



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

THE ACUTE HOSPITALS DIVISION

# Developing an Acute Floor Model for Ireland

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# 1 Foreword

Hospitals in Ireland, as globally, are experiencing unprecedented challenges in the delivery of unscheduled care. Demographic changes, increased complexity, patient choice and expectation, and shifts in the wider healthcare landscape are resulting in increased demand pressures on already stretched resources in Ireland's hospitals. "More of the same" is no longer an option to solve this problem. Innovative models of care and new ways of working are required to meet the demand for high quality, timely Acute care. There are therefore multiple compelling drivers for the development of the Acute Care Model for Ireland, and this development is a timely one.

The IHRP Programme in Tallaght in 2015/2016 tested this approach, and demonstrated proof of concept of elements of the Acute Floor. The work currently ongoing in Galway and Limerick as part of the National Patient Flow Improvement Programme is well aligned to this vision, embedding the operations management techniques required to embark on and sustain an improvement effort, and engaging staff in implementing best practice approaches to support improved flow.

This vision is in alignment with the HSE National Service Plan:

*"Our aim is to provide a health service which is available to people where they need it and when they need it. We should provide people with the best outcomes that can be achieved." This Plan acknowledges that we need to "continue to work with service users, medical colleges and nursing and therapy leads to develop and implement processes that will improve the way in which care is provided."*

The National Clinical Care Programmes have developed robust evidence based Clinical Models, with a specialist focus. The Acute Floor concept draws together the parallel threads of these Clinical Care Programmes within the context of Acute Care and empowers clinical leaders across the spectrum to work in a co-ordinated, multi-disciplinary and patient-centred way such that patients are treated and discharged without delay by the most appropriate senior clinician. This is an exciting development and the springboard for development of Clinical Standards which will embed this approach as part of the organisations Transformation and Service Improvement Programmes and broader strategic approach to the delivery of Urgent and Emergency Care. In so doing, the Acute Floor model can be a key platform and enabler in delivering on key goals contained within the Future of Healthcare Sláintecare Report (May 2017) as follows:

- All care planned and provided so that the patient is paramount, ensuring appropriate care pathways and seamless transition backed up by full patient record and information
- Timely access to all health and social care according to medical need
- Care provided free at point of delivery, based entirely on clinical need
- Patients accessing care at most appropriate, cost effective service level with a strong emphasis on prevention and public health

This document could not have been developed without the significant input of the National Clinical Programmes and in particular, the Clinical Leads and Programme Managers. Their openness to exploring new ways of collaborative working and selfless expert contributions is gratefully acknowledged and appreciated. Thanks are also extended to the large number of stakeholders who attended workshops, interviews and focus groups and contributed greatly to this body of work which is innovative and farsighted.

I would also like to highlight the huge work done by the team at GE Healthcare Fingamore who provided great technical and organisational skills to facilitate the process of engagement with all key stakeholders whilst ensuring the process was informed by best international practice. Finally, I would like to thank Dr Colm Henry and Mr Willie Reddy for their drive and leadership in bringing this report to fruition and to Ms Emma Benton for her diligence in keeping all parts intact in the delivery of this project.

***Mr Liam Woods***

***National Director***

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## 2 Executive Summary

Unscheduled care is a global challenge, with health systems around the world working hard to match capacity to demand for care in an evolving system. Meeting the size and scale of the health and care challenge with the current Irish service design is not sustainable. There is emerging political, clinical and social consensus on a radically new direction for health and social care services in Ireland with a strong evidence base indicating what form that new direction must take (1).

The front door or access point of the service is a fundamental component of this emerging agenda. Its design needs to reflect the increasing complexity of the acutely unwell patient, irrespective of age. The Acute Floor concept is recognised as part of the solution as a platform for enabling front-line change. It relates to co- or proximally-located integrated acute services within a Model 3 or 4 hospital for patients presenting for unscheduled care. Key features of the Acute Floor include:

- A single point of access is through the Acute Floor Hub, for swift two-way communication with GPs and community partners, for rapid access to specialists, advising alternatives to admission or the best course of treatment, or directing to the most appropriate acute service.
- On presentation, patients are streamed by an appropriately trained clinical staff member to the appropriate clinical services, supporting flow and rapidly getting them to the expertise they need. Streaming is distinct from triage, being a swift and immediate signposting to the appropriate clinical service on the Acute Floor, with no duplication of the formal clinical prioritisation of the triage process. Triage will take place within the respective service, whether Emergency Medicine, Acute Medicine or Acute Surgery.
- The clinical service will triage when demand outstrips capacity, such that patients are seen based on clinical prioritisation and cared for by a multi-disciplinary, multi-specialty team, led by a senior clinical decision maker on the Acute Floor.
- Early access to senior clinical decision-makers is paramount, supporting patient safety, appropriate resource use, and patient flow. Senior clinical decision-makers in core specialties will be present on the Acute Floor to support decision-making on the floor during peak hours, with robust on call arrangements to ensure continuity of care and patient safety outside core hours. Access to senior clinical decision makers and the use of Early Warning Systems have been demonstrated to improve patient safety, reduce unnecessary admissions and reduce length of stay.
- Conversion of historical in-patient episodes to ambulatory care, together with early senior clinical decisionmakers would be expected to contribute to reduced length of stay. In a hospital with 85% midnight occupancy and with an average 5 day length of stay, a 0.5 day reduction in length of stay results in effective bed gains of 17 beds in a 200 bedded hospital, or 25 beds in a 400 bedded hospital. If occupancy is 100%, those gains are 20 and 30 beds, respectively.

*(See page 55 for link to the Advisory Board discharge opportunity calculator)*

- Services will operate as a network, within a shared space of co-located, interconnected services, acting as part of a wider integrated health system, as opposed to discrete units or departments
- Capacity is designed around patient needs and the patterns of demand rather than around traditional 9-5 working practices, and will shift to an increasingly predictive, data-driven model. Services designed around averages will consistently not be resourced to actual demand. Demand determines design – of services and teams.
- The design of the services and the space will promote ambulatory assessment and care as a primary option. Bed-based or traditional in-patient provision will no longer be the default. Dedicated pathway development will assist this shift in focus. Ambulatory care should be the first filter before admission is considered. Where admission is required, the flexibility will be needed for short-stay admission or timely access to specialist wards.
- Core diagnostics will be present on or near the Acute Floor to avoid becoming a rate limiting step. Where specialist radiologists are required, remote reporting is encouraged at the hospital group level. The development of GP direct access to specified diagnostics may enable more community-based care, and open up new models of care for those who do not need the full gamut of acute healthcare resources.
- The Acute Floor Hub and governance structures will support integration with primary care, social care and community services, such that patients are discharged without delay, built on proactive, systematic operating practices and governance. Patients will be cared for in the most appropriate setting, which may not be an acute hospital, and may be closer to home. Just widening the front door alone through the Acute Floor will not alleviate system pressures, and requires jointly building, embedding and improving new pathways across the healthcare economy.
- The widening of acute expertise to assess complex patients and frailty, and respond as a multi-disciplinary and multi-specialty team will promote independence and support timely onward care planning.
- Future training will develop broader skillsets for management of the acutely ill patient, and require new roles and career pathways, focussed on multidisciplinary team training and optimal teamworking, to respond to high volume demand and complexity, and to reduce delays and hand offs.
- Activity will be captured through an Acute Floor Information System, which will align to Activity Based Funding (ABF), recognising complexity and recognising the need for rapid access to senior clinical input, and avoiding unintended incentives to admit patients unnecessarily.

Developing the Acute Floor is as much a challenge of engagement as it is a technical, capital or estates challenge, relating to working practices and clinical and operational leadership. It is therefore essential that the skills and planning needed for effective change and operations management and are mobilised and steered through a clear governance framework.

Development and ongoing management will be led through each hospital's Unscheduled Care Group (being deliberate in extending to include CHO partners), linking with the Hospital Group level where appropriate. Overall operational responsibility will rest with the Unscheduled Care lead or Chief Operating Officer, and a Clinical Lead will hold ultimate responsibility for clinical governance. However, the latter role could rotate, to gain contribution from Acute Floor services. Given the outward looking and multi-disciplinary nature of the Acute Floor, governance will reflect this as a 'team sport', and foster inclusion of all relevant specialties and disciplines.

Broadening the front door through evolution of the Acute Floor will come as part of wider improvement work that encourages preventative and proactive care in non-acute settings. Community Health Organisations and Primary Care are critical partners, such that patients are treated and discharged without delay by the most appropriate senior clinician placing emphasis on the creation of co-ordinated multi-disciplinary, patient-centred care.

Given the variability in local infrastructure, service models and workforce across Ireland, developing the Acute Floor will involve some difficult decisions. The following design principles outline the intent behind the Acute Floor, and provide the consistency and a source of guidance to inform local, site-specific decisions:

1. A person-centred focus
2. Key access to services
3. Effective assessment and care
4. Integrated care
5. Clinical justice
6. Connected networks of care
7. Integrated governance

The recommendations contained here take a pragmatic approach, recognising the variability in workforce, facilities and demand. The direction of travel is clear and it is for Hospital Groups, individual hospitals and their community partners to draw on their shared resources, drive and capabilities to bring the spirit of the Acute Floor to life (see Figure 1 below for a schematic of the Acute Floor).

Keen to realise improvements in unscheduled care, hospitals are likely to be looking for a clear set of next steps. Wanting to avoid 'paralysis by analysis', hospitals and Hospital Groups are encouraged to grasp the opportunity and avoid delay in starting this work.

The approach to local implementation is likely to be informed by existing infrastructure and configuration, the gap between current and future state, and any aligned initiatives already in motion that would enable near-term gains. Here it is encouraged that local services engage well with partners, and then move swiftly into a process of prototyping, iterating and improving; growing the breadth of service provision aligned to prioritised population need/demand.

It is intended that a national approach to implementation will compliment local development of Acute Floors across hospitals and a collaborative system of implementation will develop. There is a significant amount of enabling and other work (e.g. development of service standards, unified care pathways, etc.) that can be completed at a national level, eliminating the need for such work to be replicated across each Acute Floor.

The approach to national implementation and oversight is likely to be informed by the pace of local implementation and the requirement of clinical leadership to operate in an Acute Floor environment. It is envisaged that any national level implementation structures work hand in glove with local implementers to assist and support local service development and continue to promote the value of the Acute Floor operational model.

The following approach and timeline is suggested as one of several potential paths, which will need to be developed further, at both local and national level, as the Acute Floor moves into implementation.

<i>Phase</i>	<b>National</b>	<b>Local</b>
<b>Mobilise</b>	<p><b>Timescale: Immediate</b></p> <p>The Acute Floor Task and Finish Group is underway and this document describes the model.</p>	<p><b>Timescale: 0-3 months</b></p> <p>Map local stakeholders; communicate and engage form the Acute Floor Steering Group; establish provisional hospital governance arrangements for development of the Acute Floor (a working group with clear operational and clinical leads, the drumbeat and project management processes)</p>
<b>Map</b>	<p><b>Timescale: 0-3 months</b></p> <p>Identify the appropriate national initiatives that would most advance and support local development of acute floors, and identify with Hospital Groups the first phase implementers</p>	<p><b>Timescale: 3-6 months</b></p> <p>Assess local current state (e.g. infrastructure, workforce, technology, access to diagnostics); gather baseline data around current and projected demand; gap analysis against core Acute Floor features; target high priority pathways/patient groups (prioritising volume, readiness for alternative non-in-patient provision with an MDT team)</p>
<b>Plan</b>	<p><b>Timescale: 0-3 months</b></p> <p>Define enabling workstreams to facilitate implementation of acute floor developments within hospitals. Some workstreams will relate to the development of national level initiatives (e.g. standards development), others will relate to providing direct service development support for individual hospitals, others to align current work (cont.)</p>	<p><b>Timescale: 6-9 months</b></p> <p>Articulate the future state with a single plan across partners, starting with the priority pathways; engage the multi-disciplinary teams to prototype the design of pathways and required support services; understand the near- and medium-term workforce and technology solutions</p>



Phase	National	Local
<b>Plan (cont.)</b>	(cont.) programmes within an acute floor context. This work will also align the acute floor approach with the broader patient flow projects. The resulting output of this should be an agreed national implementation plan with associated project milestones and reporting structures.	
<b>Do and review</b>	<p><b>Timescale: 6 months +</b></p> <p>Commence workstreams that directly support local development of acute floors</p>	<p><b>Timescale: 9 months +</b></p> <p>Move to real-world testing of the key components of the acute floor, implementing, reviewing and refining on an ongoing basis. Areas that are amenable to immediate action (depending on local constraints and infrastructure) include:</p> <ul style="list-style-type: none"> <li>• Co-located multi-disciplinary teams deployed to work on general take (including existing skilled staff e.g. Advanced Nurse Practitioners, senior HSCPs, pharmacy)</li> <li>• Presence of a senior clinical decision maker from acute medicine, emergency medicine, surgery and older people's services</li> <li>• Extension of the working day, aligning to demand patterns</li> <li>• Phased extension of GP/CHO access to specialist input by developing the Acute Floor Hub (initially as little as a dedicated phone line)</li> <li>• The means of capturing demand and outcomes, to inform future improvements and development (initially may be a work-around, but ultimately an integrated Acute Floor Information System)</li> <li>• Implementation and utilisation of National Clinical Guidelines for Early Warning Systems (e.g. NEWS, PEWS)</li> </ul> <p>It is envisaged that more services are brought on line as the Acute Floor grows in confidence and capability.</p>

The Acute Floor model requires the intentional design of evidence based care pathways in such a way as to guarantee timely access to quality of care. Thus, a well-designed, resourced and governed Acute Floor will be a key foundation stone in delivering upon goals articulated the Future of Healthcare Sláintecare Report (2) such that:

*'Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver.*

*This is a service in which communication and information support positive decision-making, governance and accountability; where patients' needs come first in driving safety, quality and the coordination of care.'*

As work gets under way within hospitals and Hospital Groups on the Acute Floor, more formal clinical and operational standards for Acute Care will be developed for Irish hospitals through further collaborative work at national level. Given the pressure on acute services, there is an urgency for both to be undertaken in parallel.

The Acute Floor represents a step change in what has gone before:

- Firstly, it acknowledges that this is a leadership challenge as much as a technical challenge – which is demanding, often non-linear, and needs to encourage people – patients as well as staff – to bring their creativity, to reinvigorate them to focus on improving the experience and quality of care.
- It is asking for a shift in thinking and extending affiliation, from a 'departmental' view to one of interconnected, multi-disciplinary services sharing the same space, designed to respond to the needs of those for whom the system cares.
- It aims to improve the two-way links with community settings, through the Acute Floor governance structures, by developing new boundary-spanning roles and via new, targeted mechanisms to interact with expertise such as the Acute Floor Hub.
- There will inevitably be a significant resource challenge which needs to be acknowledged: extended hours working matched to demand will necessitate effective workforce planning and inevitably recruitment. Development of these workforce plans and new roles will take time and involvement of multiple agencies.
- As services develop and move more towards working in shared spaces, there will be cost and estates implications to be considered.
- Activity based funding is a key enabler of this process. Early engagement and planning is necessary to avoid unintentional consequences of funding models.

The Acute Floor Model establishes an ambitious and clear, evidence based platform for the direction of travel to improve access and to develop a response to the needs of complex, acutely unwell patients which is fit for purpose. It also lays out guidelines, underpinning principles, and the values and behaviours that leaders will need to draw on, such that we are able to improve how we work together for the betterment of patient care, for now and for the future.

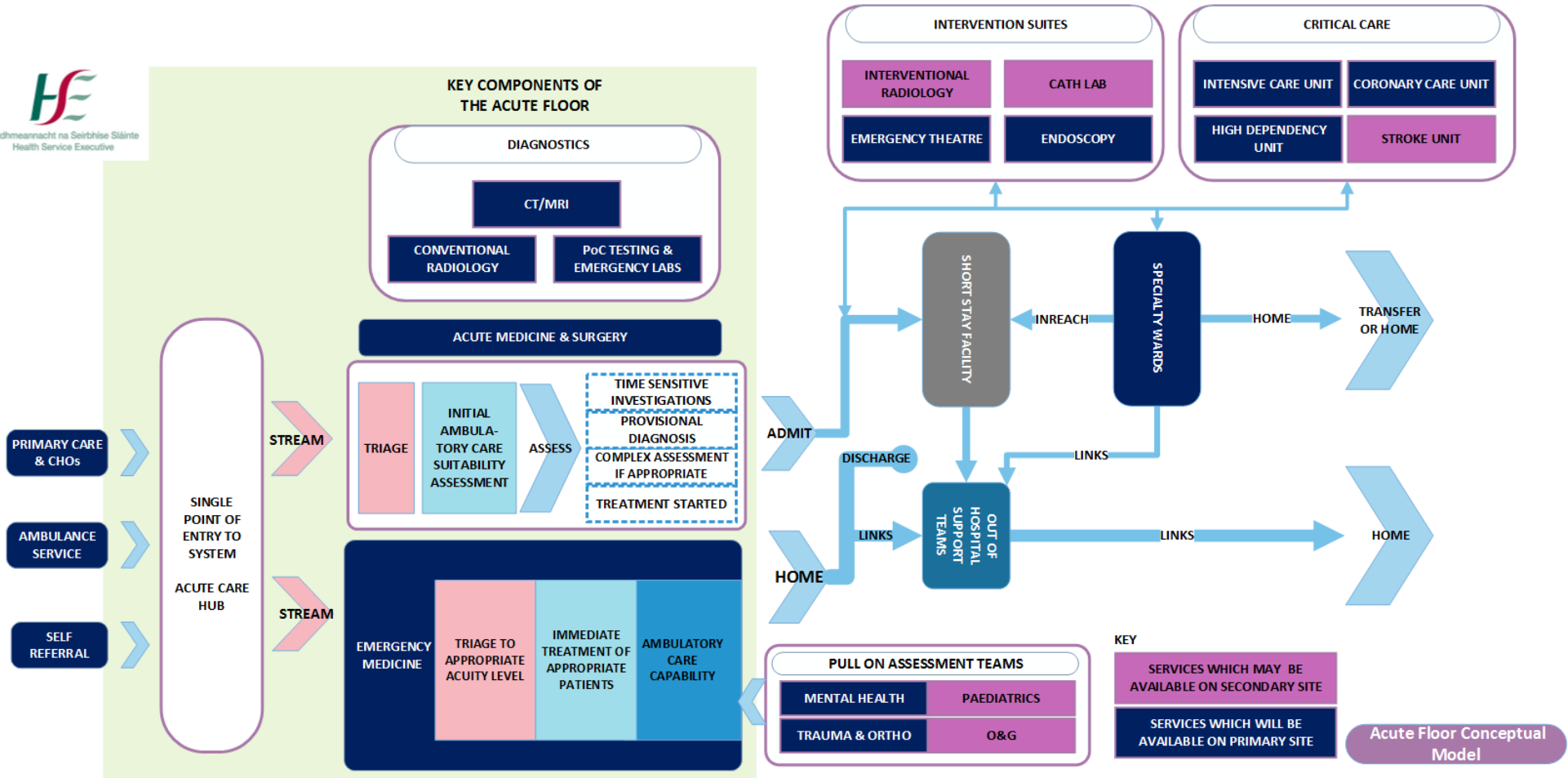


Figure 1: The Acute Floor Flow Schematic

### **3 Purpose of the document**

The purpose of this document is to provide guidance on establishing the Acute Floor in Model 3 and Model 4 hospitals.

The arrangements for Model 2 hospitals have been well described in the HSE document “Securing the Future of Smaller Hospitals: A Framework for Development” (3). The Acute Floor will support Model 2’s and act as a safety net for Acute Care.

This document should be used:

- To establish the core principles, framework and expectations around establishing and operating an Acute Floor.
- To inform and promote early adoption and implementation of the Acute Floor model in Model 3 and Model 4 hospitals.
- As a key document to inform national annual prioritisation.
- As a source document for relevant national Clinical Programmes.
- As a springboard for development of formal clinical and operational standards for Acute Care for Irish hospitals through further collaborative work at national level.

## 4 Urgent change for urgent care - finding the leverage points

The prevailing acute model is struggling to adapt to the changing nature of demand. Acute hospitals are increasingly running at “winter” levels all year round. A significant number of emergency departments are escalating to Full Capacity Protocol (FCP) and using extraordinary measures to address increased but now normal demand on a regular basis. New, systemic approaches to resilience are needed. This is not purely about volume of attendances, but additionally about the complexity of cases impacting on likelihood of admission and subsequent length of stay, leading to inpatients remaining in Emergency Medicine Services in large numbers whilst awaiting a hospital bed. These challenges are compounded by fragmented hospital processes beyond the front door, services designed around historical models of care and service design, absolute bed capacity constraints in some areas, and limited alternatives to admission or to support discharge.

The trend looks set to increase in the numbers of complex and frail patients presenting, and presenting in a more dependent state:

- Recent census data shows that those over 65 have increased by 19.1% over five years between 2011 and 2016, with those over 85 increasing by 24.8% in males and 11.4% in the female population (4).
- The overall volume of patients treated in hospitals has increased significantly, with an increase of 7% in discharges from 2012-2016, with a greater increase (12%) felt in emergency inpatient activity (5).
- Adults aged 65 years and over make up 12.7% of our population but use 53.3% of total hospital in-patient bed days and approximately 36% of day case and same day bed days (1).
- An increase in co-morbid presentations has been estimated in a recent report in the UK to add a further 6% requirement for in-patient beds (6). It is likely that this figure is similar in an Irish context.

For a system struggling to achieve flow and release the grid-lock, it becomes harder to access and flex capacity. Referrers in non-acute settings are challenged in accessing advice to avoid an acute presentation. Support for discharge back from the acute into primary and social care services can also be problematic. This is not for a lack of will, as staff are frequently recognised for their commitment and compassion. The imperative is to change the way that care delivery is designed, to adapt to the changing nature of demand.

In the last five years, there have been many initiatives aimed at improving the patient journey through the ED and during their hospital admission (about 25% of ED attendances result in a hospital admission).

These initiatives include:

- Improved internal processes within emergency medicine services, (e.g. Streaming at triage, Advanced Nurse Practitioners, Clinical Decision Units) and other aspects of the National Emergency Medicine Programme. (7)
- The establishment of Acute Medical Assessment Units (AMAU) and Acute Medical Units (AMU's) and other aspects of the National Acute Medicine Programme. (8)
- Acute Surgical Assessment Units (ASAU) and other aspects of the National Surgical Programme. (9)
- The identification of increasing number of patients in whom frailty is a feature of their emergency presentation and early initiation of Comprehensive Geriatric Assessment (CGA) Interdisciplinary teams of Health and Social Care Professionals (HSCPs) are an increasing feature in many Emergency Medicine Services and AMAUs, "pulling" patients towards them for assessment, rather than awaiting the traditional "push" from inpatient wards at a later stage in their admission (10). Where appropriate this will involve engagement with the local geriatrician or other specialty consultant teams (11).
- An increasing emphasis on the importance of ambulatory care alternatives to admission across emergency medicine, acute medicine and surgery.
- Average length of stay has reduced over the same period by 8% equating to the generation of additional relative capacity of almost 900 acute beds. Ireland now has a low length of stay compared to other OECD countries (OECD 2015 (12)).

However, there remains significant variation in how the health system has adapted to the challenges and implemented initiatives to address them. For instance, there is significant variation in structures, systems and processes that have been deployed to address urgent and emergency care in Ireland:

- 10 of the 26 hospitals that offer emergency medicine services on a 24/ 7 basis (not including the 3 dedicated Children's hospitals) do so without having a named Consultant in Emergency Medicine available and clinically accountable for the patients registering in the Emergency Medicine Service at all times of opening.
- There is significant variation in resourcing and performance in Emergency Medicine services, Acute Medical Assessment Units and Acute Medical Units across the country.
- There are infrastructural deficits in several areas across the country which have begun to be addressed but will remain an issue until capital developments are completed.
- It is important to ensure that patients who are seen in AMU/ AMAUs and utilise those scarce resources are high enough in acuity and that it is not used for patients who would be more appropriately managed in other environments such as out-patient clinics, or who could be managed in primary care if there were improved access to routine diagnostics.





- There is significant inconsistency in how data are recorded and utilised across the urgent and emergency care pathways in many Irish Hospitals. True service demand, including reliably captured data on demand and capacity, has been difficult to elucidate, and therefore effective planning becomes difficult to achieve (see section 8 – Outline specification for the Acute Floor, and 9.4 – IT enablers).
- There are significant difficulties in attracting, recruiting and retaining senior clinical staff in some specialties and some geographical areas. Extended hours working will necessitate robust workforce planning and recruitment policies.
- The move to more specialised training for doctors has resulted in a reticence to maintain exposure to undifferentiated acute presentations due to difficulties maintaining acute care skills for some consultants in some specialties.
- There is an increasing number of patients for whom frailty is a feature of their emergency presentation. The need to place specific focus on this patient group is increasingly recognised.
- Equally it is recognized that mental illness, homelessness, alcohol and substance abuse are associated with significantly higher emergency medicine service attendance rates, and require a specific focus.
- Due to demographic and financial challenges, the numbers of emergency medicine service attendances by homeless persons has increased especially in several city hospitals necessitating specific pathways of care, for emergency medicine service and for in-patients with regards to timely egress.
- The potential of ambulatory care to support admission avoidance is not well developed or co-ordinated and even where there are options, they are often not well supported. Current funding streams do not accurately support this kind of initiative, making advances difficult to embed.
- If we are to address the problems of excessive trolley waits and long Patient Experience Times, then we need to address how patients flow in and through our health system.

It is recognized that meeting this challenge with the current service design is not sustainable. There is emerging political and social consensus on a radically new direction for health and social care services in Ireland with a strong evidence base indicating what form that new direction will take.

The Acute Floor will exist as one part of a wider integrated health and social care system, and achievement of smooth patient flow and high quality care relies on true co-operation between all of the parts of that health and social care system.

This document is the start of an ongoing process of model development and aims to describe how the Acute Floor may be developed. Key issues affecting patient flow such as admission avoidance and provision of community services are recognised for their importance in the wider healthcare system, however they are out of scope for the purposes of this document.

## 5 Glossary

	Quotes from contributors to the Acute Floor Task and Finish Group
	Examples of good practice being implemented across Ireland and internationally
	Key recommendations/ requirements of the Acute Floor
	Evidence/ References

Acute Floor	An integrated service configured to manage unscheduled care demand. This may be co- or proximally located clinical and support services which work together to manage unscheduled demand on a day to day basis.
Acute Care Hub	<p>A single point of access to the Acute Care system, both a real and virtual space supported by telecommunications and ICT-based contact for timely two-way communication between community, social care and primary care services, specialists within the hospital and other hospital sites.</p> <p>Its intent is to:</p> <ul style="list-style-type: none"> <li>i) stream, in real time, GP-referred patients or their accountable clinicians to the service/ support that is most appropriate for their needs</li> <li>ii) stream, in real time, self-referred patients to the appropriate stream of care in the emergency medicine service</li> <li>iii) provide rapid access to specialist advice, to inform onward care planning or assessment</li> <li>iv) facilitate flow into and out of the Acute Floor</li> <li>v) signpost to alternative services</li> </ul> <p>Please note: where similar functions already exist within the hospital, a review may be necessary to consolidate or clarify roles, responsibilities, processes and clinical governance.</p>
AMAU	An acute medical assessment unit (AMAU) will operate as an AMU with the following exceptions: It will be located in a Model 3 (general) hospital; the hours of operation may vary from 12 to 24 hours, 7 days per week, depending on service



AMAU (cont.)	need; and it will not have contiguous short stay medical beds.
Ambulatory Emergency Care	The underlying principle of Ambulatory Emergency Care (AEC) is that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day either without admission to a hospital bed at all, or through admission for only a few hours. This principle is applicable to patients across specialties and may be provided in a variety of settings such as Acute Medical or Acute Surgical Assessment Units, Acute Medical Units or Clinical Decision Units or dedicated multispecialty Ambulatory Emergency Care Units depending on local configuration. For the Acute Floor, the physical layout should be designed to reflect the emphasis on ambulatory care, with less dependency on bed-based models.
AMU	An Acute Medical Unit (AMU) is a facility whose primary function is the immediate and early specialist management of adult patients (i.e. aged 16 and older) with a wide range of acute medical conditions who present to a Model 4 (tertiary) hospital. Its aim is to provide a dedicated location for the rapid assessment, diagnosis and commencement of appropriate treatment. Physicians, supported by a multidisciplinary team, will carry out patient assessment and treatment. It is envisaged that AMUs will operate on a 24/7 basis. The AMU should be co-located with the Emergency Medicine Service. Every AMU should have a designated lead consultant physician, clinical nurse manager and therapy lead. If required, patients can be admitted to the short stay medical beds within the unit for a short period for acute treatment and/ or observation where the estimated length of stay is less than 48 hours.
ASAU	An acute surgical assessment unit (ASAU) provides a dedicated, transitory, centralised service area where acutely ill surgical patients can be assessed prior to being admitted to a Model 3 or 4 hospital or otherwise treated and discharged. An ASAU's principle function is to provide the patient with early senior decision making. This should result in improved patient flow with better access to assessment tools and therapies. ASAUs ideally should be collocated with the Emergency Medicine Service and AMU floor services. More detail as to the structure and function of an Irish ASAU can be obtained from the National Clinical Programme in Surgery 2017 ASAU minimum standards publication ( <a href="http://www.rcsi.ie/ncps">http://www.rcsi.ie/ncps</a> ) (cont.)

ASAU (cont.)	An acute surgical care inpatient bed stock maybe collocated with an ASAU but provides a different function and therefore requires separate designation.
Clinical governance and escalation	<p>A clearly identified named clinician <i>responsible</i> for the delivery and quality of care for the individual patient from the point of registration to discharge from the Acute Floor, with facility and easy transfer of care where appropriate, as patient's diagnosis and ongoing care needs become better defined.</p> <p>A clearly identified named consultant <i>accountable</i> for delivery and quality of care for the individual patient, including supervision of junior staff from the point of registration to discharge from the Acute Floor, with facility and easy transfer of care where appropriate, as patient's diagnosis and ongoing care needs become better defined.</p> <p>Final point of clinical accountability for the quality of care within the Acute Floor is rests within the hospital's relevant clinical directorate model. Hospitals may consider a rotational approach to clinical leadership for the Acute Floor, seeking contributions from the various services which contribute to the Floor.</p> <p>Triggers for clinical escalation (patients needing senior/ specialist review) relate specifically to acuity, and include the need for resolution of input from or transfer to other clinical teams, maintaining safety and quality of care, or emerging clinical disputes. Each service should have a clear clinical escalation framework, which is communicated and easily accessible by staff and which articulates the lines of clinical responsibility and escalation for instances of clinical complexity, or departmental safety.</p> <p>Deteriorating Patient Recognition &amp; Response: Triggers for clinical escalation are supported by the use of the appropriate early warning system inclusive of track and trigger observation chart, escalation protocol, communication tool (ISBAR) timely interventions, documentation of care &amp; management plan. Key to success at institutional level is strong governance and leadership, targeted training, on-going audit, evaluation and feedback.</p>
'Frailty attuned' environment	Skills and a healthcare environment to support the early identification of frailty, recognising all acute staff need to be competent in identification and management of frailty, with a frailty pathway being a core component to support patient flow, including appropriate linkages with community services, and timely initiation of Comprehensive (cont.)

'Frailty attuned' environment (cont.)	(cont.) Geriatric Assessment (CGA). This will form a part of the assessment process in the Acute Floor.
Hospital Groups and Community Healthcare Organisations (CHOs)	Grouping of facilities including hospitals and community services with clearly defined roles and mutually agreed interdependencies, existing under a comprehensive governance structure with a robust system for assuming responsibility and accountability.
Multi-disciplinary (team)	<p>Appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, community, social care or voluntary and private sector providers to redefine, re scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s).</p> <p>Or: How health and care professionals work together to support people with complex care needs that have been identified through risk stratification and case finding</p> <p>Or: a team consisting of several disciplines e.g. medical, nursing, social care, pharmacy and therapists who collaborate to deliver care.</p>
Operational governance and escalation	Operational governance relates to managing flow and capacity, staff levels, skill mix, interface with support services and the wider health system. Triggers for operational escalation should be in line with the System Wide Escalation Framework and Procedures. The escalation framework should be communicated and be easily accessible by staff, and should articulate the operational responsibility for instances of operational stress.
Senior clinical decision maker	<p>Senior clinical decision makers are defined as:</p> <p><i>A clinician who can establish a diagnosis, define a care plan with the patient's involvement, and discharge a patient without routine reference to a more senior clinician</i></p> <p>Consultants and general practitioners typically fall within this definition. Doctors in their third year of specialist training (ST3) or above, and nurses, therapists and other clinicians with recognised advanced skills and training may also be considered 'senior clinical decision makers' within their spheres of competence e.g. ANP's in minor injuries flow in Emergency Medicine Service.</p> <p>It is expected that consultants in Core Specialties on the Acute Floor will be present to support decision-making on the floor during peak hours, and that robust on (cont.)</p>

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Senior clinical decision maker (cont.)	call arrangements are in place to ensure continuity of care and patient safety outside core hours. It is expected that lead clinicians across constituent specialisms within an Acute Floor agree a shared understanding of the term 'senior clinical decision maker' as an early part of its development as part of the Clinical Governance arrangements of the Acute Floor.
Streaming	Streaming is the process of allocating patients to different physical areas/ services, pathways or processes, to improve efficiency and effectiveness. The main objective of streaming is to ensure that the patient is directed to the correct location/ service and to the correct person to manage their clinical needs at the earliest appropriate opportunity. Streaming should always be performed by a trained clinician. Streaming may include streaming to co-located or specialist services (e.g. co-located primary care services, ophthalmology services, acute medical unit or acute surgical unit). Patients may be streamed (redirected) to off-site services.

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## 6 The Acute Floor concept

**"A designated Acute Floor (or acute area) should be developed to facilitate the seamless provision of patient-centred care across the range of specialties involved in the early management of acutely and critically ill patients."**

Report of the National Acute Medicine Programme, 2010

The concept relates to co- or proximally-located integrated acute services within a Model 3 or 4 hospital to meet the predicted requirements of patients presenting for unscheduled care through effective and efficient streaming of patients direct to the appropriate clinical services. It broadens the front door to improve rapid access to specialist services and risk assessment, and smooths flow through the acute system.

The intent is to facilitate the seamless provision of person-centred care across the range of specialties involved in the early management of acutely and critically ill patients: an opportunity to bring services together and improve access in a very focussed way, which reflects the shift in complexity of acute presentations.

The majority of attendances to the Acute Floor will still be seen through the emergency medicine service but the development of the Acute Floor provides the potential to stream patients of the appropriate acuity directly to their specialty senior decision makers. Treatment may be either on the spot, by ambulatory or out-patient care, or by admission. The streaming process and acceptance criteria will be agreed locally, depending on the services and capacity available on site and the wider system context.

### 6.1 Approach to developing the Acute Floor

In the interests of meeting the changing needs and complexity of patients presenting to acute services (who report good care, when they ultimately access it), there is an urgency in improving patient access to acute specialist services.

The Acute Floor concept is visionary and will take several years to fully implement and embed, particularly given the variability across infrastructure, workforce and estate. However, in the context of constrained financial resources, and the time-lag of both major capital projects and additional posts or new roles, there is an imperative to make best use of the shared existing resources, to take a pragmatic approach to affect more near-term gains for patient care. As Acute Floor services develop, they will need to project future needs based on predicted demand shifts, and to develop in line with the aspiration for greater access to services for complex patients.

The experience of sites across Ireland who have implemented components of the Acute Floor, state that beyond aligning operational practices, shared assessments and extending skills across the wider acute team and partners, it is principally about the harnessing the combined capabilities and will of a skilled multidisciplinary and multispecialty team through a drive to work together for the interests of the patient.



***“It’s not just about structure. It’s about culture.”***

***“It’s as much about how we work together as the building.”***

**Contributors to the Acute Floor Task and Finish Group**

## **6.2 Benefits: for the patient, for flow, for directing to the most appropriate care setting**

The objective of the Acute Floor model is to improve quality of care and experience for the patient.

Fundamental to the operational and clinical model is early access to the appropriate senior clinical decision maker at all times of operation of the Acute Floor, at the earliest point in the pathway. This enables:

- a rapid assessment of the patient's risk and care needs.
- patient experience is improved through improved access to all disciplines and ease of transfers of care between teams.
- agreement of the patient's ongoing care plan, within a multi-disciplinary environment.
- access to the right diagnostics and treatment at the right time for appropriate patients.
- improved communication between teams working in the service to enhance patient safety.
- consistently robust hand-over to other care providers (whether acute, primary, community-based or other), increasing confidence of discharge to other settings and reducing admissions for patients who are more appropriately treated elsewhere.

Access to senior clinical decision makers has been demonstrated to improve patient safety, reduce unnecessary admissions and reduce length of stay. Appropriate timing and frequency of senior decisionmaker review has also been shown to bring length of stay and cost benefits (13). It would also be anticipated that systematic application of ambulatory care pathways and proactive length of stay management in the Acute Floor setting might reliably reduce length of stay.

Section 6 goes more fully into the benefits of each of the critical features of the Acute Floor.

Unscheduled care is arguably the most predictable component of healthcare – one can more easily predict how many patients will present and be treated at a given time on a given day for unscheduled care than for scheduled or elective care. As such, services should be configured and resourced to match demand and to manage predictable attendance variations brought about by holidays, weather and well understood seasonal variation in clinical presentations. This will enable flow to be maintained and avoid logjam situations often triggered by holiday periods and other predictable events. (14)

### 6.3 Minimum features of an Acute Floor

The Acute Floor relates to Model 3 and Model 4 hospitals, at its core bringing together emergency, surgical, medical, older people's and frailty services.

The Acute Floor consists of a range of facilities and services (real and virtual) that aim to meet the likely requirements of patients presenting for unscheduled care through effective and efficient streaming of patients.


The precise configuration of the Acute Floor will depend on:

- the acute services provided in each hospital.
- the projected patient demand, based on a joint strategic needs assessment of the local population which incorporates robust public health insights on disease prevalence and strategies for management, for example cancer strategies.
- the proximity to other sites which may provide similar or specialised services.
- the physical constraints of the site.

Development of optimal service configurations from baseline will require to be based on robust capacity/ demand planning and evidence based estimations of demographic and disease prevalence trends.

As important as the facilities and layout is the readiness and commitment of specialties to work as an inter-dependent and collaborative multi-professional team, embracing a collegiate approach to provide rapid access to the care needs for the patient.

It will include the entire range of acute services which are available on site, involving many or all the following (in accordance with the recommendations from the National Clinical Programmes and Integrated Care Programmes):



- **Emergency medicine service**
- **Acute medical service**
- **Acute surgical assessment service**
- **Older people's and frailty acute services**, inclusive of Health and Social Care Professionals
- **On site critical care**
- **Ambulatory care provision**
- **Short stay units** (maximum stay 48 hours), under the governance of acute physicians or surgeons, and Clinical Decision Unit (maximum stay 24 hours), under the governance of the Emergency Medicine Physicians.

- Bed stock is likely to be broadly allocated to surgical/ medical/ geriatric care, based on local demand, and flexed by agreement.
- **An acute care hub** which provides a single point of contact between Acute Floor and community/ primary care services and other hospital sites
- **On site, proximally located diagnostics** (on site plain film radiology and CT, plus ease of access to MRI, on site cardiac diagnostics – including exercise stress testing and Holter monitors, diagnostic ultrasound, endoscopy plus microbiology, haematology and biochemistry). Consultant-directed diagnostic tests and completed reporting will be available seven days a week, and all services will be aligned to demand patterns rather than traditional service availability (e.g. 9-5).
- **Ease of access when required to senior clinicians from the entire range of onsite acute services** (or off-site and virtual, if arranged as part of a hospital group or service network), including: paediatrics, mental health, stroke, cardiology, neurology, neurosurgery, anaesthesia, burns, trauma and orthopaedics, social care and CHO services.
- **Implementation and utilisation of National Clinical Guidelines for Early Warning Systems** (e.g. NEWS, PEWS)
- Concise, action-oriented **multi-disciplinary and multi-specialty team huddles** are a core feature of integrated working (planned once daily; responsively for complex patients, inclusive of bed management). They will discuss and communicate expected demand, review care plans, identify patients appropriate for admission and those whose care needs can be met rapidly to facilitate early and safe discharge.
- All services will be **operationally aligned to patient demand** (including resourcing and operating hours). Clear understanding of actual and likely demand for all services lines, rather than focus on activity is a core principle of the operational management of the service.
- An ICT **Acute Floor Information System** must be in place to allow measurement and reflection on demand and activity and to monitor key performance indicators for the Acute Floor Service.
- **On call cover for all core services by the relevant senior clinicians** as agreed locally, ideally dedicated to one hospital. If across more than one site or drawing on remote specialist advice, local governance procedures must be in place to ensure the level of cover will protect safe, effective care. These on-call arrangements to be communicated to ensure continuity of care may be maintained at all times.



- Local service level agreements will govern the interactions between services and specialties which will be collated into a **Standard Operating Procedure for the Acute Floor** which will be communicated and agreed by all services collaborating in, or supporting the Acute Floor.

**Plus, either co-location or on site proximity and ease of access to:**

- **critical care** (intensive care, high dependency, coronary care +/- stroke unit)
- **an intervention suite** (emergency theatre, endoscopy +/- cath lab), in line with the Trauma Network
- **assessment teams:** acute psychiatry and/ or psychiatric liaison, paediatrics, obstetrics and gynaecology, palliative care, trauma and orthopaedic, frailty and geriatric input. The assessment process may include consideration for provision of care in alternative settings.
- Given the need for improved access, emergency and acute assessment areas should **be easily accessible for ambulances, for patients arriving by car or on foot.**

The Acute Floor concept cannot be developed and deployed in isolation. It requires engagement and collaboration with partners on the in patient wards and in the community who are critical in managing patients in the most appropriate setting, supported in gaining rapid access to specialist input and then contributing to a smooth and thorough handover to ensure a clear ongoing care plan. This requires the intentional design of care pathways across care settings in such a way as to guarantee timely access to quality of care and in some cases will necessitate an expansion of capacity within the system. Thus a well designed, resourced and governed Acute Floor could be a key foundation stone in delivering upon goals articulated the Future of Healthcare Sláintecare Report (2) such that:

*'Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients' needs come first in driving safety, quality and the coordination of care.'*

While the vital role of the wider health system including community partners is recognised in delivering these future care goals, the future operational detail of the wider healthcare landscape is beyond the remit of this document.

## 6.4 Interface with mental health, paediatrics and trauma and orthopaedics

### Expert Mental Health Opinion

Mental Health (MH) Services on the Acute Floor need to be available and accessible. Timely access to MH services/ expertise must be continuously available for patients attending the Acute Floor in crisis. There should be a single point of contact for Acute Floor staff to access MH services for patients and the referral procedure should be a simple one. For adult patients, during working hours, this should be the Liaison Psychiatry team based on-site. Out-of-hours in all 24/ 7 Emergency Medicine Services, there should be mental health staff available on-site supported by a Consultant on-call. Appropriate MH services should also be available for all age groups attending the Acute Floor including Child and Adolescent Mental Health Services (CAMHS) and Old Age MH services. MH services also need to develop sufficient capacity to provide acute mental health care in the community to those who need it.

### Access

The Acute Floor must not be the pathway of access to mental health care for patients with mental ill-health who have no acute medical need. The Acute Floor is not an appropriate environment for such patients. They should be assessed elsewhere (i.e. community mental health service; acute mental health unit).

The principles identified in the National Clinical Programme for the Assessment and Management of Patients who present to the Emergency Medicine services following self-harm address the challenges for patients with mental health needs. The full implementation of this [clinical programme](#) in all emergency medicine services will support greater collaborative working between Emergency Medicine teams, liaison psychiatry and community mental health teams.

An agreed mental health inpatient bed management policy that transcends mental health catchment areas should be in place in each CHO. The continued absence of such a policy is a barrier to the timely transfer of patients from the Model 3/ 4 hospital to inpatient mental health care.

Patients in Community Psychiatric Hospitals should only be transferred to the Acute Floor for the management of emergency conditions. Patients' Primary Care and non-emergency medical care needs should be met on-site by either a GP, through Physician liaison or through agreed transfer to an Acute Medicine Unit (AMU).

### Safe Environment

The Acute Floor Mental Health Assessment Area should have at least one interview room. There should be an emphasis on the safety of staff and patients in the design, location and proximity of security staff. Interview rooms should have two doors opening both ways and not be lockable from the inside. There should be shatter-proof glass panels in room walls or doors for visibility. Furniture should be fixed or heavy enough not to be moveable. The room should contain a panic button.

Guidelines for appropriate design are available and are included in the EMP infrastructure recommendations and in the National Clinical Programme on the Assessment and Management of Patients presenting to acute and emergency services following self-harm (15).

### Governance

A shared governance model between mental health services and EM is necessary in relation to mental health service provision on the Acute Floor. Meetings between key Acute Floor staff and MH staff should be incorporated into the governance activity of the Acute Floor. This should encompass clinical, educational, risk management and service issues. Clinical audit should also be undertaken across the EM/ Psychiatry interface to drive continuous quality improvement of the care of patients with MH presentations to the Acute Floor. There should be a named Psychiatrist for each Acute Floor or ECN charged with leading implementation of these recommendations and co-developing the Psychiatry/ EM interface at local level.

For further guidance, please see Quality Standards for Liaison Psychiatry Services (15).

### **Expert Orthopaedic Opinion**

Close co-operation between the emergency medicine Service and the orthopaedic service in particular is essential for safe and effective streaming and flow. A large proportion of patients with simple fractures for example, may be safely and effectively managed by emergency medicine practitioners without recourse to Orthopaedic Specialist intervention. Certain groups of patients will require urgent review and management by orthopaedic surgeons for admission, for immediate operative treatment or for semi-elective procedures in the next 24-48 hours.

The Acute Floor will require access to the orthopaedic service for immediate review of complex patients, decisions regarding admission or for assistance with decision making regarding appropriate management. Senior decision-maker level review will be necessary to decide on urgency of intervention of certain complex conditions who present to the Acute Floor. This may be supported by use of appropriate technology where that senior decision making is not immediately available on site.

Interfaces with Fracture Clinics, either Virtual or traditional face to face consultations are critical for safe and effective review of patients with fractures. The Trauma Assessment Clinic model is rolling out to manage review of patients in an appropriate care setting, minimising the requirement for unnecessary review. Protocols should be developed to stream patients with musculoskeletal injuries to the appropriate setting for management after initial diagnosis and stabilisation in Emergency Medicine Service.

Certain conditions such as fractured neck of femur require dedicated pathways to promote early pain relief, diagnosis and timely admission for surgery and other specialist management in the appropriate setting. The Acute Floor has a key role in facilitating appropriate and timely admission of such patients.

Conditions where there is a large degree of overlap between specialties, such as falls in older people with inability to weight bear and no fracture, are relatively high-volume

patient groups where an agreed protocol between the various services of the Acute Floor can bring a significant benefit. Co-operation between the emergency medicine service, older people's services, HSCP's and orthopaedic services can support patients to earlier supported discharge, potentially avoiding admission or reducing length of stay, minimising the risk of dependence and improving patient experience.

Access to dedicated emergency theatre lists and access to dedicated day ward facilities to reduce length of stay and in some cases, avoid the requirement for trauma admissions will be necessary to ensure best use of resources. Provision of these services should be based on demand.

There is an imperative for timely access to diagnostic radiology investigations (particularly plain film, CT and access to MRI), and the facilities to support these services. In addition to better outcomes for patients, bed utilisation and patient flow can be improved in acute hospitals by the provision of these resources.

Provision for management of major Trauma and the development of Trauma networks is well described in the National Model of Care for Trauma and Orthopaedic Surgery, and management of those patients will be agreed locally based on demand.

### **Expert Paediatric Opinion**

Many presentations of children to acute and emergency services are due to acute, self-limiting illnesses. When admitted, the average length of stay is low (average 1-2 days), but in the absence of paediatric emergency physicians, the average rate of admission climbs from 6% to around 40%. There is an evident rise in demand, despite significant improvements in children's health, attributed mainly to parental concern and clinicians taking a cautious route. The following are advised to develop more appropriate means of accessing care:

- The first response is critical, where the child needs to be streamed and seen quickly by a senior clinical decision maker in a child-friendly environment (visually and audibly separate from the adult service areas, in line with standards set out in Chapter 5 of the Emergency Medicine Programme (7). This is ideally a suitable Paediatric Assessment Area which may be on or off site depending on local configuration and demand).
- Development of clear clinical algorithms and pathways for the most common presentations and conditions, with an emphasis on ambulatory care models and supported care at home, to avoid unnecessary admissions. This needs to include guidance on which diagnostics are appropriate.
- In the absence of a paediatric trained radiologist, the image may need to be sent to a larger centre for reporting – and therefore establishing those arrangements and the progression to electronic patient records are encouraged. Paediatric units across Ireland range from 15-20 beds to 40-50. There is a challenge to recruit and retain experienced paediatric physicians in smaller facilities, which is an additional driver for strengthening the links between smaller and larger sites.

- A minimum of daily ward rounds and frequent review of patients by senior clinical decision makers.
- Implementation and utilisation of National Clinical Guideline Paediatric Early Warning System
- A discharge planning process which is embedded and initiated early, enabled by nurse-led discharge.
- When there are safeguarding issues, the Acute Floor needs to have relationships and systems in place that enable involvement from social care, public health nursing, and the child's GP, with a clear process for drawing up a plan with the community, including the plan for follow up.
- Strengthening of links between primary care and the paediatric department to provide ready guidance and ongoing skills development.
- The seasonal fluctuations in demand are both considerable in this population, and largely predictable, and need to be planned and prepared for.
- Younger patients must have access to the same level of appropriate investigation and management for the gamut of presentations, including mental health related presentations as adult patients.

## 7 Critical success factors to deliver an Acute Floor

Designing, executing and sustaining an Acute Floor is as much an interpersonal endeavour as it is a technical undertaking. To bridge disciplinary, hierarchical and specialty boundaries requires an understanding of the necessary shifts in thinking, relating and acting. The following working practices will take work to embed, but are necessary foundations for an effective Acute Floor.

### 7.1 Multidisciplinary working

At its simplest, multidisciplinary working is about working in teams across disciplines, whether that is a multi-specialty assessment, or bridging acute, primary, community and social care in onward care planning.

In the context of the Acute Floor, this basic precept of "in it together, for the benefit of the patient" is extended as a core principle of governance from this simple level to an extended team supporting older patients with complex medical and social needs throughout their care, and onwards to safe discharge to home. This principle of 'patient and user focus' is listed in Section 9.2 'Guiding principles for practical application and development of an Acute Floor'.

This principle also applies to medical teams working across traditional specialty boundaries in new ways to streamline care for patients. This will transform the assessment process:

<i>From</i>	<i>To</i>
<ul style="list-style-type: none"><li>• serial assessments</li><li>• by generalist junior doctors</li><li>• a paucity of definitive decision making</li><li>• long delays before senior clinical decision making</li></ul>	<ul style="list-style-type: none"><li>• smooth process of access</li><li>• direct to the appropriately trained senior decision maker from the appropriate specialty</li><li>• after a rapid process of streaming</li><li>• with multidisciplinary staff trained in robust decision making</li><li>• supported by appropriate and timely diagnostics</li><li>• made with documented patient involvement</li></ul>

Based on experience of MDTs, a distinction has been made between four levels of integration in a multi-disciplinary team (16), and should be actively considered as to which level is most appropriate to optimise care (see Appendix 3).



**The evidence: Patients who are managed proactively by a multidisciplinary team (particularly patients with complex needs or the frail and older) do better than those cared for in a traditional way and so would be less likely to have a protracted length of stay (17).**



There are many local initiatives introducing frailty pathways that to manage older people at risk or living with frailty, as they present to the front door. This is one example:

The Frailty Intervention Therapy (FIT) Team was established in Beaumont Hospital's (BH) Emergency Department (ED) in September 2015. This consists of Physiotherapy, Occupational Therapy, Medical Social Work, Speech and Language Therapy, Dietetics and Pharmacy, and has built strong links with the ED Nursing and Medical team as well as geriatricians and the geriatric wards. Since September 2015, over 9,000 patients have been screened for frailty by the FIT Team.

The inter-disciplinary screening process is conducted on all patients aged 75 and over who present to ED within core working hours and under age 75 referred by ED medical and nursing colleagues. Screening is usually initiated within 1 hour of presentation, unless contraindicated medically. This facilitates timely initiation of the appropriate treatment pathway and robust handover. Rehabilitation commences in the ED, preventing unnecessary physical and cognitive deterioration which can be caused from a delay in accessing HSCPs as patients await admission to the ward. Since June 2017, the FIT Team has jointly developed an Electronic Patient Record with Beaumont Hospital's IT Department, ensuring further improvements in handover efficiency and patient safety.

An outreach Integrated Care Service is offered to patients identified as appropriate for discharge with follow-up services. A recent test of this service model, implemented in partnership with Dublin North Services (CHO 9) found that 55 patients avoided admission by being safely discharged and maintained at home. Remarkably, 700 bed days were saved in this brief five-month test period.

## 7.2 Availability of senior clinical decision maker

Senior clinical decision makers are defined as:

*Clinicians who can establish a diagnosis, define a care plan with the patient's involvement, and discharge a patient without routine reference to a more senior clinician.*

Consultants and general practitioners typically fall within this definition. Doctors in their third year of specialist training (ST3) or above, and nurses, therapists and other clinicians with recognised advanced skills and training may also be considered to be 'senior clinical decision makers' within their spheres of competence e.g. ANP's in minor injuries flow in emergency medicine service.

It is expected that consultants in Core Specialties on the Acute Floor will be present to support decision-making on the floor during peak hours as a default, and that robust on call arrangements are in place to ensure continuity of care and patient safety outside core hours.

It is expected that lead clinicians across constituent specialisms within an Acute Floor agree a shared understanding of the term 'senior clinical decision maker' as an early part of its development as part of the Clinical Governance arrangements of the Acute Floor.

Availability of senior clinical decision makers has been shown to result in better outcomes for patients. Senior decision makers reach decisions more promptly and are less likely to order unnecessary investigations and admit patients than more junior doctors. They are also better able to assess and manage clinical risk, and therefore better able to determine suitability for ambulatory care management of many conditions.

Positioning a senior clinical maker very early in the process benefits the patient by enabling an early case management plan and assists flow by making decisions which ensure that patients only receive appropriate diagnostics and the care they need. It supports juniors in training by supporting appropriate clinical decision-making and tutoring in management of clinical risk in real time.



The evidence: Access to senior decision makers (senior doctors, Specialist Registrars or Consultants) has been shown to:

- reduce waiting times in Emergency Medicine Services and waiting time breaches (18) (19) (20)
- reduce admissions via emergency medicine service (20) (21) (22) (23) (24)
- increase swift discharges (21) (22)
- facilitate direct access to specialist wards where required (23)
- prevent inappropriate discharge (24)
- and improve the appropriate use of out-patient facilities



To make the Acute Floor work for patients, it is essential that presenting patients are streamed to the most appropriate senior clinical decision maker at the earliest opportunity. Once such example is St. Luke's Hospital Kilkenny where patients with GP letters are streamed at registration to the area suggested by the GP, who is the senior clinical decision maker in the community.

Walk-in patients are streamed at nurse triage (under agreed criteria) directly to the most appropriate clinical area in ED or the various assessment units for Medicine, Surgery, Paediatrics, Obstetrics/ Gynaecology and Psychiatry. This prevents congestion, delay and duplication of effort which is tiresome, costly and carries substantial patient risk.

A further strong focus is ambulatory emergency care and the principle of "investigate to discharge" rather than "admit to investigate". This policy reduces overnight admissions, freeing up beds for elective patients and reduces waiting lists.



### 7.3 Flexible workforce and skills

Flexibility of workforce and development of generic skillsets will be required to manage the Acute Floor optimally. It increases the ability of the multi-disciplinary team members to respond to high volume demand, reducing delays and hand offs. It also releases capacity to access specialist input when it is really needed. Future training requirements should focus on development of generic skillsets for management of the acutely ill patient from whatever specialty, and be focussed on multidisciplinary team training and optimal teamworking. Joint training brings the additional benefit of building trust and relationships across boundaries.

Robust workforce planning will be required to match staff numbers and skills to demand. This must be undertaken for all services aligned to the Acute Floor, including support services such as radiology and porters. Systematic workforce planning is a priority for all organisations adopting the Acute Floor model.

Considerations for workforce and skills include:

- Reviewing the approach to delivery of core assessments that could be done by anyone on the floor e.g. assessment of frailty
- Most effective deployment of existing resources such as Associate Directors of Nursing for Flow, and Advanced Nurse Practitioners (ANPs)
- Algorithm-based pathways for the most common, high volume presentations that allow for a multi-disciplinary team that can respond to a general take
- Building the skill-base of the wider care team in other settings e.g. primary care, community
- New role development e.g. acute care practitioners, physician assistants plus GPs working in acute care environment – informed by local workforce needs
- Development of physicians to be able to respond to general take, broadening core capabilities to release capacity of rate-limiting shared services e.g. Acute Care Common Stem training
- MDT-based decision-making on care planning, involving patients and clearly documenting their input (e.g. the “What Matters to You” initiative)
- “Frailty Attuned” workforce with skills and competencies to meet the needs of older people (e.g. NCPOP Frailty Education Programme).
- Baseline generic training such as End of Life Care and safeguarding
- Education and training in relevant deteriorating patient recognition and response programmes e.g. Compass, PEWS IMEWS education programmes

There are good examples of training for basic management of the acutely ill patient, which includes (but are not limited to) The Adult Life Threatening Events and Treatment ALERT, MedicALS, APLS, PALS and Care of the critically ill surgical patient CCRISP courses. Rotation of staff throughout the various service areas of the Acute Floor will facilitate skills retention and challenge staff to expand their skills base.

Given the ageing demographic, an understanding of frailty and its consequences should increasingly be a core requirement for all acute health care professionals. This would address both developing competencies within the acute team, as well as developing and sustaining an 'age attuned' healthcare environment (25).

In addition to developing clinical skills, development of quality and service improvement skills, analytics, flow and operational management would greatly assist the successful development of the Acute Floor.

The Colleges and Postgraduate training and education bodies play a critical role to:

- support the expansion of acute clinical competencies across disciplines and professions
- help grow the confidence and appetite for shifting working practices
- and to be able to offer assurance around the quality of development programmes.

The focus of this training and professional development should be: interdisciplinary, practical, competency based and supportive of the development of new roles within the Acute Floor. These will need to be firmly rooted in the guidance from the National Clinical Programmes and the recommended clinical models. Ultimately, it is envisaged that this will open up new career pathways, both developing those already within the service, and providing new career options either for people who have yet to gain professional accreditation, or those who have left the service who may be attracted to return.

As with other developments to support the implementation of the Acute Floor, there is an urgency in establishing these programmes. At the same time, the absence of a nationally accredited programme is not envisaged to be a rate-limiting step. While there may be a time lag as national training programmes for extended roles ramp up, it may be helpful to consider what development can be provided locally, e.g. shadowing, mentoring, an acute care seminar series, and innovative approaches to 'grow your own' from existing talent, plus tapping into existing formal professional development.



Any health care professional working with older people will need to have frailty as a focus and core part of their continuing education and professional development. A Frailty Education Programme for Older People is being piloted in Saolta, Ireland East and South/ South West Hospital Groups and corresponding Community Healthcare Organisations (CHOs). The aim of the programme is to provide healthcare professionals with an enhanced understanding of frailty and frailty assessments, thereby ensuring earlier recognition of frailty, improved healthcare management, and better health outcomes for older adults at risk or living with frailty.

On completion of the programme participants will:

- Describe the spectrum of frailty as a long-term condition.
- Identify validated screening tools as they relate to frailty (e.g. frailty assessment, falls assessment, delirium assessment tools).

- Explain the benefit of Comprehensive Geriatric Assessment in planning appropriate health promotion and care pathways to enhance outcomes for older person living with frailty.
- Discuss the significance of frailty and the impact of a gerontological approach to care.
- Recognise the importance of a Frailty Pathway and the implication of long Patient Experience Times (PET) for the frail older adult.

The development of a 'National Frailty Education Programme' envisages extending and enhancing geriatric competencies in other specialties, including Allied Health Professional staff, Emergency Medicine, Acute Medicine and Surgical trainees. Educational programmes such as this in conjunction with the development of 'frailty champions' to act as a resource for their Hospital Groups and CHOs can help promote a better understanding of the need to drive change, improve standards and outcomes for the frail older patient requiring acute care.

## **7.4 Focus on flow - addressing rate limiting steps such as diagnostics and discharge planning**

Effective flow is one of the cornerstones of the Acute Floor concept, in terms of flow into, through, and out of the Acute Floor, whether to specialty beds, home or another care setting. A detailed understanding of patient pathways must underpin the local design of the Acute Floor, with multidisciplinary collaboration required for pathway development and implementation. Strong links with Capacity and Bed Managers, and the Acute Care Hub together with clearly defined guidance and escalation policies, will be required to ensure and maintain smooth flow into and through the hospital. Strong links will be required with specialist wards to ensure flow out of the Acute Floor occurs in a timely way.

Understanding of the rate limiting steps in the patient pathway will allow for appropriate and early operational escalation for remedial action to prevent delays. Within diagnostics for example, certain modalities such as echocardiography may become bottlenecks, and these services must be planned to align realistically with demand patterns, rather than to traditional planned service hours of 9-5. Discharge planning teams (including HSCPs and pharmacists) must also be available to meet demand patterns and clinical decision making for discharge aligned to make safe discharge within daylight hours achievable for older patients in particular.

A focus on the development and integration with case management is being developed through the Integrated Care Programme for Older people, to ensure that rapidly discharged patients with complex needs do not continue to re-present on a revolving door basis. This system develops key points of contact for older populations with complex needs, supporting appropriate pathway referral and early supported discharge (26).

A day to day rhythm for the Acute Floor must be established within the context of the wider hospital, with communication and escalation points agreed at certain times in the day. The Multidisciplinary Team of the Day in the Acute Floor must be involved in early morning clinical handover and be equipped with hospital situational awareness. They must also be available throughout the day for touchpoints should surges occur or significant delays arise, thus enabling appropriate decision making in conjunction with the wider hospital and health system as appropriate. Clear identification of the responsible clinicians will enable rapid escalation and support for junior staff when required.

Early flow from wards in the hospital will support early flow from the Acute Floor into beds for patients who require specialty admission. Sequencing of bed availability and use of supporting structures such as Discharge Lounges to free beds up early in the morning are key components of overall hospital flow. Close links between the Acute Care Hub and the inpatient capacity management teams will be required to maintain smooth flow and plan for available capacity across the system, including links with downstream beds in the community to enable whole systems flow.

Diagnostics and other supports services must align their hours of operation to match demand from the Acute Floor and to support flow with appropriately balanced emergency and elective activity.

Flow through the hospital as a whole will be required to allow effective and efficient functioning of the Acute Floor. Comprehensive adoption of principles such as Estimated Date of Discharge, Home First and Discharge to Assess as part of dynamic discharge planning across the hospital will enable flow to be maintained at the front door.

The focus on flow provides a rationale for aiming to separate scheduled and unscheduled pathways where possible, to enable an efficient uninterrupted process for the former, and the flexibility to respond for the latter.

The Unscheduled Care Governance Group will have a critical role in the overall management of flow, having constituent members from across the healthcare system and a responsibility for overall operation of flow for the Acute Care system. It will also have responsibility for links with the Elective care elements of the system to ensure balance of capacity and demand across the system is planned and maintained. Most hospitals now also have a demarked Associate Director of Nursing responsible for flow, who will be a key partner on the Acute Floor leadership team.



Resource: [NHS Improvement. 'Good practice guide: Focus on improving patient flow'. 2017](#)



### **Improving flow through development of the Acute Surgical Assessment Unit (ASAU)**

Limerick, Kilkenny and Tallaght have all demonstrated faster patient journeys and shorter lengths of stay by deploying ASAs, using different approaches around a central theme of early access to a senior decision maker. In these 3 cases, assessments are concentrated in one area usually but streaming selected patients directly to the ASAU, omitting the ED stream. Direct GP

access is present in 2 of the sites, where feedback loops have been agreed to ensure the system is not overwhelmed by patients who would be better seen in an outpatient department, but are having trouble accessing same.

In the Limerick approach, the ASAU is both a direct referral unit for GPs or from affiliated Model 2 hospitals for acute surgical patients accessed only after direct phone contact with a triage nurse attached to the unit. It does not usually take patients from the ED. Referred patients are rapidly assessed by a senior registrar or the acute surgeon of the week and the inpatient or outpatient care of the patient is efficiently decided and actioned. There is a well-resourced on call General Surgery rota of 1:9 and above. This allows for a “surgeon of the week” (reduced elective commitment on call) model which perfectly supports a busy ASAU. The Kilkenny approach is also very successful at streaming selected cases through their ASAU. Their success, with a much smaller acute surgery rota, (1:5, commensurate with the Model 3 staffing rates) is based on the close working relationship with the community physicians and effective feedback loops for inappropriate referrals. It is an exemplar of how the culture among clinical and nursing staff can effectively mitigate resourcing challenges.

The Tallaght model has elements of both. Selected patients are streamed to avoid the duplication of an unnecessary additional ED assessment before the surgical assessment. Tallaght, a Model 4 hospital, has a small on call general surgery rota (less than 1:4 WTE) and therefore no reduction in elective commitment is undertaken for the on-call surgery team (supra elective model). This has the potential to lead to some inefficiencies which they have been able to mitigate through ASAU cohorting (27) and the first appointment in Ireland of an Acute General Surgeon. The current model is sustained at current patient volumes. As volume grows, however, a reassessment of the on-call model will have to be undertaken to move toward a “surgeon of the week”/ reduced elective model to efficient support the ASAU and acute patient care.

Although the 3 ASAUs were grown organically, based on local needs, each has a central core tenet of providing early and robust decision making. Each model had specific value in developing a document by the NCPS in 2017 which sets out National Minimum Standards for Irish ASAUs. ([www.rcsi.ie/ncps](http://www.rcsi.ie/ncps)).

It is important to also note that in addition to positively effecting efficient patient flow in hospitals, these ASAUs have additional benefits. Inappropriate admissions are avoided, by converting potential admissions to ambulatory management pathways where appropriate. Consultant-led assessment can be provided regularly throughout the day. Other features include: same-day imaging and diagnostics; nurse-led early discharge; anticipation of appropriate aftercare treatment and follow-up.

These demonstrated benefits of ASAUs has led to the HSE and NCPS supporting the development of 2 further ASAUs to be rolled out in 2017 in Galway and the Mater in North Dublin.



### **Growing the impact of an Acute Medical Unit**

In University Hospital Galway, a Short Stay Ward under the governance of the Acute Physicians opened in January 2016. In March 2016, the AMU relocated to an area adjacent to this, in close proximity to the ED. For the first time, AMU was protected for assessment and boarding ceased. The effects were evident quickly. This allowed inflow from ED and GPs and the daily discharges from the Short Stay Ward allowed egress.

The percentage of medical patients on the AMU pathway increased month on month thereafter. Over four thousand patients went through the AMAU pathway during 2015, an average of 345 per month, increasing to an average of 445 patients per month in 2016. The proportion of medical patients who are same day discharged rose from 20% in January to 23% in July, a steady increase month by month.

These improved trends are also reflected in the overall length of stay for the medical patients in Galway which has fallen to 7.07 days in July 2016 compared to 7.43 in March 2016 and also had a significant effect on the TrolleyGar. The improvement was sustained and by 2017, 47% of all Acute Medicine was through the AMU pathway.

## **7.5 Extending access across hours of day and days of week - driven by demand**

The basic principle of matching capacity to demand and “doing today's work today” must apply to the Acute Floor. Services should align to their demand patterns. This will allow hospitals to design their Acute Floor to deliver the most appropriate care needed within their local context. Forensic understanding of demand patterns and projected future demand based on robust demographic projections and public health intelligence on disease prevalence will therefore be required at hospital, department and service level to ensure appropriate capacity and resourcing can be planned.

A better understanding of demand, as opposed to activity, will be required across the system.

Review of patient pathways will be required to establish current and future pathways for high volume groups of patients. Not all work is value-adding; a proportion of the activity will be ‘waste work’ due to issues further upstream. For example, it is estimated that each ward move while in hospital will increase the length of stay for a person aged over 75 years by two days (28). Thus, improvements in patient flow and reductions in length of stay can be made by putting a mechanism in place in all hospitals for admitting patients to appropriate specialist wards and a focus on reduction of moves for patients.

Robust data to support genuine demand analysis and resource planning will require an Acute Floor information system to be in place. However, hospitals should not delay awaiting establishment of national information systems to commence this important work. Local systems should be configured to allow baseline plans to be developed.

Resourcing should be planned according to demand, rather than historical practice. Staffing and shift patterns must be aligned to demand i.e. patient need rather than service need.

Matching service capacity to demand may necessitate a movement towards extended hours working, and in some cases 24/7 service provision in some clinical and support services. This may therefore include significant changes to service operations such as radiology, cardiology diagnostics, portering and pharmacy as well as the core clinical services.



Resource: [NHS Improvement. Seven day services in the NHS](#)

Evidence: Data shows that around 4,400 lives in England could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday (29) (30). There is every reason to expect that mortality could be lowered by at least the same proportion across Ireland.

## 7.6 The Acute Care Hub - streaming from a single point of entry

The Acute Care Hub is:

A single point of access to the Acute Care system, both a real and virtual space supported by telecommunications and ICT-based contact for timely two-way communication between community, social care and primary care services, specialists within the hospital and other hospital sites.

Its intent is to:

- i) stream, in real time, GP-referred patients or their accountable clinicians to the service/ support that is most appropriate for their needs.
- ii) stream, in real time, self-referred patients to the appropriate stream of care in the Emergency Medicine or Acute Medical or Surgical Service.
- iii) provide rapid access to specialist advice, to inform onward care planning or assessment.
- iv) facilitate flow into and out of the Acute Floor.
- v) signpost to alternative services where appropriate.

Where similar functions already exist within the hospital, a review may be necessary to consolidate or clarify roles, responsibilities, processes and clinical governance. In order to streamline access to services and reduce unnecessary duplication of assessments, a single point of entry to the system is preferred for the Acute Floor. From this point, patients will be streamed to the appropriate part of the service using a combination of clinical streaming and pragmatic signposting.

The single point of entry should field referrals from GPs and other sources and direct them to the most appropriate service on the Acute Floor. Patients who self-present will have a clear, unified point of entry to the system where they will be streamed to the most

appropriate available part of the service, based on a rapid assessment of their needs and robust streaming guidelines. These guidelines will be jointly developed and iterated by the Clinical Governance Group for the Acute Floor.

The Acute Care Hub will also field calls from GPs and community providers for rapid access to specialist input specifically if an acute care episode could be avoided by alternative forms of provision, coupled with specialist acute advice.

At the point of streaming patients may be identified as being suitable for care in a non-acute part of the system e.g. community services or Primary Care. Patients may then be streamed to appropriate services which may be co-located. In the ideal system, there will be access to a variety of services to support the patient at home if hospital admission is not required. More formal Manchester Triage or Early Warning Score (EWS) processes will then be undertaken once the patient is aligned to the correct part of the service, to ensure that clinical risk is effectively managed within those services. It is imperative that streaming does not unduly delay access to the appropriate clinical service. Where there is doubt, a pragmatic decision should be made at streaming and any subsequent dispute about appropriateness of patient placement should be deliberated on by the Clinical Leads for the area once the patient has been clinically assessed.

Streaming will be undertaken by a member of nursing staff of sufficient seniority to identify clinical risk and manage patients appropriately into the system. This is however not a second layer of triage, but high level “sieve and sort” applied swiftly to ensure patients are not delayed in their ultimate triage destination.

The member of staff undertaking streaming will however require to be proficient in triage in order to identify clinical risk, as well as familiar with the operations of the wider Acute Care system and will have the authority to refer direct to specialties if required. The Acute Care Hub will be staffed by a team with the clinical and administrative skills to identify and manage clinical risk and also manage the complex communications and administrative processes required to enable effective and efficient operations.

The Acute Care Hub will be distinct from the Emergency Medicine Service and Assessment Services, but closely linked to all elements of the Acute Floor and be in close communication with those core elements on a real-time basis.



Resource: [The Royal College of Emergency Medicine. Initial assessment of Emergency Department patients. 2017](#)

Evidence:

- Combining or centralising emergency admissions within one place, accessed through a single point of entry is associated with significant and beneficial reductions in mortality and admissions (Addenbrookes (31)).
- The emergency floor at Worthing Hospital (32), includes a clinical coordination centre and acute care hub (inward facing) plus onsite presence of community-based staff. Despite 5.2% increase in admissions, achievements include:
  - Half day reduction in LoS - 17.9 bed days saved = £1M saving per year
  - Significant reduction in surgical LoS – by 25%
  - Reduced daily outliers by 23%



## 8 Demand-driven access to diagnostics

Timely access to appropriate diagnostics will be required to allow the Acute Floor to function to its full capability, and for length of stay efficiencies to be achieved. Diagnostic services should be planned based around demand flowing through key services rather than around traditional working hours. This principle applies to laboratory investigations, radiological modalities and other high-volume investigations required by the Acute Floor, such as cardiac diagnostics.

While there may be an argument for dedicated facilities for the Acute Floor for some key investigations such as CT scanning, provision should again be demand driven, with an eye to making best use of existing resource. Attention needs to be paid to resource planning and scheduling to allow both elective and emergency services to make best use of expensive and constrained resources such as MRI.

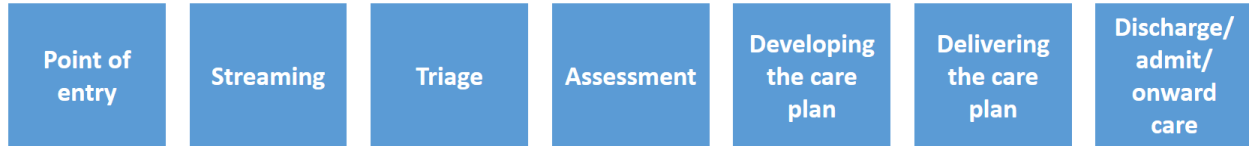
Development of new patient pathways in the Acute Floor must involve diagnostics and support services at an early stage to ensure that length of stay can be optimised. Ambulatory access for older people to a day hospital, for example, provides alternative diagnostic pathways where rapid access models are supported and developed.

Whilst workforce is a potential constraint to more timely diagnostics, radiology in particular is well-suited to working collegiately across a hospital group. Given the ability to relay diagnostic images electronically and virtual reporting, not all diagnostics depend on an onsite specialist. Where possible, there should be consideration of how resources and skillsets across a hospital group are deployed and developed, based principally on population demand.


There are also opportunities in enabling GP direct access to diagnostics without the need to see a specialist first. As long as shared diagnostic resources are managed prudently, this enables patients to be managed in community settings, without defaulting to hospital-based care, and opens up possibilities for more light-touch/less intensive models of patient care for those patients who do not need to access the full gamut of healthcare resources.

## 9 Outline specification for the Acute Floor

From a patient's point of view, in principle the flow through the Acute Floor should be both uncomplicated and swift:



To enable each of these processes to function effectively, and as part of a co-ordinated system, they will need to be tailored given local infrastructure, skills and capacity. The means by which the following guidance is adapted and employed locally is an important part of growing engagement and ownership in designing and delivering the Acute Floor.

 <b>Acute Floor design requirements</b>	
<b>Routes in</b>	<p><b>Designing the processes for entry to the service to accommodate and enable predictable high volume appropriate routes of referral:</b></p> <ul style="list-style-type: none"> <li>• GP</li> <li>• Outpatient department</li> <li>• Community services (including nursing homes and mental health services)</li> <li>• Ambulance</li> <li>• Self-presenting</li> <li>• As part of the Acute Floor: Emergency Medicine Service, AMAU/ AMU, ASAU</li> </ul> <p>This supports design features of:</p> <ul style="list-style-type: none"> <li>• single point of entry</li> <li>• acute care hub (linking the Acute Floor with community/ primary care services and other hospital sites)</li> </ul>
<b>Assessment</b>	<p><b>Getting onto the front foot, to enable flow and reduce delays:</b></p> <ul style="list-style-type: none"> <li>• At the single point of entry, all patients rapidly streamed (within minutes) to the appropriate service by a suitably experienced and independent clinician</li> <li>• When there is uncertainty about streaming or level of acuity, a fuller triage is to be carried out by a suitable senior clinician according to Manchester Triage System (level 2 defaults to Emergency Medicine Service unless prior agreement, with levels 3 &amp; 4 - stable patients and those with pre-defined clinical needs - suitable for the wider Acute Floor).</li> <li>• Use of National Early Warning Systems for early recognition escalation and response to the deteriorating patient (cont.)</li> </ul>

## Assessment (cont.)

- Early involvement of therapy and medical social work – including GP/ PHN to assess against frailty markers.
- A single point of contact to access mental health services, with an uncomplicated referral process such as the on-site Liaison Psychiatry Team during working hours, and mental health staff on-site out of hours, supported by a Consultant on-call. Please note: where there is no acute medical need, assessment should be in a more appropriate setting than the Acute Floor e.g. acute mental health unit.
- Discharge planning to be commenced within assessment wherever appropriate.
- Early referral for diagnostics (recognising the need for prudent use and the value of an observational period), and anaesthesia assessment.
- Pharmacy review where appropriate to reduce polypharmacy and medication interactions.
- Access to advice from sub-specialties spread across a regional network.
- Multi-disciplinary morning huddle/ rounds on Acute Floor.
- Introduction of evidence-based screening tools, including frailty and mental health assessments where appropriate, with staff across disciplines trained in their use.

This supports design features of:

- Multi-specialty/ multi-disciplinary review of patients – ‘services’ sharing a space rather than ‘units’.
- Shared operational processes, agreed MDT response to high volume pathways.

## Pathways

### **Pathways designed to respond to the variety within predictable high-volume demand, to take place in the most appropriate setting**

- Promoting and developing suitable alternatives to admission where present, including:
  - Ambulatory care
  - OPAT
  - CIT
  - Rapid Assessment and Treatment (RAT)
  - Palliative care
  - Integrated care teams
  - Community Mental Health Teams
  - Closer links with CHOs for supported discharge
- With acute care hub, outreach, phone support and telemedicine to known patients, primary care or community, with rapid access to ambulatory settings (e.g. OPD/ Acute Floor)
- GP direct (managed) access to diagnostics
- Acute flow separated from elective where possible
- Development of ambulatory care models, avoiding the assumption that care delivery defaults to occupying a bed
- Some centres may serve a wider catchment/ network where specialist capacity exists (e.g. paediatric surgery, trauma)
- Standardised core documentation across emergency/ acute/ surgical/ critical care areas

**Pathways  
(cont.)**

- Pre-agreed surge SOP to share staff/ capacity with Emergency Medicine Service
- Urgent access to specialty clinics as an acute episode of care, or for patients in need of urgent review
- For older people with frailty and complex needs the key components of care integration and the pathways that need to be established include:
  - A case management approach that provides ease of access and care co-ordination
  - Bespoke care pathways that are age attuned (facilitating rapid assessment, community intervention, early supported discharge).
  - A multidisciplinary, interagency approach (common assessment and shared care plan focused on a high priority population
  - The establishment of a care hub that incorporates the key elements of social care and provides a coordinating care area for this population reflecting these structures will be key in meeting the needs of this population
- An agreed mental health inpatient bed management policy that transcends mental health catchment areas should be in place in each CHO.

This supports design features of:

- Pathways established based on population need, with services developed based on optimising local infrastructure
- Rapid specialist input, with alternatives to admission

**Roles -  
multi-  
disciplinary/  
multi-  
specialty  
team  
working**

**Recognition that a responsive and agile service needs the development of a broad skill base across disciplinary boundaries, with breadth as well as depth**

- Fundamental prerequisite of the presence of a lead clinician
- Nursing and advanced nursing (including ANPs, CNSs) – protocol-enabled assessment, prescribing, discharge and clinical nurse manager
- Health and social care professionals (therapy, medical social work, mental health)
- Critical enabling/ rate limiting clinical roles e.g. anaesthetist, radiologist, pharmacist
- Ease of access to senior clinicians from the entire range of onsite acute services
- Discharge co-ordination – including CHO staff, GPs and PHNs, case manager
- Supported by joint inter-disciplinary training for high volume acute presentations, with basic clinical training in acute assessment
- A workforce review and horizon scanning for opportunities to develop new interdisciplinary roles e.g. physician assistant, extended scope therapist, reporting radiographer, nurse prescribing

This supports design features of:

- Ease of access to senior clinicians from the entire range of onsite acute services
- Ability to respond effectively and efficiently to complex patients or those with multiple co-morbidities, through an integrated care plan and minimal hand-offs

<p><b>Operating hours</b></p>	<p><b>Intent to align the services within the Acute Floor to the demand/ presentation profile. This is likely to extend service provision across hours in the day and days in the week, recognising that a period of transition will be needed, as well as balancing with sustainable staffing</b></p> <ul style="list-style-type: none"> <li>• Beyond a 24/7 emergency medicine service, move to extended acute assessment units working day that aligns with demand (e.g. 8am-10pm) and over 7 days within 1-2 years</li> <li>• Move to full alignment with demand patterns and suitable staffing levels (which may or may not demand 24/7 working) over 3-5 years. On call cover will be needed for general surgery, acute medicine, frail and older peoples' services and anaesthesia during periods the Acute Floor is not fully operational. Options may be needed for cover to be spread across a network of sites</li> <li>• Agreement to a surge plan, SOPs and triggers for when demand is predicted to exceed capacity, which covers the Acute Floor response, site response, and wider system response</li> <li>• When components of the Acute Floor close, the expectation is any patients part way through their care pathway will complete it without retrograde flow to the emergency medicine service. The principle is that once accepted as under a clinician's care, they remain their responsibility until clinical handover.</li> <li>• Availability of cover for medical social care, therapy professionals, discharge co-ordination, diagnostics, pharmacy and anaesthesia across working day/ week, ideally with parity across CHOs to achieve a seven-day health and care system</li> </ul> <p>This supports design features of:</p> <ul style="list-style-type: none"> <li>• The same high quality of service, and the same likelihood of good clinical outcomes, whenever a patient needs care</li> <li>• Supporting flow through the acute system, reducing backlogs, surge demand and bottlenecks</li> </ul>
<p><b>Access to diagnostics</b></p>	<p><b>Recognised as a rate-limiting step in flow through the Acute Floor, ease of access to core diagnostics and timeliness of reporting needs to be assured, without increasing competition for access for scheduled care. In line with operating hours, diagnostic access needs to be configured to meet the demand profile.</b></p> <ul style="list-style-type: none"> <li>• Core diagnostics located in/ near the Acute Floor: CT, ultrasound, plain film x-rays</li> <li>• MRI accessible on site</li> <li>• Pathology, biochemistry, haematology and blood transfusion</li> <li>• Interventional radiology (arrangements could be across a hospital group), in accord with Trauma Network expectations</li> <li>• Results accessible and stored electronically</li> <li>• Same day delivery and reporting</li> <li>• Diagnostics conducted during the same care episode should accompany the patient</li> <li>• Diagnostic capacity based on expected growth in volume</li> </ul>

<p><b>Access to diagnostics (cont.)</b></p>	<ul style="list-style-type: none"> <li>• GP direct (managed) access to diagnostics</li> <li>• Access to range of other diagnostic services (e.g. echo, stress testing, Doppler, neuroelectrophysiology) plus lab based diagnostics over extended day</li> <li>• Extension of point of care testing</li> </ul> <p>This supports the design feature of:</p> <ul style="list-style-type: none"> <li>• Diagnostics, managed prudently to enable a timely, informed decision about the patient's on-going care plan (including the decision to admit)</li> </ul>
<p><b>Discharge planning and communication</b></p>	<p><b>A multi-disciplinary activity where the overall quality of care and ability to achieve flow is as much about how on-going care is managed across boundaries as it is about the care within the Acute Floor</b></p> <ul style="list-style-type: none"> <li>• Discharge planning present at each stage of patient journey, to start as soon as possible after admission</li> <li>• Timely two-way communication with community and primary care services, with same day electronic discharge communication, with ease of access to medical social care enabled by an acute care hub</li> <li>• 7-day ward rounds, with discharge processes aligned to demand and to facilitate flow</li> <li>• Dependency on 7-day therapy, pharmacy, diagnostics, medical social care</li> <li>• Development of a range of discharge pathways across acute and CHO provision which offer the appropriate level and capacity of follow-up care (including flow between hospitals models 1-4)</li> </ul> <p>This supports the design feature of:</p> <ul style="list-style-type: none"> <li>• Smoother hand-over of care, where the on-going management of a patient's condition is a recognised need within the acute phase</li> </ul> <p>Please note: navigational hubs may already be present in the hospital. If so, a review may be needed to ensure roles, responsibilities and processes are clear or what alternatives exist that enables timely access to specialist acute advice, flow and maximises efficiency and productivity.</p>
<p><b>Estates and physical design</b></p>	<p><b>Core generic features of a modern, flexible and shared space for the multi-speciality and multi-disciplinary care of the acutely unwell patient, making best use of local space and infrastructure</b></p> <ul style="list-style-type: none"> <li>• The ideal is to be co-located within the same space. Where not possible, clear process and clinical governance arrangements will need to be established, to ensure both flow and clear accountability for the patient</li> <li>• Co-located or proximal to the emergency medicine service</li> <li>• Co-located or ease of access to core diagnostics</li> <li>• Features: trolley-based monitoring areas, ambulatory care facility and a mix of bed-based and chair-based care areas, clinical support areas, and non-clinical activity, a single point of entry for streaming, rooms designed to meet the needs of: procedure rooms; rooms for mental health assessment (compliant with the Royal College of Psychiatrists</li> </ul>

<p><b>Estates and physical design (cont.)</b></p>	<p>recommendations for emergency medicine service infrastructure (15)) and frailty assessments; space for team huddles and handover</p> <ul style="list-style-type: none"> <li>• Clear visual management of patient care, responsible clinician and where the patient is in the process</li> <li>• Age-friendly and delirium-friendly layout</li> <li>• Flexibility of design for areas to be re-purposed according to changes in demand and to facilitate multi-disciplinary working (a shared space as opposed to discrete units)</li> <li>• Audio-visual separation from adult services for paediatric care</li> <li>• Ideally a designated emergency theatre (potentially configured across a hospital group – but transport and critical care capacity would need to be considered)</li> </ul> <p>This supports the design feature of:</p> <ul style="list-style-type: none"> <li>• A pragmatic approach to physical layout and facilities, making best use of shared existing resources to enable multi-disciplinary and multi-specialty working. Workarounds may be needed (whether interim or long-term) to avoid delaying implementation of an Acute Floor, where services cannot be physically co-located.</li> </ul>
<p><b>Information and coding</b></p>	<p><b>The introduction of a shared approach to data capture that supports i) continuous and quality improvement ii) the sharing of clinical information with providers outside the Acute Floor iii) the ability to adjust services to respond to the nature of demand, and iv) to support a method of payment/ resourcing which is equitable across the Acute Floor</b></p> <ul style="list-style-type: none"> <li>• Acute Floors will be expected to be compliant in capturing a nationally agreed minimum data set, through an Acute Floor Information System (AFIS). Where sites have yet to install one, the AFIS being developed nationally is recommended.</li> <li>• Data will need to measure access (time stamps or compliance with processes in care pathways), throughput/ flow (both volumes and LoS), outcomes (mortality, readmission rates) and patient experience/ satisfaction</li> <li>• HIPE and NQAIS data, though relating only to inpatient activity should be regularly reviewed to assess the impact of the Acute Floor on flow through the hospital, and inform service- and quality-improvement.</li> </ul> <p>This supports design features of:</p> <ul style="list-style-type: none"> <li>• Timely, sufficiently detailed and accurate data transfer that enables flow, quality of care and appropriate resourcing.</li> </ul>
<p><b>Governance</b></p>	<p><b>Governance arrangements reflect both i) oversight from key members as well as the broader constituency that has a relationship with the Acute Floor, and ii) clarity of day-to-day responsibilities</b></p> <ul style="list-style-type: none"> <li>• On a day-to-day basis, the duty or on-call consultant and team are the default clinical governance structure. A senior decision maker must be immediately contactable if not resident on the Acute Floor</li> </ul>

## Governance (cont.)

- A responsible consultant for each service needs to be identified and clear at all times the Acute Floor is operational, in the event of clinical escalation. The Clinical Lead is the ultimate point of clinical escalation
- A designated Clinical Lead for the Acute Floor will be identified from one of the services contributing to the Acute Floor. This role may be designated locally and may rotate through the various specialties who contribute to the service.
- To reduce the need for and impact of operational escalation, surge demand planning needs to identify local triggers and thresholds, and allow for a scalable, proportionate response, within the Acute Floor, the hospital, up to and including the health and care system It will need to factor in capacity (e.g. beds, placements, care packages), and workforce. This will be aided by an embedded discipline of business-as-usual processes which aid flow – every patient has a care plan and predicted discharge date/ time, discharges are proactively managed on a daily basis etc.
- Oversight is likely to be a component of each hospital's Unscheduled Care Governance Group, and requires representation from the following partners:
  - GPs and primary care
  - Executive Clinical Director of the CHOs
  - Integrated Community Teams
  - Medical lead
  - Surgical lead
  - Geriatrician
  - Psychiatry lead
  - Emergency physician
  - AHP lead
  - Nursing lead
  - Diagnostics lead
  - Patient representation
  - Business manager
  - Bed manager
  - Clinical director
  - Executive lead (likely to be COO)
- The group will hold responsibility for establishing the Acute Floor (including engagement and leadership development), undertaking the demand based planning, clinical risk management, performance and quality metrics, and quality and service improvement.

This supports design features of:

- Absolute clarity on accountability and clinical responsibility for every patient's care at any point along the care pathway
- The ongoing evolution of an Acute Floor that recognises that it exists as part of a system and builds strong relationships and communication to maximise its impact/ lessen any unintended consequences.



## 10 Implementation

Aspects of the Acute Floor Concept are already being implemented on various sites across Ireland. The challenge in spreading and embedding this concept will be to expand and integrate these examples of good practice in the medium and short-term.

The ability to do this depends more on working practices and service developments than on facilities. When we asked stakeholders to feed back on the necessary elements of estates and physical design for the Acute Floor, one of the strongest themes that emerged was the relative importance of team functioning and other key enablers over estates and physical design.



***“More than anything else, we need a willingness on the part of the stakeholders (ED, medicine, surgery, paediatrics, etc.) to buy in to the project. After that the physical changes required to buildings etc. will be relatively straightforward.”***

**Contributor to the Acute Floor Task and Finish Group**

### 10.1 Change management

The development of the Acute Floor represents a requirement for investment in a significant change management programme, not merely a project management approach. It will necessitate widespread clinical and operational engagement to succeed. Leadership must be aligned to delivering this approach as a priority, and to dedicate time and resource to allow services to come together and plan, problem solve and redesign their services around the imperatives of the changing demand and needs of the patient. Hospitals must be able to articulate a robust methodology for this change management approach, in addition to the business case and project management components. Above all this must be a data-driven exercise, with clear alignment between the demand and the service redesign. New roles and responsibilities for staff working together as new teams within the Acute Floor will require robust change management to underpin their introduction.

### 10.2 Guiding principles for practical application and development of an Acute Floor:

The following design principles are a useful point of reference when reaching critical decision points in practical implementation. Resources and facilities vary across sites and Hospital Groups, such that the specific configuration of each Acute Floor may vary. However, the following design principles outline the intent behind the Acute Floor, and provide the consistency and source of guidance to inform local, site-specific decisions. They may also help to prioritise areas for development, as the Acute Floor is mobilised and matures.



## Acute Floor design principles

<b>Patient/ User Focus</b>	Put people and their families at the centre of decisions ensuring continuity of communication so all members of the team are working to the agreed care plan until discharge from the pathway.
<b>Key access to services</b>	Provide simple access to services, information and advice. Ideally, patients attending Model 3 and 4 hospitals should access Emergency Medicine Service, AMU/ AMAU, ASAU and other Assessment Units through a common entrance.
<b>Effective assessment and care</b>	<p>Safe, quality care for acutely ill patients in an appropriate and dignified environment.</p> <p>Ensure that assessment is rapid, effective and able to mobilise the required services, e.g. NEWS, Frailty assessment, Manchester Triage.</p> <p>Ensure duplication of assessment is avoided throughout the patient journey. All clinical investigation results should accompany patients transferred from Emergency Medicine Service to the AMU/ AMAU or a medical ward and there should be no unnecessary repetition of test.</p> <p>Have the right person with appropriate competency and skillset make timely decisions about care and services in the appropriate environment underpinned by professional specialisation, standards and distinct patient flows (early senior review of patients).</p> <ul style="list-style-type: none"><li>• Use data and business intelligence to inform service design and performance responses.</li></ul>
<b>Integrated care</b>	<p>Patients with acute and emergency medical problems should experience a continuum of high quality medical care, from their first point of contact through their entire pathway of care.</p> <p>Emergency medicine, critical care, acute medicine, surgery and older persons' care are complementary systems of patient care.</p> <p>The interface between these specialties should be developed and managed in a co-ordinated manner to maximise the quality and cost-effectiveness of care provided by both services.</p> <ul style="list-style-type: none"><li>• Ensure seamless transitions in care and timely flow of information and services to meet patient need across networks of care.</li></ul>
<b>Clinical justice</b>	The same principles of equity of access to senior clinical decision makers and diagnostic resources apply for all patients across the Acute Floor. The relevant metrics in terms of time of assessment by the relevant senior clinician (e.g. one hour from arrival or sooner depending on patient acuity or the 3:2:1 timepoints for patients needing hospital admission from the Emergency Medicine Service, in order to comply with the 6hr PET requirement) and timely access to diagnostic resources should apply to patients in the Emergency Medicine Service and AMU/ AMAU, ASAU and other Assessment Units.

<b>Clinical justice (cont.)</b>	<p>There is parity of esteem in how we measure and incentivise/ reward performance to ensure fairness and consistency and optimise timely decision making and efficient workflows.</p> <ul style="list-style-type: none"> <li>Resources follow the patient pathway of care.</li> </ul>
<b>Connected networks of care</b>	<p>Connecting services together into a cohesive network such that the overall system becomes more than the sum of its parts.</p> <ul style="list-style-type: none"> <li>Build networks of care and service that emphasise the patient's needs rather than organisational boundaries e.g. frailty pathways.</li> </ul>
<b>Integrated governance</b>	<p>Having a named consultant clinically responsible and accountable for a patient's care at all points in their patient journey (HIQA Tallaght)</p> <p>There is clarity on roles, responsibility, authority and accountability of all staff within the Acute Floor which are explicitly stated especially at the boundaries between services</p> <p>Having clarity around how care is planned, delivered and performance managed across all streams within the Acute Floor.</p> <p>Have key performance indicators agreed which are critical to quality performance</p> <ul style="list-style-type: none"> <li>Have a clearly defined governance structure which includes GPs and CHO representatives</li> </ul>

### 10.3 Strategic, tactical, and operational capacity planning

Capacity planning typically happens in a reactive manner, when it has been outstripped by demand. The more proactive and predictive services can become, the less likely the need to escalate operationally, the more in tune the service will be with local need, and the better the experience for staff and patients.

Consideration needs to be at three levels: strategic, tactical and operational

#### **Strategic: Seeing into the future - anticipating and planning ahead for long-term shifts in demand**

Front door emergency pressures are seldom self-contained, instead reflecting wider and deeper capacity constraints, and variation throughout the entire healthcare system, in scheduled and unscheduled care, social and primary care. The overall impact of the Acute Floor would be maximised by managing capacity and demand across the system, rather than merely widening the front door to acute care. This should be done as a part of a multi-stage process, based on joint assessment of population health needs and how they are changing, including cross-boundary shifts through choice.

#### Stage 1: Modelling trends in occupancy, activity, and waiting lists by service line

The starting point is an understanding of recent trends (1-2 years) in activity (met demand) and waiting lists (unmet demand) by age band (recommended 5-year bands) for each

service. Bedded occupancy rates should be modelled in order to determine capacity shifts required to target 89% occupancy for optimal patient flow.

#### Stage 2: Using population projections by age band and waiting list growth to model expected changes in activity

For services without waiting lists, such as Emergency Medicine Service admissions by service line, growth in demand can be modelled by amplifying historic activity by the expected population growth. This is an advanced analytics exercise which may require specialist input and software. Services with waiting lists can be estimated by extrapolating recent trends in waiting list growth.

#### Stage 3: Developing improvement scenarios: shifting activity to match genuine demand

Stage 1 and 2 will highlight the major areas where capacity and activity are likely to be misaligned in the long term. Focusing on these areas, the next stage is to identify opportunities to reduce activity to meet genuine demand, for example preventing attendances, primary admissions and readmissions, and aligning length of stay to recommended guidelines. These scenarios should be informed by any improvement work currently underway, and in turn, the results of strategic capacity and demand planning should guide future improvement plans in stage 5. As such, specialist change management expertise may be required.

#### Stage 4: Modelling the expected impact of scenarios

Once the opportunities have been identified in stage 3, the next stage is to quantify the assumptions of improvements that can be made through specific interventions. For example, if the proposed intervention is to increase the hours of operation for the Acute Medical Unit to 24/7, this stage would quantify how many candidate patients would go through this pathway, and model the resulting impact on Emergency Medicine Service and AMU capacity. This stage can also include workforce modelling and estates recommendation. Scenario modelling may require specialist input and software.

#### Stage 5: Scenario implementation

Once the scenarios have been specified and their impact has been modelled, the final stage is to implement the changes into routine practice. This must include stakeholder engagement, empowerment, and alignment with other organisational and political factors, and again specialist change management expertise may be required.

#### **Tactical: Planning for tomorrow and next week**

Tactical capacity planning involves responding to anticipated peaks in demand e.g. seasonal fluctuations and building in capacity. Careful consideration must be given to the 'flaw of averages,' that is, if service capacity is planned to meet the average demand, patients will have to wait when demand is higher than average. But when the demand is lower than average, the unfilled capacity cannot be carried forward to the future.

Ability to handle seasonal pressure depends on both forecasting and ability to flex capacity to meet demand. Service lines should more generally adopt planning estimates of 80% of the maximum demand variation to enable a better match of capacity to demand.

## Operational: Doing today's work today

- routine use of predictive data for emergency care
- assessing likely demand for the day – morning huddles - proactive planning for the day's projected demand, and for what next week is likely to bring
- protect availability of senior clinical decision makers to manage those on the Acute Floor
- maintain ability to respond to community/ primary care-based queries (which may prevent admission)
- Right sizing and longer-term planning, beyond optimising immediate operational management – building infrastructure to respond to predicted population needs, such as cardiac catheterisation labs or emergency theatre access.



### Patient Flow Improvement Programme Limerick and Galway

This programme is delivered by GE in partnership with HSE, University Hospital Limerick, and Galway University Hospitals.

As part of this programme, a five-year Capacity Strategy was conducted for both hospitals according to the strategic stages set out above. Although both hospitals were well over the recommended occupancy limits and both attendances and admissions were expected to rise with the aging population, several scenarios were identified to introduce capacity savings, for example increasing the hours of operation for the Acute Medical Unit, and aligning length of stay with best practice guidance.

As an additional part of this programme, it was identified that operational flow management processes were unfit for purpose, including multiple overlapping communications and a reactive culture of bed placement rather than a proactive culture of operational capacity planning. For example, at GUH, bed management meetings alone could take over 2 hours per day, leaving little time to facilitate discharges and patient flow. These hospitals were able to demonstrate improvements by focusing on a few key areas, such as reframing the bed management meetings around capacity management, improving the flow of information to inform bed management, and targeting early morning discharges. As a result, pre-noon discharges have increased by 200-300% thereby creating inpatient capacity earlier in the day, and reducing pressure on ED.

## 10.4 IT enablers

Acute Hospitals need modern health information infra-structures which facilitate and enhance care and business processes related to patient treatment and safety. Hospitals must move away from locally developed single service databases which cannot integrate or interface with other systems and which cannot operate in a multi-disciplinary working environment. Acute Floor Hospitals also need easy access to current and past patterns of demand to enable tactical planning of resource requirements.

All Acute Floors will require an Acute Floor Information System (AFIS) as part of their move to develop an acute floor operating environment. To facilitate this, the HSE is advancing a framework for the procurement of a single supplier of an AFIS for hospitals. As part of this framework, the HSE has developed a specification of requirements based on an acute floor operating environment. In the interim, there will be a requirement for hospitals to develop their complex of information systems to integrate those systems. This will give the necessary level of data and intelligence on system performance, in line with the agreed AFIS minimum data set. The priority information requirements for such integration will be based on the agreed national AFIS specification.

Accurate data capture will be required to ensure reliable and appropriate funding of activity in the Acute Floor, particularly with regard to Activity Based Funding implementation. A core common data set will need to be developed and implemented – the Australian Independent Hospital Pricing Authority URGGrouper system is being explored as a potential platform. Data systems will need to integrate and normalise data from across multiple systems and databases to facilitate seamless patient care. This will also facilitate predictive analytics, drawing on the AFIS and other database/ systems to predict workflow and scheduling over the next 72 hours to support the operational capacity planning (see section 9.3) and operational decision making.

ABF needs to be supportive of the clinical approach e.g. ambulatory care, across the Acute Floor, recognising the complexity of some of the assessments and treatment required in the Acute Floor environment. Much of the focus will be on converting admissions to ambulatory care episodes or assessments followed up by rapid access clinic review. Such presentations will be relatively resource intensive in a semi-elective setting, and remuneration should reflect the intensity of the workload.

## **10.5 Clinical and operational governance**

### **Operational Governance**

- Hospital Unscheduled care groups already exist and would be an appropriate vehicle for the oversight of Clinical and Operational governance of the Acute Floor. If alternative groups are set up, they will necessarily have data requirements to underpin strategic capacity planning, short and medium-term planning and day to management.
- Arrangements for Directorate governance may vary from hospital to hospital, however consideration should be given to developing a distinct directorate to oversee the performance and functioning of the Acute Floor.
- Key operational performance indicators must be developed for the Acute Floor and shared at the Operational Governance forum, whatever its form.
- The Unscheduled Care lead will have overall operational responsibility for the Acute Floor services.
- Escalation processes and procedures will be developed which articulate actions to be taken in event of demand exceeding capacity or any other operational emergency. These will align with the National Escalation Framework.

- Structures such as daily Flow Huddles may assist teams to have a high level of situational awareness regarding flow status within the hospital, the group and the wider health community. Flow leaders from group hospitals and community partners should participate in daily operational huddles or calls to ensure that information is shared across the system and the hospital is not working in isolation.

### **Clinical governance**

- A Clinical Lead will be appointed, to have oversight of the Acute Floor and will have ultimate responsibility for clinical governance on the Acute Floor. The individual will hold the respect, credibility and skill at engaging a broad constituency in cultural and operational change. This will include oversight of clinical governance processes such as dealing with complaints, incidents and near misses as well as putting in place robust outcome measurements and Clinical Audit processes for the Acute Floor. Variations in delivery of services will be identified and addressed through these processes. Safety and quality interventions and measurements will also be implemented via processes developed through the Clinical Governance channels of the Acute Floor.
- The General Manager/ COO, Director of Nursing, Acute Floor Clinical Lead and Clinical Services Manager are the leadership team responsible for ensuring the effective delivery of operational systems and processes on a day to day basis.
- A Standard Operating Procedure for the Acute Floor will be developed in conjunction with the leads of the services operating on the Acute Floor and the support services aligned to it. This will describe the normal operating parameters of the service, the resourcing plan, processes for escalation. It will define the service level agreements between specialties and services which govern day to day operations, as well as the routes for resolution of disputes whether clinical or operational.
- Pathways out of the Acute Floor are also within the remit of the Operational and Clinical Governance of the Acute Floor, and are a keystone of effective functioning. Clear focus on these pathways will ensure that flow out of the Acute Floor is optimised and therefore access for new patients is assured.

## **10.6 Sustainable funding model for Acute Floors**

It is clear that successfully operating acute floors need a sustainable funding model and a financial system of incentives to maintain high standards of operation. There is an expectation that hospitals operating acute floors will also innovate and continuously improve the quality of service and such efforts must be incorporated by a funding approach.

The continued strategic development of an activity based funding (ABF) approach within the Irish health service will be the platform upon which a sustainable model for funding of acute floors will be developed. The activity based funding model already includes reimbursement mechanisms for same day discharges and medical assessment units. Work is currently progressing to define a classification system to appropriately capture the spectrum and complexity of patients presenting and being treated within Emergency Departments and more recent work has commenced to incorporate the funding of surgical assessment units within the ABF model.

As these individual strands of data collection and pricing approaches develop and mature, the HSE including the Healthcare Pricing Office will work to develop a unified Acute Floor ABF mechanism that integrates the individual funding streams for the range of assessment and treatment services across the acute floor. At this point, there will be opportunities to capture and include the full spectrum of services that will encompass the Acute Floor but are not yet included (e.g. allied health professional consultations within ED / assessment units, critical care services provided, in sourced community care services, etc.).

The development of the Acute Floor funding approach will be aligned to the overall strategic value offered by the acute floor model (i.e. encouraging more same day discharges, see and treat consultations, reducing the need for in-patient admissions, streaming patients away from ED, etc.) and will capitalise on developments in information system developments (e.g. AFIS) and HIPE coding services.

## **10.7 Interfaces with community and wider partners**

The Acute Floor, whilst located on an acute site, offers an interface between acute, primary care and community provision. Flow will not be achieved by widening the front door alone. It requires input from non-acute partners to:

- i) Reduce avoidable demand and acute episodes of care (by both developing new care pathways and providing rapid access to specialist advice)
- ii) Support discharge planning and arrangement of onward care at the earliest possible opportunity
- iii) Improve the management of those with chronic, multiple or complex conditions through proactive care

Broadening the front door, in and of itself, will not be sufficient to alleviate pressures on the acute system. There is a need to develop and build confidence in pathways which do not default to an admission, but enable care to be delivered in community or home settings. Whilst this document is principally focused on the developments needed within the acute setting, it will need to be supported by a broader body to strengthen community services. From the earliest stages of development, it is expected that non-acute providers will be involved in the design – to support patient pathways, clear communication flow and clarity of governance. Broader partners also have a key role to play in the governance. Primary care and GPs, CHOs and Integrated Community Teams (ICTs) are likely to be a core part of the local Acute Floor development group.

## **10.8 A roadmap for implementation**

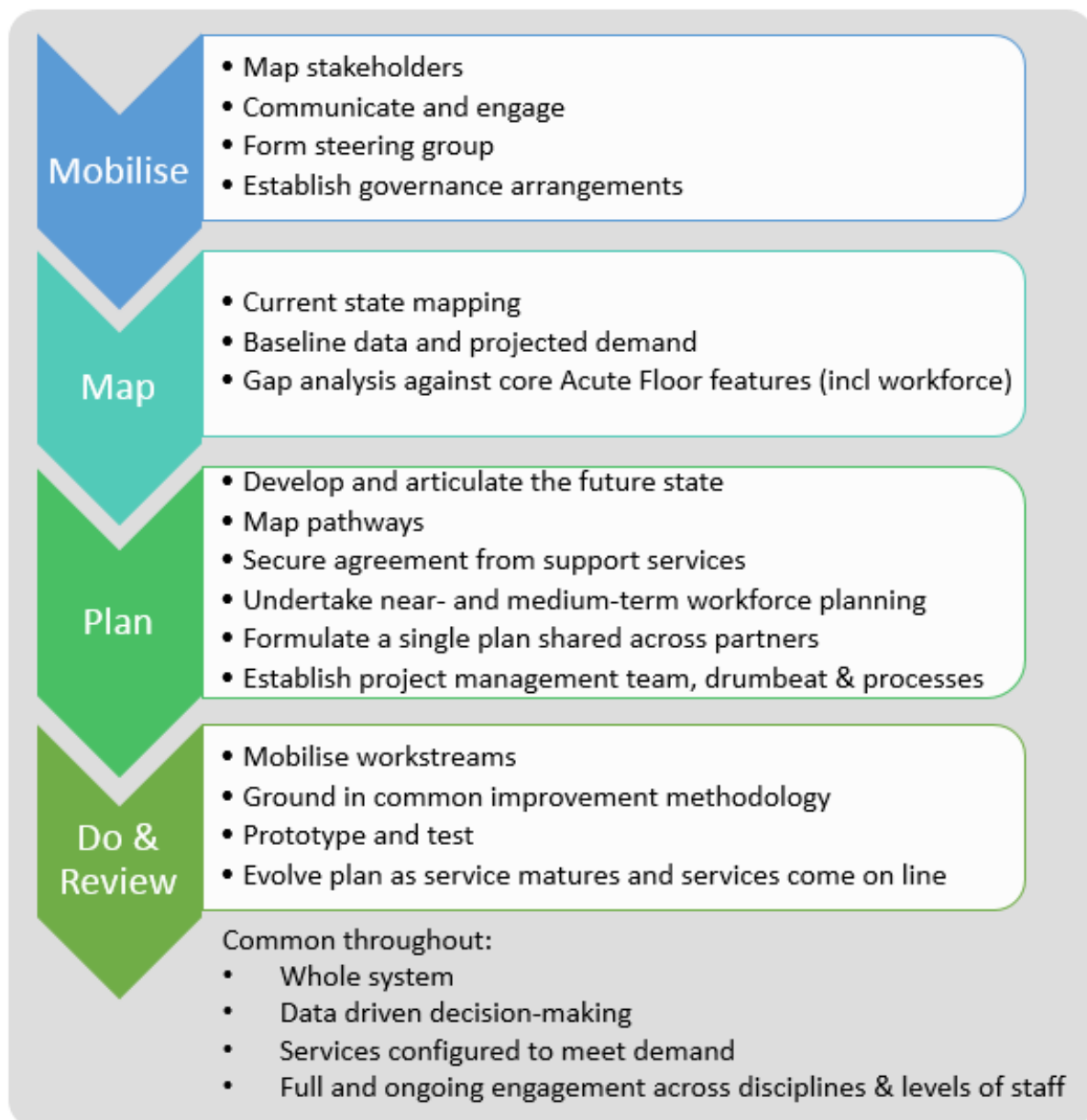
The task of establishing an Acute Floor is as much one of engagement as it is a technical project to manage. Providing some clear stages as indicated below assists by:

- helping partners orientate to where they are in the end-to-end process
- providing reassurance that development will be both phased and tested, to manage any unforeseen consequences and risks



- building momentum and a clear sense of progress as the configuration of the Acute Floor builds

The owner of the development of an Acute Floor is likely to be either the Chief Operating Officer or Unscheduled Care Lead. Contributions from all services aligned to the Acute Floor at the earliest stage will support engagement and ownership of the development, increasing the speed of adoption and sustainability.



## 11 Who can help?

The National Clinical Programmes and Integrated Care Programmes have provided a foundation of valuable learning of the need to maintain and enhance clinical leadership and develop clinical pathways that are truly patient-centred. They are regarded as one of the most significant, positive developments in the Irish Health Service, with the ultimate aim of improving quality, access and value of healthcare in the country.

It is strongly encouraged that those developing an Acute Floor draw heavily on the guidance from the relevant programmes.

For links to the National Clinical Programmes, click [here](#).

For links to the Integrated Care Programmes, click [here](#).

For further information on Acute Floor Information Systems, contact: Dr Ciaran Browne, Acute Hospitals Division, HSE [[ciaran.browne@hse.ie](mailto:ciaran.browne@hse.ie); Tel: 076 695 99 45]

The Special Delivery Unit (SDU) works with hospitals and Hospital Groups to improve access for Scheduled and Unscheduled Care [[acutehospitals@hse.ie](mailto:acutehospitals@hse.ie); Tel: 01 6352000]

An array of resources relating to Quality Improvement can be found at <http://www.hse.ie/eng/about/Who/QID/>

The Programme for Health Service Improvement can be reached at [programmefor.healthserviceimprovement@hse.ie](mailto:programmefor.healthserviceimprovement@hse.ie) or Tel: 01 635 2537

Advisory Board Discharge Opportunity Calculator:

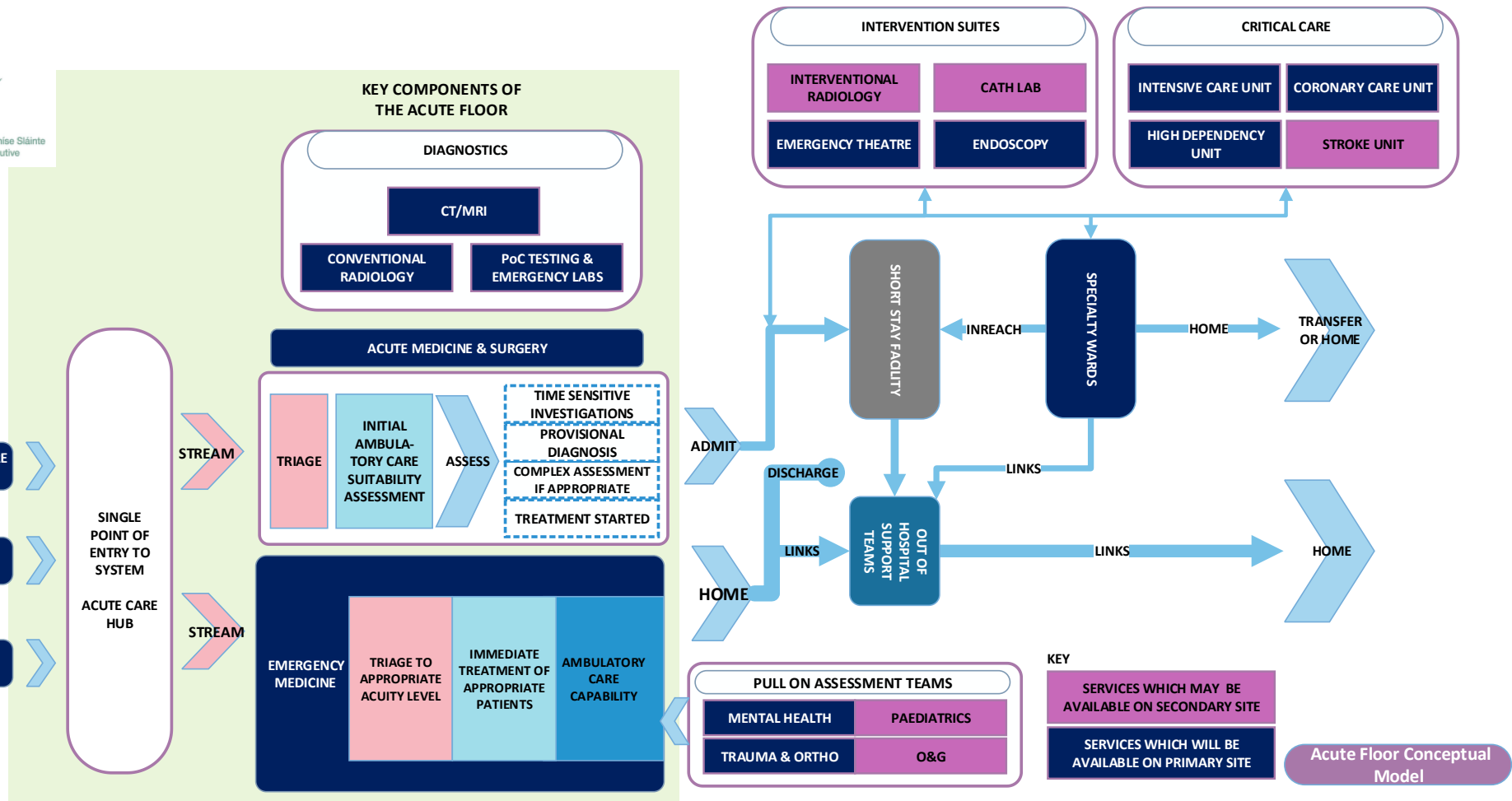
<https://www.advisory.com/es-es/international/research/clinical-operations-board/resources/2014/discharge-opportunity-calculator>

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# Appendix 1 Acute Floor Flow Schematic



## Appendix 2 Best practice references

It is strongly encouraged that those developing an Acute Floor draw heavily on the guidance from the relevant programmes.

For links to the National Clinical Programmes, click [here](#).

For links to the Integrated Care Programmes, click [here](#).

In addition to these, other source material and points of reference and inspiration may be found in the following references.

1. RCP medical care – designing services

<http://www.rcpmedicalcare.org.uk/designing-services/specialties/acute-internal-medicine/services-delivered/acute-medical-unit/>

2. Design of Acute Care Units in the US

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2980831/>

3. The impact of facility design on patient safety

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6. HSE Acute Floor concept model

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8. The Acute Assessment Unit – Dumfries and Galloway

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9. AHA Reconfiguring the bedside care team of the future

<http://www.aha.org/content/13/beds-whitepapergen.pdf>

10. The critical care/ acute medicine interface

<http://futurehospital.rcpjournals.org/content/3/1/55.full.pdf+html?sid=edfcf26a-bc59-418c-9006-9959c96ad66d>

11. The evidence for acute medical units

<http://futurehospital.rcpjournals.org/content/3/1/45.full.pdf+html?sid=edfcf26a-bc59-418c-9006-9959c96ad66d>

12. Characterising the acute take

<http://futurehospital.rcpjournals.org/content/1/1/28.full.pdf+html?sid=ad1ccc9c-d5e0-4ae6-bad0-039c1d1072bf>

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<http://futurehospital.rcpjournals.org/content/4/1/9.full.pdf+html?sid=b208a831-251d-45ad-ac97-ca0b57ed5897>

14. Western Sussex Acute Floor

<http://www.westernsussexhospitals.nhs.uk/news/emergency-floor-wins-prestigious-support/>

[https://www.youtube.com/watch?v=iQTi3eZd\\_LA#action=share](https://www.youtube.com/watch?v=iQTi3eZd_LA#action=share)

15. Pod nursing in an acute medical/surgical unit

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3968792/>

16. Acute Cardiac Care Unit

[http://www.bcs.com/documents/BCS\\_Report\\_on\\_Coronary\\_Care\\_Units.pdf](http://www.bcs.com/documents/BCS_Report_on_Coronary_Care_Units.pdf)

17. Commonwealth Fund strategy on acute care for elders

<http://www.cfhi-fcass.ca/sf-docs/default-source/on-call/commonwealth-fund-ace-strategy-overview.pdf?sfvrsn=2>

18. NHS 7 day strategy

<https://www.england.nhs.uk/wp-content/uploads/2013/12/evidence-base.pdf>

19. RCP Acute Care Toolkits 1-4

<https://www.rcplondon.ac.uk/projects/acute-care-toolkits>

20. NHS Improvement ECIP Rapid Improvement Guides

<https://improvement.nhs.uk/uploads/documents/maximising-aec-services-RIG.pdf>

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21. Acute and Emergency Care- prescribing the remedy

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## Appendix 3 Levels of interdisciplinary working

In developing new working practices of interdisciplinary and inter-professional working on the acute floor, it may be helpful to reflect on both where the teams are currently, and the level of interdisciplinary working that is needed for the Acute Floor to operate successfully.

It is likely that there will be a period of transition (not leaping immediately from level 1 to level 4) and so concrete action planning and introduction of new processes and working practices will support the team's growth into interdisciplinary working.

**Level 1: unidisciplinary** - where the professional with continuing responsibility co-ordinates the care for the patient, with input from other professionals on an irregular basis. Notes tend to be held separately, and communication tends to be between team members and the patient rather than with each other. This approach might be most appropriate when quick decisions are needed.

**Level 2: work closely as an internal team**, and include the patient to varying degrees. Records may be shared and external agencies may be invited to formalised meetings. A care plan might be prepared within the organisation but are not necessarily agreed with external parties.

**Level 3: core team - all the key members needed to carry out the care from several organisations work closely together.** Assessments are carried out by each profession and patient plans worked up as a collaborative effort, including the patient/carers. Records are shared. The members of the core team are generally able to commit resources to the common effort. Many other disciplines can be called upon for specific purposes.

**Level 4: transdisciplinary working - barriers between different disciplines break down and roles within the team are redesigned to make the optimum use of team skills and knowledge.** Assessments may be carried out by different disciplines working together with insights from one discipline informing the assessments of another. Transdisciplinary working means that one discipline may take on the traditional role of another by agreement. This is particularly true of care co-ordination and some teams have created specific roles to carry this out. This sort of working requires team members to sink part of their individual professional role into the team effort

In general terms, it is envisaged that as the acute team matures in its working together, it will develop processes (and a level of trust) that supports level 3 and level 4 working, that supports patients from a multi-specialty and multi-agency perspective. At the individual patient level, the degree of involvement from others will depend on the patient's level of complexity.

## Appendix 4 Contributors

This work would not have been possible without the generous time, commitment and thoughtful input from the following people:

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