North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 28/5/2013	**Agenda Item No:** 6.3	**Enclosure:** 6a
Intended Outcome:		
For noting	**For information**	**For decision** ✓

Title of Report:

Progress on implementing the actions and recommendationsd from the Emergency Care Intensive Support Team (ECIST)

Aims:
To provide the Board of Directors with assurance that the recommendations and actions from the ECIST visits to CIC and WCH in February 2012 have been completed or are in progress with realistic completion dates.

Executive Summary:

The ECIST Action Plan is well advanced and over time has led to improvements in the delivery of emergency care. A Trusdt Board development session is to be held on 4 June to consider the enhanced delivery of it and the whole acute medical service at WCH to continue to provide high quality emergency and acute care.

The ECIST reports for CIC & WCH are attached as Appendix 1, the current Emergency & Acute action plan as Appendix 2 and DTOC action plan as Appendix 3

Specific implications and links to the Trust's Strategic Aims:	
We deliver excellent clinical outcomes along closely integrated pathways	✓
We provide excellent patient-centred services	
We deliver excellence in safety, quality and regulatory compliance	
We deliver efficient care and work within budgets	

Recommendations:

The Board are asked to approve the current A&E and DTOC Action Plans with the assurance that all recommendations and actions from the ECIST are completed or are in progress with realistic completion dates.

Prepared by:	**Presented by:**
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Appendix 1

ECIST Cumberland Infirmary Carlisle Implementation Review May 13

No	IST Recommendation	Outcome	Delivered	Risk
1	The Trust should consider a planned expansion of consultant numbers in the ED with the aims of providing extended floor cover (weekend cover is very thin) and the ability to introduce a consultant led RAT service at least 4 hours a day.	Additional number of consultant posts agreed at SMT Aug 12. Board decision to increase provision to 10pm but need to maintain current numbers of permanent staff.	Dec 2013	H
2	Nurse staffing should be reviewed to ensure it can meet surges as well as average demand	Nurse staffing shifts changed following a review to align with demand; an additional nurse per shift was implemented, and capacity aligned to demand by changing a number of shift patterns.	Complete Aug 2012	L
3	Review consultant job plans to optimise their available floor time, matching periods of known peak demand. Emergency consultants should not manage inpatients (other than on CDUs) without adequate numbers and 24/7 junior support. Consider new pathways and approaches in order to eliminate review clinics – ED should not manage patients because other specialties do not want to do so.	Job plans reviewed and realigned	July 2013	L
4	Create a protected stream for walk-ups and use See and Treat as the operational model.	The minors stream is protected with see & treat in place	Complete Aug 2012	L
5	Introduce, monitor and performance manage Internal Professional Standards to achieve appropriate standardisation of practice and consistent response times.	Internal professional standards agreed and implemented – see Emergency and Acute Care Action Plan	Complete Aug 2012	L
6	Review the PCAS service	PCAS service reviewed; new model for ambulatory care due for implementation Jun 13 – see Emergency and Acute Action Plan	4 June 13	L
7	Work with commissioners and the MH Trust to agree out of hours response time for MH referrals	MHLT Service enhanced '12 increasing capacity to improve response time in support of the A&E emergency care standard	Complete Aug 2012	M
8	Move to a "consultant of many days" model.	Introduction of Acute Care Physician model	Complete Aug 2012	L
9	Review the objectives and methods of ward rounds. Rolling ward rounds are best practice on assessment units	New rolling ward round implemented as part of new physician model Aug 12	Complete Aug 2012	L
10	Ensure that every patient is reviewed by a consultant every day in both the EAU and short stay	See 9 above	Complete Aug 2012	L
11	Review the number of assessment and short stay beds	ECIST Tool used to agree future bed numbers.Aug 2012. Needs redoing in the light of sustained increased demand	Aug 2013	H
12	Ensure all patients have consultant approved care plans within a maximum of 12 hours that contain a differential diagnosis, EDD and clinical and functional criteria for discharge	Admission proforma redesigned and on-going audit of standards underway	Complete Aug 2012	L
13	Provide additional consultant input at weekends and create a 'bleeding rota' rota fpr emergency gastro-intestinal bleeding	Additional weekend cover provided for core wards; bleeding rota subject to Gastro OOH Strategy. To be presented to CPG	July 2013	L
14	Change practice to require discussion with referring GPs before patients are accepted for admission; consider an integrated front-end model so that senior decision makers are involved from the beginning of all patient's pathways	Professional point of Access Implemented in line with health economy integrated emergency floor work. Review of new process underway within that team to be presented July 13	Complete Jan 2013	M
15	Patient flow from the EAU should be reviewed to ensure patients are allocated to the correct flow stream at the earliest point possible during their admission and transferred promptly to an appropriate ward following assessment.	Flow reviewed; new operational policy for EAU implemented Dec 12 with new Surgical Assessment Unit Open May 2013	Complete May 2013	L
16	There should be daily board rounds to ensure that the care plan of every patient is reviewed every day by a senior clinician.	Daily board rounds including rounds performed by Directors underway	Complete	L

17	All patients should have consultant approved EDDs and written criteria for discharge which form the teams objectives for all patients. EDDs should only be changed with the consultants permission	EED process implemented with a focus on morning discharges, alongside senior daily review	May 2013	M
18	There should be a corporate aim to normalise morning discharges	See 17 above. There are bi-weekly letters from the CEO detailing A&E performance the key priority corprately	May 2013	L
19	Reintroduce a bed prediction tool (the DH 6-week rolling average approach can be used in the absence of more sophisticated modelling).	This was done in Jun 12	Complete Jun 12	L
20	Recognise that bed management is dependent on ward processes that are driven by medical practice – poor processes will frustrate even the most skilled bed manager	Recognised; review of bed management led to new model based on more senior staff being implemented	Complete April 2013	L
21	Create a programme to encourage morning discharges, beginning with publishing monthly ward performance	Less than 50% of discharges confirmed by noon. Performance management of ward rounds reported to EMT. All processes under review.	Aug 13	M

ECIST West Cumberland Implementation Review May 13

No	IST Recommendation	Outcome	Delivered	Risk
1	Review the current medical staffing and agree the clinical model of care for Whitehaven ED	Charles Brett brought a paper to SMT detailing proposed model to increase staffing to enhance service with an additional staff grade to help in the introduction of senior review for the very sick; extra medical cover approved. Further work being undertaken Jul 13 around job plans to better alighn capcity to demand.	Complete Aug 12	M
2	Consider an Acute Medical/ED role to increase interest	Was not a suitable proposal, Superseded by recruitment commitment for ACPs And A&E consultants. Recruitment in progress	Complete Nov 2012	M
3	Consider GP involvement integrated to ED	CHoC integrated at night to provide additional cover	Complete Jan 2012	L
4	Develop internal standards and operational models that are approved and signed off by every member of the ED team	Internal professional standards agreed and incorporated into EAU operational policy. A&E have quality makers in addition as standards. Have not seen an operational policy for A&E produced by the team	Complete Aug 2012	L
5	Articulate role of the Clinical Manager for both Consultant and Registrar	See 1 above. No evidence that model changed as awaiting recruitment	TBC	M
6	Develop standardised board rounds on an hourly basis, with bed manager present every two hours	Bed managers traverse A&E regularly; bed management office relocated to central area	Complete Jan 2013	L
7	Enhance departmental capacity to support a 'see and treat' model for minors and a 'SIFT' model for majors with clear time periods when these will be in operation and a clear contingency process when they are not in place.	Model agreed but limited by space issue; awaiting re-purposing of Eskdale Unit	TBC	L
8	Identify skills gaps to deliver the preferred model of care Develop a workforce strategy for the ED. See also recommendation 1	The department have a workforce strategy, led by Charles Brett & Clare Summers	Complete Aug 2012	L
9	Enhance the skills of the nursing workforce	A&E consultant leads the nursing development to enhance skills of nursing workforce	Complete Aug 2012	L
10	Develop PGD's in the interim	Not started – for review	Not started	L
11	Establish regular weekly meetings with the ED business manager, Senior Nurse and Consultants	Louise Gibson attends weekly departmental meetings, plus business manager meeting.	Complete Jul 2012	M
12	Ensure pathways for common medical and surgical emergencies are developed, adopt a CDU (Leeds approach) style proforma to fast track 'barn door' admissions to specialities	Pathways implemented for ambulatory care at WCH	TBC	L
13	Review consultant job plans and map against current demand	Mapping performed with Deputy BM and Charles Brett to align to demand.This to be reviewed with Chris Biggin and Denis Burke	Complete Sep 2012	M
14	Ensure clear standards are developed and monitored on speciality response and support to the ED	See 4 above	Complete	L
15	On take speciality teams should establish regular (9am, 2pm, 5pm and 9pm) contact with the senior doctor in ED to ensure workload is understood	A new system, enhancing the current process whereby ACPs attend A&E and review patients in the department, is due to de defined	3 Jun 2013	H
16	Seek alternative accommodation for pre-assessment to establish a minor's area within the Primary care area.	Pre-assessment could not be relocated. The repurposing of Eskdale Unit will resolve this issue once agreed by the Business Unit	TBC	L
17	Review the medical model for the Medical Assessment Unit	New ACP model implemented Dec 12	Complete	M
18	Investigate variance in the existing cardiology care pathways	Cardiology service enhanced in Jan 13. Cardiology model under review to enhance further moving towards a 7 day service.	Sep 13	M
19	Consider a review of LoS (by site, by consultant, by case mix) to identify the scale of any variance	Consultant information pack completed and sent out monthly to all consultant.Process for DToC in place	Complete	L
20	Match skilled resources to demand (nursing and medical) o Eliminate batch processes in patient care.	New model of care introduced and live take instituted	Complete	L

21	Develop and implement internal standards that are approved and signed off by every member of the MAU.	New operational policy in draft form; includes clear internal professional standards. Standardised with EAU Carlisle.	TBC	L
22	In partnership with the ED agree what constitutes a senior clinical review. Develop reporting processes for the MAU	Senior clinical review detailed in operational policy in conjunction with A&E bu Site CD	Complete Dec 12	L
23	The modelling of the number of assessment beds should be reviewed and changed to trolleys, this should be undertaken in conjunction with modelling to review the Short Stay units capacity	IST provided a tool which has been use to confirm the number of beds on EAU, which found current numbers (30 beds). Required repurposing of short stay.	Complete Dec 12	L
23	Ambulatory care task and finish group should be established to analyse potential activity and conversion from 0-1 day LOS	The Trust joined the ambulatory care network to improve this aspect of service	Complete	L
24	Review and reinstate the short stay criteria for access to the short stay ward. Identify where new patient groups wherever possible for short stay.	New operational policy for short stay instituted; working well	Complete	L
25	Review and assign appropriate leadership and multidisciplinary support to ensure the ward throughput is maintained.	AHP input increased to be responsive to Short Stay needs * lead nurse role concentrated	Complete	L
26	Move to daily consultant ward/board rounds Introduce one stop ward rounds	Daily review of board rounds agreed.	3 Jun 13	H
27	Implement record and monitor Expected Dates of Discharge set by the consultant Monitor discharges by day of week and time of day	Electronic EDD introduced in April 2013	April 2013	H
28	Establish incentives to manage patients to their care plan	Realtime	Complete	L
29	Align operational standards to the consultant appraisal through audit, and establish a process whereby Internal Professional Standards are a fundamental component of all CEA processes	In progress with Northumbria model for CEAs and consultant appraisal	TBC	L
30	Increase clinical involvement in daily bed management	Closer liaison established with ACP model. Risk re: use of locums; A&E staff come to bed meetings	Complete	M
31	Reduce outliers and avoidable patient movements • Monitor improvement against this commitment	Reviewed system for ACP	3 Jun 13	H
32	Support the rollout of Realtime	Realtime rolled-out	June 2013	L
33	Ensure appropriate support to ward staff is available in the early stages of implementation	Approved	2013	L
34	ECIST to raise out of area social care issues with Commissioners	Adult Social Care attend the health economy Patient Access Group (PAG) where NCUH provides leadership. There has also been the North Cumbria Clincial Strategic Leaders Group have been meeting since Jan 13	Dec 2013	H
35	Review the medical model that supports the 'hospital at night' program	Nurse practitioners recruited to augment H@N. Task Group being led by Business Unit Director for Medicine	Aug 2013	H