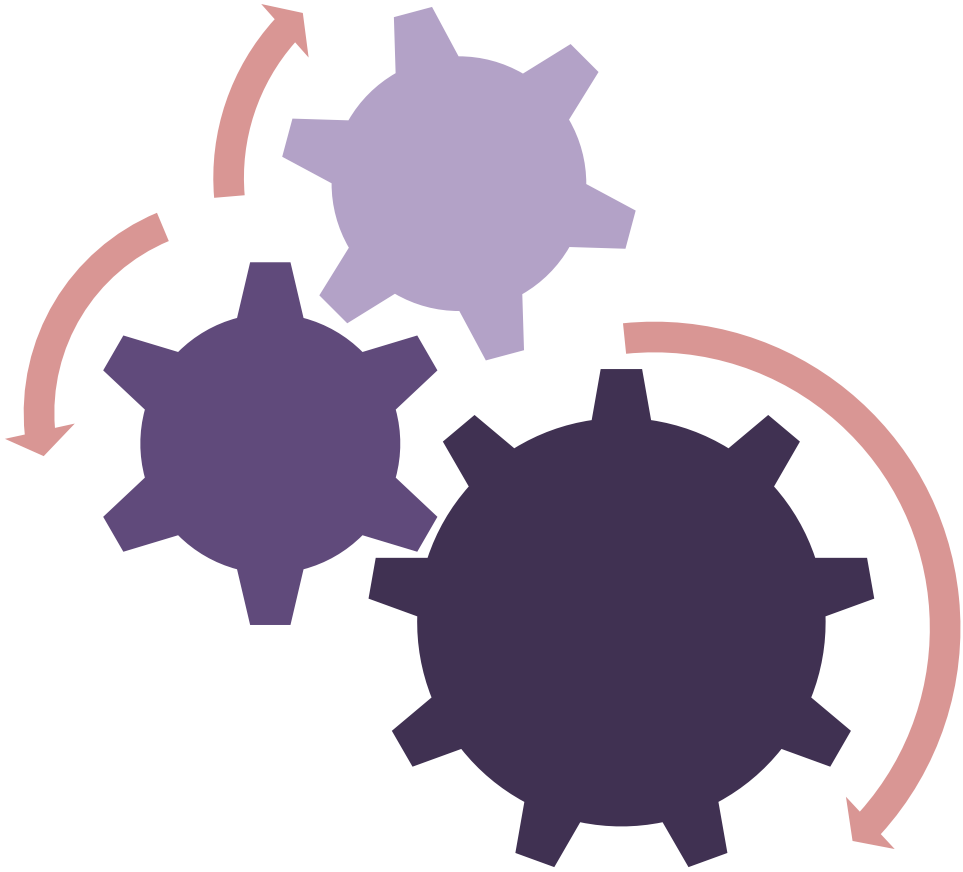
The College of Emergency Medicine



Emergency

Commissioning the delivery of high quality care in the Integrated Emergency Department

Guidance for Commissioners, clinicians & managers

Contents

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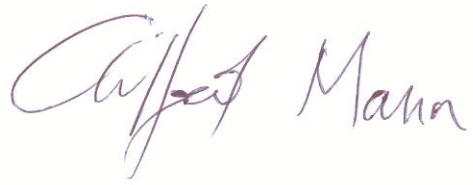
Foreword

This document is published at a time of considerable flux in the NHS in England. New organisations have been tasked by primary legislation, to deliver healthcare with a clear delineation between commissioning and providing care. In consequence whole systems of management and accountability have been replaced; the stated intention is to render healthcare more locally accountable and clinically driven.

The guidance within this document is provided to assist both Acute Trusts and local Commissioners understand the key requirements for a safe, effective, efficient and sustainable Emergency Department. For the Emergency Medicine Practioner the requirements are obvious and self-explanatory; this is not necessarily the case for those tasked with hosting and commissioning such services. The principles contained herein are readily transferrable and generalizable to the health services of Northern Ireland, Republic of Ireland, Scotland and Wales



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Summary

The commissioning landscape (In England) at present can seem confusing to many. Regardless of the new arrangements, Emergency Departments are facing a continuous rise in attendance that shows no indications of declining in an era of reduced financial support, increasing costs of providing 24/7 care and a shortfall in the workforce required to deliver emergency medicine.

The Emergency Department is at the core of the Emergency Care System. This position paper by the College of Emergency Medicine provides guidance for commissioners, clinicians and managers on how to deliver high quality care in the integrated Emergency Department. In Scotland, Wales & Northern Ireland and the Republic of Ireland the same principles are equally applicable though delivered within the organisational framework established by their legislatures.

This guide recommends ten key recommendations that the College believes should always be considered when the configuration of local EDs are made. These are:

1. Structured engagement and involvement between the Lead Clinician for Emergency Care, Executive teams of provider Trusts and local commissioners is essential in order to develop a shared vision and delivery strategy.

2. A full network of emergency care stakeholders is essential. In England this is being delivered by development of Urgent Care Boards. The Board must have clear strategic, operational and governance structures ideally with a dashboard of metrics of success. Structures and networks are required. These should include Emergency Department senior staff, Primary Care, Minor Injury Units, Pre-Hospital care, tertiary centres, mental health teams, community health care teams, allied health services and social services.

3. Alternative pathways of care and ease of accessibility to urgent care, especially out of hours. Co-located primary care services with streaming strategies should be in place and encouraged. These will be vital in order to help reduce Emergency Department attendances and hospital admissions.

4. A department should be staffed by senior decision makers 24 hours a day. Consultants should be on the shopfloor for a minimum of 16 hours a day, 7 days a week, and 24 hours a day in major centres.

5. Ensure adequate staffing levels are in place to cope with surges in demand.

6. The fabric of the department needs to be fit for purpose. The design and environment can ensure a more appropriate experience for patients and staff.

7. The department needs to be supported by a suitable IT infrastructure which facilitates patient flow and quality assurance.

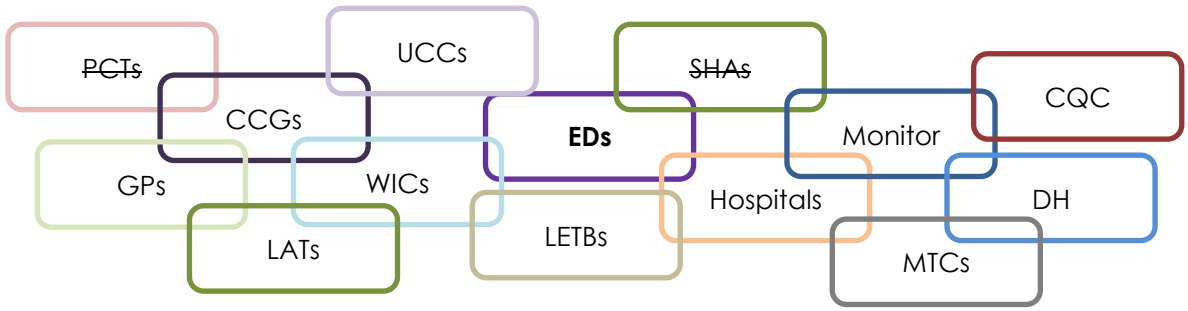
8. There needs to be ready access to diagnostics and in patient services.

9. Local commissioning should reflect costs and cost effectiveness of providing high quality care. Funding should reflect diagnosis and acuity of illness in order to promote best practice. 'Item of service' type payments and 'block contracts' should not be used.

10. Observation medicine and ambulatory care strategies are an integral part of the service provided by many Emergency Departments. It is important that the Same Day Emergency Care (SDEC) tariff is applied to cases managed in ED based Clinical Decision Units / Observation Units and local tariffs developed to enhance ambulatory care activity within the ED itself.

The College will publish further iterations of this guidance as new evidence emerges and excellent models of practice evolve and are refined.

Commissioning Framework



The new Health Act for the NHS in England will be a powerful stimulus for optimising efficiency and cost effectiveness of care if managed well. Whilst much of the infrastructure for commissioning is being built, the first 1-2 years will require close co-operation between stakeholders to create and bed down new systems. As witnessed with past events, failure to develop and support an integrated emergency care pathway can potentially result in parts of the pathway becoming overloaded and failing.

The College's recent policy paper "The Drive for Quality" demonstrated poor involvement between commissioners and Emergency Department (ED) clinicians. In order to ensure a well commissioned service it is imperative to have effective discussions between clinicians and commissioners.[1] In England the establishment of Urgent Care Boards may better enable this.

Whilst allowing for systems to be flexible and adaptable going forward, a long term vision for excellent emergency care needs to be agreed with local stakeholders now, to ensure that developments remain focussed on delivering high quality, safe, cost-effective and accessible emergency care.

Recommendation 1
Structured engagement and involvement between the Lead Clinician for Emergency Care, Executive teams of provider Trusts and local commissioners is essential in order to develop a shared vision and delivery strategy.

[1] *The drive for quality - How to achieve safe, sustainable care in our Emergency Departments*, The College of Emergency Medicine; 14 May 2013
http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/default.asp

The Emergency Care System

The commissioning landscape at present can seem confusing to many. Regardless of the new arrangements, EDs are facing a continuous rise in attendance that shows no indications of declining in an era of reduced financial support, increasing costs of providing 24/7 care and a shortfall in the workforce required to deliver Emergency Medicine (EM).

The ED is at the very core of the Emergency Care System (ECS). The development and delivery of a high quality ECS is an absolute priority for the NHS as a whole. Patients cared for in an ED should receive prompt, high quality and safe emergency care.

In configuring the local ECS, it is important to remember that there is no 'one-size fits all' model; the principles and evidence that are outlined within this paper must be placed within a local context and configured to meet the needs of patients within each locality. Key participants in the ECS will include:

- ***Patients***
- ***EDs***
- ***Primary care, both in and out-of-hours***
- ***Urgent Care Centres***
- ***Minor injuries units***
- ***Pre-hospital care / ambulance services***
- ***Secondary, tertiary and more specialised services, including rehabilitation services***
- ***Mental health teams***
- ***Social and welfare services***
- ***Community care***
- ***Other services such as drug and alcohol services***

A coherent and integrated ECS needs to be developed ensuring patients reach the right service in as few steps as possible. Not only is this good for patients, but it reduces inefficiency and enables each of the various components to concentrate on what they do best. Consideration must be given to alternative models of care to help avoid unnecessary ED attendances and reduce admissions.

Recommendation 2

A full network of emergency care stakeholders is essential. In England this is being delivered by development of Urgent Care Boards. The Board must have clear strategic, operational and governance structures ideally with a dashboard of metrics of success. Structures and networks are required. These should include Emergency Department senior staff, Primary Care, Minor Injury Units, Pre-Hospital care, tertiary centres, mental health teams, community health care teams, allied health services and social services.

Recommendation 3

Alternative pathways of care and ease of accessibility to urgent care, especially out of hours. Co-located primary care services with streaming strategies should be in place and encouraged. These will be vital in order to help reduce Emergency Department attendances and hospital admissions.

Delivering safe and quality emergency care

EDs lie at the heart of emergency care and function as the focal point for emergency networks. They provide specialised, irreplaceable, cost effective care, 24 hours a day, 365 days a year.

The key role of the ED is to provide resuscitation for patients with life threatening injuries and illness and care for those with sudden onset of serious illness and injury.

The ED also provides a safety net for patients of all ages with concerns about their health. Though this is not perhaps the traditional role of the service, it provides vital access in the absence of alternatives. No other component of the health service is expected to deal with such a vast spectrum of patients and their problems. However, the ED must not be regarded as a 'default service' nor be expected to cover the deficiencies of other services/providers and agencies

Care should be delivered as close to the patient as possible, ensuring that the patient is seen by the right health care professional, in facilities that are able to support assessment and management of their problem.

Delivery of safe and quality care should at all times be the key objective of any ECS that is commissioned. Following the Francis Report into care at Mid-Staffordshire Hospital and the Berwick Review of patient safety, the importance of ensuring safe quality care is provided within your ECS is imperative.[2]

Demand for urgent and emergency care is increasing. A coherent system needs to be developed ensuring patients reach the right service in as few steps as possible. Not only is this good for patients, but it reduces inefficiency and enables each of the various components to concentrate on what they do best.

Resourcing your Emergency Department

To deliver safe and high quality care your ED should be resourced with:

- ***Senior clinical decision maker:*** The presence of a senior clinical decision maker, trained and experienced in EM 24 hours a day
- ***Balanced and integrated team***: This team should be comprised of EM doctors, nurses, allied health practitioners and support staff to deliver high quality and safe care
- ***Director of Emergency Care***: This position should be held by an experienced EM consultant appointed in each acute trust/hospital to oversee and manage the Emergency Care process
- ***Facilities and resources for resuscitation, emergency care and ambulatory care***
- ***24/7 access to x-rays, ultrasound and computed tomography (CT)***
- ***Inpatient team support:*** Timely support from inpatient teams and efficient procedures for admission to hospital. Adequate support from Mental Health services is essential.
- ***Clinical Decision Unit (CDU) or Observation Unit***

[2] *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 2013
http://www.midstaffspublicinquiry.com/report
A promise to learn – a commitment to act: improving the safety of patients in England - Berwick review into patient safety, Department of Health 2013
https://www.gov.uk/government/publications/berwick-review-into-patient-safety
The College has prepared a range of documents to support Emergency Medicine doctors following the Francis Report. These can be found here.
http://www.collemergencymed.ac.uk/Shop-Floor/Safer%20Care/Safety%20in%20your%20ED/Francis%20Report/default.asp

- ***Information Technology***: Fit for purpose information technology and records system integrated with hospital and community care records
- ***Suitable facilities***: The fabric of the department needs to be fit for purpose. Departments should have sufficient space to provide adequate clinical areas with appropriate privacy and equipment. Waiting areas should be comfortable with easy access to facilities including toilets and refreshments. A high standard of cleanliness and hygiene should be maintained throughout. Effective departmental design and environment can ensure a more appropriate experience for patients and staff.[3] [4]
- ***Facilitation of further treatment and follow up:*** Processes must be in place to enable timely communication with the patient's GP and other relevant healthcare workers and services
- ***Systems for Patient Feedback***: Patients should have the opportunity to provide feedback on the level of care they have received. IT systems must be capable of supporting this.

Emergency Physicians

Emergency Physicians are specialists in the initial assessment and management of the full range of emergency and urgent conditions in patients of all ages. Core elements of EM practice include:

- ***Delivering a consistent and resilient 24 hours a day, seven days a week service***
- ***Resuscitation of patients with life-threatening illness or injury***
- ***Sudden serious illness or injury***: Assessment and early treatment of patients with sudden serious illness or injury, including those who self-present
- ***Lesser severity illness or injury***: Assessment and treatment of patients with lesser severity illness or injury, in collaboration with primary care services
- ***Programmed investigations and observation***: The management of patients requiring a short period of programmed investigations and observation to ensure safe discharge. Many of these patients will present with symptoms that might suggest serious disease, and they would otherwise be admitted.
- ***Avoiding unnecessary admissions:*** Providing high quality and cost effective care that avoids unnecessary hospital admissions
- ***Service for the whole community***: Delivering a service that meets the needs of all patients in the local community, including children, older people and vulnerable adults
- ***Patient flow***: Facilitating patient flow in conjunction with the whole hospital in a manner that can cope effectively with surges in demand such as winter pressures
- ***Contingency planning for dealing with major incidents***
- ***Strong influence in the planning, delivery and management of the ECS***
- ***Teaching and training***: Training doctors and other staff in the care and assessment of the ill and injured patient

[3] *Health Building Note 15-01: Accident & emergency departments - Planning and design guidance*, Department of Health, 2013
http://www.institute.nhs.uk/ambulatory_emergency_care/public_view_of_ambulatory_emergency_care/ambulatory_emergency_care_homepage.html

[4] *ED Design Toolkit*, 2011
http://www.designcouncil.org.uk/AEtoolkit/

Considering your workforce

The clinical workload of EDs continues to rise unabated despite initiatives to reduce this.[5] [6] This relates both to the number of patients presenting over a given time period and the acuity of these patients when set against the capacity of the system.

An appropriate ED workforce profile is the single most important requirement to deliver safe and effective high quality clinical care in a timely and cost-effective manner.[7] [8] The anticipated clinical workload must be matched with the appropriate number and skill mix of staff. There is no 'one size fits all' ED workforce model.[9]

A paradigm shift is required from the historic ED medical workforce model where the majority of clinical care was delivered by inexperienced junior doctors to one where the majority of clinical care is led and increasingly delivered by EM consultants (or senior EM doctors) supported by middle grade and junior doctors as well as Emergency Nurse Practioners, Advanced Care Practitioners and Physician's Assistants - providing resilience and breadth to the system.

The CEM recommends that all EDs should have a minimum of 10 EM consultants to provide up to 16 hours of on-site shop floor cover seven days a week. Greater numbers will be required in larger EDs or to provide 24 hours of on-site shop floor cover seven days a week.[10] [11]

Increasing the number of EM consultants demonstrably improves the quality of patient care, enhances patient safety and results in cost efficiencies.[12]

Clinical care must be led by experienced middle grade doctors at those times when there is not an EM consultant present in the ED.

The greatest challenge to the ED medical workforce is the national recruitment crisis of EM doctors at both middle grade (training and non-training grade) and consultant levels.

Increasing work intensity and anti-social work patterns for the same remuneration as other specialties have decreased the attractiveness of EM as a career option for junior doctors. This has significantly contributed to the national recruitment crisis.

Additionally, the European Working Time Directive and the specialty doctor contract have reduced the number of hours that middle grade and junior doctors are available for actual clinical work.

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[5] *The drive for quality - How to achieve safe, sustainable care in our Emergency Departments*, The College of Emergency Medicine; 14 May 2013
http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/default.asp

[6] *The Emergency Medicine Operational Handbook (The Way Ahead)*, The College of Emergency Medicine, 2011.

[7] *The Emergency Medicine Operational Handbook (The Way Ahead*), The College of Emergency Medicine, 2011.

[8] *Emergency Department staffing in England and Wales,* Paw RC.Emergency Medicine Journal. 2008; 25(7): 420 - 423.

[9] *Foundation Trust Network Briefing Driving Improvement in A&E Services,* Foundation Trust Network; 2012.
http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CC8QFjAA&url=http%3A%2F%2Fwww.foundationtrustnetwork.org%2Fresource-library%2Fftn-benchmarking-aande-2012%2Fbriefing-benchmarking-a-e-181012-final-.pdf&ei=iy35UcSDD4iN7QbfioGYBw&usg=AFQjCNFspRjT-z3lW3AQwOQFSn6unCYIZA&bvm=bv.49967636,d.ZGU

[10] *The Emergency Medicine Operational Handbook (The Way Ahead),* The College of Emergency Medicine, 2011.

[11] *Emergency Medicine Consultants: Workforce Recommendations,* The College of Emergency Medicine; 2010.
http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Consultant%20Working%20and%20Job%20Planning/Expanding%20the%20Consultant%20Workforce/default.asp

[12] *Emergency Medicine Consultants. Workforce Recommendations*, The College of Emergency Medicine; 2010.
http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Consultant%20Working%20and%20Job%20Planning/Expanding%20the%20Consultant%20Workforce/default.asp

Excellent supervision and training of middle grade and junior doctors by EM consultants is essential to increase the attractiveness of EM as a career option for junior doctors while also ensuring the delivery of safe and effective high quality clinical care in a timely and cost-effective manner.

Work patterns must be sustainable and sufficiently attractive to ensure the recruitment and retention of EM doctors if the recruitment crisis is to be resolved. The College is undertaking work to ensure a sustainable and attractive work/life balance.

Senior EM doctors may also be supported in the delivery of clinical care by other independent or dependent clinical decision makers such as Advanced Care Practitioners or Physicians Assistants.

Recommendation 4
A department should be staffed by senior decision makers 24 hours a day. Consultants should be on the shopfloor for a minimum of 16 hours a day, 7 days a week, and 24 hours a day in major centres.

Recommendation 5
Ensure adequate staffing levels are in place to cope with surges in demand.

Recommendation 6
The fabric of the department needs to be fit for purpose. The design and environment can ensure a more appropriate experience for patients and staff.

Recommendation 7
The department needs to be supported by a suitable IT infrastructure which facilitates patient flow and quality assurance.

Recommendation 8
There needs to be ready access to diagnostics and in patient services.

Measuring and understanding the care delivered

In order to measure the care delivered there is a need to understand how many patients are being cared for, where they are being cared for, what their care entails, and what the outcomes are. This requires the development of effective informatics systems.

Informatics systems

Informatics systems are not only essential from a commissioning perspective, they are also clinically essential. Key features of an IT system are:

- ***Recording clinical activity***: Including presentation, diagnosis, investigations and procedures
- ***Decision support***
- ***Communication:*** *Timely communication* of information with ambulance services, GPs and in-hospital services
- ***Informing development of quality services***
- ***Research and audit***
- ***Disease and injury surveillance***
- ***Remuneration:*** *Ensuring EDs are correctly remunerated for their activity*

As a minimum ED IT systems must be able to produce the relevant datasets for the EM tariffs and mandatory reports, integrate with the main hospital patient database and be compatible with the radiology and laboratory systems. They should also be able to generate meaningful discharge summaries to GPs.

What is needed to develop good information systems?

- ***Common data coding*****:** CEM has developed a **Unified Diagnostic DAtaset (UDDA).** The aim is to enable consistent coding in EDs, in a way that is easy for IT systems providers to implement. UDDA creates a bridge between ICD10, SNOMED, CDS and "real world" descriptions of disease. CEM has also developed a **Minimum Data Set** to promote improved data collection with a focus on activity and quality of care provided in EDs, and on creating a common standard for communication with GPs and other health and social care providers.
- ***Emergency Department Information Systems (EDIS):*** There is a need for the development of "Clinical Information Systems" (CIS) that allow clinical information to be useful and accurate for patient care. Currently 81% of EDs report that their information systems are poorly integrated with hospital information systems.[13]

At a national level there needs to be agreement around the common datasets, along with a mandate to implement them. This will mean that IT providers will include them in their systems.

An additional and simple driver for change is the development of standard discharge summaries aligned to AoRMC headings and meeting CEM standards. The information required to produce such discharge summaries is the same as that required to manage and integrate services, commission them, and develop them at a local level EDs can download the UDDA from the College website and discuss with IT providers how it can be integrated into their IT system.

[13] *The data vacuum in emergency and urgent care*, Hughes et al, British Journal of Healthcare Management. 2011:17(1); 8-15. http://secure.collemergencymed.ac.uk/code/document.asp?ID=5959

Funding the care delivered

To provide high quality care, EDs need to be properly funded. This requires measurement of their activity.[14] At present there are limited case mix systems available to UK Emergency Physicians. They include:

- **Simple demographics**: (e.g.) numbers of new attendances, proportion of patients who are children
- **Measures of acuity**: Triage category, majors/minors splits, ESC groups
- **Measures of activity / resource use**: Healthcare Resource Group (HRG) (see below)
- **Proxy measures of acuity**: Mode of arrival, age of patients, disposition
- **Proxy measures of resource use**: Triage category, diagnostic coding.

The Department of Health (England) implemented "Payment by Results" (PbR) to link healthcare activity in the NHS with remuneration. To do this, activities thought to have similar costs are grouped together using Healthcare Resource Groups (HRGs), and remuneration is calculated in the form of a "tariff" linked to each particular HRG.

Until recently HRGs used for UK EDs have been too broad-based to accurately reflect ED activity. The current HRG 4.0 system, which has 11 groups, offers more detail than previously. Unfortunately, the information upon which reference costs are based is poor, and the reference costs are therefore inaccurate. Tariffs, which should be based on reference costs, are consequently not a true reflection of costs. In particular the tariffs associated with more complex patients underestimate the costs of providing modern, high quality, front-loaded, care in EDs. Such care reduces morbidity and mortality and reduces wastage and admission rates. It benefits both patients and tax-payers

Block contracting, whereby commissioners pay a fixed sum for activity over a period of time, is not an appropriate method to fund emergency care. Block contracts are usually based on historical financial and activity data. In a specialty where demand is rising, and historical funding is inadequate, this will lead to a substantial funding shortfall.

[14] *Funding Emergency Departments: Why the current system is failing our patients and what needs to be done about it*, College Of Emergency Medicine, June 2013

What is needed to ensure emergency care is adequately funded?

- Nationally the PbR system should be developed and strengthened based on improved, standardised data as described above
- Local commissioning arrangements should fairly reflect the cost, and cost effectiveness, of providing high quality emergency care. Funding should reflect current activity levels rather than historical levels
- Integral ED services including observation medicine and ambulatory care need to be adequately recognised within tariffs.[15] Ambulatory emergency care and observation medicine are proven to be cost effective and efficient strategies for certain groups of patients attending the ED. They lead to safer care, optimise gate keeping into the hospital bed base and provide added opportunity for safer discharge from the ED.[16]

Recommendation 9

Local commissioning should reflect costs and cost effectiveness of providing high quality care. Funding should reflect diagnosis and acuity of illness in order to promote best practice. 'Item of service' type payments and 'block contracts' should not be used.

Recommendation 10

Observation medicine and ambulatory care strategies are an integral part of the service provided by many Emergency Departments. It is important that the Same Day Emergency Care (SDEC) tariff is applied to cases managed in ED based Clinical Decision Units / Observation Units and local tariffs developed to enhance ambulatory care activity within the ED itself.

[15] *Ambulatory Emergency Care*, NHS Institute for Innovation and Improvement. http://www.institute.nhs.uk/ambulatory_emergency_care/public_view_of_ambulatory_emergency_care/ambulatory_emergency_care_homepage.html

[16] *The drive for quality - How to achieve safe, sustainable care in our Emergency Departments*, The College of Emergency Medicine; 14 May 2013 http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/default.asp

Achieving success in your Emergency Care System

Attention is now being paid to defining and assuring quality in emergency care to ensure that our patients receive the best possible evidence based care within finite resources. As a commissioner your ECS should ensure safe and quality care.

What are the challenges?

Quality is a multi-faceted concept and there are a number of challenges for the EM.

- ***ED does not sit in isolation***: It is at the hub of an ECS which in turn is responsible for the entire patient journey. A systems approach to quality across the ECS is necessary.
- ***Definition of a medical emergency is often perception-driven:*** Although EM is defined in terms of the emergency management of illness and injury, the definition of a medical emergency is often perception-driven , and EDs are usually expected to provide safe, high-quality healthcare to all those who seek it, regardless of the actual degree of acuity or urgency.
- ***EM has a diverse case mix:*** This may vary in different locations. Some of the work is "rule out" rather than "definitely diagnose" and not followed up within the specialty, meaning that true outcome measures are difficult to define across the breadth of emergency care.
- ***EM is "decision dense"***: It requires analytical and intuitive thinking skills. Creating an environment that enables this to be sustained underpins safety. EDs, unlike most other healthcare settings, cannot control inflow and outflow resulting in crowding which is a substantial threat to patient safety.
- ***Unacceptable delays can result in worse outcomes:*** These increase the likelihood of unnecessary admission and remain a common source of decreased patient satisfaction. Increased adverse events and mortality are related to overcrowding.
- ***ECS must also interface with the planned elements of a healthcare system***: Particularly in the demand for hospital beds and the availability of specialists.

High quality emergency care is often adversely affected by commissioning decisions in areas that are not directly or obviously related to urgent care. Consequently, all commissioning decisions should be subjected to a final test: "What is the impact of this course of action on unscheduled and out-of-hours care?" This is not a new concept. At present, all commissioning decisions are evaluated for their effect on equality and diversity of access to healthcare.

How is quality measured?

The NHS Plan introduced a series of targets for England in 2000, including that patients should spend no longer than 4 hours in the ED from arrival to discharge or transfer to a ward[1]. It has been demonstrated that focused targets can help drive improvement. However over-focus on one time based target can cause perverse actions aimed at solely achieving that target and losing sight of the reason it was created, representing an oversimplification of challenges outlined above.

In England a new set of clinical quality indicators was introduced in 2011 to balance the adverse effects of over-focus on a single time measure and to encourage continuous

improvement. The current regulatory system that only centrally monitors the total time in the ED and no other components has the potential to promote a continuation of the single target culture.

For monitoring to enable the delivery of quality care any indicator needs to be part of a balanced suite of worthwhile measures of patient care across the patient pathway. This must include quantitative and qualitative data and reflect both process and outcome of care.

Commissioners should consider how to render financial penalties and incentives to enable rather than obstruct the delivery of high quality care for patients in the ED.

Conclusion

This report has made ten important recommendations which we hope commissioners, clinicians and policy makers involved in configuring emergency services will consider. The adoption of these recommendations should ensure the delivery of safe and high quality care within the Emergency Department.

Appendix - Tools to support Commissioners

The College recommends that all commissioners, clinicians and managers involved in configuring Emergency Departments read the College's key policy documents 'The Drive for Quality – How to achieve safe, sustainable care in our Emergency Departments,' and '10 priorities for resolving the crisis in Emergency Departments'

These documents can be accessed here:

The drive for quality - How to achieve safe, sustainable care in our Emergency Departments, The College of Emergency Medicine; 14 May 2013
http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/default.asp

10 priorities for resolving the crisis in Emergency Departments (England), The College of Emergency Medicine, 6 November 2013
http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/10%20priorities%20for%20Emergency%20Medicine/

The following resources will also be helpful in understanding the priorities for commissioning an effective and integrated emergency service.

College of Emergency Medicine

The Emergency Medicine Operational Handbook (The Way Ahead), College of Emergency Medicine, 2010
http://secure.collemergencymed.ac.uk/code/document.asp?ID=6235

Mental Health in Emergency Departments - A toolkit for improving care, College of Emergency Medicine, 2013
https://secure.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/Clinical%20Guidelines/Mental%20Health/default.asp

Funding Emergency Departments in England - why the current system is failing our patients and what needs to be done about it, College of Emergency Medicine, July 2013
http://secure.collemergencymed.ac.uk/Shop-Floor/Informatics/Casemix%20-%20how%20your%20ED%20is%20paid/default.asp

Emergency Department Clinical Quality Indicators: A CEM guide to implementation, College of Emergency Medicine, 2011
http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Further%20Resources/Quality%20Indicators/default.asp

Stretched to the limit - A survey of Emergency Medicine consultants in the UK, College of Emergency Medicine, October 2013
http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Consultant%20Working%20and%20Job%20Planning/Stretched%20to%20the%20limit/default.asp

External resources

Emergency Services Review. Good practice in Delivering Emergency Care: A Guide for Local Health Communities. Office of Strategic Health Authorities, 2009. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107339

Framework for Quality and Safety in the Emergency Department 2012. International Federation for Emergency Medicine. http://www.ifem.cc/Resources/PoliciesandGuidelines.aspx

International Standards for Children in Emergency Departments 2012, International Federation for Emergency Medicine. http://www.ifem.cc/Resources/PoliciesandGuidelines.aspx

Breaking the mould without breaking the system – new ideas and resources for commissioners on the journey towards integrated 24/7 urgent care. Primary Care Foundation, 2011. http://www.primarycarefoundation.co.uk/commissioning-urgent-care.html

Quality care of older people with urgent and emergency care needs. The Silver Book, 2012. http://www.bgs.org.uk/index.php?option=com_content&view=category&layout=blog&id=207&Itemid=888

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