Introduction

A series of ‘urgent and emergency care improvement ǔides ’ have been designed for providers and systems to consider embedding as good practice to reduce ambulance handover delays.

The contents have been drawn from the Winter Improvement Collaborative which was set up to identify solutions to the problems facing the system over the winter period. Members of the collaborative were asked to co-design a series of plans and potential improvement measures, to be adapted and trialled at local level.

Throughout the process there were opportunities to understand what is working and what is proving challenging, and to iterate the approach to ensure it has maximum benefit.

The learnings from the programme cover a range of areas including the flow of patients within hospitals from emergency services to wards, streaming patients into the most appropriate services, and standardising operational processes to be as efficient as possible.

The example trust used in this document has been anonymised.

Each trust is different and will need its own bespoke approach; examples are provided to inform local decision-making and action.

Key principles of specialty support to UEC flow

Learning from some of the most successful organisations in the country in ambulance handover delays shows that **specialty engagement and support** is key to the success of UEC flow and getting patients to the right service in a timely way. This process is clearly articulated in the CQC People First Guidance and Patient First Document. The way staff work together can make or break the flows required to achieve safe, effective and timely emergency care.

There are **three key areas** in which these organisations attributed specialty support, which this UEC improvement guide aims to assist you with. It is important to recognise that any **process** change will not work without strong **leadership** effecting a positive **culture**;

1. **Process** : Internal Professional Standards (agreed principles and times around specialty engagement – "the way we do things here")

2. **Culture** : Specialty accessibility (staff are empowered by specialties to stream / direct / refer patients easily to them)

3. **Leadership** : One 'community' (clinical leadership empowers all services to support each other operationally and strategically for the greater benefit of all patients)

Further information on the top findings

Video of the presentation https://www.youtube.com/watch?v=Dn-y-BsGbBI&t=1s

Slides referred to on video https://future.nhs.uk/AHIN/view?objectId=154840101

Specialty support to UEC flow

Overall description of the creation of internal professional standards (IPS):

- Every clinical service and specialty should have agreed internal professional standards that fit with each other
- Internal professional standards are a clear, unambiguous description of the **values** and **behaviours** expected within the organisation. They are most powerful when centred on patient care, are written collaboratively with clinicians and are openly championed by the Executive team.
- Clinical directors and heads of nursing / allied health professional (AHP) leads should be brought together from across the trust to help create a local set of standards that translate into professional standards which they, themselves, are empowered to be the champions and advocates for. As part of the internal professional standards, each service should define steps of escalation when the standards are not being met. The standards should be discussed and promoted throughout the organisation and especially when new staff start / locums attend to define simply 'this is how we work here – every day, all day'
- Leaders (especially consultants and senior nurses / AHPs) should role model the standards in their routine and daily interactions with their teams so that the standards form part of their core behaviours and values. Role modelling and reinforcement will make standards stick and cause positive cultural ripple effects.
- Organisations should develop internal professional standards in line with their governance procedures so clear steps are articulated to show how in-day challenges in meeting them are escalated, and also to show how they are regularly reviewed on a more formal basis. Organisations should be regularly auditing the efficacy of internal professional standards.

Benefits

- Safer, more effective, timely urgent and emergency care
- Reduced delays in the UEC pathway
- Cultural understanding of the 'way we work here'
- Simple escalation when agreed standards are not being met
- Empowered clinical leadership
- Increased clinical and operational collaboration
- Clinical excellence in an improving organisational culture
- Improved opportunity to challenge behavioural norms
- Improved visibility of performance and of the things that effect it

Lessons learned from those who have implemented internal professional standards:

- Staff engagement and meaningful listening is key in relation to enabling all staff to understand total risk along the UEC pathway.
- Internal professional standards must be clinically and operationally engineered through mutual collaboration and review
- The key to success is not in the writing of internal professional standards but in the consideration of escalation, clinical advocacy and in the audit, review & organisational learning when they are not met
- Medical Director oversight with the support of the clinical directors / COO / DoN is key to maintaining conversations to support real improvements
- Enabling all staffs understanding of the risk to patients is key in accomplishing change

Enablers*
Project management team resource inclusive of data analytical support and clinical leads
Triumvirate executive SROs and Board oversight
Significant staff engagement exercises
Parallel working of the whole MDT
Strict adherence to scientific improvement methodology (PDSA)

Barriers*	Cause	How the barrier was addressed
Staff concerns, understanding and support	Staff not given opportunity to see 'bigger picture', the reasons for internal professional standards or staff not being educated / empowered	Significant staff engagement and presentation of risks across whole UEC pathway. Clinical Director oversight and the empowerment of Consultants and HoNs in role modelling is paramount.
Lack of adherence / entrenched behaviours	Poor communication, poor escalation, little action once escalated	Simple and well defined escalation chain for each service which results in 'champions' role modelling internal professional standards. Each service and the trust must audit compliance, react to need and effectively communicate 'you said, we did' narratives to staff

Supporting documents used other Trusts:

- Trust contingency strategy
- Board assurance framework (BAF)
- Patient flow SOP
- UEC Improvement action plan
- Project plan and/or organogram
- UEC risk presentation
- Risk log / register
- Project quality metric checklist
- UEC data dashboard

*this list is not exhaustive: Further enablers and barriers can be provided. For more support please contactengland.improvementdelivery@nhs.net

Specialty support to UEC flow (2)

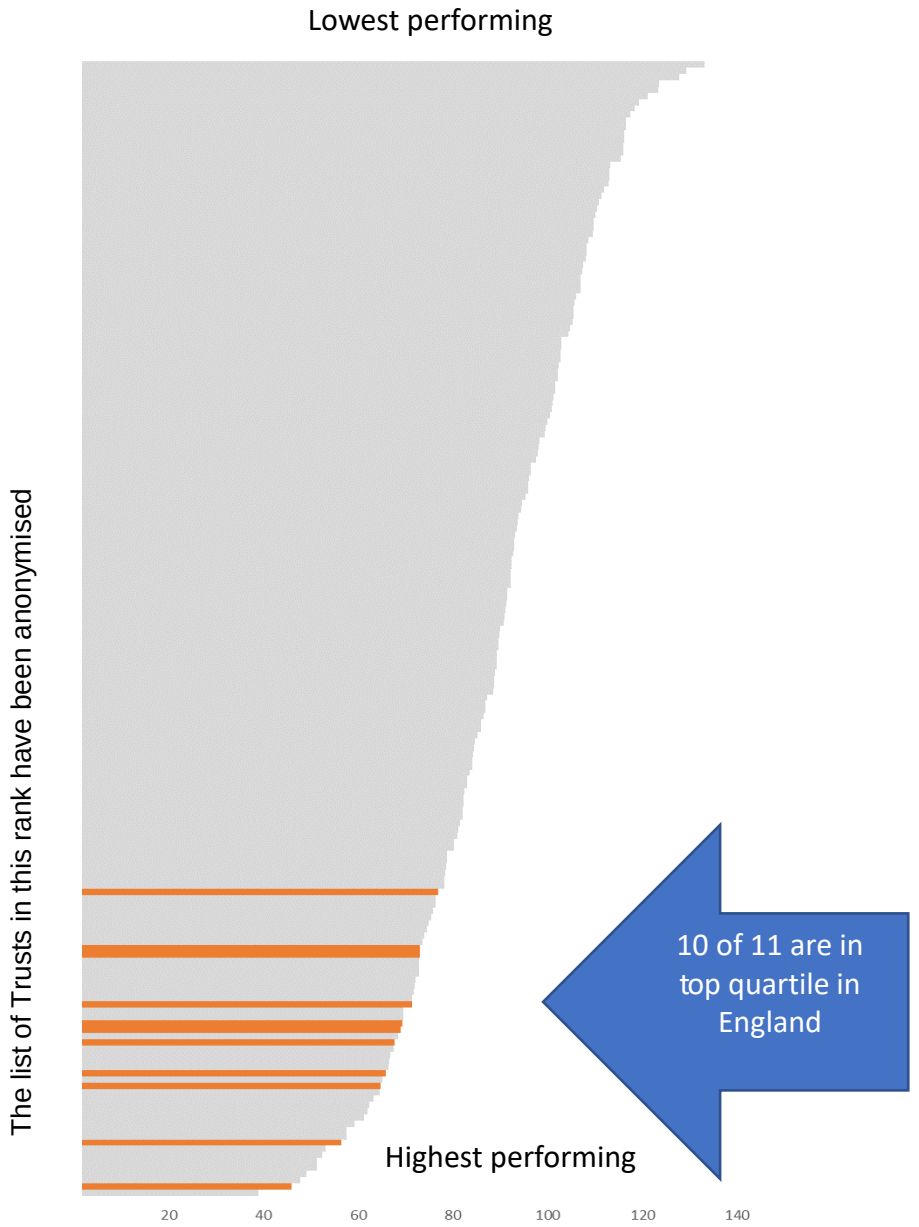
Of the top performing organisations for ambulance handover delays, 11 had strong clinically supported embedded internal professional standards cultures. These organisations when compared to the rest of the country on a combination of key UEC measures performed in the top quartile on the following combined UEC metrics :

1. Emergency admissions
2. 4 hour performance
3. 12 hours in ED performance
4. Conversion rate from ED
5. Total time to treatment
6. Over 60 minute HHO delays
7. Medical 0 day %
8. Medical <2 day LoS
9. Surgical 0 day %
10. Bed occupancy

Consistency in the internal professional standards between these 11 organisations include:

- Leaders state that their internal professional standards models are key to their organisational and care provision success
- Clinically and operationally designed
- Clinically role modelled
- Executive empowered
- Clear escalation that works
- Strong staff engagement
- Strong ongoing communication
- Board level reporting and monitoring

Ranked aggregate trust performance on key UEC metrics (source SAPIT)



Internal professional standards efficacy cannot be easily tracked through just one or two performance metrics. There are many contributing factors which help or hinder performance. However, we can easily see that there appears to be a direct correlation in successful UEC performance from those organisations who have well defined, clinically led internal professional standards that are used to frame their collaborative culture.
These trusts all have the following in common:

- Defined internal professional standards which were created collaboratively with clinicians
- A consistent culture of ‘we’, ‘us’ and ‘trust’
- ED streamers, ambulance staff, HCPs empowered to contact specialities through open access criteria to refer patients to areas other than ED
- Monitor and empower internal professional standards compliance
- Have clinical leaders who are visible and role model values (such as internal professional standards) in practice

Specialty support to UEC flow (3)

Roles and responsibilities that enabled intervention delivery:

Role	Responsibility
COO	SRO maintain triumvirate oversight – Operational. Manage PMO team. Project lead for comms, performance and data. Daily point of contact for project team. Daily end of day huddle attendance. Empowered reactive decision making to ensure traction. Liaison with Trust Board and CEO. Lead on disseminating actions following audit / huddle findings where internal professional standards has not been met against daily operational challenge
Medical Director	SRO maintain triumvirate oversight – Clinical and risk. Project lead for signing off each clinical service's internal professional standards and escalation framework. This includes ensuring consistency, equity and parity. Further, the MD should lead a clinical director oversight group which is responsible for dissemination, role modelling and clinical championing.
Chief Nurse / AHP Lead	SRO maintain triumvirate oversight – Quality and risk. Critical friend lead for reviewing each service's internal professional standards and escalation framework. Daily end of huddle attendance. Responsible for ensuring that occasions of non-compliance are audited and raised. Further the ND should lead a heads of nursing oversight group which is responsible for dissemination, audit, role modelling and clinical championing.
Roles critical in implementation	PMO (DCOO lead with ops nurse (clinical area liaison and staff engagement) and service manager (GANTT chart oversight / performance oversight / reporting) full time to role out), Comms (staff engagement), Data Analysis (performance), divisional triumvirate (engagement and SOP design), patient representatives (PALS).

Critical implementation path:

	Critical action	Timeframe	Lead
Process	Exec role allocation and review of current internal professional standards / SOP / FCP / Streaming / Direct Access documentation Create definition of project outcome	Week 1	COO/MD/DON
	Full service internal professional standards review performed collaboratively with divisional triumvirates.	Week 1 – 3	PMO Lead / SROs
Policy	Collaboratively design an internal professional standards for each service and metrics to be monitored / methods of audit	Week 2-4	PMO Lead / SROs
	Significant staff engagement exercises	Week 2-4	PMO Lead / SROs
Comms	Coordination of engagement events and range of mixed media staff comms encouraging collaboration and feedback. Strong focus on culture – 'this is the way we want to work here'	Week 2-ongoing	PMO Lead / SROs / Comms
	Daily meetings and weekly PMO / SRO project meetings.	Implementation – ongoing	PMO Lead / SROs / Comms
Data/ BI	Metric check list to include qualitative and quantitative measures chosen collaboratively.	Week 2-4	PMO Lead / SROs / Divisional Reps
	Daily and weekly metric monitoring and reporting	Implementation – ongoing	PMO Lead / SROs / Divisional Reps

Metrics (top 6):

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Ambulance	Ambulance handovers >15/30/60m
In ED	Mean time in ED by chief complaint / age (consider the CQC People First guidance : whether these patients should even be in ED or a spec area)
	12h waits from arrival to ED
In Hospital	No. of patients directed to assessment areas / SDEC / hot clinics
	No. of patients directed to ED for ED / Specialty review (inappropriate)
	No. of patients redirected to community services of attendance avoided

* this list is not exhaustive You may wish to consider adherence to internal professional standards Please contact england.improvementdelivery@nhs.net for more support

Supporting roles and responsibilities: national, regional and system

The following table represents a list of 'responsibilities' that were shared by members of the collaborative on subjects that were barriers/ enablers to implementing this intervention. These have been allocated against suggested roles that could provide support on these items. The collaborative has worked with subject matter experts in the national UEC team who have developed suggested actions that regulatory /national / regional / system / local teams may wish to consider in supporting solutions to those asks and, ultimately, would be at their discretion

Role	Responsibility	What action could be taken?
National	Share good practice on the provision of speciality clinical advice services	National UEC team to work with Winter Collaborative on the guidance, advice and case studies around speciality clinical advice
	Mandate around specialty in reach standards	National UEC team to work with ECIST and the Collaborative of internal professional standards good practice document
Regional	Ensure that all organisations have the staffing compliment to ensure speciality assessments can occur in a timely way	Regional UEC team to work collaboratively with ICSs/trusts to produce a gap analysis of workforce deficit. This should then inform the creation of a regional workforce strategy.
System	Opportunity for systems to standardise internal professional standards and employ good practice peer reviews	System medical director to work collaboratively with other clinicians to establish a system internal professional standards, methodology for auditing compliance, and a peer review/critical friend process.
Local	Ensure that there is engagement from both execs and clinicians to ensure compliance with internal professional standards	Trust medical director to work collaboratively with divisional clinical leads to establish an agreed internal professional standards, methodology for auditing compliance and a peer review/critical friend process.

Metrics

The level of data availability, completeness, quality and ability to extract these items varies significantly from organisation to organisation and therefore the final decision about the most useful indicators of success sits at a Trust level

Top 6 : Flow Area	Possible metric		Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Ambulance handovers >15/30/60m		Collected on UEC Daily SitRep for 30/60, 15m is collected in Daily Ambulance Collection – trusts may require ambulance service to share	Trust, system, region	Outcome
In ED	Mean time in ED by chief complaint / age		ECDS	Trust	Balancing
	12h waits from arrival to ED		Collected on UEC Daily SitRep	Trust, region	Balancing
In Hospital	No. of patients directed to assessment areas/SDEC/hot clinics	Locally collected	Trust	Process	Y
	No. of patients directed to ED for ED/ speciality review	Locally collected	Trust	Process	Y
	No. of patients redirected to community services or attendance avoided	Locally collected	Trust	Process	Y

Flow Area	Possible metric	Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Cat 2 performance	Collected through Ambulance Daily Collection – trusts may require ambulance service to share	Ambulance service	Outcome
	Ambulance arrivals direct to SDEC	Locally collected	Trust	Process
	Total 999 referrals to SDEC of which were directly transferred/referred			
In ED	No. of patients in ED by hour	Locally collected	Trust	Process
	Type 1 patients seen within 60m	Collected on UEC Daily SitRep	Trust	Process
	Type 1 patients seen by senior decision maker within 60m	Locally collected	Trust	Process
	4h A&E performance	Collected on UEC Daily SitRep	Trust, region	Process
	12h waits from decision to admit	Collected on UEC Daily SitRep	Trust, region	Balancing
	Clinically ready to proceed	Should be collected on ECDS – Data quality may be poor	Trust, region	Balancing
	Number of emergency admissions from ED	Collected on UEC Daily SitRep	Trust, region	Balancing
	Number of admissions by hour	Locally collected	Trust	Process
	Reattendance rate	Locally collected	Trust	Balancing
	comprehensive geriatric assessment (CGA) within 30 mins of arrival			
In Hospital	Call answering performance/ abandonment for the contact hub	Locally collected	Trust	Process
	Total 111 referrals to SDEC of which were directly transferred/referred			