. Risk stratification tools (eg Wells, TIMI, CURB65, etc) may support decision-making.
- **Is the unit equipped to manage the casemix?** Frail, older people can often be managed in AEC units and thus avoid lengthy admissions. Getting

the care environment right to support this patient group maximises the potential of AEC.

- **Would the patient otherwise have been admitted?** AEC is a model designed for patients who, in the absence of the service, would require inpatient admission. Patients with conditions that do not require emergency inpatient care are not candidates for AEC.
- **Is there another appropriate non-admitted pathway?** Patients who can be managed in ED, outpatients or primary care should not be managed in AEC to avoid wasting capacity and driving up system costs.

AEC units should operate 14 hours a day, seven days a week to maximise their impact. They should use chairs and trollies rather than beds, with a care environment suitable for all adult age groups (including frail, older people and those with learning difficulties). Patients should remain in their own clothes, where possible, to promote independence and an ambulatory mindset.

Capacity for same-day emergency care must be preserved by completing care within one day wherever possible (that is, not delaying diagnostics to the following day). AEC capacity should not be limited by co-locating planned care (eg iron infusions, blood transfusions and other medical daycase procedures) in the same setting.

For a more detailed discussion of AEC see:

- [*The directory of ambulatory emergency care for adults*](#)
- [*Ambulatory emergency care network operational guide*](#)
- *Same day acute frailty guide* (to be published shortly).

Improvement metrics

Process metrics:

- number of non-elective presentations seen and treated in AEC (use an SPC chart)
- ratio of new AEC patients to emergency inpatients with LoS >0 days.

Balancing metric:

- number of patients admitted as an emergency inpatient within seven days following treatment in AEC.

5. Therapy at the front door

What is it?

Therapy at the front door is a tactic that brings therapists into EDs. Senior therapists identify and assess patients with frailty who can be discharged on the same day or may require a short admission. This drives a 'home first' approach based on recognising that being in their familiar environment whenever possible optimises patient recovery and delivers better outcomes. Therapy at the front door enables early care planning and can greatly reduce LoS.¹ Contact is made as close to the time a patient arrives as possible, ideally as part of the ambulance handover process.

Impact

The impact can be high where the approach is implemented effectively. Overall bed days used by frail older people will decrease, while short stays (0 to 2 days) will increase.

Works best with

Therapy at the front door works best as part of an acute frailty service or as an element of a defined frailty pathway involving social care, mental health liaison, dementia specialists, frailty nurses and geriatricians. Where a frailty service supports the ED, patients can be identified and pulled through to the frailty or acute medical unit.

Ease of implementation

Implementing this model of service delivery needs buy-in from senior therapists and they may be concerned about workload implications. Experience has found that moving therapists to the front of the pathway means that assessments and interventions are completed earlier. As a result, fewer patients decondition and more can be discharged earlier. Overall, therapist workloads reduce rather than increase.

¹ Watch these two short videos for a demonstration of the power and possibilities of this approach: [Home first – supporting patient choice](#) and [Embracing risk; enabling choice to support patients to return #homefirst](#).

Typical time to implement

Three to six months to allow for planning and staff consultation on change of roles.

Team needed to implement

Implementation requires the participation of the multidisciplinary team (MDT). Heads of service, senior managers, consultants and lead nurses working together are best placed to provide the essential leadership and support for change. The team needs to understand the benefit of early information gathering and discharge planning: unnecessary waits and deconditioning that contribute to poor outcomes are avoided. This makes it more likely that the patient will quickly return to their usual place of residence.

Best way to implement

Where therapists are already working in the acute assessment areas, they should relocate closer to the 'front door' and test the new way of working using regular PDSA cycles. Therapy managers should consider rotational positions with community partners. The overall skill mix of the team should be regularly reviewed and discussed. To fulfil rota requirements and seven day working it may be prudent to recruit generic band 3 and/or band 4 therapy assistants. An effective competency framework must be in place. Registered therapists should be fully integrated in their roles and the team should use a generic assessment method in the management of their patients. Good leadership is important to support implementation and some initial investment may be required to ensure seven day, 8-8 working.

Improvement metrics

Therapy at the front door aims to reduce LoS. Metrics include:

- number of patients discharged within two midnights
- readmission rates within seven days of discharge
- proportion of patients discharged to their usual place of residence.

6. SAFER patient flow bundle

What is it?

The [SAFER patient flow bundle](#) is a practical tool to reduce delays for patients on adult inpatient wards (excluding maternity, intensive care and high dependency) that blends five elements of best practice (described below). It is important to implement all five elements together to achieve a cumulative effect. When the SAFER patient flow bundle is followed consistently, LoS reduces and patient flow and safety improve.

Impact

The impact is considerable when all five elements are successfully implemented.

Works best with

The SAFER patient flow bundle is most effective when used with Red2Green days, clinical criteria for discharge (CCD) and expected date of discharge (EDD). A well-designed 'at a glance' board enables staff to visualise plans to support decision-making.

Ease of implementation

Implementing the SAFER patient flow bundle requires significant and sustained changes to multidisciplinary working practices, good record keeping, effective escalation, and clinical and senior management engagement. All elements complement each other and should be implemented as a bundle. This can be a significant challenge as many staff will want to adopt those that are easier to implement, not the entire bundle.

Effective clinical leadership is needed to support implementation as well as some additional resources (eg replacing white boards). Changes to job plans may be required to free senior clinicians' time to attend daily board rounds (each may take up to 20 to 30 minutes).

Typical time to implement

One month for each ward and three to six months for a hospital. Implementation is best done concurrently with Red2Green days. If there is a decision to change job plans to enable daily senior reviews, a longer notice period may be needed.

Team needed to implement the change

Implementation requires the participation of the MDT. Consultants and ward managers working together are best placed to provide the essential leadership and direction. The whole ward team needs to see the SAFER patient flow bundle as a priority and understand the rationale behind it. The active participation of therapists, ward nurses, junior doctors, ward clerks and service managers is key to success. The aim is to embed the SAFER patient flow bundle as 'business as usual' rather than to implement it as a short-term project. This requires focus and resolve until the way of working becomes habit.

Best way to implement

Executive sponsorship and active involvement are vital, backed by a strong narrative about the benefits of using the bundle on patient outcomes and staff job satisfaction. Daily executive visits to wards will encourage staff. Clinical leadership is essential to support operational teams to implement the bundle effectively.

Start with two or three 'exemplar wards' using PDSA cycles. Success flows from effective ward leadership and MDT working.

The elements of the SAFER patient flow bundle and tips for effective implementation are:

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. A set of simple rules to standardise processes is key to success. Variation between clinicians and clinical teams must be minimised. Effective board and ward round processes are crucial to decision-making and care co-ordination. Early board rounds enable teams to rapidly assess progress of every patient in every bed and address any delays to treatment or discharge. **Red2green** days are a visual tool to support the board round process. A second board round later in the day (2 to 3pm) enables a review and completion of the actions planned for the day for each patient.

A – All patients must have both an EDD and CCD set by assuming the ideal recovery and no unnecessary waits (see Section 7 for a more detailed discussion). A consultant-approved care plan containing the EDD and CCD should be set within 14 hours of admission. Patient progress towards their EDD should be assessed daily by a senior decision-maker. Patients should understand their care plan and be aware of their progress. Early conversations with patients and their carers, social care and/or existing care providers, should be prioritised to enable discharges to happen swiftly once a patient no longer requires acute care.

F – Flow of patients from assessment units to inpatient wards must start as soon as possible. Wards that receive patients from assessment units should ensure the first patient arrives by 10am. A ‘pull’ approach from assessment units should be adopted by specialty wards to achieve this. To free up beds, ward teams should consider ‘sitting out’ patients who are due for discharge; transferring patients to the discharge lounge; or expediting discharge. For patient flow to create space for new patients, patients must be transferred from assessment units early in the morning.

E – Early discharge. A third of patients should be discharged from specialty inpatient wards before midday. Morning discharges must become the norm. This practice reduces ED crowding and outlying. It allows new patients to be assessed, admitted and their treatment plan started at the earliest opportunity.

R – Review. All patients who have been in hospital for more than six days (‘stranded patients’) should be reviewed **weekly** as part of the routine business of every hospital ward. A peer-to-peer review process is best, carried out by a consultant and a senior nurse from a different ward. They meet the senior nurse and consultants on each ward to ask three questions and offer supportive challenge.

- Is the patient sick enough to need to remain in hospital? What is the **evidence** for this (not just ‘because I say so’)?
- If not sick enough, what is being done to get them home – and can we help overcome any delays?
- What could and should have been done on days 1 to 6 that would have stopped the patient becoming ‘stranded’? This is a ‘learning question’ that

encourages reflection on missed opportunities for early interventions to reduce extended LoS.

Frail, older patients on short-stay units should be similarly reviewed after 48 hours to reduce the risk of long stays for this vulnerable group.

Improvement metrics

Improvement metrics enable teams to see their progress in implementing the SAFER patient flow bundle. This motivates staff to maintain momentum. All elements need to be measured using SPC charts. All wards should display 'know how you are doing boards' that demonstrate improvement in delivering the five elements of the SAFER patient flow bundle.

Measures should demonstrate the position for each of the elements. Useful measures include the number of discharges before 10am; the stranded patient metric; the number of internal delays identified through the application of the Red2Green days; and number of patients moved out of assessment wards before 10am.

7. Expected date of discharge and clinical criteria for discharge

What is it?²

Expected date of discharge (EDD) is set by the consultant and based on their judgement of when the patient is likely to have recovered sufficiently to return home. Anticipated delays should not be factored in. EDDs should only be changed for clinical reasons.

Clinical criteria for discharge (CCD) are what the patient must achieve to leave hospital. They consist of functional and physiological criteria. For example, functionally the patient may need to stand unaided and walk five metres; physiologically, their haemoglobin may need to have risen to 110 g/L.

EDD and CCD are linked care co-ordination tools that can be applied in both acute and community bedded settings. They must be clearly defined and consistently used together if they are to work effectively. They should be set by a consultant within 14 hours of the patient's admission as part of the clinical care plan.

Impact

The impact is high when EDDs and CCDs are used by senior clinicians to co-ordinate and expedite patient care. They have less impact when 'nurse led', are seen as a tick box exercise or are used as a performance management tool.

Works best with

EDDs and CCDs are an important part of the SAFER patient flow bundle and most effective when used alongside Red2Green days with multidisciplinary input. A well-designed 'at a glance' board is a useful enabler.

² Watch this short video on the [EDD and CCD](#).

Ease of implementation

Implementing the use of EDDs and CCDs requires changes to clinical practice, good record keeping and the involvement of patients and carers in decision-making. Effective escalation is required where EDDs are threatened by internal or external delays. Clinical and senior management commitment and leadership are essential to implementation.

Typical time to implement

Two months for each ward and six to nine months for a hospital.

Team needed to implement the change

Implementation requires the participation and commitment of the MDT. Consultants and ward managers working together are best placed to provide the essential leadership and direction. The whole ward team needs to see this element of the SAFER patient flow bundle as a priority and understand the rationale behind it. The active participation of therapists, ward nurses, junior doctors and ward clerks is key to success. To streamline processes, prioritise planning conversations and minimise delays for patients, system partners such as social care and care providers must also understand the definitions and principles of this approach. The aim is to embed EDDs and CDDs as 'business as usual'. This requires focus and resolve until the way of working becomes habit.

Best way to implement

A trust's medical director, nursing director and chief operating officer all need to be committed to implementing the SAFER patient flow bundle and these important elements of it. The SAFER patient flow bundle and EDDs and CCDs should be discussed with the consultant body, matrons, ward managers and those involved in arranging discharges – for example, integrated discharge teams. The aim is to implement these tools as part of 'the way we do things around here'.

As with the SAFER patient flow bundle, it is sensible to implement EDDs and CCDs on two or three exemplar wards before attempting to roll out the tools across a hospital. Use PDSA cycles, involve the whole team in implementation, and identify and resolve any problems as quickly as possible. Once EDDs and CCDs have been embedded on exemplar wards, you will have a team of clinicians who can champion the approach and coach inexperienced teams.

The tools' principles need to be understood for them to be implemented without undue variation. The EDD should be set by a consultant at the first consultant review and no later than the consultant post-take ward round. It represents a professional judgement of when a patient is anticipated to achieve their clinical and functional goals and can leave hospital to recover, assuming an ideal recovery pathway without internal or external waits. It should be ambitious and focus teams on getting the patient home promptly. If a patient is to be transferred to a ward team, the EDD and CCD should be set by the team who will be responsible for their discharge.

The CCD is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge and should be agreed with the patient and carer. The CCD should include physiological and functional criteria, but not focus on 'medically optimising' a patient or 'returning them to baseline'. A period of recovery and rehabilitation following discharge should be anticipated.

The effective use of EDDs and CCDs means all members of the MDT have the same specific objectives for every inpatient stay. EDDs and CCDs can help identify internal and external constraints and delays, but only when effort is given to doing so will reduced lengths of stay be realised.

Patients' progress towards their EDD should be assessed daily by a senior decision-maker and routinely discussed with patients.

Good communications with patients and the use of EDDs and CCDs will enable patients (and the teams caring for them) to answer four questions:

- **Do I know what is wrong with me or what is being excluded?** This requires a competent senior assessment and discussion.
- **What is going to happen now, later today and tomorrow to get me sorted out?** The 'inputs' needed (diagnostic tests, therapeutic interventions, etc) with specified timelines.
- **What do I need to achieve to get home?** The CCD. 'Back to baseline' is not a useful phrase and should be avoided.
- **If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?** This is the EDD.

If the EDD is exceeded for non-clinical reasons, recording this on the 'at a glance' board can be helpful. Some hospitals write this as 'EDD +1/EDD +2', etc.

Executive sponsorship of the SAFER patient flow bundle and their active involvement are vital, backed by a strong narrative as to why the approach benefits patients. Daily executive visits to wards will encourage staff. Clinical leadership is essential at all levels – executive, senior management and ward – to support operational teams to implement the SAFER patient flow bundle. Start with two or three 'exemplar wards' using a PDSA cycle approach. Success is realised where leadership is strong and MDT working is promoted.

Improvement metrics

Hospitals typically measure the number of patients with an EDD, as this can be recorded as a date on most patient information systems. However, the emergency care intensive support team (ECIST) has found that this is not a particularly useful metric because, too often, the principles are not followed. EDDs are frequently set by nurses as a tick box exercise or are adjusted regularly for delays as they crop up. CDDs are not always included in care plans even when EDDs are recorded, which misses the important link between the two.

Given that EDDs and CCDs are clinical care co-ordination tools, it makes sense to audit their recording frequency and the quality of both EDDs and CCDs using a standardised approach. Simply recording the proportion of records containing an EDD or using EDDs as performance metrics is counterproductive.

8. Red2Green days

What is it?³

[Red2Green days](#) is a tool to reduce unnecessary waiting by patients.

Multidisciplinary board rounds are held twice daily (the morning round requires a senior clinical decision-maker). During the morning board round, the tasks, tests and procedures required to progress each patient towards appropriate discharge are agreed and recorded. Note that simply transferring a patient from a hospital bed to a residential or nursing home bed without a clear reason based on planned additional therapeutic benefit will exacerbate patient deconditioning and lead to further 'red' days in another setting.

All patients are considered to have a 'red' day until the agreed actions required to progress the patient's journey towards discharge have been completed. The day is then converted to a 'green' day. Progress is assessed at the afternoon board round. Anything not completed and which cannot be resolved at ward level is escalated to the level of seniority that can unblock delays. Each week a list of the top five delays should be collated and shared for action with senior management.

Impact

Experience shows that impact is high where the approach is used every day as part of the ward routine.

Works best with

Red2Green days are most effective where used in conjunction with the SAFER patient flow bundle. Each ward needs a standardised 'patient status at a glance' white or electronic board to act as a focal point for board rounds; it can also be used to note the day's work for each patient.

Ease of implementation

Implementing Red2Green days requires changes to working practices, good record keeping, effective escalation and senior management support. Good clinical

³ Watch this short video on the [Red2Green days approach](#).

leadership is important to support implementation and some additional resources may be needed (eg white boards may need replacing and teams freed up to help with implementation).

Typical time to implement

One month for each ward and three to six months for a hospital.

Team needed to implement

Implementation requires the participation of the MDT. Consultants and ward managers working together are best placed to provide the essential leadership and direction. The whole ward team needs to see Red2Green days as a priority and understand the rationale behind this approach. The participation of therapists, ward nurses, junior doctors, ward clerks, social care/discharge co-ordinators, pharmacists and service managers is key to success. The aim is to embed Red2Green days as 'business as usual' rather than to implement it as a short-term project. This requires focus and resolve until the way of working becomes habit.

Best way to implement

A small, dedicated team trained to deliver the process will facilitate organisation-wide delivery. Executive sponsorship is vital, backed by a strong and compelling narrative of why the initiative is needed. Daily executive visits will encourage staff. Start with two or three 'exemplar' wards to test the process using an improvement approach (eg PDSA) and publicise success within the trust and with external partners, such as social care and care providers, using data and patient stories.

Internal professional standards (see Section 12) should be agreed between clinical teams, specifying lead times for diagnostics, reports, assessments, etc. Lead times should be tight. Anything identified as necessary to progress a patient's discharge should be completed that day. Internal professional standards should be clear so it is obvious if waits are longer than agreed (thereby causing the patient to have a red day). Once these standards have been agreed, each ward can develop a list of reasons for red days. Many will be the same across a hospital, but some may be specific to local circumstances. 'Process-created' waits are not acceptable as reasons for red days; if they were, unnecessary delays would be masked. For example, a lead time of five days to order standard patient equipment is unacceptable and needs to be flagged as a reason for 'red' days and corrective

action taken. As well as time-based standards, it is helpful to include practical reasons for 'red' days; for example, if the patient has not mobilised as planned, the day stays red until they have. Highlighting these days as 'red' early in the day will give teams time to take in-day action that will aid patient recovery.

An early morning board round involving a senior clinical decision-maker, the nurse in charge, ward nurses, social care/discharge co-ordinator and therapists ensures a plan is agreed for every patient. An afternoon board round between 2pm and 3pm works well and ensures there is still time to take action to resolve reasons for 'red' days. The afternoon board round does not necessarily require a senior clinical decision-maker but as a minimum should involve the nurse in charge, therapists and the medical staff on the ward at that time.

Successful implementation relies on not performance managing the number of 'red' days. Typically, wards that declare the most 'red' days are adopting the process effectively. The key to successful implementation is flushing out the reasons for unnecessary patient waiting ('red' days) and taking improvement action.

The constraints identified by wards to converting a 'red' day to a 'green' day need to be managed proactively at the board round. Those that cannot be resolved immediately need to be escalated that day to the level where the delay can be addressed. Failure to resolve constraints proactively by only reporting them adds no value to the process.

Improvement metrics

Using improvement metrics enables teams to see the progress they are making in implementing Red2Green days. This motivates staff to maintain momentum.

Before starting to implement Red2Green days, it is sensible to find out how long patients are currently on the ward so that improvements can be identified. If possible, get a year's worth of data for each ward. Segment this into time bands; for example, the proportion of bed days used by patients on the ward for up to 3, up to 7, up to 10, up to 14, up to 20 and 21 or more nights? Then see how the numbers change. You are looking for a decrease in the proportion of bed days in the longer-stay bands and an increase in the shorter-stay bands. You should disregard very long length of stays (say over 28 days) as these will be rare and may distort your figures.

A weekly summary chart (eg a Pareto chart) that visually summarises the reasons for 'red' days is also helpful. At the end of each week, the top five constraints that cannot be resolved by ward teams or the escalation process should be the focus of the hospital's improvement programme. Management and ward teams should be able clearly to articulate the main reasons for unresolved 'red' days.

Every ward should have a 'knowing how we're doing board' that displays weekly improvement metrics (using SPC charts) so all team members know if efforts to reduce unnecessary patient waiting are having a positive impact.

9. Long-stay patient reviews

What is it?

Long-stay patient reviews focus on patients who have been in hospital for more than 20 days. Reviews are conducted weekly, usually on the same day each week to develop the habit. They introduce supportive challenge and help ward MDTs tackle obstacles that are delaying the treatment and discharge of patients who have been in hospital for a prolonged period.

Impact

The systematic use of weekly long-stay patient reviews can reduce the number of inpatients with a LoS exceeding 20 days by up to 50%, freeing up a large number of beds.

Works best with

The [SAFER patient flow bundle](#) and a strong [‘home first’ approach](#). Long-stay patient reviews work well with CCDs (see Section 9) – what the team and their patient need to achieve to enable discharge. A clear ceiling of what needs to be achieved prevents over-investigation or inappropriate treatment. It is also important that the hospital effectively implements its Patient Choices policy (for more information, see the [Quick guide to supporting patient choices](#)).

Ease of implementation

Implementation is straightforward, although it does require a permanent change to working practices and staff commitment.

Typical time to implement

The process may take up to two months: to plan it, to coach team members to ask probing questions and to communicate the new approach.

Team needed to implement

The team should include:

- a senior manager or the manager of the integrated discharge team
- a senior member of the discharge team who is familiar with the ward patients. A social worker and discharge nurse are needed if the hospital lacks an integrated discharge team
- a senior therapist
- a matron (there should be a rota for matron cover of the entire review day each week)
- an administrator (from the discharge team) who fills in the list on the ward, enters the data, comments and actions into an Excel spreadsheet, and produces the weekly report.

Best way to implement

Each ward should have an agreed time during the review day when the review will happen. A list of all acute patients (over the age of 18, but excluding those in intensive care or high dependency) who have been in hospital for more than 20 days should be run off the patient administration system. This should include:

- patient name
- age (not date of birth)
- LoS (number of days) from the point of admission to hospital
- an empty column in which to add delay reason codes and notes
- a further column in which to write actions.

The ECIST LoS review codes may be used (see below), supplemented by local codes where necessary.

A small MDT does the review (see Section 3). They should meet the ward manager on their ward at an agreed time. Many hospitals conduct these reviews by the 'at a glance' white/electronic board. For each patient with a LoS exceeding 20 days, ask 'what is the plan'?

This is about the entire clinical plan, not just the discharge plan. Ideally there should be a clear clinical plan with a diagnosis and clinical and functional criteria for

discharge. Clearly establish what the patient is waiting for – ‘medically unfit’ is not an acceptable response. A probing question to ask is, ‘What is the next thing that needs to happen to progress this patient’s discharge?’

Once it has been established if the person is medically optimised/fit/stable, the team should record an appropriate code using the ECIST LoS review codes.

The team should advise the ward manager on action the ward can take to reduce delays.

Many trusts have found that the reviews greatly enhance awareness of the hospital’s choice policy and encourage staff to issue letters promptly (see Section 12). However, it is important that the timing of the issue of letters takes into account the LoS for the whole hospital and not just the LoS in one ward. Multiple ward moves often add many days to a patient’s overall LoS. Timely conversations with patients about their discharge plan are also essential for smooth discharge and avoidance of delay.

Reviews will take less time as the ward and review team become used to the process. Generally, each long-stay patient review takes one to two minutes.

Ward managers should give feedback on progress as the process becomes embedded and the number of over 20-day patients reduces. SPC charts should be prominently displayed. Concurrent implementation of the SAFER patient flow bundle, Red2Green days and discharge to assess can greatly accelerate the reduction in extended lengths of stay.

Following the review, the administrator should input the data into an Excel spreadsheet that automatically generates a report that can be shared widely. The administrator should collate the actions and send them to the ward managers and members of the peer review team. These actions must be followed up and escalated if delays are not resolved. Significant constraints can be tackled through task-and-finish groups led by the senior manager.

Over time, the number of patients with LoS will decline. Reviews should then switch their focus to patients with shorter lengths of stay (eg over 13 days) to maintain downward pressure on delays.

Improvement metrics

Use SPC charts to plot the **number** of patients with lengths of stay of:

- >20 days
- >13 days
- >6 days.

Other measures to consider are:

- number of times patients are moved to a different ward (each move may increase LoS by a day or more).
- proportion of patients discharged from the hospital to their prehospital residence (an outcome metric)
- readmissions within seven days (a balancing metric)
- Pareto charts to show the top five constraints identified each week.

ECIST codes

- F = 'fit' or no longer benefitting from acute inpatient care
- NF = 'not fit' or requires ongoing acute inpatient care

F1: Waiting return to other acute hospital – fit to travel

F2: Waiting for transfer to acute hospital for treatment – tertiary fit to travel

F3: Waiting for community hospital placement or any other bedded intermediate/reablement care

F4: Waiting for continuing healthcare panel decision

F5: Waiting for continuing healthcare package

F6: Waiting for equipment/adaptations

F7: Housing needs/homeless

F8: Waiting for patient/family choice or input to decision-making

F9: Waiting for internal CHC processes, eg checklist completion, assessments, 2 and 5 referrals

F10: Waiting for occupational therapy/physiotherapy approval for discharge

F11: Ready for home today – ask whether they are confident nothing will stop discharge

F12: Waiting for hospice place

F13: Waiting for internal transfer – ward to ward

F14: Discharge planned for tomorrow – what is stopping them going today?

F15: Waiting for social care reablement or home-based intermediate care time limited

F16: Waiting for internal assessments/results before discharge agreed

F17: Waiting for external agency assessment – social care/MH/RH/NH

F18: Waiting for start or restart of domiciliary care package – long-term packages

F19: Out of county/borough assessments – we define this in the preparation section

F20: Waiting for residential or nursing home, social care or self-funder

F21: No plan

F22: Waiting for DST to be completed

F23: Safeguarding concern raised

NF1: End of life and wants to die in hospital

NF2: Active ongoing clinical treatment non-specific and not as sick as category NF4

NF3: Waiting for internal test, specialist opinion or similar – state what

NF4: NEWS 5 or above, unpredictable and erratic condition that may require immediate intervention, care only available in acute setting

NF5: Intravenous therapy – ask if it can be given elsewhere (ambulatory or in the community)

NF6: Infectious, a risk to others, therefore cannot be discharged

NF7: Requiring clinical intervention that can only be provided in hospital

NF8: No plan

NF9: Other – waiting return to another acute hospital, not fit to travel

NF10: Other – waiting transfer to an acute hospital for treatment, not fit to travel

CHC, continuing health care; DST, decision support tool; MH, mental health; NEWS, national early warning score. NH, nursing home; RH, residential home.

A review of longer length of stay patients can be undertaken using the ECIST LoS review tool above or other tools such as the appropriateness evaluation protocol. The latter is being used in a day-of-care audit approach in Scotland and can be particularly useful for peer challenge.

10. Multiagency discharge event (MADE)

What is it?

MADE is a process that brings together senior staff from across a local health and social care system to review individual patient journeys. The aim is to introduce peer challenge between community and hospital teams, increase the number of discharges and generate plans to address process constraints in the system. MADE is increasingly used as part of system escalation plans.

During the event, delays to patient journeys that may have been caused by local processes are exposed. Action from the review team can unblock delays for individual patients and bring forward discharges. Team members need a level of seniority that allows them to commit their organisation's resources and, where appropriate, override established systems and processes. If a process is shown to be a problem, a task-and-finish group should be formed after the event to change it.

Impact

The impact of MADE is high, but may be short term unless system leaders address the identified constraints and process issues. A major benefit of MADE is its impact on local cultures, as it challenges the beliefs of staff who sometimes put all the blame on other agencies for discharge delays.

Works best with

MADE works best after a review of all patients with a LoS of over six days, as it highlights the wards where most benefit may be gained from an event. Typically impact is greatest on wards with a high number of medically unfit patients, particularly if there is strong GP input to the MADE team as part of the peer challenge and review. Access to good quality patient information is important to the success of an event.

Ease of implementation

Implementing MADE is moderately easy, although it does require system-wide commitment and visible leadership. Diary co-ordination can be challenging, but if all leaders are committed to prioritising the event, dates are agreed in advance and good patient information is available, then the process is straightforward. Some systems routinely use MADE as part of escalation, setting up events within 24 hours in response to rising pressure.

Typical time to implement

Dates for MADE should be agreed at least six weeks in advance to ensure attendance from all appropriate system partners. Systems may agree a schedule of events a year in advance, helping them to prepare for times of anticipated pressure, such as before or after bank holidays, or across the winter period.

Team needed to implement

Senior leader representation is required from across a local system, including:

- acute trusts
- community services
- CCGs
- mental health services
- local authorities
- voluntary sector
- primary care
- care home provider representatives
- home care provider representatives
- local Health Watch.

The absence of any of the above, or attendees without the necessary decision-making authority, will limit the success of MADE. These events can be supported, but not delivered, by external agencies or consultancies. Local engagement, leadership and commitment are essential. All members of the team should agree the aims of the process and work collaboratively in the interests of the patients they review. A no-blame approach should be agreed to foster effective relationships.

Best way to implement

A decision to run a MADE should be agreed through the A&E delivery board. The commitment of each system partner to provide appropriate representation should be documented in the minutes. A senior officer, ideally from a CCG, should lead organising the event. A dedicated room at the hospital should be available to the team throughout the day, and an agenda for the day provided. Team members must commit to full days, and should agree not to leave to attend non-urgent meetings. MADE can take place over one day, but is often more effective and practical when the process runs over two consecutive days.

MADE can cover an entire hospital or an agreed number of wards (prioritised from the findings of LoS reviews). All patients, including those with a short LoS, are reviewed. To benefit from the 'wisdom in the room' MADE teams must have both breadth and depth of membership. Very small groups tend to be ineffective. MADE teams need accurate, up-to-date, printed information on the acute adult inpatients they intend to visit (except those in intensive care units or high dependency wards). Ward teams need to be briefed in advance about the process and be available and prepared to discuss their patients with the teams.

The key questions to answer for each patient are:

- What is the next critical step in the patient's care?
- Is that step being taken today?
- If not, what can be done to enable it to happen today?
- Why can't the patient go home, and why not today?

Team members take responsibility for tackling any constraints on the critical step that they can influence. Working together they take action the same day to address delays. Team members record the constraints identified, actions taken and problems that could not be resolved that day.

Where the critical step is achieved on the same day, the team records a 'green' day for the patient. A 'red' day is recorded where the critical step is delayed and not achieved on the same day. Teams report back to a central co-ordination room after visiting allocated wards and submit their information so it can be collated and turned into Pareto charts.

Improvement metrics

Using improvement metrics enables teams to see the impact of MADE. Before an event it is important to know how many stranded patients (with a LoS of six or more days and 20 or more days) are in the hospital and the number of discharges per day. A successful MADE will show a reduction in the number of stranded patients and an increase in the number of discharges each day, but possibly not until several days later. The team should generate an action plan to address process issues or constraints that they identified through the event.

11. Health and social care multiagency peer review

What is it?⁴

A peer review or peer challenge is an effective sector-led improvement tool whereby a local system invites a team of external peers from other health and social care systems to conduct a review using agreed key lines of enquiry (KLOE). This method has been tried and tested in local government and adult social care and, more recently, extended across the health and social care landscape. In relation to improvement around LoS, KLOE can include a review of admission and discharge processes and pathways, including at the interface between health and social care and how patients experience this.

Works best with

Peer reviews work best when there is commitment from both health and social care leaders, and an agreed set of objectives/KLOE.

Ease of implementation

A lead in time of at least eight weeks is needed to fully scope the review and source a peer team with the skill set that best matches the scope.

Typical time to implement

A review usually lasts between two and five days. This includes a half-day for a feedback and action planning session at the end of the review and during which a draft report (slide pack) and recommendations are presented. A fuller report follows, usually within three to four weeks, and is signed off and agreed with the local system. There may be a follow-up discussion with system leaders to review progress and identify any ongoing support needs.

⁴ For more information see the [Local Government Association's website](#) or contact chip@local.gov.uk

Best way to implement

Senior leaders locally agree with the review manager (from the Care and Health Improvement Programme, Local Government Association) the scope and dates for the review, as well as what data and reading material may be helpful to the peer review team ahead of their arrival on site.

The review manager sources the peer team and shares details of the team with the local system. Team size depends on local needs.

The local system appoints a co-ordinator to timetable the review. This involves interviews and discussions with senior leaders, frontline professionals and clinicians, people who use services and/or their representatives, health and social care providers and wider stakeholders, and possibly also an audit of patient records/case files. The team, using a critical friend approach, uses a set of questions that follows the agreed KLOE. The peer review team meets at the end of each day to share, cross-check and capture what they have heard, summarising this in a presentation on the last day. This summary is followed by a fuller slide pack report and set of recommendations.

Improvement metrics

Which metrics to use will depend on the scope agreed for each individual review.

12. Supplementary advice, links and resources

Patient choice

Delays relating to choice are among the leading causes of discharge delays. All hospitals should have an effective policy for the implementation of national guidance relating to patient choice. There is an excellent [quick guide](#) to supporting patient choice.

An agreed process for issuing letters 1, 2 and 3 is important. Here is an example:

Letter 1 should be given to all patients admitted to hospital, at pre-assessment for elective patients and at the point of admission for non-elective patients. A simple policy that assessment units give all patients letter 1 works well and ensures a consistent basis for the issuing of letter 2. For patients admitted directly on condition-specific pathways (eg stroke, fractured neck of femur pathways, etc), this letter needs to be included in the pathway documentation. Putting a sticker on the notes to confirm that the letter has been given is worth considering.

Letter 2 is given to the patient and/or their family (where appropriate) by the ward manager or nurse who is leading their care, once there is an agreed pathway for discharge. If the agreed pathway is to a long-term placement, the letter should be given **at the same time** as a list of available homes. The quick guide includes examples of how to support people make the decision about which home they would like to live in.

Letter 3 is rarely required if letters 1 and 2 are given at the appropriate times. Clear, consistent communication to reassure patients and their families and clarify the process is important. If letter 3 does need to be issued, this should be done by a more senior person in the trust (eg divisional nurse or someone of similar seniority).

The quick guides

NHS England and partners have published a series of [quick guides](#) to support local health and care systems, including:

- *Discharge to assess*
- *Supporting patients' choices to avoid long hospital stays*
- *Better use of care at home*
- *Improving hospital discharge into the care sector.*

The quick guides provide practical tips, case studies and links to useful documents, and can be useful when implementing solutions to commonly experienced issues.

They:

- clarify how best to work with the care sector
- help you find out how people across the country are working with the care sector to reduce unnecessary hospital admissions and delayed transfers of care
- break down commonly held myths; for example, sharing patient information across integrated care teams and continuing healthcare assessments
- allow you to use other people's ideas and resources
- enable you to break down barriers between health and care organisations.

Best practice guides and resources

Patient flow

The Keogh review's [Safer, faster, better: good practice guide to delivering urgent and emergency care](#) lays out the principles for improving patient flow across whole systems. This easy to read and well-evidenced guide should be part of every hospital's delivery toolkit.

[The good practice guide: focus on improving patient flow](#) published in 2017 was endorsed by the Royal College of Physicians, Royal College of Surgeons, Royal College of Emergency Medicine, Society of Acute Medicine, British Geriatrics Society and Association of Ambulance Chief Executives. It gives solid advice on the priorities that need to be adopted to optimise patient flow through hospitals.

High impact change model

The Local Government Association's [high impact change model](#) provides a clear framework against which local care and health systems can assess and improve their management of patient flow and discharge.

Ambulatory emergency care

[The directory of ambulatory emergency care for adults](#) is the definitive guide for any hospital aiming to develop AEC. Local health systems should be aware that AEC is the most cost-effective means of reducing the whole-system costs of providing emergency care without compromising safety or effectiveness. The [toolkit](#) looking at 'channel shifts' produced by the vanguard programme provides useful evidence.

Emergency admissions

The Royal College of Physicians' [Acute care toolkits](#) are essential reading for managers and clinicians working to improve the care of medical patients admitted as emergencies.

The Royal College of Surgeons' [Emergency surgery: standards for unscheduled care](#) is an essential toolkit for managers and commissioners interested in the management of surgical emergencies.

The Royal College of Paediatrics and Child Health has published [standards](#) for the management of children and young people in emergency care settings.

NHS Improvement's [website](#) has a host of resources covering emergency care and improvement science:

- [resources from the Emergency Care Improvement Programme \(ECIP\)](#)
- [quality, service improvement and redesign tools](#) curated by NHS Improvement's ACT Academy.

Managers and clinicians interested in preventing emergency admissions should read Sarah Purdy's King's Fund [paper](#): *Avoiding hospital admissions. What does the research evidence say?*

Most experts point to the lack of impact of most hospital admission avoidance schemes and recommend focusing on reducing length of stay as a more practical alternative. See, for example, the [publication from the Nuffield trust](#).

Frailty

The definitive guide to the care of frail, older people is the [Silver book](#), and NHS England has published a [practical guide to an integrated care pathway for frailty](#).

Internal professional standards (IPSSs) are mentioned in this guide and can be highly effective tools in reducing delays. A [rapid guide on IPSSs](#) is available.

Medicines in care homes

For guidance on managing medicines in care homes, see the websites for [Prescipp](#), [National Institute for Health and Care Excellence \(NICE\)](#), [Royal College of Nursing](#) and [gov.uk](#).

See and treat

For guidance on ambulance 'see and treat', see NICE's [acute medical emergencies guideline](#).

Deconditioning – the evidence base

The evidence base for the impact of hospitalisation on older and vulnerable people is extensive, including Asher's 1947 paper in the *BMJ*: 'The dangers of going to bed' [1].

Hospital-related functional decline in older patients and the subsequent harm is a known but often overlooked issue in hospitals: 35% of 70-year-old and 65% of 90-year-old patients decondition during a hospital admission [2]. Bedrest in hospital over 10 days leads to 10 years of muscle ageing for people over 80 [3]. Even a minor illness can result in a significant change in health status [4]. People in hospital spend most of their time in bed despite being able to walk independently [5]: the average time a patient walks each day while in hospital is 45 minutes. The impact of deconditioning is not only on the musculoskeletal system, although this is the most visible. It affects all body systems, including psychological wellbeing. The effect of sleep deprivation is also significant [1].

Older people make up a significant proportion of patients whose LoS is 21 days and over. They may experience significant harm related to deconditioning and are likely to have second and third phase illness due to missed opportunities for discharge.

Recognising acute frailty at the point of admission and offering appropriate care is vital. Older people who have a comprehensive geriatric assessment, rather than routine medical care after admission to hospital, are more likely to be discharged to their usual place of residence and less likely to be admitted to a nursing home [6].

Assessment of care needs in hospital adds to LoS, increasing the risk of deconditioning and loss of confidence. It may also undermine the community networks that supported a frail person before they were admitted. Of assessments, 60% could be done out of hospital and 40% in parallel with other actions. Evidence shows that hospital teams can over-prescribe home care and may be inappropriately risk averse [7].

Many audit tools look at the potential for patients to be cared for in alternative settings to hospital. They typically show that 20% to 25% of admissions and 50% of bed days do not 'qualify' for the use of an acute bed as these patients' medical needs could be met at a different, usually lower, level of care [7]. Of people who are delayed in hospital, 39% could have been discharged using different, lower dependency pathways. A striking and typical finding is that up to half of the reasons why patients are not discharged earlier are under the direct control of hospitals and relate to ineffective internal processes, lack of senior decision-making and poor discharge planning.

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