Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS

Walsall / ECIP concordat final – approved AEDB March 2018

Richard Beeken
Chief Executive Officer
Walsall Healthcare NHS Trust

16th March 2018

Dear Richard,

Re: Emergency Care Improvement Programme (ECIP) – Agreement

As you will know, the Emergency Care Improvement Programme (ECIP) has been asked to support your system to improve patient flow along emergency pathways based on the principles outlined in the Good practice guide: Focus on improving patient flow[1]. The aim is to help you improve and maintain A&E performance to above 90% throughout 2018/19.

From discussions with local clinicians and managers and our observations during visits, we believe that the local system will make most progress by focussing on the following priorities:

1. Establish an improvement approach to support the UEC improvement programme
2. Test and implement effective emergency department and acute pathway improvements
3. Test and implement improved ward processes including; the SAFER patient flow bundle, Red2Green days approach and a robust model for escalation, response and constraint resolution
4. Co-design, test and implement new ways of working to improve the management of frail older adults across Walsall
5. Improve admission, transfer and discharge processes including; discharge to assess, home first and trusted assessment

What you can expect from ECIP

- A named ECIP improvement manager who will coordinate our work with you and provide on-site support.
- Support from the wider ECIP team that includes senior clinicians, social care advisors, therapists, pharmacists, analysts and ambulance service specialists.
- Help from ECIP to develop plans and metrics to support delivery of your priorities. We will work with your staff to implement improvements using well established improvement techniques.
- Access to our website, all ECIP resources, webinars and events.
- ECIP does not provide interim managers and our model is one of collaborative consultancy. However, we will provide hands on support, not just advice, so you can expect to see us

[1] Link to paper:
https://improvement.nhs.uk/uploads/documents/Patient_Flow_Guidance_2017___13_July_2017.pdf

working with your teams when, for example, they carry out PDSA cycles and prepare action plans.
- We will provide a monthly written progress report.
- We will work with you in an open and accountable way, listening to colleagues and offering constructive challenge

What we need from you

- We need a short meeting with the Trust's CEO weekly to update him/her on progress and discuss obstacles.
- We need the trust's senior team to join a one-off meeting to complete the NHS Sustainability Tool to understand your organisation's improvement capacity and capability.
- Active executive support and participation in driving agreed improvement priorities is essential.
- A nominated senior manager (ideally the COO) to lead the trusts work with ECIP, together with the appointment of work stream leads to lead on delivery of each of the agreed priorities.
- We need you to provide your teams with programme management and improvement support. It is very difficult to deliver complex change as part of the day job without additional help.
- Honest feedback when requested on the quality of our support to you.

What role will the regional office play?

- The Regional Office will support the trust and ECIP as necessary to deliver the agreed priorities and will provide continuing support to the trust to deliver outstanding actions following ECIP's disengagement. ECIP will provide the Region with monthly progress reports.
- The Trust and system will remain accountable to the regional offices of NHS Improvement and NHS England for their performance. ECIP does not have a performance management role.

Agreement

If you are happy to agree the priorities and the mutual responsibilities outlined in this letter, please sign below:

Name _____

Chief Executive [name of trust]

Signed _____

Date _____

Regional confirmation:
Name:
Role:
Date:
State signed or confirmed by email:

We look forward to working with you. If you would like to discuss any aspect of our work or to raise any concerns, my contact details are below.

Best wishes

Russell Emeny

Director of Emergency care Improvement and ECIP
NHS Improvement
Email: r.emeny@nhs.net
Mobile 07984 185349

Copies to:
Dale Bywater, Regional Director
Pete Gordon, ECIP Regional Senior Improvement Manager
Jyothi Nippani, ECIP Regional Clinical Director

Priorities and work streams for emergency care improvement and support for Walsall Healthcare NHS Trust

Success criteria/ overall aim
Through collaborative effort by the local health and social care system to improve patient flow, the trust's emergency department four-hour performance will improve and stabilise at 90% or above (in aggregate) throughout 2018/19.

Five top priorities: The trust / system needs to:	Executive Sponsor & Named work stream lead	Deliverables – what five key actions will be taken to achieve the priority?	By when	ECIP will support delivery by:	Outcomes – what do we want to achieve?	Suggested improvement metrics
1. Establish an improvement approach to support the UEC improvement programmes	**Executive sponsor:** Phi Thomas-Hands, Chief Operating Officer / Daren Fradgley, Director of Strategy and Improvement **Clinical / Programme leads:** Chris Harris, Improvement Programme Manager	The trust and system will: 1. Work with ECIP to co-design and establish an improvement approach to support the UEC improvement programme and UEC improvement board by March 2018. 2. Identify executive sponsors, clinical and managerial leads to support the priority areas identified within this concordat. 3. Allocate improvement, informatics and communication leads to support the programme. 4. Complete the sustainability tool across relevant programmes. 5. Co-design an improvement training programme with ECIP and the Leadership Academy to be delivered concurrently with the UEC improvement programme.	**April 2018** **May 2018**	ECIP will: Provide expert advice and practical support to facilitate the co-design of the UEC improvement programme. Provide improvement and clinical experts to support the assigned leads. Provide expert advice and share examples of good practice. Support completion and analysis of sustainability tool. Support in the co-design and delivery of improvement training programme.	Establishing a robust UEC improvement programme to enable the identified priorities work streams to test continuous improvements, implement and sustain changes at the point of care.	**Outcome measures** UEC improvement programme established. Improvement training programmes delivered to a range of staff across acute and non-acute settings. Sustainability tool measured improvement. **Process measures** Clinical and programme leads identified. UEC improvement groups established and priority actions agreed/progressed. Use of informatics to inform improvements embedded as part of the UEC programme. Delivery of improvement training sessions to enable to UEC improvement programme.

Five top priorities: The trust / system needs to:	Executive Sponsor & Named work stream lead	Deliverables – what five key actions will be taken to achieve the priority?	By when	ECIP will support delivery by:	Outcomes – what do we want to achieve?	Suggested improvement metrics
2. Test and implement effective emergency department and acute pathway improvements	**Executive Sponsor:** Amir Khan, Medical Director **Clinical / Programme leads:** Debbie Hill, Care Group Manager Ruchi Joshi, Clinical Lead Najam Rashid, Divisional Director of Medicine **Improvement support:** Chris Harris, Improvement Programme Manager	The trust will 1. Complete bed modelling / right sizing to inform future acute pathway developments. Assess and test alternative uses of space in the ED, assessment areas and other areas located near the department to improve flow. Utilise a Fit2Sit approach within the department. 2. Test approaches to implementing alternative pathways including, managing GP referrals and ambulance arrivals to relieve pressure on the constrained ED. 3. Develop and agree internal professional standards to reduce delays for speciality reviews and access to support services for patients in the ED and acute assessment areas to facilitate early identification and assessment, in-reach, handover and early pull of patients to improve appropriate access and flow. 4. Complete a staffing skill-mix review across ED, AEC and acute assessment including matching staffing to meet demand. 5. Assess and agree an approach to reduce the frequency and number of patients boarded and use of assessment areas to bed in-patients, this should be developed as part of the use of a robust escalation plan and full capacity protocol.	**Sept 2018**	ECIP will: Provide expert advice to complete bed modelling and review of capacity. Facilitate patient flow improvement workshops to support collaborative working, inform acute pathway development and use improvement methodology to support teams to test and implement changes at the point of care. Provide advice and best practice resources to support improvements; e.g. Fit2Sit materials, IPS examples, PDSA examples. Complete ambulance review and provide expert support to enhance ambulance handover and use of alternative pathways. Support the development of internal professional standards (IPS) through the sharing of good practice, facilitating workshops and supporting tests of change / PDSA cycles. Support the trust to complete a staffing / skill-mix review using a tested approach and methodology. Support the trust in the development of a robust approach to escalation and use of full capacity protocol. <u>ECIP support will include;</u> Improvement manager, clinical associate and ambulance lead.	Flow through the ED and acute setting will improve, with less instances of crowding and exit block. Improved early identification, assessment and intervention by the most appropriate clinician in the appropriate setting. Patients are only admitted to an inpatient bed when acutely unwell. Admissions from emergency department attendances will reduce and more patients will be discharged within the first three days of admission.	**Outcome measure** Improved 4 hour performance % increase in no. of AEC patients % emergency patients with zero LOS Non-elective medial bed days used Reduced conversion to admission rate Reduced No. of patients boarded **Process measure** Reduced ambulance conveyance Time to handover Time to assessment and treatment in ED Total time in ED No. of GP referrals directly admitted to non-ED settings Patients seen by speciality within 2 hours TBC Access to radiology 1 hour TBC Rota to meet demand % compliance TBC No. and time patients boarded in non-bedded areas Use of boarding aligned with escalation policy Patient related outcome measures TBC **Balancing measure** Rate of emergency re-attendances and re-admissions

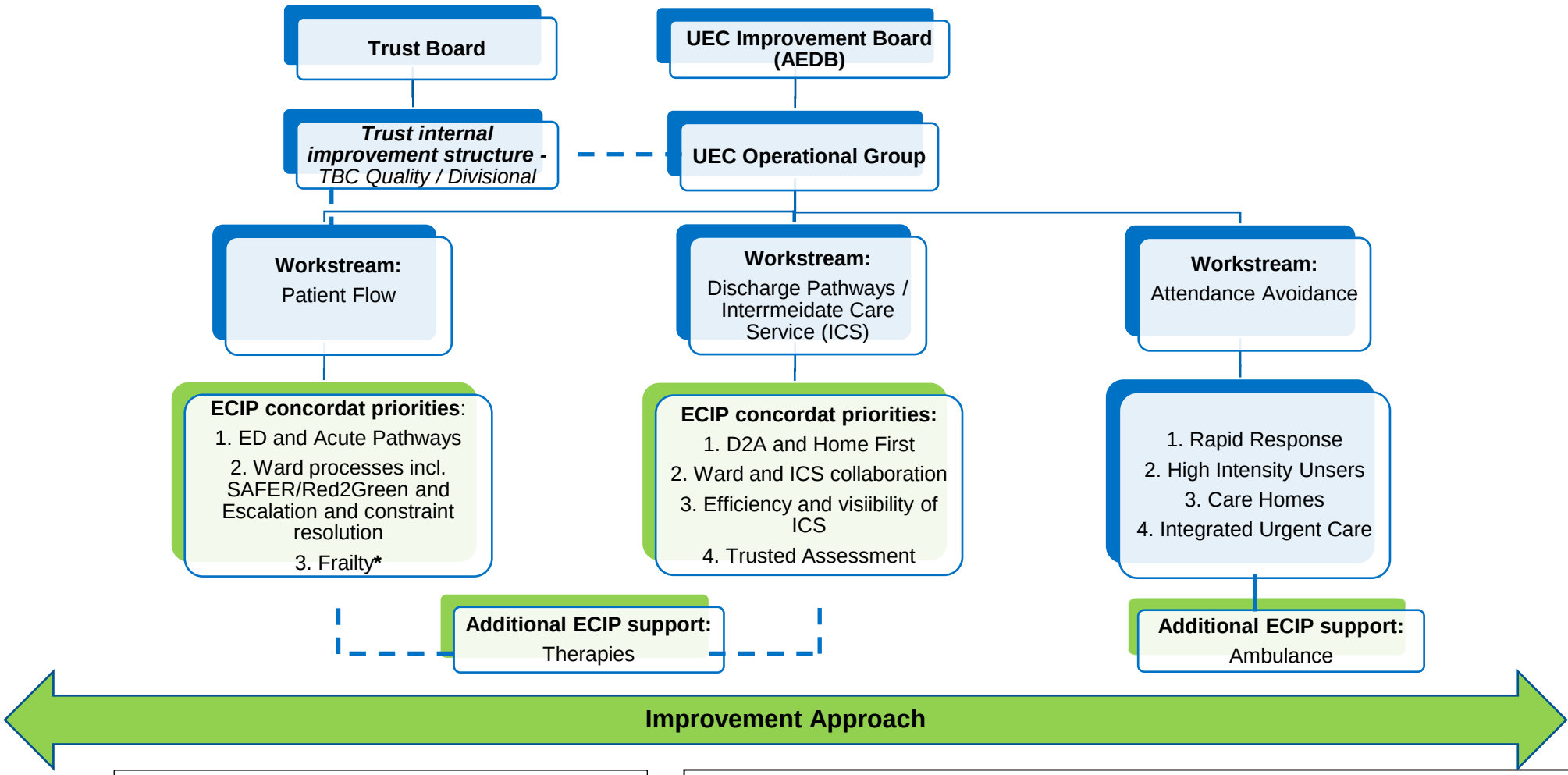
Five top priorities: The trust / system needs to:	Executive Sponsor & Named work stream lead	Deliverables – what five key actions will be taken to achieve the priority?	By when	ECIP will support delivery by:	Outcomes – what do we want to achieve?	Suggested improvement metrics
3. Test and implement improved ward processes including; the SAFER patient flow bundle, Red2Green days approach and a robust model for escalation, response and constraint resolution.	**Executive Sponsor:** Phi Thomas-Hands, Chief Operating Officer **Clinical / Programme leads:** Najam Rashid, Divisional Director of Medicine Matthew Dodd, Divisional Director of Operations Medicine Kara Blackwell, Deputy Director of Nursing **Improvement support:** Chris Harris, Improvement Programme Manager / Ian Billington, Improvement Lead	The trust will: 1. Implement a trust approach to implement the SAFER patient flow bundle and Red2Green days approach. 2. Implement training and engagement with multi-disciplinary teams to develop understanding of the compelling story and approach to using the SAFER patient flow bundle and Red2Green day's tools to reduce delays and prevent deconditioning. 3. Use improvement methodology such as a PDSA (plan, do, study, act) approach to test changes in relation to the areas identified; i.e. pull from AMU, use of expected date of discharge (EDD) and clinical criteria for discharge (CCD), afternoon board round (huddle), greater use of the discharge lounge, etc. 4. Implementation of a standardised approach to escalation, responsiveness, constraint resolution and monitoring of stranded patients. Review of the process to identify patients as medically stable for transfer and management of these patients through to discharge. 5. A review of the medically fit ward model including staffing and level of medical support to avoid re-admissions via the ED.	**Sept 2018**	ECIP will: Provide expert support, training, ward visits, coaching and sharing of best practice resources. Facilitate improvement workshops, support communications and engagement through coaching and sharing of resources in relation to SAFER/Red2Green tools, home first and preventing deconditioning. Support stranded patient/LoS reviews and multi-agency accelerated discharge events (MADE) to inform improvements. Work with the trust and partners to establish appropriate forums to enable pro-active escalation and constraint resolution. Provide improvement experts and resources to support PDSA cycles and development and implementation of internal professional standards (IPS). Provide expert therapy support and advice regarding best practice models of care. <u>ECIP support will include;</u> Improvement manager, clinical associates, social care and therapy leads.	Patients' time and home first principles will become the main priority. All wards and departments will understand their local constraints to delivering safer, faster and better care. Patients will be discharged earlier in the day, after a shorter period in hospital with no unnecessary waiting and reduced deconditioning.	**Outcome measure** Reduced no. of stranded patients Reduced LoS Increase in discharges to usual place of residence Reduction in constraints by top themes **Process measure** MDT board round attendance No. of patients reviewed by a decision maker by 9:30am Use of / time to discharge lounge % of patients discharged before midday % increase of EDD and CCD recorded % increase in No. of patients pulled from AMU/SAU in the morning (pre 10am daily) Stranded patient reviews completed weekly Standardised approach to escalation implemented % patients supported to be up and dressed Patient related outcome measures TBC **Balancing measure** Rate of emergency re-admissions

Five top priorities: The trust / system needs to:	Executive Sponsor & Named work stream lead	Deliverables – what five key actions will be taken to achieve the priority?	By when	ECIP will support delivery by:	Outcomes – what do we want to achieve?	Suggested improvement metrics
4. Co-design, test and implement new ways of working to improve the management of frail older adults across Walsall	**Executive Sponsor:** Daren Fradgley, Director of Strategy and Improvement **Clinical / Programme leads:** Graeme Johnston, Care Group Manager Irfan Qazi, Clinical Lead Nurse lead TBC Therapy lead TBC **Improvement support:** Chris Harris, Improvement Programme Manager	The trust and system partners will: 1. Develop, establish and resource a whole system transformation programme to deliver improvements for frail older adults across Walsall. 2. Develop and agree an approach to managing frailty across Walsall, including agreement of system wide frailty screening and assessment tools and increase knowledge of services to support patients across Walsall. 3. Reconfiguration and continuous improvement of the acute frailty service to include scoping and testing of place and/or process based model, staffing and skill-mix, access to support services (e.g. radiology) and access to non-acute services to support admission avoidance and early supported discharge as clinically appropriate. 4. Collaborative working across frailty service, ED, AMU and Short-stay to include implementation of frailty flag and early assessment, intervention and treatment, e.g. Rockwood Frailty Scale and Comprehensive Geriatric Assessment (CGA) 5. Develop and deliver a training programme to support the improved management of frail older adults admitted to Walsall hospital.	**Sept 2018**	ECIP will: Work with the trust and system partners to support identified frailty improvement and programme leads. Facilitate service re-design sessions and whole system engagement events to support co-design of services. Work with the trust to process map current frailty pathway and redesign as necessary. Support PDSA cycles to support implementation of key deliverables. Support with training design and delivery, including preventing deconditioning campaign. Provide links with other organisations to share approaches and best practice. <u>ECIP support will include;</u> Improvement manager, clinical associates, social care and therapy leads.	Frail patients will be identified as soon as they present to the ED (if not sooner) and their needs comprehensively assessed. They will receive specialist high-quality person centred care and be managed assertively to ensure they are discharged as soon as their acute illness resolves, with appropriate support provided at home.	**Outcome measure** Reduced no. of stranded patients >75 years Increase in discharges to usual place of residence Reduced LOS >75 years Reduced emergency conversion rate Appropriate use of frailty assessment area No. of staff trained in frailty % patients supported to be up and dressed Patient related outcome measures TBC **Process measure** No. of patients > 75 years accessing the service % of patients identified using the frailty flag % of patients receiving CGA Increase in No. of days frailty assessment area used appropriately Improved hours and access to service/s No. of staff trained in preventing deconditioning **Balancing measure** Rate of emergency re-attendances and re-admissions Reported falls

Five top priorities: The trust / system needs to:	Executive Sponsor & Named work stream lead	Deliverables – what five key actions will be taken to achieve the priority?	By when	ECIP will support delivery by:	Outcomes – what do we want to achieve?	Suggested improvement metrics
5. Improve admission, transfer and discharge processes. Incl. discharge to assess (D2A), home first and trusted assessment	**Executive Sponsor:** Paula Furnival, Executive Director for Adult Social Care **Clinical / Programme leads:** Kerrie Allward Head of Integrated Commissioning, Adult Social Care Lloyd Brodrick, Group Manager Integrated Health & Adult Social Care **Improvement support:** Chris Harris, Improvement Programme Manager	The trust and system will: 1. Work to clarify and simplify the discharge pathways with an emphasis on Home First. Provide training, communication and awareness of discharge and community support services at ward level. 2. Work collaboratively with ward staff to help identify and provide early notification of patients who are medically stable and safe to transfer. This will include the provision of targeted training to wards with high volumes of stranded patients and support to the use of SAFER patient flow bundle and Red2Green day tools and support to the escalation and constraint resolution approach in development. 3. Improved visibility of number of patients on the discharge pathways, LoS and capacity available. Including the implementation of a clear set of improvement metrics to monitor impact. 4. Develop a trusted assessment model to enhance the Intermediate Care Services (ICS) model and reduce delayed discharges.		ECIP will: Provide expert advice and share examples of good practice in relation to Discharge to assess (D2A), Home first and trusted assessors. Support approaches to communication, engagement and training through workshops, ward visits and direct coaching. Support with the development and implementation of a process to provide visibility of pathways and capacity e.g. system dashboard. Work with the trust and partners to establish appropriate forums to enable pro-active escalation and constraint resolution. Support PDSA cycles to reduce delays and implement change. Support LoS / stranded patient and multi-agency accelerated discharge events (MADE) <u>ECIP support will include;</u> Improvement manager, clinical associates and social care.	Patients are discharged as soon as they no longer benefit from acute hospital care. In most cases, discharge is to a person's usual place of residence. Assessments for on-going care take place within the patient's usual place of residence.	**Outcome measure** Reduced no. of stranded patients Reduced length of stay in acute and on discharge pathways Increase in discharges to usual place of residence **Process measure** No. of patients accessing D2A pathway No. of discharges on D2A pathway Patients able to access the right service within 24 hours of being assessed as clinically optimised Numbers of notifications /referrals to social care/community from D2A pathway Discharge pathway timeframes TBC Patient related outcome measures TBC **Balancing measure** Rate of emergency re-admissions No. of patient moves (acute and community)

Other areas of support:	Barbara Beal, Director of Nursing Lynne Boulter, Head of Therapies and Dietetics Community therapy lead TBC	**Therapies** 1. Continued review and testing of improvements to the therapy model across the acute and community in line with best practice.		1. Complete therapy service review and provide expert advice, training and practical improvement support to test and embed change.	Patients receive therapy intervention at the most suitable time and appropriate setting to meet their needs.	Reduced time to initial assessment Reduced interventions (as clinically appropriate) Increased therapy interventions provided in patients own home.
	Andy Rust, Strategy lead for commissioning Tom Jackson, Walsall Manor HALO	**Ambulance** 2. Review and continued improvements in relation to ambulance conveyance, use of alternative pathways, improved handover processes and preventing deconditioning (Fit2Sit)		2. Complete ambulance site visits and provide expert advice and practical improvement support to test and embed change.	Patients are supported to stay at home and only conveyed to hospital when acute care is required.	Improved 4 hour performance Reduced ambulance conveyance Time to handover Increased use of alternative pathways Patients assessed for Fit2Sit
	Daren Fradgley, Director of Strategy and Improvement Alison Phipps, Head of Performance & Strategic Intelligence	**Informatics** 3. Review use of informatics to support the UEC improvement programme and work stream priorities to support continuous improvements.		3. Provide expert informatics support to the UEC improvement programme and identified work streams.	UEC improvement programme leads have an increased understanding of the impact and benefits for patients resulting from tests of change and are able to make informed decisions regarding continuous improvement.	

Appendix 1: UEC improvement programme structure and ECIP support for consultation - March 2018v3



***AEDB agreed a frailty whole system workstream also be developed**

Existing improvement workstream

ECIP supported priority

Notes:

ECIP to prioritise new improvement areas and support existing groups as identified within the concordat agreement, concordat priorities specifically align to:

1. Improvement approach
2. ED and Acute Pathways
3. Ward processes; SAFER / Red2Green, escalation, response and constraint resolution
4. Frailty
5. Discharge pathways; incl. D2A, Home first and Trusted Assessment

Other ECIP supported areas within the concordat include ambulance, therapies and informatics.