



# **CLEAR urgent and emergency care programme**

## **Key findings and learning**

March 2023



## Key messages

- Improving urgent and emergency care (UEC) is a national priority highlighted in the NHS Long Term Plan. Recent figures highlight ongoing system-wide problems with patient flow and record pressures across urgent and emergency care. To address the challenges over the next two years following the impact of COVID-19, the Delivery Plan for Recovering Urgent and Emergency Care Services (January 2023) was published to reduce waiting times, improve urgent care in the community, avoid unnecessary hospital admission and speed up discharge.
- To meet national objectives for improving UEC, Health Education England commissioned the national CLEAR Programme to support NHS trusts across England on service innovation, workforce redesign and implementation of new ways of working within their UEC services.
- The national Clinically Led workforce and Activity Redesign (CLEAR) programme trains clinicians to use a combination of big data analysis, clinical insight and local knowledge to deliver new models of care and workforce redesign. It is hosted by East Lancashire Hospitals NHS Trust and delivered by the trust and 33n, a team of NHS clinicians, education specialists and data engineers who are united in their passion to improve services, address workforce challenges and enhance patient care.
- Six NHS trusts from different regions in England took part in phase one (pilot) of the CLEAR UEC Programme in 2019 following an expression of interest process. After completion of the pilot programme, another four NHS trusts serving a total population of 1.5m people took part in phase two of the programme in 2021.
- In both phases the programme ran over 24 weeks and comprised four key elements: clinical engagement, data interrogation, innovation and recommendations. Projects were delivered under the supervision of the CLEAR national faculty.
- The key challenges in both phases were focused around four themes: 1) Congestion in ED resulting in patients waiting longer than necessary 2) Misalignment of streaming pathways to meet patients' needs 3) Challenges in managing high volumes of frail older patients 4) Ensuring clinical staff have the right skills mix for managing different patient cohorts presenting to ED.
- To address these challenges, clinicians made a number of recommendations to their executive teams focused on new models of care and ways of working, new skills mix and new roles. They included improvements to front-door triage and streaming, better use of existing streaming pathways, and new roles and teams dedicated to the care of frailty patients. Around 70 per cent of the phase one recommendations were implemented. Implementation of phase two recommendations is ongoing.
- Both phases resulted in forecast improvements to the quality, safety and efficiency of care, including reductions in patient length-of-stay in ED and overall overcrowding, admission avoidance of frailty patients, enhanced patient experience, and improved job satisfaction and staff retention.
- The projected total productivity gains for the NHS trusts involved in phase one of the programme was £10.5m and £4.5m for phase two.

## Introduction

Urgent and emergency care (UEC) services play a pivotal role in providing care for people whenever they need it and as quickly as possible, but mounting pressures are making it increasingly difficult to manage demand in a timely and effective way.

The number of patients attending EDs has risen by 40% over the last 15 years and at the same time the numbers of inpatient beds have fallen. Recent figures highlight ongoing system wide problems with patient flow, with record pressures across urgent and emergency care (highest 12 hour waits in the past 12 years).

The disruptions in patient flow – for both hospital admissions and discharges into appropriate community settings - is causing overcrowding in ED, leading to unnecessarily longer waits, performance challenges, poor patient experience and low staff morale.

This is exacerbated by demand from a growing ageing population with increasingly complex needs, many of whom struggle to navigate an array of out of hospital urgent care services, resulting in a high number of potentially unnecessary ED attendances.

Improving UEC services is a national priority highlighted in the NHS Long Term Plan. This includes expanding and reforming urgent and emergency care services to ensure patients get the care they need as quickly as possible, easing pressure on emergency departments and enabling health systems to better manage spikes in demand during, for example, the winter months.

In January 2023, the NHS and Government jointly published the *Delivery plan for recovering urgent and emergency care services* to help recover urgent and emergency care services, reduce waiting times, improve urgent care in the community to avoid unnecessary hospital admission, and speed up discharge. The two-year plan aims to stabilise services to meet the NHS's two major recovery ambitions, to help achieve ED four-hour performance of 76% by March 2024 and to improve category two ambulance response times to an average of 30 minutes over the next year, with further improvement in the following year.

The CLEAR Urgent and Emergency Care Programme was commissioned by Health Education England to support NHS trusts across the country on service innovation, workforce redesign and implementation of new ways of working within their urgent and emergency care services.

Six NHS trusts from different regions in England took part in phase one (pilot) of the CLEAR Urgent and Emergency Care Programme in 2019 following an expression of interest process.

After completion of the pilot programme, another four trusts from different regions in England took part in CLEAR Urgent and Emergency Care 2021.

This paper is a report on the programme's findings, the themes that emerged and learning for the healthcare system.

## **Background**

The CLEAR programme, developed with Health Education England (HEE), trains and enables clinicians to use a combination of big data analysis, clinical insight and local knowledge to deliver new models of care and workforce.

It is hosted by East Lancashire Hospitals NHS Trust and delivered by the trust and 33n, a team of NHS clinicians, education specialists and data engineers who are united in their passion to improve services, address workforce challenges and enhance patient care.

The programme began in 2019 with its first CLEAR transformation projects in UEC, since then it has expanded including providing rapid support and training to the NHS during the COVID-19 pandemic.

It continues to support the NHS in the recovery and transformation of services with projects across key priority areas including mental health, critical care, urgent and emergency care, elective recovery, primary care and ophthalmology. In March 2023, it had completed more than 40 projects and trained more than 2,600 staff.

## **CLEAR Urgent and emergency care**

The six NHS trusts who elected to take part in the CLEAR UEC pilot programme in 2019, following an expression of interest process, were Blackpool Teaching Hospitals NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust, East and North Hertfordshire NHS Trust, Calderdale and Huddersfield NHS Foundation Trust, Taunton and Somerset NHS Foundation Trust and North Middlesex University Hospital NHS Trust.

After completion of the pilot programme, a further four trusts took part in CLEAR Urgent and Emergency Care 2021. These trusts were Mid Cheshire Hospitals NHS Foundation Trust, Hampshire Hospitals NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust and Kettering General Hospital NHS Foundation Trust. Together they serve a population of 1.5m people and employ a total of 25,000 staff.

## **The CLEAR approach and methodology**

CLEAR places clinicians at the heart of healthcare decision making and innovation. The integrated learning and working programme allows clinicians to develop new skills in data science, transformation and leadership while delivering live redesign projects in the NHS.

The 24-week education programme comprises four key elements, all are led by trust clinicians supported by the national CLEAR team:

- Clinical engagement - Understand baseline models of care, form relationships and discover key issues through qualitative data collection. This secures buy-in and gains operational insights about the service and challenges.
- Data interrogation - Find evidence for key challenges, link qualitative themes to deeper insights, use quantitative data to find impact of change. CLEAR data tools offer accessible data analysis and visualisation, allowing staff to evidence issues and possible solutions.
- Innovation - Create solutions for key issues with new models of care and workforce using bespoke modelling techniques, co-design and collaborate with staff and other CLEAR teams, share best practice and examples of innovation.
- Recommendations - All elements of the previous phases come together to communicate the need, evidence, and the benefits of the recommended changes.

The aims of the programme are to deliver solutions that are clinically owned, increase the control of clinical teams in healthcare delivery, embed improvement technique and provide an efficient solution to complex change programmes.

## **Key challenges**

The key challenges faced by trusts in both phases of the programme were focused around four themes:

1. **Congestion in ED** resulting in patients waiting longer than necessary, performance challenges and low staff morale.
2. **Misalignment of streaming pathways to meet patient need** including underuse of specialist streaming pathways, which was hampering patient flow and resulting in poor patient experience.
3. **Challenges in managing high volumes of older patients living with frailty** including prolonged length-of-stay in ED, high admission rates, with significant proportion of inpatient discharge within one day.
4. **Ensuring clinical staff have the right skills mix for patient cohorts** – the experience and skills of the workforce were not always aligned to patient need.

### ***Congestion in ED and misalignment of streaming pathways***

Trusts involved in both phases of the programme reported a yearly increase in the number of ED attendees. At the same time, they experienced challenges around streaming patients quickly and efficiently, which in turn led to overcrowding, unnecessarily long waiting times and increased pressure on staff.

There was a duplication of front door streaming and triage processes, leading to long waits for initial assessment. This was partially caused by patients having to be screened for COVID-19 before they entered ED. Other tasks and activities at the point of streaming were causing long pre-assessment waits and a delay in the patient journey through the ED.

Trusts reported challenges around the outflow of patients requiring admission to inpatient wards and ineffective flow through rapid assessment and treatment (RAT) due to departmental congestion. This was exacerbated by limited space to assess and treat new patients.

Some indicated that the increase in attendances in ED without more space (estates) resulted in an incongruity between care location and care needs, with the delivery of more complex care in locations that were designed for the treatment of minor injuries and illnesses.

Same day emergency care was underused and the criteria for referral was unclear, contributing to overcrowding and unnecessarily long waits, particularly for frail patients. Trusts reported an underuse of condition specific streaming pathways.

Despite improvements in the ED performance of many of the trusts involved in both phases of the programme, congestion from problems with streaming meant some trusts were reporting a decline in performance related to the four-hour target. Overcrowding was having an adverse effect on staff morale with many trusts reporting staff burnout.

### ***Challenges in managing high volumes of older patients living with frailty***

One of the biggest challenges trusts in both phases of the programme faced was the large number of ED attendances and care of frail older patients.

Trusts reported a yearly increase in attendances, with many presenting with highly complex health and care needs. Despite some trusts undergoing reconfiguration of services to help tackle these challenges, most were still experiencing overcrowding, long waits and a high risk of poor patient experience.

Trusts reported that the high number of older frail patients outpaced the existing frailty services. Many were waiting 90 minutes for initial assessment and were spending longer in ED than non-frail patients. A high number of patients required admission into the hospital and, even when patients were fit for discharge within 24 hours, transport difficulties resulted in a longer length of stay.

Challenges also arose from some organisations not having dedicated frailty assessment areas or early discharge planning. Same day emergency care for frailty patients was underused and the criteria for referral was often unclear.

A high number of frail patients was having a knock-on effect for all patients attending ED, resulting in long waits, performance challenges and avoidable admissions.

### ***Ensuring clinical staff have the right skills mix for patient cohorts***

Trusts reported that the overall experience and skills of their workforce were not always aligned to the needs of patient groups with appropriate streaming and delivery of high-quality care.

They reported a need to enhance senior decision-making for new patient arrivals and the streaming of patients, as these processes were often inefficient and led to overcrowding in ED.

Trusts cited that on occasion, emergency nurses were only trained to deal with minor injuries not more complex cases. There was a lack of capacity around discharge planning, which was causing unnecessarily long stays both in ED and in hospital, if admitted.

It was reported that fixed nursing shift patterns were not always aligned to activity and the needs of patients. High staff turnover rates and problems with recruiting were causing challenges around workforce planning and workload pressures.

### **Recommendations**

Both phases of the CLEAR Urgent and Emergency Care Programme culminated in clinicians recommending a series of solutions to their executive teams.

Around 70 per cent of the recommendations made during phase one of the programme were implemented by the NHS trusts involved. Implementation of the phase two recommendations is still ongoing.

All recommendations were accompanied with detailed implementation plans together with metrics to measure success.

The recommendations made across both phases of the programme broadly fell into the following categories:

1. **New models of care and ways of working** – to improve the quality, safety and efficacy of patient care.
2. **New skills mix** – broadening the skill base of staff and enabling colleagues to work in more flexible and new ways to meet patient needs and to relieve pressure on the workforce.
3. **New roles** – introducing new positions to ensure high quality care, easing pressure and optimising pathways.

Some of the key recommendations are outlined below:

### ***New models of care and ways of working***

**Creation of an Older Persons' Emergency Department (OPED)** – in response to older frail patients experiencing unnecessarily long delays in ED and stays as inpatients.

An OPED was recommended to improve the care of patients over the age of 65, including those with dementia, confusion and who are at high risk of falling. It would run 24/7, staffed by a registered nurse and healthcare assistant, and be designed specifically for older frail and confused patients – for example with low trolleys, grab rails and clear pictorial signs. Frailty teams, nursing staff and doctors would work collaboratively to ensure patients receive a comprehensive rapid assessment tailored to their individual needs. There would be a focus on discharge planning on arrival with the aim of reducing admissions and lengths of stay in hospital.

**New early assessment process for adult walk-in patients** – in response to significant workload pressure on ED assessment nurses

A new initial assessment streaming process was recommended for adult patients who self-presented to ED to help staff cope with high demand and ensure these patients received the most appropriate clinical input.

Existing models often mean assessment nurses are having to make many decisions, navigate multiple pathways and carry out time consuming tasks. The new model would divide key parts of the assessment and assign patients to different professionals in line with their needs. This would start with a healthcare assistant (HCA) taking a set of observations shortly after the patient arrives enabling the ED to identify sick patients early. A nurse would see the patient at the same time, or immediately following observations, and make a clinical decision about the needs of the patient.

Patients who are acutely unwell would be diverted to the Fast Initial Treatment (FIT) Zone. Those with minor illness or injury would be directed to the urgent care team after being offered pain relief. Patients in need of ED care would be offered pain relief when appropriate and wait for further assessment.

**Introduction of a new Triage and Treat area** – in response to multiple triage assessments and long waits in the ED

A new Triage and Treat (TaT) zone to be introduced combining the current triage and rapid assessment functions. This would be the first area that patients attend, except for paediatric patients and those immediately in need of resuscitation. The aim would be rapid triage to decide which patients needed immediate treatment and where other patients should be sent

for ongoing care. Patients would be triaged by an experienced nurse within 15 minutes of booking-in at reception or when arriving by ambulance.

An assessment would be made regarding the likely problem and an early management plan put together. A senior clinician would always be available to assist and assess patients when required.

### ***New skills mix***

#### **Upskill emergency nurse practitioners to treat minor illnesses – in response to duplication of front-door streaming and long waits for non-urgent patients**

Existing emergency nurse practitioners (ENPs), trained to treat minor injuries, should be upskilled to provide a minor illness service for non-urgent patients. They would form part of a team consisting of healthcare assistants, nurses and receptionists, with initial support from senior doctors during the workforce development phase. The service was forecast to generate an extra five hours and 20 minutes of doctors' time per day, enabling them to prioritise the care of acutely unwell patients.

The service would improve the front-door streaming process, eliminate the need for further triage, reduce waiting times and offer career development opportunities to ENPs.

#### **Creation of a new team to assess all priority walk-in patients – in response to delays in assessments and electrocardiograms (ECGs) due to work overload**

A new team consisting of two healthcare assistants, nurse, nursing associate and either a senior registrar or advanced nurse practitioner to be established to provide an "ambulatory pit stop" for seriously ill walk-in patients. Patients with symptoms including chest pain, shortness of breath and abdominal pain would be assessed by a senior decision maker, have appropriate investigations quickly and streamed to the most appropriate services. Those not fit to be discharged would be moved to same day emergency care or a monitored bed.

This new way of working would speed up assessments for priority patients, reduce the need for extra investigations and improve the experience of patients and ED staff.

#### **A new multidisciplinary (MDT) team to run an assessment zone for non-urgent patients – in response to significant congestion in the ED**

A senior nurse appointed to run a new assessment zone for non-urgent patients needing assessment which is expected to take longer than four hours. A senior clinical team, consisting of a named medical and surgical consultant, would be dedicated to the zone with access to the expertise of the ED and care of the elderly teams.

The use of junior clinicians, including physician associates and advanced nurse practitioners, would be essential to maintaining patient flow through the zone, and patients needing physiotherapy, occupational therapy or social services, would be proactively identified and highlighted to the frailty team for early intervention. The concept of a virtual ward system, with suitable patients discharged home and booked for a return visit, would allow certain conditions such as deep vein thrombosis to be managed out of hospital. Certain patients who would previously have needed short stays in hospital – including those with a new diagnosis of hypertension or diabetes – could potentially go home with GP follow-up.

This new MDT way of working would provide an opportunity for clinical training as well as help reduce congestion and improve flow through the ED.



## **New roles**

### **Longer stays nurse – in response to long waits in the ED**

It was recommended that a new role of longer stays nurse (band 5) be created to oversee the care of patients waiting in the ED for more than six hours. This 24/7 role would promote patient safety and ensure there were no missed medications, such as second doses of antibiotics, extra intravenous fluids, time-critical medicines and analgesia.

The time patients spent waiting for a bed could be used efficiently and the workload for ED staff, primarily nursing staff and HCAs, in caring for long-wait patients, would be eased enabling them to devote more time to arriving patients.

### **Discharge facilitator role – in response to ED overcrowding because of lack of referral pathways, high volume of frailty patients and discharge delays**

A new role of discharge facilitator (band 3) should be created to enable the proactive, timely and safe discharges of patients and improve flow through the ED. Departure processes previously undertaken by a nurse would be undertaken by the discharge facilitator including completing safety checklists, arranging transport and take-home medication and preparing discharge notes. The facilitator would also refer patients to other services, liaise with families, and decontaminate and restock cubicles.

The service would cover the busiest times between 10am and 8pm, resulting in reduced waiting times, breaches of national ED targets and an improvement in collaborative working, staff wellbeing and satisfaction.

### **Frailty advocate role – in response to congestion in the ED with long waits for inpatient beds, particularly impacting older people living with frailty**

A new role of frailty advocate (band 3) to be established as part of a mobile frailty team tasked with streaming, assessment, investigation and care planning for older frail patients attending the ED between 8am and 11pm.

The role would involve information gathering and sharing to obtain a holistic view of patients and their needs. This would include finding about care packages and any unmet needs, for example, mobility and communication aids, as well as keep families and loved ones updated. They would arrange for any essential personal possessions, including hearing aids and glasses to be brought into hospital and for any valuable items such as money and jewellery to be returned to patients' homes. The new role would lead to more comprehensive holistic care for vulnerable older patients, reducing the occupancy of ED bed spaces and enabling earlier discharges.

## **Forecast impact of CLEAR recommendations**

Across the NHS trusts, involved in both phases of the programme, the projected benefits were improvements to the quality, safety and efficacy of patient care, improved job satisfaction and staff retention, enhanced performance and productivity gains.

This included reductions in length of stay, overcrowding and up to 50% unnecessary admission avoidance for older frail patients. Performance against key performance indicators would improve including time in initial assessment and the four-hour waiting time target.

The total productivity gains for NHS trusts involved in phase one of the programme was £10.5m and £4.5m in phase two of the programme.

Potential impacts for each NHS trust are outlined below.

### **Phase one sites**

#### **Blackpool Teaching Hospitals NHS Foundation Trust**

By introducing a senior decision-maker early in the patient journey and an agile, responsive triage and treat service, the trust will see improvements in the quality of patient care, more efficient patient streaming and reductions in congestion.

A new assessment zone for low acuity, non-emergency patients and streamlined pathways for specific patient cohorts is forecast to improve patient flow, with care being delivered in the right area of the hospital, according to patient need.

Reduced emergency admissions and length-of-stay would also be expected from implementation of the recommendations.

The predicted productivity gains for the trust is £2.6 million.

#### **Oxford University Hospitals NHS Foundation Trust**

The introduction of a navigator role in ED is forecast to reduce assessment waiting times for 48,500 walk-in patients by up to 70 minutes with most seen in under 15 minutes, improving efficiency.

There would be reduced patient moves with the creation of a new ambulatory emergency care centre which would aim to deliver all clinical care in a single area, improving patient experience and potentially eliminating more than 28,000 nurse and 4,750 doctor handovers a year. The extended opening hours for the urgent care centre and the acute admissions unit (AAU) would result in a 50% reduction in evening activity on ambulatory majors, enabling staff to care for other patients more effectively.

#### **East and North Hertfordshire NHS Trust**

By introducing new ways of working including enhanced triage pathways and updated technologies, congestion and patient streaming is expected to improve. With new models of care - including rapid assessment and triage for ambulances, a MDT senior-led triage team at the front door, an urgent treatment centre and elderly assessment unit co-managed between the ED and the Care of the Elderly team - it is forecast that the trust would see improvements in the efficiency of patient care and reduction in length-of-stay in ED and within the wider hospital, particularly among vulnerable patient cohorts.

By using existing staff and estates, developing new skills and the use of new technologies, the trust will be able to improve processes, become more agile and enable improved responses to changing demands.

The predicted productivity gains for the trust is £4 million.

#### **Calderdale and Huddersfield NHS Foundation Trust**

By introducing new models and care and ways of working, the ED is forecast to improve patient care, particularly for frail patients, reduce congestion and prevent more than 1500 admissions.

A dedicated streaming and triage service would enable patients presenting with minor illness or injury to be efficiently diverted to appropriate services, which will subsequently reduce 'majors' congestion. A rapid ambulance assessment service for frail patients as soon as they arrive to the ED will ensure their care needs are identified early and efficient streaming to appropriate services, including same day emergency care.

Extending the opening hours of the same day emergency care service to a seven day, 16-hour service would meet weekend and out-of-hours demand. Creation of a dedicated urgent care centre and urgent treatment centre would enable patients with minor illnesses and injuries to receive timely and appropriate care as well as reduce congestion in ED.

The predicted productivity gains for the trust is £400,000.

### **Taunton and Somerset NHS Foundation Trust**

A new senior decision-maker to assess patients as they arrive to ED would enable improved streaming to the most appropriate care, including the identification of paediatric patients who could be treated in a paediatric assessment unit and frail patients who could be managed by a dedicated frailty team. This is forecast to decrease congestion in 'majors' and improve the quality of care for these patients.

Streaming patients with minor injuries who require an X-ray and directing them to a radiographer-led discharge pathway, which would require upskilling, has the potential to reduce unnecessary demands on clinicians. Redirecting patients with low risk needs to existing external commissioned services would help to reduce congestion in ED and, at the same time, ensure patients receive faster access to specialist treatment.

The predicted productivity gains for the trust is £1.9 million.

### **North Middlesex University Hospital NHS Trust**

The introduction of a new initial assessment model of care for self-presenting adults that aligns staff numbers and roles to varying patient demands has the potential to improve patient safety and reduce congestion in the ED.

The creation of an elderly care assessment unit, staffed by a multidisciplinary frailty team which proactively identifies frail patients for assessment and treatment could improve the breach rate within the department by up to 17% and reduce the number of handovers for up to 5900 patients, which in turn could enhance patient safety among this patient cohort. There would be additional potential productivity savings of up to £1.6m through reduced length-of-stay among these patients.

An adjustment in nursing shift patterns to align staffing better to activity in the ED, including busy periods, would improve efficiency, productivity, and the experience and retention of staff.

The predicted productivity gains for the trust is £1.6 million.

### **Phase two sites**

#### **Mid Cheshire Hospitals NHS Foundation Trust**

Recommendations included a same day emergency care service for patients with chest pain who would be referred directly to the ambulatory care unit after a brief assessment by the streaming nurse and an ECG. Frailty patients meeting specific criteria could be referred

directly to a new ambulatory frailty SDEC for assessment and treatment by a multidisciplinary team with the aim of same day discharge.

Patients having an ECG on streaming would lead to faster assessment and reduce overcrowding. This could release 8,397 hours per year, equating to 23 hours a day of clinical time, which would increase the ED's capacity by eight patients per day. It would also reduce avoidable overnight admissions, potentially saving up to £662,000.

The ambulatory frailty SDEC would lead to improved patient outcomes, reduced ED overcrowding and the potential to discharge patients sooner. The service has the potential to save 52 hours a day of patient time in ED and 9,254 bed days per year.

### **Hampshire Hospitals NHS Foundation Trust**

A key recommendation was the creation of a minor illness service within the ED and the upskilling of existing emergency nurse practitioners (ENPs), enabling them to treat patients with minor illnesses and injuries.

The establishment of an OPED run 24/7 would ensure frail patients received the most appropriate care tailored to their needs. This includes a rapid assessment and discharge planning, with the aim of reducing unnecessary admissions and lengths-of-stay in hospital. Other recommendations included walk-in patients being assessed by an experienced nurse, eliminating the need for extra triage.

The proposals have the potential to prevent up to 6,900 annual admissions of older patients living with frailty and reduce the length of stay in hospital. The South Central Ambulance Service would be able to refer patients directly to both the minor illness service and the OPED, relieving pressure on main ED staff.

Predicted productivity gains for the trust based on reducing unnecessary admission and length-of-stay is £3.2 million.

### **Mid Yorkshire Hospitals NHS Trust**

A new mobile frailty team would directly alleviate ED pressure, speeding up the care and flow of frail patients. The team would ensure that the decision to admit and a comprehensive geriatric assessment was made at the earliest opportunity. A new role of frailty advocate would gather information to complete a holistic view of patients and their needs to improve their experience. A frailty co-ordinator would be introduced to oversee admissions, discharges and transfers.

It is forecast that early specialist input could significantly reduce hospital length of stay with savings in bed days of between £3,400 and £6,800.

It was recommended that the same day emergency care criteria should be expanded to accept frail patients with two additional staff (an HCA and porter) to support their needs to alleviate overcrowding in the main ED. This would optimise existing resources and reduce ED congestion, potentially saving 22,510 hours of ED time per year. Together with the new mobile frailty team, there is a potential to prevent 1,305 patients being admitted to hospital, saving £451,530.

## **Kettering General Hospital NHS Foundation Trust**

An Ambulatory Pit Stop would provide a dedicated area for rapid assessment and early senior decision-making for priority patients. This would be carried out by a team of medical and nursing staff. The area would be operational from 8am to 10pm Monday to Friday. This would improve streaming and access to same day emergency care, and reduce the number of investigations needed. The forecast reduction in admissions for these patients would result in £423,225 productivity savings.

Patients over 65, who are 'fit to sit', should be assessed in a dedicated Older Adult Assessment unit, which would run from 8am to 10pm Monday to Friday. Outside of these hours, a mobile team would provide outreach services in ED. This would reduce waiting times, improve patient experience and enhance safety by, for example, preventing falls in ED. The unit would have an enhanced discharge process, with early therapy assessment if needed, resulting in reduced out-of-hours admissions.

## Case Study: Hampshire Hospitals NHS Foundation Trust

*Reducing admissions and ED waiting times with two new services and upskilling existing staff*

### The challenge

Patients and staff in the ED were being adversely affected by long waits for initial assessment, partly caused by patients first being screened for Covid-19 at the front door followed by the triage process. Patient referral pathways were fragmented and many older frail patients were experiencing unnecessarily long delays in ED and stays as inpatients. There was no dedicated frailty assessment area or early discharge planning and emergency nurses were only trained to deal with minor injuries not minor illnesses.

### What they did

Supported by the national CLEAR team, five clinicians gathered insights from key stakeholders from all professional backgrounds and levels of seniority. One-to-one interviews were held with 44 individuals and the team carried out clinical observations within the department. This qualitative analysis was combined with detailed examination of more than 170,000 clinical records to identify trends and patterns which would help pinpoint the specific challenges facing the department, enabling the team to redesign services and workforce roles to provide solutions.

### CLEAR recommendations

A key recommendation was the creation of a minor illness service within the ED and the upskilling of existing emergency nurse practitioners (ENPs), enabling them to treat patients with minor illnesses as well as those with minor injuries.

The establishment of an Older Persons' Emergency Department (OPED) was recommended to improve the care of frail patients over the age of 65, including those with dementia, confusion and at high risk of falling. It would run 24/7, staffed by a registered nurse and healthcare assistant, and be designed specifically for frail and confused patients – for example with low trolleys, grab rails and clear pictorial signs. Frailty teams, nursing staff and doctors would work collaboratively to ensure patients receive a comprehensive rapid assessment tailored to their individual needs. There would be a focus on discharge planning on arrival with the aim of reducing admissions and lengths of stay in hospital.

Other recommendations included walk-in patients being assessed by an experienced nurse, eliminating the need for extra triage.

### Forecast impact

The proposals have the potential to prevent up to 6,900 annual admissions of older frail patients and reduce the length of stay in hospital (in cases where admission is unavoidable) generating more than £3 million of savings.

The £1.2m cost of the minor illness unit would be offset by giving doctors more than five extra hours per day to treat seriously unwell patients, reducing the overall cost to £200,000. ENPs would have career development opportunities and patient satisfaction would be improved with reduced length of stay in ED.

The South Central Ambulance Service would be able to refer patients directly to both the minor illness service and the OPED, relieving pressure on main ED staff. Ambulance waiting times outside the ED would be reduced, resulting in the faster release of crews.

### **Further information**

More information on the National CLEAR Programme can be found on the [CLEAR website](#) which includes additional [case studies](#). You can contact us by emailing [info@clearprogramme.org.uk](mailto:info@clearprogramme.org.uk)