Interim Management and Support

Emergency & Urgent Care Baseline Assessment Tool

Version 2

Local Health Communities

ECIST 2011

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This diagnostic tool was developed for use by the Emergency Care Intensive Support Team (ECIST).

The aim of the tool is to provide structure to expert discussions. It is not a 'checklist', although may be regarded as a 'litmus test' of good practice. We strongly recommend that the tool is used at the outset of a performance improvement or assurance process, and *not* used to support performance management. To be effective, facilitators should have specific expertise and experience in the subject area, and experience in facilitation or consultancy.

We recommend the following approach:

- The process should be voluntary, with all parties in agreement to work together to explore potential gaps in performance or approach
- The process should be inclusive, with all stakeholders represented at a sufficiently senior level to make things happen. We strongly recommend the participation of directors from the acute Trust and PCT/Cluster, with senior representation from other relevant organisations, including social services and GP commissioners
- Clinical leaders must be included
- There should be a facilitator who is seen by all parties to be neutral and have expertise in the subject area
- The tool/questionnaire should be completed ahead of the first meeting, and then used during the first meeting to structure the discussion. At a minimum, both the acute provider and the commissioner should complete the tool separately.
- Facilitators should probe, but the assumption must be that all parties will be honest and open
- After the meeting, the facilitator should complete a short, practical report, giving prioritised recommendations
- All parties should agree the factual accuracy of the report within an agreed (short) deadline
- A further meeting should be held to reach agreement on what recommendations to implement, over what time, and who will lead on implementation
- Effective governance is key to effective implementation
- Follow-up meetings should be scheduled to check and encourage progress and to support the ongoing performance improvement process

The Emergency Care Intensive Support Team is available for advice and support in the use of this tool. Local Health Communities may request direct support from the team through their SHA Director of Performance, Monitor or by contacting NHS IMAS. We would also welcome feedback on these tools to russell.emeny@southwest.nhs.uk

1. Governance	YES	NO
a. Do you have a local health economy urgent (emergency) care network/group?		
b. Is the urgent (emergency) care network a decision making forum?		
c. Is the network / group responsible for holding the system to account for delivery and is a decision making forum?		
d. Is the urgent (emergency) care network chaired by an executive director who acts as the accountable officer for the network?		
e. Is there full and regular senior clinical representation (consultants and GPs) at the meetings?		
f. Are executive directors (with named operational deputies) identified as emergency care leads for each organisation?		
Comments		

2. Commissioning	YES	NO
a. Are commissioning intentions incorporated within a whole systems strategy for delivering urgent and emergency care?		
b. Are commissioning processes and responsibilities clear and transparent to all stakeholders within the urgent (emergency) care network?		
c. Have commissioned baselines and the assumptions behind them, been shared and agreed with all relevant stakeholders?		
d. Have the commissioned activity baselines been adjusted for demand management initiatives?		
e. Have CQINs and KPI's been approved and measures indentified across the whole system to include Primary Care, Community and Acute Providers?		
f. Are there effective commissioning arrangements in place for Ambulance Services, with all parties feeding into these?		
Comments:		

3. Information	**YES**	**NO**
a. Is up-to-date data on demand and capacity used to inform management decisions in:		
i. Primary care		
ii. Out of hours		
iii. Home based intermediate care		
iv. Bed based intermediate care/community hospitals		
v. Ambulance services		
vi. Acute care		
b. Is Statistical Process Control (SPC) being by all parts of the local health community to support the interpretation of statistical data?		
c. Is predictive modelling used to support chronic disease management?		
d. Have the clinical quality indicators for A&E been incorporated into performance reports/dashboards for the monitoring of A&E performance?		
e. Has a clear process been designed to ensure a meaningful and clinically agreed narrative is produced to support clinical quality indicator data submissions?		
f. Have clinical and performance standards been agreed for reporting from all urgent and emergency service providers, including primary care, community services, integrated teams, social care and mental health?		
g. Do you use comprehensive datasets to review whole system status, including metrics for urgent and emergency care delivery in acute care, community and intermediate care, ambulance services, mental health and primary care?		
h. Is there a local information strategy that sets out how information within organisations and across the health system will be shared?		
i. Do you have a systematic approach to evaluating changes/interventions and the lessons learned?		
Comments:		

4. Primary Care	YES	NO
a. Do all GP practices have a lead GP responsible for urgent care?		
b. Have all GP practices reviewed their appointments within the last year to match capacity to demand?		
c. Have all GP practices assessed their ability to manage peak telephone call demand and taken effective steps to respond efficiently?		
d. Do all GP practices offer 'walk-in and wait' / urgent care clinics where a patient can expect to be seen within a defined timeframe?		
e. Do all GP practices measure and review their patient consultation rates with GPs and health care professionals?		
f. Is the ratio of same day to advance appointments for all GP practices approximately 1:2 (one third same day, two thirds advance)?		
g. Do GP practices have times when they regularly run out of same-day appointments?		
h. Are there any times during the day when GP practices are closed and their patients cannot contact them directly?		
i. Do all GP practices offer telephone consultations as alternatives to face-to-face appointments for urgent care requests?		
j. Are all patients requesting a home visit called back by a clinician within 30 minutes to assess urgency?		
k. Does the PCT/GP Commissioning Consortium/PBC cluster have a written strategy to improve urgent care delivery?		
l. Has there been an evaluation of the effectiveness of the management of Ambulatory Care Sensitive Conditions?		
m. Does the OOH Provider meet all telephone answering, initial assessment and face to face treatment National Quality Requirements?		
n. Does the OOH Provider have appropriate access to sufficient individual patient primary care information to support decision making?		
o. Is there sufficient clinical leadership and involvement in primary and secondary care to resolve local issues in relation to emergency admission and unscheduled care management?		
p. Is the utilisation rate of OOH by patients from individual GP practices known, particularly during the 60 minutes following the end of the in-hours period?		

q. Are GPs locally involved in work to implement 111, including developing a local directory of services?		
r. Has there been a comprehensive review in the past 2 years of urgent/same day care provision by primary care across the local patch (e.g. by the Primary Care Foundation or another suitable organisation?)		
Comments:		

5. Community Services	**YES**	**NO**
a. Is there a case management strategy with locality based community teams providing a range of integrated services?		
b. Are the roles of core teams across social care and community health integrated to minimise overlap and duplication?		
c. Are there clear links and referral pathways to specialist community nurses and patient training e.g. Diabetes and COPD self management?		
d. Is there an integrated case management strategy for patients with Long Term Conditions / a high risk of multiple admissions?		
e. Do community services have input from mental health and social workers to address all relevant health needs?		
f. Do community services have the capacity and range of resources to provide alternatives to admission at least 12 hours per day and 7 days per week?		
g. Is there clarity about the appropriate balance between admission avoidance and early supported discharge schemes?		
h. Do admission avoidance schemes extend into the acute trusts' assessment units as well as their EDs?		
i. Are there step-up and step-down beds that acute and primary care staff can access at least 12 hours per day and 7 days per week?		
j. Are performance standards in place for admission avoidance and early supported discharge?		
k. Are referrer based assessments for transfer accepted by intermediate care services?		

l. Are there specific strategies for admission avoidance schemes for care home residents?		
m. Are there end of life pathways available for patients with chronic disease as well as cancer that can be accessed by any Health Care Professional?		
n. Are advance care plans systematically used for all appropriate patients?		
Comments:		

6. Ambulance Service and PTS	**YES**	**NO**
a. Has there been local benchmarking and investigation in line with the DoH 'Tackling Demand Together' toolkit?		
b. Has this analysis led to any system wide demand management schemes?		
c. Is there a locally agreed indicator for non-conveyance rates that is routinely reported against?		
d. Does the ambulance service deploy emergency care practitioners (ECPs) and / or advanced practitioners?		
e. Is the volume of hospital attendances that ECP's and Advanced Practitioners prevent known and reported across the system?		
f. Can the ambulance service redirect patients to care setting other than A&E departments? (e.g. Minor Injuries Unit, GP OOH, Urgent Care Centres)		
g. Is the volume of redirected patients to alternative care settings known and reported across the system?		
h. Is there a locally agreed multi-disciplinary approach to the case management of frequent 999 callers?		
i. Is there an approved 'managing patient handover' procedure with the Acute Trust?		
j. Is there an agreed data capture method for arrival to handover time between the ED and Ambulance Service?		
k. Are trends in handover time breaches published and jointly reviewed between the Ambulance trust and receiving provider?		

l. Has patient transport capacity for hospital discharges and transfers been commissioned in line with demand?		
m. Is there an effective agreement in place for the management of same day booking requests?		
n. Can PTS step up to cope with increased discharges when the hospital is in escalation?		
Comments:		

7. WIC/MIU/Urgent Care Centres	**YES**	**NO**
a. Are there alternatives to ED available within the LHC e.g.; WIC, UCC, Open Access Primary Care?		
b. Is the full aim of these services understood? (i.e. was the service initially set up to 'bolster' Primary Care provision, or reduce demand on ED services?)		
c. Has a recent impact assessment been carried out to demonstrate reductions in demand at the Emergency Department or improvements in Primary Care?		
d. Where the service is co-located with a hospital emergency department, are governance arrangements integrated?		
e. Are these services available after 10pm and at weekends?		
f. Do these services have a consistent offer whenever they are open?		
g. Are there clear links with community health services and primary care?		
Comments:		

8. Emergency Department		YES	NO
a.	Is there an internal performance framework with clear time triggers?		
b.	Are the time triggers performance managed in real time?		
c.	Is there a clear, written process in place to ensure a meaningful initial assessment is carried out on all ambulance cases within 15 minutes of arrival?		
d.	Are the levels of staff (both medical and nursing) mapped to the demand profile for the department and seasonally adjusted?		
e.	Are escalation policies in place to manage increased demand?		
f.	Is there a mechanism to manage patients who have LWBS?		
g.	Is there a written process in place for the review and management of frequent attenders and reattenders?		
h.	Do you use 'see and treat' (SAT) for 'minors'?		
i.	Do you deliver a rapid assessment and treatment model (RAT) in 'majors'?		
j.	Is there a clear, written process for consultant sign-off for specific conditions / scenarios?		
k.	Is there a mechanism for recording and auditing senior review and a change in treatment plan?		
l.	Are there clear pathways in place for the management of patients with cellulitis and DVT?		
m.	Is there a separate paediatric area?		
n.	Is there an observation area, and if so does it have a clear operational policy?		
o.	Does the Emergency Department have direct admitting rights?		
p.	Is there continuous (24/7) active 'floor' management by a Senior Nurse and Senior Doctor working together?		
q.	Does the Department have a data system that supports real time management of patient pathways through the department?		
r.	Does the data system link into the main IT system and are regular reports generated?		
s.	Does the IT system have the ability to capture the full minimum data set to report on the Clinical Quality Indicators (2010)		

t. Is the Department measuring admission rates and referral rates to speciality?		
u. Is there an established process to evaluate patient experience and implement improvements based on findings?		
COMMENTS		

9. Acute Assessment Units *(for the initial assessment of emergency admissions, typically with LOS <12 hours)*	**YES**	**NO**
a. Is there an acute assessment unit ?		
b. Is the assessment unit co-located/adjacent to ED?		
c. Have you profiled the AAUs capacity based on the demand profile?		
d. Does the assessment unit have dedicated staff (i.e. not just staffed by on-call teams)?		
e. Does the AAU have the capability of delivering single organ (level1) support to patients?		
f. Are GPs offered systematic advice on a range of alternatives to avoid Emergency Department attendance?		
g. Do the assessment units take GP referrals direct?		
i. If so, are GP referrals diverted to the ED at times of increased pressure?		
h. Is there a committed AHP and Social Care Team for the assessment unit (and short stay unit)?		
i. Is the unit covered by consultant staff 12 hours per day 7 days per week?		
j. Are patients reviewed by consultants on a rolling basis (rather than only on ward rounds)?		
k. Do all patients leaving the assessment unit have an *expected* date of discharge?		
l. Are there operational performance frameworks for the assessment units paralleling those in the ED?		
m. Are there regular joint governance meetings (quarterly) with the Emergency Department with the participation of senior clinicians?		
Comments:		

10. Short Stay Unit *(for emergency admissions assessed to have conditions justifying admission and a short hospital stay <3 midnights)*	**YES**	**NO**
a. Is there a short stay unit?		
b. Has short stay capacity been calculated based on an activity analysis?		
c. Is the unit co-located/adjacent to the assessment unit?		
d. Does the admitting clinician continue to manage the patient on the short stay unit?		
e. Is ease of access to diagnostics on the short stay unit the same as in the ED and the assessment unit?		
f. If the short stay unit is separate from the assessment unit, is there a policy to minimise handovers?		
g. Is there a standardised handover system e.g. SBAR for receiving patients from A&E and AAU?		
h. Are short stay patients reviewed at least twice daily?		
i. Are readmission rates from the Short Stay Unit monitored with plans developed to minimise readmissions?		
j. Is there an operational performance framework that defines maximum length of stay on the short stay unit?		
k. Is there a system of speciality 'in-reach' to support short stay patients who require this input?		
Comments:		

11. Provision of emergency day care *(e.g. ambulatory emergency care, clinical decision unit)*		
a. Is there a facility that delivers emergency day care on site e.g. CDU and/or emergency ambulatory care unit?		
b. Is it located in close proximity to the A&E department or AAU?		
c. Does the emergency day care facility have identified staffing?		
d. Is there IT support to maintain a virtual ward to ensure patient care is regularly monitored?		
e. Has there been an impact assessment to understand the capacity and demand for emergency day care using the Directory for Ambulatory Care?		
f. Does the service availability match the demand for the service e.g. 12 hours per day 7 days per week?		

Do the following services support the delivery of emergency day care? IV anti-biotic service Allied health professionals Falls service Heart failure Chest pain outreach Respiratory outreach team Diabetes team Pharmacy		

12. General/Specialty Wards	**YES**	**NO**
a. Are your general medicine wards differentiated into sub specialties (e.g. respiratory, renal)?		
b. Are there clear criteria for transfer to a sub specialty ward?		
c. Is there a clear, documented process for the management of 'outlying' patients?		
d. In the last 12 months have you opened any escalation beds, or swung any wards from one speciality to another?		
e. Are there daily consultant delivered reviews (ward rounds or board rounds) of the entire bed base?		
f. Are there daily morning business ward rounds to support seven day discharge?		
g. Is there a requirement for formal discussion with the attending consultant if there is a plan to change an expected date of discharge?		
Comments:		

13. Discharge Planning	YES	NO
a. Is there a consultant signed-off medical care plan, which incorporates a clinically owned expected date of discharge (EDD), set within a maximum of 12 hours of decision to admit?		
b. Is the admitting consultant responsible for setting the EDD?		
c. Is there evidence that structured individualised discharge planning starts at the point of admission?		
d. Do all partner organisations (primary care, community services, social services and voluntary sector) work collaboratively and deliberately with acute care to deliver the EDD?		
e. Is there a policy that the expected date of discharge can only be altered by the responsible consultant?		
f. Have medical teams established clear, written clinical criteria for discharge to support criteria-led discharge?		
g. Is the discharge process for complex patients governed by a few simple rules (e.g. a document no longer than one side of A4)?		
h. Do you measure the percentage of actual discharge dates against the originally set expected discharge dates?		
i. On a daily basis, do you know how many definite discharges there will be at the morning bed management meeting?		
j. Do all patients in Community Hospitals have an expected date of discharge assigned within 12 hours of admission?		
k. Can transfer to Community Hospitals routinely be delivered up to 22:00 hrs?		
l. For referral to home based or bed based intermediate care, are there simple inclusion criteria checklists for referrers?		
Comments:		

14. Capacity Management	YES	NO
a. Is there predictive modelling, based on historical demand and capacity?		
b. Is there a minimum of a twice daily bed management meeting at the Trust, covering the acute bed base?		

c. Does the bed meeting have access to up-to-date information on community capacity (bed based and non-bed based) and social care provision?		
d. Do you have a central operations centre where capacity and flow processes are coordinated?		
e. Do you have a set agenda and agreed TORs that clearly describe the value and purpose of the meeting and the roles and responsibilities of those attending?		
f. Do you formally note / minute the meeting generating allocated actions and have a process for feeding back that holds individuals to account?		
g. Do you have agreed criteria for what constitutes 'medically fit' / 'clinically stable' that has been agreed and signed off by social care, primary care and PCT provider / commissioner?		
h. Do you have an agreed process to manage elective admissions against known emergency demand profiles?		
Comments:		

15. Social Services	**YES**	**NO**
a. Is there a simple, single phone-call process for restart of existing care packages to allow same day discharge?		
b. Will social services hold packages of care following admission allowing patients to be discharged in a timely manner (7-10days)?		
c. For new simple care packages, are there call-off procedures available to clinical teams in the ED and assessment units without the need for care manager assessment prior to discharge?		
d. For complex care packages, is the frequency of funding approval at least daily?		
e. Is the demand for care packages clearly understood?		
f. Is there local agreement that all referral processes (e.g. CHC) have been made as simple as possible? (i.e. simple, short documentation that is quickly and easily completed?)		
Comments:		

16. Mental Health	**YES**	**NO**
a. Is there an agreement in place, between the ED and Mental Health Liaison service, with clear response standards, in respect of the referrals process?		
b. Can patients with deliberate self-harm, not requiring medical/surgical treatment, be discharged from the ED in a timely fashion with mental health support?		
c. Are there sufficient community-based options to avoid patients with dementia, but without new acute physical illness, defaulting to acute care?		
d. Is there rapid access to non-acute based detox' services?		
e. Are mental health inpatient units capable of delivering basic physical nursing needs (e.g. parenteral fluids) without defaulting to acute care?		
f. Is there clarity around the management of MH Act (Section 136) referrals across the system?		
Comments		

17. Escalation	**YES**	**NO**
a. Is there sufficient clinical leadership and involvement in primary and secondary care to resolve local issues in relation to escalation?		
b. Are system wide trigger levels for escalation clearly defined?		
c. Are there named executive leads to whom issues are escalated?		
d. Are escalation plans and processes coordinated across the local		

health economy?		
e. Is there an auditable process for decision making and lessons learned?		
f. Is there a plan to open additional capacity to support excess demand above normal variance across the whole system?		
g. Is there a timely de-escalation plan?		
h. Have activity triggers been agreed for all urgent care providers that can provoke a whole system response to spikes in demand?		
Comments:		

ECIST is funded by the NHS and provides support and guidance to organisations that commission or are commissioned to provide NHS urgent and emergency care services to people living in England. ECIST is an arm of NHS IMAS.

For further information, visit www.nhsimas.nhs.uk