University Hospitals of Leicester NHS
NHS Trust

Caring at its best

UHL Emergency Care Quality Improvement Charter

One team shared values

June 2014 vo.3

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Background & Purpose

Background

The University Hospital Leicester Trust, UHL, has faced significant challenges over a number years in the delivery of an effective emergency care pathway.

The Leicester, Leicestershire and Rutland, LLR, system as well as UHL has had significant input from the Emergency Care Intensive Support Team, ECIST, and Right Place Right Time Consulting. They have both identified the key processes that need to be improved to deliver an effective emergency care pathway.

However, these recommendations have not been embedded in a consistent manner.

Purpose

The main purpose of this Charter is to articulate how UHL will set out a clear vision and embark on a programme of change, driven by clinical leadership on the shop floor in order to deliver:

1. Reduced Mortality
2. Reduced Harm
3. Reduction in Long Term Care Placements from Hospital
4. Reduced Re-Admissions
5. Reduction in Complaints – Increase in Compliments
6. Reduced Cancellations of Electives

Scope

Emergency Care Pathway

The scope of this is limited to the Emergency Care Pathway within the hospital, from front to back, excluding:

- The elective care pathway
- Emergency outpatient pathway, (except hot clinics, which are included)

There are four principal areas or working groups that will drive the necessary changes on a day to day basis.

The Working Groups terms of reference are detailed in Appendix B, however, the high level roles are captured opposite.

Working Groups

1. **Organisation -** this covers the communication strategy, organisational development, customer service processes
2. **Front Door –** this deals with assessment, initial investigation, decision making, referral and short stay
3. **Base Wards –** will cover base wards and mono-organ Specialties looking specifically at effective case management for non-short stays
4. **Frailty** – this group will look at optimising the inputs and flow for all frail older patients admitted to the emergency pathway

Approach

Membership of Working Groups

The Working Groups will be Consultant led and will be made up of a multi-disciplinary team of clinicians.

The broad remit of the Working Groups is to develop simple, new ways of working in order to address the poor performing areas along the emergency care pathway.

The work of the Working Groups needs to be action focused, whereby:

- New ideas or processes can be deployed/tested quickly
- Feedback on new ideas or processes tested on wards can be received quickly
- Processes can be refined quickly, to achieve further improvement
- Good practice can be easily replicated and rapidly disseminated amongst the wider team
- Tracking of specific KPIs will provide “live feedback” on how well interventions are doing

Initial Actions

A detailed list of specific actions, broken down by working group, are captured in Annex A, however, the specific outcomes for each of the clinical Working Groups is captured below:

Working Group	Measure of Success
Front Door	A 5% to 10% reduction in A&E referrals for admission from the non-GP stream.
	Admitting Specialties to achieve 30% of discharges within 12 hours of referral, with a further 40% discharged with a length of stay of 2 midnights or less.
Base Wards	Reducing the number of beds occupied by patients aged under 75 by 10% to 20%.
Frailty	Reducing the number of beds occupied by patients aged over 75, with a stay of over 14 days, by 25% to 50%

Governance

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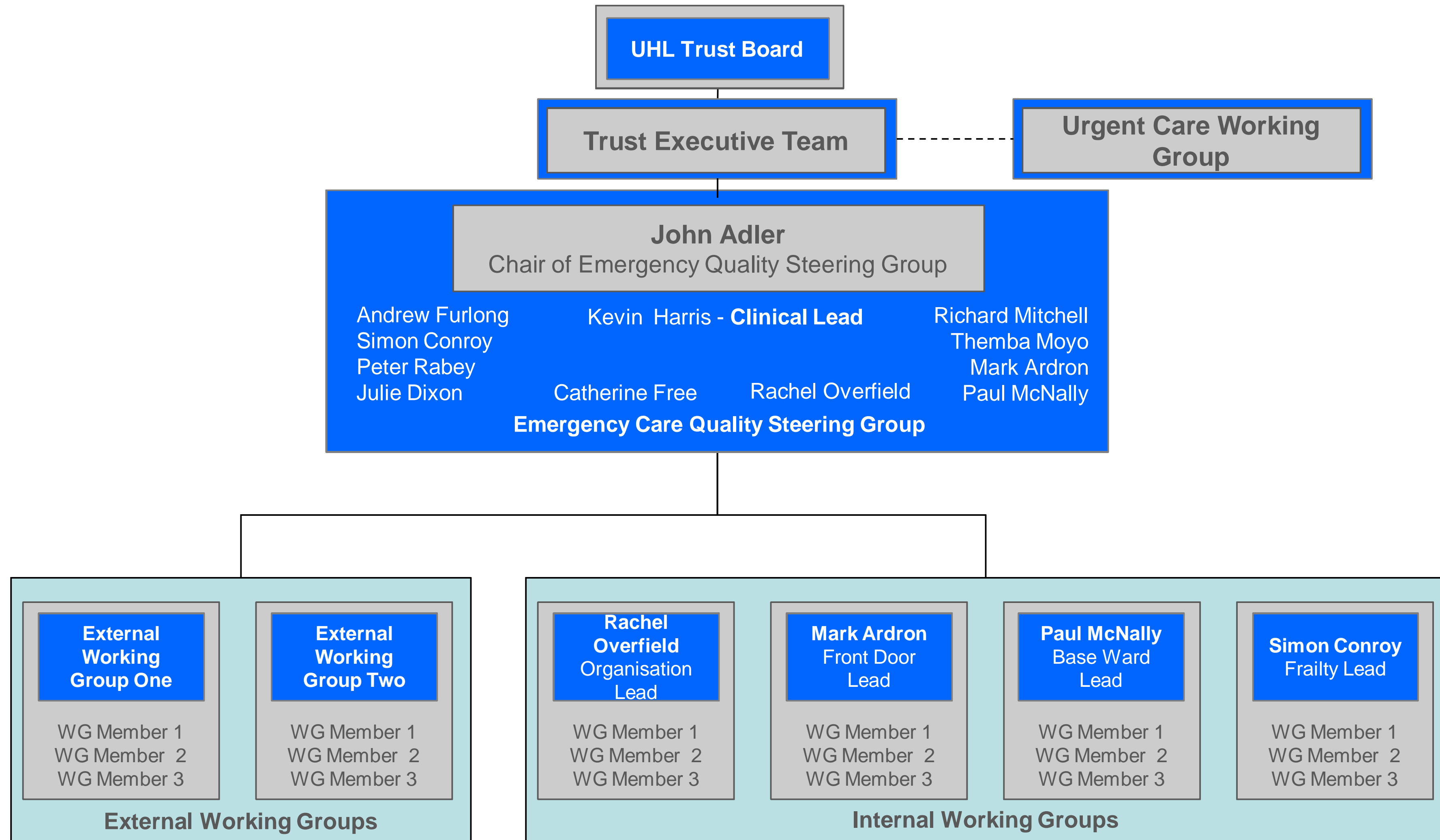

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Roles and Responsibilities

Role	Responsibilities
UHL Trust Board	• The highest internal escalation point within the programme • Provides consent for any expenditure over £1m
Executive Team	• Acts as escalation point for the Emergency Care Steering Group • Acts as link between the Trust and Local Health Economy, (via the Urgent Care Working Group) • Engaging external agencies in improving the quality of the Emergency Care Pathway • Approve any expenditure up to £1m
Urgent Care Working Group	• Membership made up of representatives from National Trust Development Agency, NHS England, East Midlands Ambulance Service, LLR CCGs • No formal role, however will receive regular updates from Executive Team on quality improvements in Emergency Care
Emergency Care Quality Steering Group	• Oversees internal and external activities to improve the quality of the Emergency Care Pathway • Acts as escalation point when issues can't be resolved at Working Group Level • Acts as senior decision making body, giving guidance where appropriate to the Working Groups
Clinical Lead	• Responsible for providing overall clinical leadership, unblocking issues in a timely manner • Acts as arbiter on conflicting priorities across Working Groups
Working Group Leads	• Leads and chairs Working Groups • Provides inspiration to Working Group members in idea generation and issue resolution
Working Group Members	• Act as champions of the Change, sharing and communicating best practice amongst clinical fraternity • Contributing regularly to Working Group Meetings and fostering engagement and input from the shop floor

Meetings

Working Group Meetings

Working Group meetings need to be action based meetings, focusing on the identification of what is working well and what needs changing.

It needs to take place on a weekly basis and to be chaired by the Working Group Lead.

The key items to be discussed are:

1. Performance against KPIs
2. Confirmation of interventions that are working well and how to spread them
3. Ideas for interventions not performing well
4. Key messages or escalations for Steering Group

Steering Board Meetings

The Steering Board has it's own terms of reference, (see Appendix C), and will have oversight of both internal and external activities required to improve the emergency care pathway across the whole of the Local Health Economy.

The Steering Board will meet initially on a fortnightly basis, dropping to once a month once more grip and control is achieved across the whole emergency care pathway and performance indicators are above an agreed baseline and on a consistent upward trajectory.

Reporting and Feedback

Creation of KPI Measures

Each working group will create their own set of KPIs that will be signed off by the Steering Group. These KPIs will relate specifically to the outcome.

The main purpose of the KPIs is for the working groups to measure the efficacy of their actions taken in improving the Emergency Care Pathway.

The monitoring and reporting of the KPIs will occur at all levels from Ward to Board enabling:

1. *Clinicians*
- To receive live feedback on interventions
- To make quick improvements to processes
- To identify what works well, quickly
- Share good practice rapidly

2. *Working Groups*
- To review performance at weekly meetings
- To have clear oversight of what is working well
- To be responsive to what is working well and areas for improvement
- Provide updates on progress to Steering Group

3. *SRO*
- To have oversight of performance across all Working Groups
- Identify unintended consequences on one Working Group caused by actions in another
- Report on overall progress to the Steering Group

4. *Steering Group*
- See improvement right across the emergency pathway
- Provide evidence to the Urgent Care Working Group and other external stakeholders on improvements across the emergency pathway

Appendices

Appendix A – Working Group Actions (1/5)

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	Working Group	Action
1	Steering Group	Agree plan with CCG colleagues to reduce the volume of attendances in ED
2	Steering Group	Agree plan with CCG colleagues to increase the proportion of patients who are treated in the UCC
3	Front Door	Stop specialty 'ping pong' - ED are getting repeatedly bounced between specialties – simple rule – **when ED refers the answer is 'yes'** – if that team assess the patient (in ED if physiologically unstable or in their assessment area if stable) and feel it should be under another specialty, they refer on.
4	Front Door	Stop specialty dumping – here the specialty suggest to GP for the patient to go to ED when they should be direct to specialty – **the only patients who should go to ED from a GP referral are those that are or become unstable.**
5	Front Door	Improve specialty response times to ED – 30 mins to arrive to assess in ED if unstable or probable direct home or 30 mins to leave Department
6	Front Door	Standardise process and performance manage teams to improve floor management in ED.
7	Front Door	Standardise process and performance manage teams in assessment units.

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Appendix A – Working Group Actions (2/5)

	Working Group	Action
8	Front Door	RAT in assessment area – variable. **Set 15 min processing time, senior led** (Consultant or ST5 and above – training opportunity for more junior docs to shadow seniors) with support of Band 5 nurse +/- generic worker with phlebotomy, ECG etc. skills
9	Front Door	Review the opportunity and benefit of Acute Physician and Acute Geriatrician at front door during key demand period 1000 hrs. until 2000 hrs. seeing the query admit and query discharge patients
10	Front Door	Seven day analysis of the breach standards to understand causes of breaches.
11	Front Door	100% minor case compliance in ED
12	Front Door	Prompt booking of patients - Review potential mechanisms to speed handover between from both EMAS and UCC to release staff
13	Front Door	Improve access to diagnostics in line with national standard 'waits due to delays in pathology or radiology should be rare. There should be 7 day access to diagnostics for A&E, EAU and all wards including admission avoidance schemes. Requests from A&E should be prioritised for immediate response. There should be escalation processes in place if delays are occurring.' **Confirm what the key performance indicators are for access times.**

Appendix A – Working Group Actions (3/5)

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	Working Group	Action
14	Front Door	Time to medical assessment in line with national standard ‘Delays due to first medical assessment should be rare. **Patients should be seen by a clinician within one hour and there should be appropriate escalation where this is not delivered**. This should be monitored daily with the breach analysis.’
15	Front Door	Agree specific process with each speciality to improve medical in-reach into AMU.
16	Front Door	AMU assessment and decision timelines are not being performance managed. Set **‘door to doctor’ of 30 minutes and ‘door to consultant‘ of 4 hours (80% of the time) for ED referrals.** For GP referrals – rapid assessment by Consultant - at least 30-50% of GP referrals can have a zero LOS.
17	Front Door	Deliver an improved consultant triage service. Confirm what the key metrics are for the service. The implementation plan requires: • Appointment of 4 ortho-geriatricians and 3 acute physicians – (these jobs are out to advert) • Revision of existing consultant job plans which will include daily consultant ward round and increased weekend presence in support of emergency flow– formal notification has commenced and job plan review meetings are scheduled for June 2014 • General Surgical triage service – the CMG is developing a plan to pilot but a definitive service will require new substantive appointments and job plan review for existing consultants.

Appendix A – Working Group Actions (4/5)

	Working Group	Action
18	Base Wards and Frailty	Implement one stop ward rounds – this is a ward round where EDD and CCD are re-enforced to everyone, where actions required are carried out immediately eg requests, discharge summary, TTOs etc..
19	Base Wards and Frailty	Implement 'assertive board rounding' and follow up with observation and feedback and a peer to peer process.
20	Base Wards and Frailty	Ward referrals to other specialties for advice – variable response times – **standardise to <4 hours if non-urgent and <1 hour if urgent and at an appropriately senior level** – default is Consultant.
21	Front Door	Construct of the Consultant clinical decision – EDD and CCD not consistently being done – i.e. an end to end case management plan which is then assertively delivered.
22	Base Wards and Frailty	Improve bed availability in line with national standard
23	Base Wards and Frailty	Senior medical review in line with national standard 'Senior medical review is critical to ensure the day's discharges are made; a particular day's discharges will need to be preceded by a senior medical review early the following morning. Unless this happens, there will be insufficient beds made available during the morning to meet that day's demands. Daily senior review rounds and during periods of peak demand twice daily senior review ward rounds should take place.'

Appendix A – Working Group Actions (5/5)

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	Working Group	Action
24	Base Wards and Frailty	Agree process for morning discharge rate in line with national standard
25	Base Wards and Frailty	Improve use of discharge lounge in line with national standard
26	Organisation	Standardise site meetings
27	Steering Group & Organisation	Agree with CCGs and LPT a plan to reduce DTOCs down to 3.5% as a minimum
28	Steering Group & Organisation	Begin process of creating a 'social movement' to back the change – similar to 'NHS Change day'
29	Steering Group & Organisation	Review key performance indicators to monitor performance across LL health economy
30	Organisation	Begin process of creating a 'social movement' to back the change – similar to 'NHS Change day'
31	Organisation	Review key performance indicators to monitor performance across LLR health economy
32	Organisation	Review ED Medical staffing to ensure that resources (processing power) are best matched to demand
33	Front Door	Review working protocols with the UCC to ensure the most efficient possible patient pathway and monitor compliance with KPIs

Appendix B – Working Groups ToRs (1/5)

Organisation ToRs

The key a activities for this workstream are:

- Development of communication strategy
- Development of high-level metrics
- Organisational development
- Development of internal and external customer processes
- Act as arbiter across working groups
- Escalate inter-Working Group issues not resolved to Steering Group

Front Door ToRs

The key a activities for this workstream are:

- Optimisation of the following front of house processes that take place in A&E, Medical/Surgical Assessment and any other acute/emergency assessment areas, short stay including EDU:

Front Door ToRs Continued:

- Assessment
- Initial Investigation
- Decision Making
- Referral
- Short Stay

The product of this working group will be an “assess once, investigate once and decide once” model.

Key outcome measures:

- 5% to 10% reduction in A&E referrals from non-GP referred stream
- Admitting specialties to achieve 30% of discharges within 12 hours of referral, with a further 40% discharged within 2 midnights or less

Peer to peer measures to include

- 6 week rolling average of discharges with LOS of 0
- Stays < 3 days by consultant balanced by re-admission rate

Key outcome metrics will be deaths and harm events within the first 48hrs and re-admission numbers/rates.

Appendix B – Working Groups ToRs (2/5)

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Base Wards ToRs

This work-stream will be responsible for designing and delivering effective case management delivery for non-short stay admissions, minimising the impact of handover between the assessing team and the base ward team, and ensuring that all internal 'waits' are abolished.

The two key processes to optimise within this group will be the effective delivery of the 'board round' and the 'one stop ward round'.

Key outcome measures:

- A reduction in beds occupied by patients aged under 75 with the aim to reduce this by 10% to 20%

Peer to peer measures to include either:

- Monthly league tables of discharges by ward
- Or 6 week rolling averages against expected discharge rate for that ward

Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

Frailty ToRs

There is an overlap between this group and the assessment and base ward groups but this group will be tasked with optimising inputs and flow for all frail older patients admitted to any specialty in the emergency pathway.

The main purpose of this group will be to reduce the 'deconditioning' impact of hospitalisation by early and assertive management of patients with frailty.

Key outcome measures:

- The number of beds occupied by patients aged 75 and over who have been in hospital 14 calendar days or more, with an aim to reduce this by 25-50%

Peer to peer measures to include either:

- Monthly league tables of discharges by ward
- Or 6 week rolling averages against the expected discharge rate for that ward

Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

Appendix B – Working Groups ToRs (3/5)

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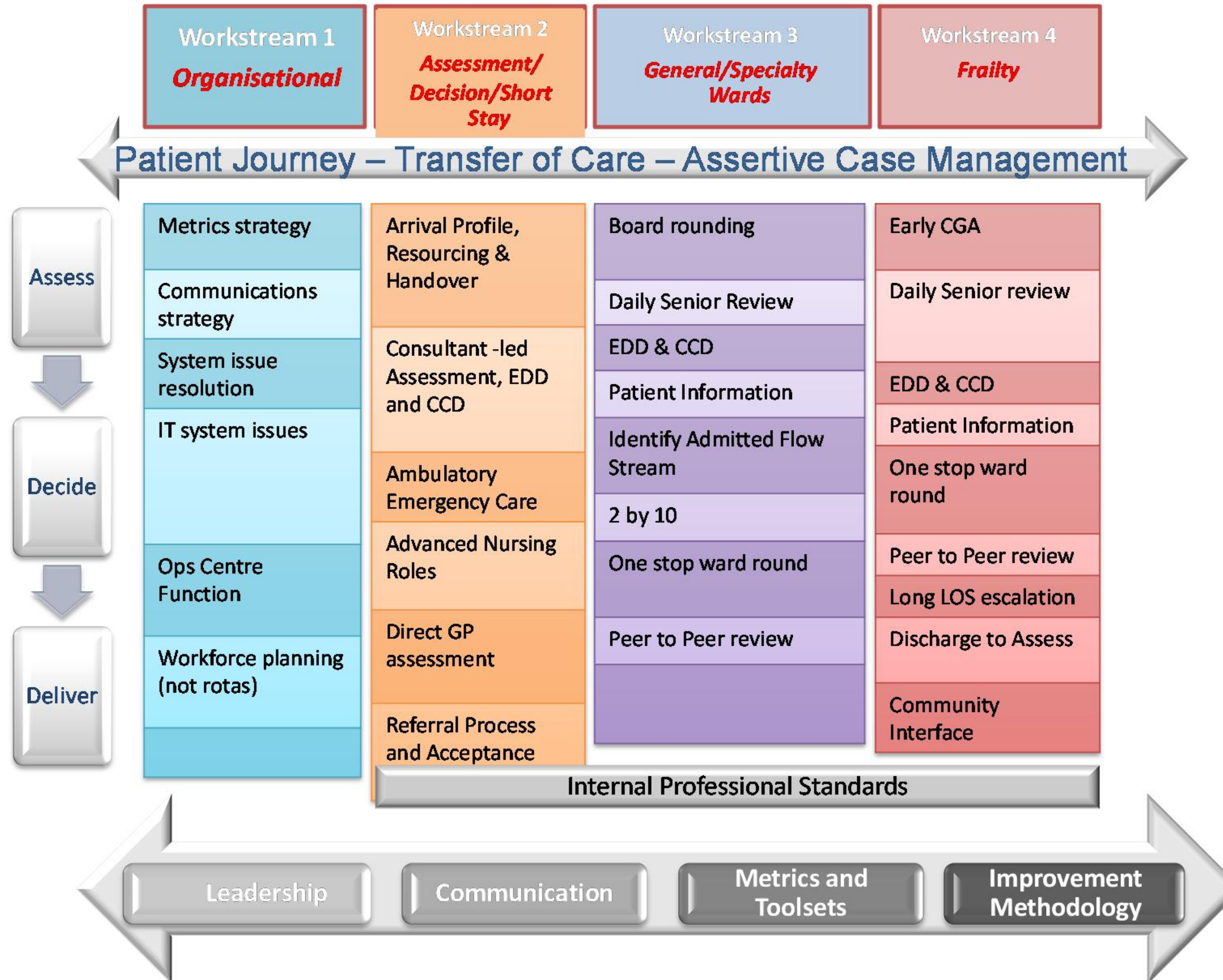

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Appendix B – Working Groups ToRs (4/5)

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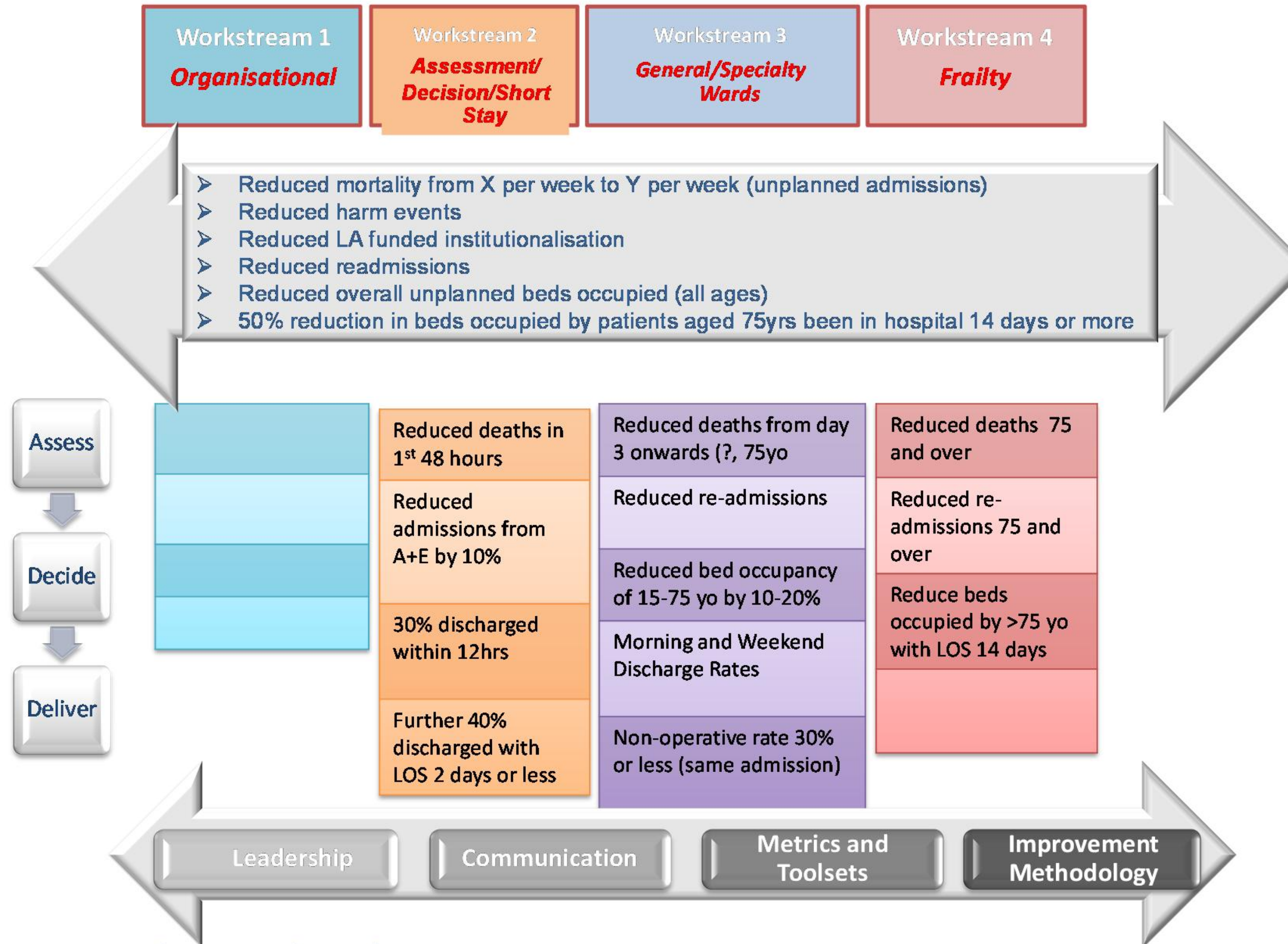

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Appendix B – Working Groups ToRs (5/5)

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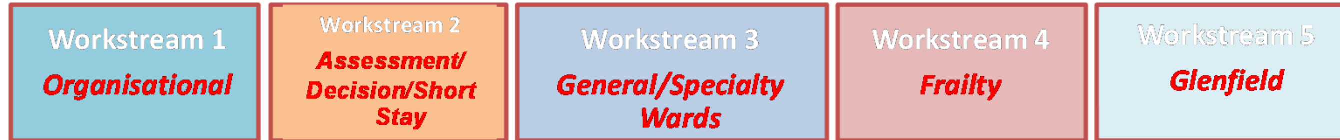
Emergency Care Programme – Working Group Overview



Membership:				
Rachel Overfield	Mark Ardron	Paul McNally	Simon Conroy	John Bennet
Julie Dixon	Ben Teasdale	Consultants x 2 – Med and Surg	Consultants x 2	Consultants x 2
	Lee Walker	Nursing Leads x 3	Nursing Leads x 3	Nursing Lead x 3
	Surgical Lead	AHP Lead	AHP Lead	AHP Lead
	Diagnostic Lead	Junior Doctors x 2	Junior Doctors x 2	Junior Doctors x 2
	Nursing Lead x 3	Managerial Lead	Managerial Lead	
	AHP Lead			
	Junior Doctor x 3			
	Managerial Lead			

Appendix C – Steering Group ToRs (1/3)

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Purpose

To ensure the delivery of the Emergency Care Quality Programme, by monitoring and taking actions to address any potential failures to deliver.

To review performance against the plan, receiving regular updates from each Working Group on progress against delivery.

To ensure all actions are completed within timescales set.

To gain assurance from individual Working Group Leads on the progress of quality improvement across the emergency care pathway.

To provide assurance to the Executive Team on the delivery of the Emergency Care Quality programme. To escalate as necessary to the executive team any issues for decision / discussion / assurance / endorsement.

To provide a forum of support for Working Group Leads in delivering enhanced quality performance across the emergency care pathway, enabling escalation of concerns, joint resolution of problems.

Appendix C – Steering Group ToRs (2/3)

Scope

The Emergency Care Steering Group will have oversight of all the Trust led Working Groups tasked to deliver quality improvements across the whole emergency care pathway, both within the Trust and with key partners outside of the Trust such as East Midlands Ambulance Service, Leicester, Leicestershire and Rutland CCGs, NHS England.

The Emergency Care Steering Group will meet on a fortnightly basis initially and will drop to monthly once performance levels have reached a pre-agreed level across the emergency care pathway.

Membership

The following are the substantive members:

Post / Remit	Post Holder(s)
Chief Executive Officer, CEO (Chair)	John Adler (chair)
Senior Responsible Officer, (SRO)	Kevin Harris
Deputy Medical Director	Andrew Furlong
Deputy Medical Director	Peter Rabey
Clinical Director, Emergency Medicine	Catherine Free
Director of Nursing	Rachel Overfield

Post / Remit	Post Holder(s)
Chief Operating Officer, (COO)	Richard Mitchell
Chief Technical Advisor	Ian Sturgess
Organisation Working Group Lead	Julie Dixon
Front Door Lead	Mark Ardron
Base Ward Lead	Paul McNally
Frailty Lead	Simon Conroy
Glenfield Lead	TBC
Project Manager	Themba Moyo

Appendix C – Steering Group ToRs (3/3)

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Constitutional Arrangements

1.A quorum shall be four members, one of these members must be the Chair or SRO and one must be either the COO or Deputy Medical Director.

2.The Emergency Care Quality Steering Group will meet fortnightly and run for two hours.

3.Minutes of this meeting will be provided to the Working Groups and Executive Team.

4.The Emergency Care Quality Steering Group is responsible and accountable to the Executive Team. The Chair will report on a fortnightly basis to the Executive Team and provide updates on progress.

5.Actions arising from the Emergency Care Steering Group will be captured and circulated to the membership, Working Groups and Executive Team post-meeting. Actions will further be captured in the Emergency Care Quality Action, Risk & Issue, (ARI), log, to be updated and circulated to all members post-meeting.

6. Attendance at the meeting is a mandatory requirement; where attendance is not possible due to annual leave, members must ensure a nominated deputy attends. The deputy should be fully conversant with all the key issues in their area.
7. All apologies are to be given to the Chair five days prior to the meeting along with the name of the nominated deputy.
8. Any associated papers must be forwarded electronically to the Chair three working days prior to the meeting, to enable review / consideration.
9. Co-option of key stakeholders will occur at the discretion of the Chair. Any individuals attending for ad-hoc agenda items are to be confirmed / agreed by the Chair prior to the meeting. The Chair will invite individuals to update the meeting as necessary.
10. In the interests of time management, meeting members must ensure timely attendance due to the information required to be reviewed at each meeting.

Appendix D – Project Management (1/4)

DRAFT FOR DISCUSSION

Defining and Capturing Risks

A risk in project terms is defined as "an uncertain event or set of events that, should it/they occur, will have an effect on the achievement of objectives". A risk is measured by a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impact on objectives.

Project risks will be logged centrally in the Actions, Risk and Issues, (ARI), Log and capture the following:

1. A description of the risk
2. It's potential impact
3. Mitigating actions, (to reduce the chances of the risk occurring or to reduce the impact if it does occur)
4. The probability of the risk occurring
5. The potential impact of the risk occurring on the project
6. The overall risk score
7. A risk owner, (who is part of the project organisation), to lead on the mitigating actions

The risk owner is to provide an initial description and resolution plan for the risk to the Project Manager who is the "custodian" of the ARI log.

Appendix D - Project Management (2/4)

DRAFT FOR DISCUSSION

Probability Scoring Matrix

Probability		
What is the Likelihood that the Risk will Occur		
Level	Approach and Processes	
1	Not Likely	0 - 20% Probability of Occurrence
2	Low Likelihood	20 - 40% Probability of Occurrence
3	Likely	40 - 60% Probability of Occurrence
4	High Likely	60-80% Probability of Occurrence
5	Near Certainty	80 - 100% Probability of Occurrence

In order to arrive at an overall risk score, the probability of the risk occurring and the impact are multiplied, resulting in a risk score. The table below provides the combination of scores and corresponding RAG status that can occur using the matrices opposite.

Impact Scoring Matrix

Potential Impact			
Given the Risk is Realized, what would be the magnitude of the impact?			
Level	Technical	Schedule	Cost
1	Minimal OR No Impact	Minimal OR No Impact	Minimal or No Impact
2	Minor OR < 2%	Slight delay < 1 month	Budget Increase of (< £1M)
3	Moderate performance	Minor Schedule Slip	Budget Increase of (£1 - 2M)
4	High Performance	Major Schedule Slip	Budget Increase of (£2 - 5M)
5	Unacceptable; Over 10%	Unacceptable Schedule	Budget Increase of (> £5M)

Risk Score Matrix

Probability					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	*2*	*3*	*4*	*5*

Potential Impact

Appendix D - Project Management (3/4)

DRAFT FOR DISCUSSION

Defining and Capturing Issues

An issue in project terms is defined as "a relevant event that has happened, was not planned, and requires management action".

Project issues will be logged centrally in the ARI log and will capture the following:

1. A description of the issue
2. It's impact
3. A resolution plan
4. When the issue should be resolved by
5. The issue owner, (who is part of the project organisation), to lead on the mitigating actions
6. Status, (i.e. whether it is open or not)

As with risks, the issue owner is to provide an initial description and resolution plan for the issue to the Project Manager who is the "custodian" of the ARI log.

Appendix D - Project Management (4/4)

Purpose of the Action Log

The purpose of the action log is to capture important things that need to be done in a timely fashion but aren't large enough to warrant integrating into the project plan.

The action log should capture:

1. The action description
2. The owner
3. A deadline for completion of action
4. Any comments
5. Status, (i.e. whether the action is open or closed
6. Date of closure

Review of Action, Risk and Issue Logs

The action, risk and issue logs will be reviewed on a regular basis by the project manager.

As a minimum, the action and issue log should be reviewed and updated at every team meeting.

As a minimum the risk log will be reviewed in depth on a fortnightly basis ahead of each Steering Group meeting in order to ensure the risks are being proactively managed.

As with risks, the action owner is to provide an initial description of the action and progress update on the action to the Project Manager who is the "custodian" of the ARI log.