

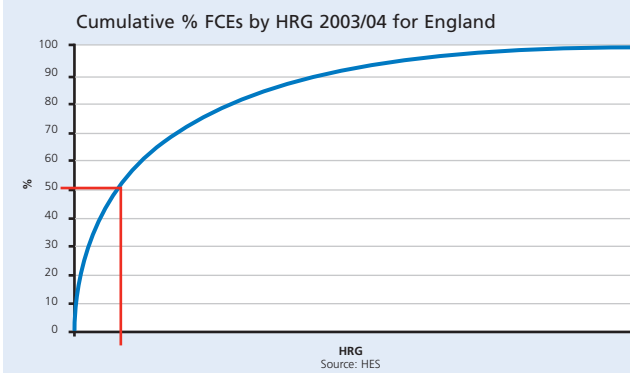
Introduction

Purpose

This initial discussion document aims to help local health communities and organisations improve the quality and value of care for NHS patients. It is designed to build on the Productive Time Delivery Board's Efficiency Map¹ by focusing on Healthcare Resource Groups (HRGs) with the highest potential for improving the quality and value of clinical care.

Healthcare Resource Groups (HRGs)

HRGs are groups of clinically similar activities which consume a similar amount of resources to produce them. They are also the basis for the NHS Payment by Results system. As the graph below shows, a relatively small number of HRGs account for a large proportion of NHS resources.



50 HRGs account for 50% of all bed days. 50 different HRGs (however, there is overlap) account for 50% of all finished consultant episodes (FCEs).

As part of the Productive Time Programme, the Department of Health and the NHS Institute has commenced a programme to identify the characteristics of high performance (quality and value) for selected HRGs; detailed guidance will be published in 2006. Initially, the NHS Institute has produced this review of a selected number of HRGs, or patient care groups, to help local health communities target key areas for improvement. These five areas would usefully help local health communities to address areas for improvement and plan integrated development initiatives in line with the integrated service improvement programme's, single benefits realisation framework.

Drawing on existing evidence, the key characteristics of high performance systems have been summarised on a 'focus on...' card for each of the following:

- Fractured neck of femur
- Primary hip and knee replacement
- Acute stroke
- Caesarean section
- Short stay emergency care

On each card there is a graph to compare local performance against a list of high performing system characteristics. Each has a symbol indicating how these relate to changes which enable improvement. The most successful systems tackle service improvement using all aspects of the enablers listed below:

Enabler	Examples
People 	<ul style="list-style-type: none"> • redesigned and extended roles • multidisciplinary working • skill mix changes • increase prevalence of team working
Process 	<ul style="list-style-type: none"> • optimising patient flow by matching capacity and demand • effective discharge planning • development and implementation of care protocols
Information / technology 	<ul style="list-style-type: none"> • using information to improve care and care management • new diagnostic technologies • improved communication with patients and the public

Guidance on implementing these and other improvements can be found in the Improvement Leaders' Guides².

How to use this document

Compare your performance to the graphs. If your performance could be improved, the benefits would include:

- improved patient outcomes and satisfaction
- improved staff morale
- bed day savings
- release of financial resources for investment elsewhere

Use the 'focus on...' cards as a starting point for your discussions to agree high performance improvement goals. Also to start planning integrated improvement initiatives that will use the more detailed guidance on delivering quality and value for high volume HRGs which are due in 2006.

Feedback

If you would value your contributions to our future work. We would like to be involved, or have any comments, please contact the Delivering Quality & Value team at HRG@institute.nhs.uk or 02476 857055.

Acknowledgments

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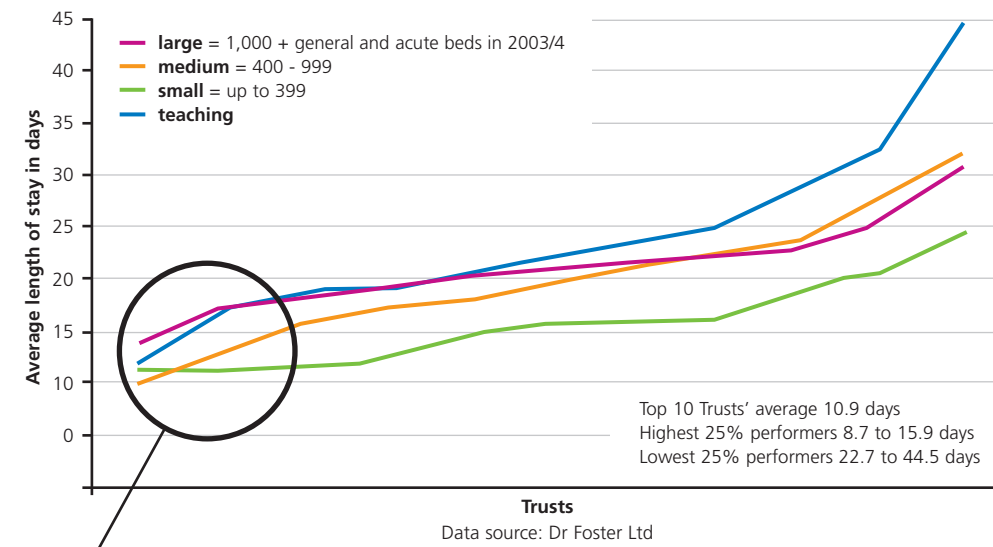
- 1 Productive Time Delivery Board, The Efficiency Map, Department of Health, London, 2005
- 2 NHS Modernisation Agency, Improvement Leaders' Guides, Department of Health, London, 2005

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Delivering quality and value: characteristics of high performing systems

Fractured neck of femur

HRG Code: H87 - Fractured neck of femur
Distribution of Trusts' average length of stay by type
England, 2004/5



The highest performing systems achieve a length of stay of between 10 to 14 days

Focus on:

Accident & Emergency (A&E)

- develop fast track protocols. All patients to be admitted within one hour of diagnosis. 90% should be admitted within two hours of arrival. 100% in four hours
- discharge planning to commence on arrival to the A&E department, including an osteoporosis risk assessment

In-patient stay and discharge planning

- effective multiprofessional team working is crucial and can reduce re-admissions. Orthopaedic surgeons, anaesthetists, physicians, nursing, and therapy staff should be involved in the management of patients
- trauma co-ordinators and trauma assistants, in particular, can reduce delays in admissions and can liaise with families/carers to ensure arrangements are in place for a timely discharge/transfer
- full assessment to be performed within six hours of arrival to the ward. Patients to be operated on by an experienced clinical team within 24 hours of decision of fitness for surgery to optimise clinical outcomes

Optimise theatre capacity by:

- minimising cancellations
- scheduling all day lists to increase cases per day
- having sufficient dedicated trauma lists
- introducing flexible working patterns/arrangements to match the demand of trauma, including weekends and bank holidays

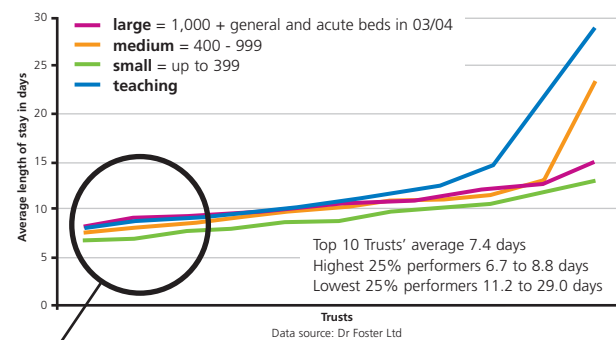
Discharge

- early supported discharge schemes have shown to significantly reduce length of stay

Delivering quality and value: characteristics of high performing systems

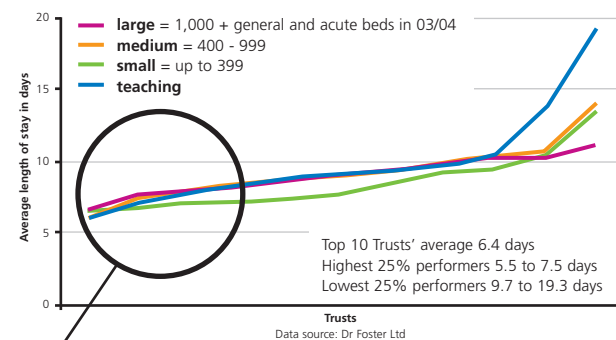
Primary hip and knee replacement

HRG Code: H80 - Hip replacement
Distribution of Trusts' average length of stay by type
 England, 2004/5



The highest performing systems achieve a length of stay of less than 8 days

HRG Code: H04 - Knee replacement
Distribution of Trusts' average length of stay by type
 England, 2004/5

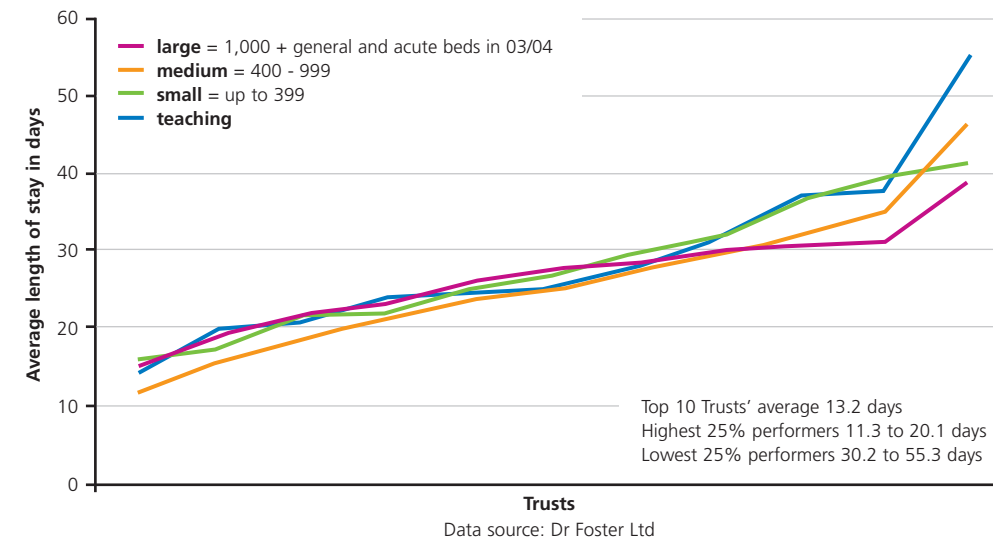


The highest performing systems achieve a length of stay of less than 7 days

Delivering quality and value: characteristics of high performing systems

Acute stroke

HRG Code: A22 - Distribution of Trusts' average length of stay by type
 England, 2004/5



There is a large variation in Length of Stay around the mean of 26 days. Stroke services account for more than 4% of NHS spending¹

Focus on:

Assessment

- assessment at the time of decision to admit to make sure patients are fit for surgery and wish to be listed for surgery
- pre-operative assessment six weeks before surgery to include discharge planning, ensuring that patients' social care and occupational therapy needs are met, as well as reminding patients about expected length of stay - this will prevent delayed discharges
- agree a date for surgery at the time of the assessment to minimise cancellations

In-patient stay

- patients should be admitted on the day of surgery, unless clinically indicated
- mobilisation on the day after surgery, unless clinically indicated

Optimise theatre capacity by:

- making sure the session is right for the casemix
- introducing flexible working patterns
- scheduling all day lists to increase cases per day
- managing trauma and daycases on separate dedicated lists
- having a process for managing vacant lists

Discharge

- criteria led discharge on planned discharge date
- early supported discharge schemes have shown to significantly reduce length of stay

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Focus on:

Time to treatment

- consistently treating stroke as a time-dependent medical emergency. Evidence shows that treatment options are optimised when treatment is initiated within six hours of symptom onset^{2,3}
- educate the public and professionals to recognise the symptoms and act immediately⁴
- improve emergency response times through well developed multiprofessional guidelines and protocols⁴

Specialist stroke units

- ensuring rapid admission to a specialist stroke unit. Evidence shows that patients admitted to a stroke unit are more likely to be alive, independent and living at home one year after their stroke⁵
- 100% of all hospitals that care for people with stroke to have a specialised stroke service, as described in the stroke service model, by April 2005⁶
- stroke services should be organised so that patients are admitted under the care of a specialist team for their acute care and rehabilitation⁷

Discharge

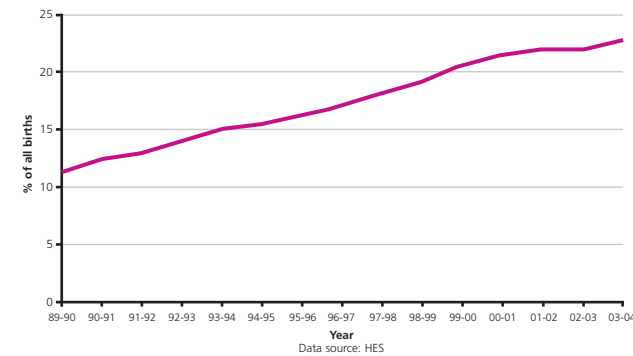
- early discharge services can allow stroke patients to return home early and improve recovery. Evidence shows that early supported discharge can potentially reduce length of stay by up to eight days⁸
- specialist stroke services should be available in the community as part of an integrated system of care to facilitate early supported discharge⁹

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Delivering quality and value: characteristics of high performing systems

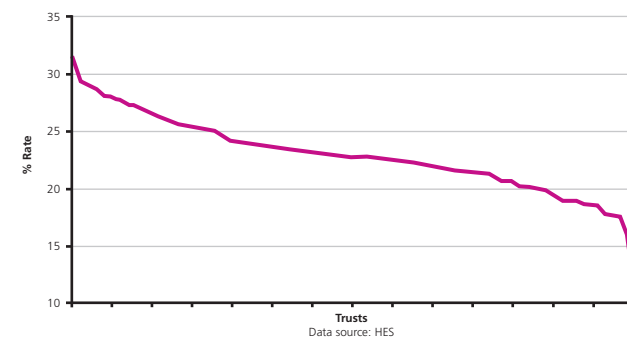
Caesarean section

Caesarean sections as a % of all births (with and without complications)
England 1989-2004



Caesarean sections now account for 22.8% of all births

Caesarean section rate (%) by Trust of all births (with and without complications)
England 2003/4



The caesarean section rate varies from 12.4% to 31.3%

Focus on:

Accessing services

- ensure there are adequate services for disadvantaged, vulnerable, and minority ethnic groups who may present late to maternity services and who tend to have a greater risk of complications^{1,2}
- ❗ for out of hospital labours/births, midwives should have access to the most senior obstetrician on call²
- referrals to, and between, services should be managed through agreed and understood multidisciplinary protocols²

Making the decision

- ❗ birth should be promoted as a normal physiological process. Women who have had a vaginal birth are less likely to have a caesarean section with subsequent births¹. The length of hospital stay is likely to be longer after a caesarean section (an average of three to four days) than after a vaginal birth (average one to two days)⁴
- ❗ when considering a caesarean section, NICE guidelines should be followed⁴
- ❗ consultants should be involved in the decision to undertake a caesarean section as this reduces the likelihood of caesarean section^{3,4}
- ❗ healthcare professionals should provide clear, evidence based, up to date information about the risks and benefits of having a caesarean section, compared with a vaginal birth³
- ❗ one to one supportive care should be available during labour as this has been shown to reduce the caesarean section rate³

Undertaking a caesarean section

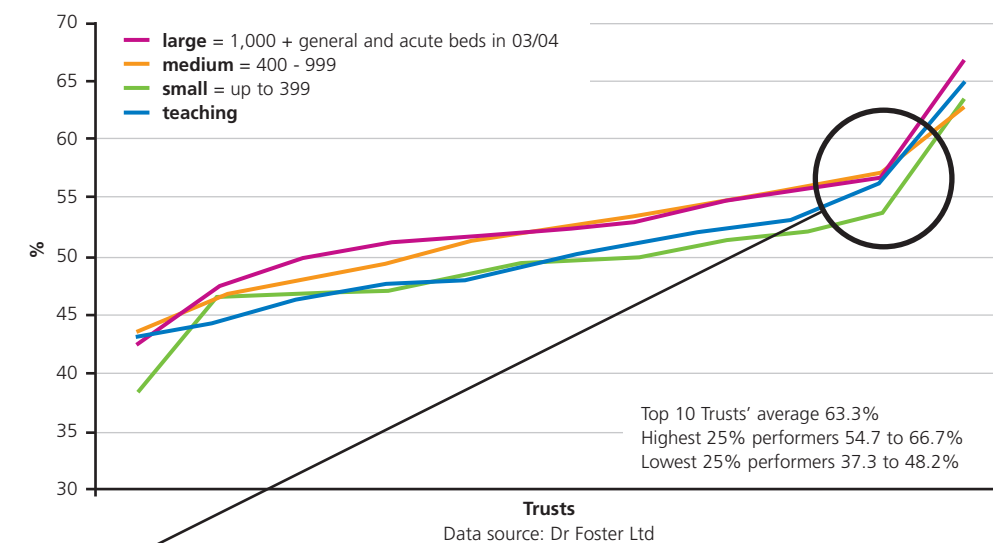
- up-to-date, evidence based guidelines, protocols or care pathways, based on national guidelines, should be followed for the management of caesarean sections. There should be a system in place for auditing, monitoring and reviewing processes and clinical practice
- ❗ workforce skill mix should be reviewed to ensure it is appropriate for the clinical setting. For example consider the use of maternity support workers⁶

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Delivering quality and value: characteristics of high performing systems

Short stay emergency care

Distribution of % of all emergency admissions with length of stay ≤ 2 days for all Trusts by type, England, 2004/5



- High performing services care for in excess of 55% of emergency admissions (excluding direct A&E discharges) with a length of stay of between 0-2 days. However, the effective management of patients within A&E can reduce the number of admissions to assessment units and short stay units.

Focus on:

Integrated objectives and operational policies for the care of emergency patients in A&E, assessment units and short stay units

- the objective should be to assess and make clinical decisions and commence delivery of care for the majority of patients within four hours for A&E and assessment units. Except where there is a likelihood of discharge within 12 hours, and where transfer may reduce efficiency. The philosophy of assessment units should be of an outpatient service with beds attached
- within A&E and assessment units, there should be structured decision options based on a 'decide to admit rather than admit to decide' principle, including:
 - return home with or without outpatient follow up
 - intermediate care or social care
 - admit to short stay unit if estimated length of stay 12-72 hours
 - admit to appropriate specialty unit if estimated length of stay greater than 72 hours
- ❗ short stay units should be specifically for patients with expected length of stay over 12 hours but no more than 72 hours with the objective of delivering highly structured care in a short timeframe. This requires a minimum of twice daily case management reviews of all patients

Operational and quality standards

- clear operational and quality standards with performance timeframes - for example:
 - one hour from arrival to assessment
 - two hours from arrival to formulation of a clinical decision
 - four hours (from time of arrival) to implementation of clinical decision
 - estimated discharge date set on admission or at time of clinical decision
- ❗ senior clinical leadership input to assessment units, matched to demand, 24 hours a day, seven days a week
- patient journey maps, guidelines and algorithms with timeframes linked to acute care standards covering top 40 diagnoses, with explicit discharge criteria
- ❗ diagnostic services available on the day, as defined in patient journey maps, including guidelines and algorithms

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Case manage all patients to an Estimated Discharge Date (EDD) set on admission

- explicit criteria led discharge for all admitted patients
- ⓘ postponement of discharge beyond EDD to be approved only by consultant
- one-stop inpatient rounds facilitating doing 'today's work today'
- no handover of short stay patients between specialities

Services to support early discharge

- agreement with Social Services to continue the Social Care packages for first two days of an admission
- ⓘ simple care package structured as part of a 'call-off' system
- operational standards, including response times, of intermediate care should match those of A&E and assessment care units
- ⓘ increase prevalence of team working

Proactive performance management and quality improvement

- ⓘ continuous monitoring, review and corrective action of clinical assessment performance, including length of stay profile, variation by day of week and time of day
- ⓘ regular reporting of performance at department and Board level
- ⓘ clinical audit of 'tracker diagnoses' against discharge criteria in clinical maps, the patient journey, including guidelines and algorithms

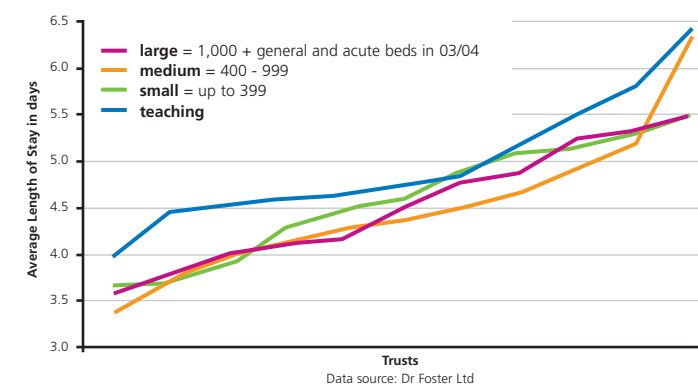
Further information

- Department of Health and Royal College of Nursing, Freedom to practice: dispelling the myths, Department of Health, London; 2003
- Health and Social Care Joint Unit and Change Agent Team, Discharge from hospital pathways, process and practice, Department of Health, London; 2003
http://changeagentteam.org.uk/_library/docs/GoodPracticeGuides/discharge_getri.pdf
- National Electronic Library for Health, Emergency care specialist library
<http://libraries.nelh.nhs.uk/emergency>
- Department of Health Emergency care checklists
<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare/EmergencyCareChecklists/>
- NHS Modernisation Agency, 10 High Impact Changes for Service Improvement and Delivery: a guide for NHS leaders, Department of Health; 2004
<http://www.wise.nhs.uk/cmsWISE/HIC/HIC+Intro.htm>
- Royal College of Physicians, Acute medicine: making it work for patients, A blueprint for organisation and training, Royal College of Physicians, London; 2004
<http://www.rcplondon.ac.uk/pubs/books/AcuteMedicine/index.htm>

'Key is an efficient high quality emergency admission process with early, senior level (consultant) patient centred assessment, focusing on illness severity. This supports, mainly, the first 24-48 hours of care, with fast track investigations facilitating early decisions and appropriate discharge of patients who can be investigated and managed from home. This is achieved in an integrated general medical and A&E setting, minimising duplication.'

Dr Tanzeem Raza. Consultant Physician in Acute Medicine, Royal Bournemouth Hospital

HRG Code: N11 - Caesarean section without complications
Distribution of Trusts' average length of stay, England, 2004/5



There is more than a 2 day variation in length of stay between Trusts

Tariff payments (2005/6) and activity for caesarean section and normal birth⁷

	Without complications	Annual volume ⁸	With complications	Annual volume ⁸
Normal delivery	£758	353,159	£1490	18,465
Caesarean section	£1489	109,502	£2067	19,513

There is a great potential for local health systems to release resources by managing caesarean section rates.

References and further information

- 1 Paranjothy S, Frost C, Thomas J. How much variation in CS rates can be explained by case mix differences? International Journal of Obstetrics & Gynaecology, 2005; 112:658-666
<http://www.blackwell-synergy.com/doi/abs/10.1111/j.1471-0528.2005.00501.x>
- 2 Department for Education and Skills, Department of Health, National Service Framework for children, young people and maternity services – maternity services, Department of Health, 2004
<http://www.rcog.org.uk/resources/public/pdf/PCT%20Guide.pdf>
- 3 Ontario Womens Health Council, Caesarean section best practices project: impact and analysis. November 2002
http://www.womenshealthcouncil.on.ca/userfiles/page_attachments/C%20SectionENG.pdf
- 4 National Collaborating Centre for Womens and Children's Health. Caesarean section. Clinical guideline, London: RCOG press, 2004
<http://www.nice.org.uk/pdf/CG013fullguideline.pdf>
- 5 National Institute for Clinical Excellence, Caesarean section, understanding NICE guidance - information for pregnant women, their partners and the public, April 2004
<http://www.nice.org.uk/pdf/CG013publicinfoenglish.pdf>
- 6 NHS Employers, National Large Scale Workforce Change Team, Maternity Support Worker, Programme Report, August 2005
- 7 Department of Health, National Tariff 2005-2006 Appendix B, 20th October 2004
- 8 Department of Health, Hospital Episode Statistics, 2003/4

'All staff are committed to promoting pregnancy and birth as a normal physiological process. All women are afforded the opportunity to deliver in a low risk unit in their own locality. This approach has resulted in a low caesarean section rate at Royal Shrewsbury.'

Sue Breslin. Divisional Manager, Women's Services, Royal Shrewsbury Hospital NHS Trust

Further information

- 1 World Health Organisation. World Health Report – 2002
<http://www.who.int/whr/2002/en/>
- 2 Lott C, Hennes HJ and Dick W. Stroke - a medical emergency. *Journal of Accident and Emergency Medicine*, 1999; 16(1): 2-7
<http://emj.bmjournals.com/cgi/content/abstract/16/1/2>
- 3 The Stroke Association. Stroke is a medical emergency
http://www.stroke.org.uk/campaigns/latest_campaigns/stroke_is_a.html
- 4 Act Now Expert Panel, Improving patient management and outcomes in acute stroke: a coordinated approach, 2004
- 5 Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke. *The Cochrane Database of Systematic Reviews*, 2005; (3)
<http://www.cochrane.org/reviews/en/ab000197.html>
- 6 Department of Health. National Service Framework for older people
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4002292&chk=Z9zK4j
- 7 Intercollegiate Working Party for Stroke. National clinical guidelines for stroke, London Royal College of Physicians, 2004
<http://www.rcplondon.ac.uk/pubs/books/stroke/>
- 8 Early Supported Discharge Trialists. Services for reducing duration of hospital care for acute stroke patients. *The Cochrane Database of Systematic Reviews*, 2005; (3)
<http://www.cochrane.org/reviews/en/ab000443.html>
- 9 Intercollegiate Working Party for Stroke. National clinical guidelines for stroke, London Royal College of Physicians, 2004
<http://www.rcplondon.ac.uk/pubs/books/stroke/>

'Stroke is a common medical emergency that has been neglected by our health service. The stroke standard in the NSF for older people is driving up standards of care but there is considerably more work to be done to ensure that all stroke patients experience service excellence in line with the research evidence.'

Professor John Young, Department of Elderly Care, St Luke's Hospital, Bradford

Further information

- British Orthopaedic Association and British Association for Surgery of the Knee, Knee Replacement: A guide to good practice (undated)
<http://www.boa.ac.uk/PDF%20files/BASK/TKR%20-%20a%20guide%20to%20good%20practice.pdf>
- British Orthopaedic Association, total hip replacement: A guide to best practice, 1999
<http://www.boa.ac.uk/BOAhome.htm>
- McDonald S, Green SE, Hetrick S. Pre-operative education for hip and knee replacement, *The Cochrane Database of Systematic Reviews*, 2005, Issue 3
www.cochrane.org/reviews/en/ab003526.html
- Sheppard S, Parkes J, McClaran J, Phillips C, Discharge planning from hospital to home. *The Cochrane Database for Systematic Reviews*, 2005, Issue 3
<http://www.cochrane.org/reviews/en/ab000313.html>
- NHS Modernisation Agency: Improving orthopaedic services a guide to clinicians, managers and service commissioners, Dec 2002, Operating Theatre and Pre-Operative Assessment Programme, 2004

The following have provided case studies where some or all of the recommendations listed have been successfully implemented

- Karen Phillips, General Manager, Doncaster and Bassetlaw Foundation Trust, Doncaster, Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire, DN2 5LT
- Ashley Milburn, Orthopaedic Sister, Harrogate Healthcare NHS Trust, District Hospital, Lancaster Park Road, Harrogate, North Yorkshire, HG2 7SX
- Brian Wells, Director, South West London Elective Orthopaedic Centre, Epsom General Hospital, Dorking Road, Epsom, KT18 7EG
- Jo Hayes, Senior Sister, Gloucestershire Hospitals NHS Foundation Trust, Trust Headquarters, 1 College Lawn, Cheltenham, GL53 7AG
- Liz Moore, Service Director of Occupational Therapy, The Pennine Acute Hospitals NHS Trust and Bury PCT, Westhulme Avenue, Oldham, OL1 2PN
- Elizabeth Warner, Patient Planning Manager, Isle of Wight Healthcare NHS Trust, St Mary's Hospital, Parkhurst Road, Newport, Isle Of Wight, PO30 5TG
- Mark Emerton, Consultant Orthopaedic Surgeon and Clinical Director Elective Orthopaedics, Leeds Teaching Hospitals NHS Trust, Chapel Allerton Hospital, Chapel Town Road, Leeds, West Yorkshire
- Jo Seah, Nurse Manager, South Devon Healthcare NHS Trust, Hengrave House, Torbay Hospital, Newton Road, Torquay, Devon, TQ2 7AA
- Jenny Bramhall, Consultant Nurse, Pre-Operative Assessment, Heart of England Foundation Trust, Birmingham Heartlands Hospital, Bordesley Green East, Birmingham, B9 5SS

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- Ian Bayley, Consultant Orthopaedic Surgeon and Clinical Lead on the National Orthopaedic Project
- Sally Howard, Programme Director, Tailored Support Programme, National Orthopaedic Project
- Sheena Parker, Medical Advisor, Department of Health (leading the work on musculoskeletal services)

'I was up the second day after the operation. After that there was no stopping me. I was in hospital for five days.'

Patient quote

Further information

- British Orthopaedic Association Report: The care of fragility fracture patients, Sept 2003
<http://www.boa.ac.uk/PDF%20files/care%20of%20fragility%20fractures.pdf>
- Royal College of Physicians and the British Orthopaedic Association: The care of fragility fracture patients, Jan 1989
http://www.rcplondon.ac.uk/pubs/brochures/pub_print_fnf.htm
- Scottish Intercollegiate Guidelines Network (SIGN), national clinical guideline no.56, Prevention and management of hip fracture in older people, Jan 2002
<http://www.sign.ac.uk/guidelines/fulltext/56/index.html>
- British Association for Accident and Emergency Medicine (BAEM) Clinical Evidence Committee, Jan 2002 and Healthcare Commission recommendation in its review of Accident and Emergency Departments, August 2005
http://www.healthcarecommission.org.uk/InformationForServiceProviders/ReviewsAndInspections/AcutePortfolio/Guidance/fs/en?CONTENT_ID=4000208&chk=T4tCBU and <http://www.baem.org.uk/fnof.xls>
- Department of Health, The NHS Plan: a plan for investment, a plan for reform, p102, July 2000
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002960&chk=07GL5R
- Department of Health, National Service Framework for older people, p57, May 2001
<http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf>
- The New Zealand Guidelines Group report, Acute management and immediate rehabilitation after hip fracture amongst people aged 65 years and over, June 2003
http://www.nzgg.org.nz/index.cfm?fuseaction=fuseaction_10&fuseaction=docs&documentid=22
- Avenhall A, Gillespie WJ, Gillespie LD, O'Connell DL, Vitamin D and vitamin D analogues for preventing fractures associated with involutional and post menopausal osteoporosis, Cochrane Database of Systematic Reviews 2005, Issue 3
<http://www.cochrane.org/reviews/en/ab000227.html>
- NHS Modernisation Agency: Improving orthopaedic services, a guide to clinicians, managers and service commissioners, 2002, Operating Theatre and Pre-Operative Assessment Programme, 2004

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- Jo Seah, Nurse Manager, South Devon Healthcare NHS Trust, Hengrave House, Torbay Hospital, Newton Road, Torquay, Devon, TQ2 7AA
- Beverley Routh, Patient Services Manager and Annette Roscoe, Trauma Co-ordinator, Trauma Unit, Bradford NHS Trust, Bradford Royal Infirmary, Duckworth Lane, Bradford, West Yorkshire, BD9 6RJ
- Sharon Budd, Trauma Co-ordinator, Derby Hospitals NHS Foundation Trust, Royal Infirmary, London Road, Derby, DE1 2QY
- Liz Moore, Service Director of Occupational Therapy, The Pennine Acute Hospitals NHS Trust and Bury PCT, Westhulme Avenue, Oldham, OL1 2PN.
- Jacqui Flynn, Manager of Surgical Services, St Helens & Knowsley Hospitals NHS Trust, Whiston Hospital, Warrington Road, Prescot, Merseyside, L35 5DR
- Alan Reece, Consultant A&E Department and Maureen Tann, Head of Performance Management, South Tyneside Healthcare NHS Trust

Acknowledgments

- Ian Bayley, Consultant Orthopaedic Surgeon and Clinical Lead on the National Orthopaedic Project
- Sally Howard, Programme Director, Tailored Support Programme, National Orthopaedic Project
- Sheena Parker, Medical Advisor, Department of Health (leading the work on musculoskeletal services)

"In December 2004, the North West London Strategic Health Authority set up a fractured neck of femur length of stay taskforce. This was managed through the orthopaedic network, comprising of seven Trusts and eight PCTs. Benchmarking and performance data were shared across the sector, as well as identifying challenges and bottlenecks. The key changes introduced from the resulting action plans involved bringing fractured neck of femur length of stay on to the agenda of existing operational improvement programmes, identifying a clinical co-ordinator to oversee trauma patient pathways and improving multiprofessional working. The average length of stay for the seven trauma units fell by 20% in the six months to June 05, releasing 2,600 bed days."

Ralph Elias
Orthopaedic Network Manager

'Fractured neck of femur patients are vulnerable. They need prompt and appropriate management to optimise their clinical outcome and to minimise their hospital stay. Experience of the Modernisation Agency's work with the Orthopaedic Services Collaborative and Action On programmes shows this can only be achieved by fully engaged, multiprofessional working across the whole of the patient's journey; ensuring the right processes of care are in place and utilising the most up to date techniques and technology.'

Mr Ian Bayley, Consultant Orthopaedic Surgeon and Clinical Lead for the National Orthopaedic Project

**Delivering quality and value****Focus on:****Fractured neck of femur****Primary hip and knee replacement****Acute stroke****Caesarean section****Short stay emergency care**