CareQuality Commission

Meeting the quality challenge
Sharing examples of best practice from clinical leaders in

Emergency Departments

November 2017

Introduction

When services are under pressure, the Care Quality Commission's priority is to ensure that the people who use them remain safe. CQC recognises the huge pressures facing emergency departments, so to help address these and support local quality improvements, we teamed up with senior staff including consultants, clinical leads, senior nursing staff and managers from leading emergency departments in 17 NHS acute trusts across England where we have identified good practice.

The senior leaders attended a workshop in September 2017 to discuss the strategies and positive action that their trusts are using to meet the challenges of managing capacity and demand. They also identified the areas of greatest risk for patients in emergency departments. These issues were considered the most important, and we now present the discussions from the workshop as a resource for trusts. We hope that by sharing these practical examples of best practice, other emergency departments can learn from them and adapt them to their own departments to improve the quality of emergency care for patients.

We would like to thank all those who attended the workshop for sharing their valuable knowledge and experience of meeting the challenges.

Professor Ted Baker
Chief Inspector of Hospitals

"The emergency department is the front door of our healthcare system where many patients first come into contact with the service, which is there to meet their most urgent and serious health needs. Unsurprisingly, it is the area of hospital activity that is the subject of intensive public and political focus. For patients, there can be no more important place for the best practice to be available to them. That is why it is vital that practical methods of providing the best possible care need to be shared widely across the NHS.

Translating the ambition to provide outstanding care into reality will not require the same solutions everywhere, but this guide collects together some of the practical solutions that have helped make emergency departments outstanding. It is happily free of jargon and I hope can inspire all who work in this speciality to ask themselves, "Can we find a better way to deliver outstanding care to our patients?" It should be read by everyone who works in this specialty."

Sir Robert Francis QC

"The ever increasing pressures and complexity of challenges affecting emergency departments have been well documented. In the midst of this, it is a great pleasure to hear of how staff have focused on innovative, and yet at times remarkably simple, schemes that lead to safer patient-centred care. At a time when our NHS is struggling badly due to resource constraints and staffing shortages, it is heartening to see such fresh thinking and passion to improve care delivery and not just system performance.

The Royal College has been keen for departments to showcase their excellent work and I am grateful to CQC for bringing this particular project to fruition in this way. It is a real delight to read about and support this collection of initiatives that have been developed by emergency department staff, and I hope that in the future we can increasingly move towards allowing senior staff the time to design, test, refine and embed such positive change into their systems."

Dr Taj Hassan
President, Royal College of Emergency Medicine

Examples of best practice

We have mapped the areas of risk that senior clinicians identified and discussed at the workshop to four of CQC's five key questions and corresponding key lines of enquiry (KLOEs) in the assessment framework for healthcare services.

The vast majority of emergency departments that CQC has inspected are rated as good or outstanding for the caring key question, so the workshop did not focus on this.

In this document, we have listed the KLOEs that are relevant to the issues that clinicians highlighted, and summarise examples of good practice that trusts shared.

SAFE:	**By safe, we mean that people are protected from abuse and avoidable harm.**
EFFECTIVE:	**By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.**
RESPONSIVE:	**By responsive, we mean that services meet people's needs.**
WELL-LED:	**By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning an innovation, and promotes an open and fair culture.**

If you would like more information about a specific example, the contact details for all the trusts that contributed to the workshop are available at the end of this document.

SAFE

KLOE S1: How do systems, processes and practices keep people safe and safeguarded from abuse?

Clinicians and managers identified crowding and caring for patients in areas not intended for clinical use as a key risk. Patients should receive safe and effective care in a safe environment that protects their privacy and dignity. This involves always being cared for in an area where clinical staff can monitor them and where there are enough staff available to do this. Clinicians are very clear that providing care and treatment in non-clinical areas of an emergency department, such as a corridor, should not be normal practice. If this happens routinely, hospitals must have a substantive plan, with timescales, to prevent it so that it does not become the norm; in the meantime, they must take action to mitigate risk to patients cared for in this way.

A number of departments also described how they ensure the effectiveness of their safeguarding processes.

Royal Bournemouth Hospital has introduced an electronic child safeguarding process, which identifies all children and ensures that a safeguarding assessment is completed. It opens an e-form, which the emergency department's IT system feeds into, and which then automatically sends an email to both the patient's GP and local Social Services if there are any safeguarding concerns. This has ensured timely escalation of cases and 100% compliance with safeguarding for children. The e-forms portal was developed in-house by the trust's IT department.

KLOE S2: How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

The feedback from clinicians for this KLOE largely concerned how effectively departments assess and respond to risks to patients, as well as how they ensure safe levels of staff.

Clinicians advised that any emergency patient who is physically on the hospital site should be regarded as under the care of the emergency department and should be booked in without delay: the clock should start ticking at that point. Patients should not wait in ambulances and there should be no delay to booking them in to the department, and no 'two-tier' system that differentiates between patients arriving in an ambulance and those who arrive independently.

At **Frimley Park Hospital**, a qualified nurse receives patients arriving by ambulance and a dedicated receptionist books the patient in. The emergency department uses a validated, standard streaming process (Emergency Severity Index (ESI)) to identify high-risk patients and distinguish between those that should be in minor injuries. Between 8am and 8pm, a dedicated Band 7 emergency nurse practitioner (ENP) is at the front desk. The ENP uses ESI to identify sick patients and to redirect or signpost to other services if necessary. The ENP also identifies patients that need a head CT or review by the stroke team. The department applies the same process to patients arriving by ambulance as those who walk in, so all patients are booked in without delay.

In the **Royal Devon and Exeter Hospital**, the Rapid Assessment at Triage (RAT) team meets all ambulance patients and any walk-in triage category 2 patients in a dedicated room. The team consists of a consultant, Band 6 nurse and F1 doctor, and allows rapid decision-making not only about investigations, but also about care issues such as early top-up of analgesia and the patient's ability to eat and drink. This process has a standard operating procedure and takes no longer than five minutes to avoid delays with ambulance handovers.

The advice of clinicians is that the patient's initial clinical assessment must be carried out within 15 minutes by an experienced clinician capable of identifying a patient who is seriously unwell or at risk of deteriorating. There is a range of processes and tools to identify deteriorating patients – many departments use checklists (including SHINE) and early warning systems (EWS) to identify and monitor deteriorating patients.

However, at the workshop, clinicians felt that there was no benefit in advocating a particular tool to use in all emergency departments, as needs will vary between departments. The key is for the nurse and doctor in charge to have a real time oversight of all patients in the department, including their risk of deterioration.

Bristol Royal Infirmary designed and developed the SHINE safety checklist. This is a time-based framework of tasks that is completed for every patient (apart from those with minor complaints). It is prescriptive and contains all basic elements of care. This checklist was designed to mitigate the risks associated with over-crowding in the emergency department, in particular in patients suffering from stroke, heart attack or sepsis. For patients, this has resulted in a mean increase of 25% in hourly observations and early warning score calculations, and a mean increase of over 5% in CT scanning within one hour for patients with suspected stroke.

Emergency department clinicians at **Royal Bournemouth Hospital** have visited several emergency departments around the country rated as outstanding, to review good ideas to improve safety and then modify these to their own local circumstances. The hospital's emergency department has implemented its own version of the SHINE safety checklists used at Bristol Royal Infirmary. Royal Bournemouth Hospital is now taking this one step further by making the checklist entirely electronic and integrating it into the trust's own Electronic Nursing Assessment (ENA) system, which involves nurses inputting patient information and vital signs into handheld devices. These communicate with their department's IT system, allowing continuous and visible monitoring of patients and easier and automatic audit of performance. The ENA software has been developed by the trust's in-house App development team.

Royal Derby Hospital uses an electronic dashboard containing key patient safety information, for example triage category, National Early Warning Score (NEWS) and waiting times. This is refreshed every 15 minutes and is available throughout the department on touchscreens.

Clinicians acknowledge that departments tend to provide sufficient staff for average demand. However, a safe department will recognise that peaks in demand are usually predictable, and will therefore align staffing levels with them.

St Thomas' Hospital has carried out work to assess staffing demand and productivity using 'heat maps'. The rota pattern is combined with data on the demand and then with productivity. This showed that they required more staff on Monday evenings than at any other time of the week. The research team at King's College London validated the emergency department's staffing pattern.

Southmead Hospital has matched staffing to demand. The emergency department looked at the average attendance data and then staffed according to this. This means that additional consultant staff are available late on Mondays, and night working times have been changed to bring in some of the night staff at 8pm rather than 10pm, which helps to be prepared for the increased attendance later in the evening.

Emergency departments frequently have to rely on temporary staff. As well as having sufficient staff to meet demand, clinicians recognise that it is imperative to have a clear, structured and efficient induction for locum and agency staff to support them in providing safe, effective, caring and responsive care for patients.

New locum doctors in the emergency department at **St. Thomas' Hospital** are assigned to a day shift at first, even if this is surplus to requirements, so that they can be assessed. Before they arrive in the department, they receive an induction pack by email, which they must sign to confirm that they have read it before they start. The induction pack includes:

- the department's values
- maps and pictures of staff uniform
- descriptions of software
- information about the bleep system, emergency numbers and where to get help
- EMU protocols, pathways and proformas
- the antibiotic policy.

Clinicians are concerned that temporary staff brought in at times of excessive demand are often inexperienced in caring for the types of patients in an emergency department, and will often be inappropriately allocated to an escalation area where they may potentially pose more risk.

Southmead Hospital uses escalation nurses from wards to look after stable patients in the major treatment area. This releases emergency department nurses to look after high-risk patients in other areas of the department.

Bristol Royal Infirmary has three escalation nurses from other departments on the rota every day so that, if needed, there is already a plan in place for them to be moved. They receive training before being allocated as an escalation nurse, particularly focusing on the SHINE safety checklist.

Sunderland Royal Hospital has a pool of emergency nurse practitioners (ENPs) who work in parallel with the F2 junior doctors and who can cross cover into gaps in the F2 or CT1 rota to limit the impact of working in an under-staffed department. The hospital prefers to cross cover from higher to lower grades, for example, using higher trainees to fill ENP gaps rather than leaving the department short staffed or using external locums. By maintaining links with former employees and having a supportive culture, the hospital has a pool of staff that can be contacted to cover short-term sickness. In this way, they avoid using short-term locums and the risks of working in an unfamiliar environment.

The emergency department at Sunderland Royal Hospital has not used short-term locums for several years, but if a short-term locum is needed, there is an agreement that they always spend a period working in the emergency department during the day before they are considered for night shift work. Sunderland Royal Hospital has a policy of not using locum doctors at night, as there is insufficient senior supervision for them.

KLOE S3: Do staff have all the information they need to deliver safe care and treatment to people?

Access to shared care records in an emergency department provides a significant benefit. Clinicians in departments that have this agree that it is essential, and told us that it has resulted in increased efficiencies by reducing time spent on clerking records and assessing patients.

At **St Thomas' Hospital**, staff in the emergency department can access most relevant local care records for patients. The department can see the list of the most complex attendances, medications and investigations by local GPs who are signed into the system. There are also shared medical records (for example, clinic letters and results) with Kings College Hospital, Princess Royal University Hospital and South London and Maudsley NHS Foundation Trust through the electronic patient record.

The emergency department team at **Sunderland Royal Hospital** has designed an electronic records system, which can be modified and updated by the team themselves. It allows the team to link in their electronic guidelines, prescribing and ordering sets. The system also allows clinical decision support tools to be added and completed within the medical record. Staff feel that being closely involved in developing and introducing new IT systems has been a worthwhile investment.

KLOE S6: Are lessons learned and improvements made when things go wrong?

A transparent learning culture is essential to ensure that emergency departments consistently provide safe care. At the workshop, the attendees from emergency departments shared a number of examples of how they ensure that they learn from incidents. Clinicians discuss incident reports at governance meetings as a matter of course, and some departments have developed innovative ways to build an 'organisational memory' to learn from incidents, which they felt was key, given the high staff turnover in the department.

The emergency department at **St Thomas' Hospital** recognise that in an area of high staff turnover, it is crucial to ensure that new staff have the opportunity to learn from previous incident investigations. They review incidents from the previous six months so that new staff will hear about the learning from an incident that occurred before they started.

At **Luton & Dunstable Hospital**, one of the consultants and a Band 7 nurse produce a monthly newsletter, which highlights new guidance relevant to the emergency department, learning from incidents, and a 'case of the month'. It also tells staff about any new or innovative equipment that has been introduced.

Homerton University Hospital promotes learning from incidents and complaints through a 'Risk Alert theme of the month'. During that month, the emergency department's newsletter and trust-wide safety briefing highlight learning from complaints and incidents around a common theme, for example, confidentiality or note-keeping. Alongside this, the department holds a five-minute education session for all doctors and nurses every week day. Each week, the topic is directly related to the risk alert theme for that month.

At **Frimley Park Hospital**, the emergency department safety lead (the ED consultant) produces a monthly safety newsletter based on the recent incident reporting patterns. This is sent out by email, shared on a secure staff social media group and posted on noticeboards throughout the department. The practice development nurse also sends a monthly email to staff about incident lessons.

EFFECTVE

KLOE E2: How are people's care and treatment outcomes monitored and how do they compare with other similar services?

Some of the clinicians felt that the 50 Quality Standards of the Royal College of Emergency Medicine are very specific and bespoke to the service and should be used to develop a dashboard. Although dashboards can be useful, some clinicians feel they have too little control over some indicators or metrics on their dashboard, and had taken a more individual approach. There was a clear feeling that the dashboards are most effective when they are led and developed by the emergency department rather than imposed on them.

Staff in the **Royal Derby Hospital** took part in a survey to capture what they think are the markers of quality care. This had a very good response and the department used the feedback to develop 'SAFECARE'. This is the acronym for eight internal standards of care groups:

- Sepsis
- Analgesia
- Fist see/time to be seen
- Entrust/handover
- Consultant review
- Admission time
- Review by senior clinician
- Experience (patient)

A lead for each group (half nursing and half medical) is responsible for the standards of care. Quality improvement projects are developed to support the objectives, which include measurable outcomes.

Clinicians consider monitoring and managing pain to be an important patient outcome measure in emergency departments.

The safety checklist implemented at **Bristol Royal Infirmary** includes regularly monitoring pain scores and administering analgesia. The checklist has resulted in an increase in the number of patients receiving analgesia in a timely way.

At **Southmead Hospital** the emergency care checklist data includes pain scoring and re-scoring. The data on pain is reviewed every week along with other key time-based parameters such as ECG sign-off within 15 minutes. The department uses sample selections to make sure that these critical time-based activities are being met.

KLOE E3: How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?

Clinicians felt that departments that cope better with the challenges of recruitment and retention are those that have been able to secure funding for nurse education, such as the advanced nurse practitioner course.

Bristol Royal Infirmary has designed a touch screen portal for use in all its resuscitation cubicles, which provides immediate access to the most evidence-based guidance required in that environment. The portal allows quick access in an acute situation and displays it for everyone in the cubicle to see clearly. Since the portal was implemented, errors in the resuscitation department have reduced.

Southmead Hospital has a nurse education team who are responsible for providing and delivering all in-house education. The department has more than 150 nurses, who are divided into teams led by a Band 7 nurse and incorporating all grades of nurses. A consultant and specialty doctor are attached to each team, which acts as a supportive smaller team to make sure that the educational needs of individual members of staff are met.

Given the high turnover of staff (particularly medical staff during August), the clinicians felt that a measure of good quality is how well the emergency department manages the induction for its junior doctors and trainees. Some departments have implemented simulation focused induction training, which also relates to KLOE S6 in how departments ensure continued learning from incidents. This sets the benchmark for the quality of care in the service.

St Thomas' Hospital has changed its approach to induction for junior doctors. Evaluation showed that having many short presentations across a range of topics was not particularly effective and there was little retention by the junior doctors. Now, junior doctors spend half of their induction time using simulation, which is inspired by issues covered through incident analysis. One particularly effective simulation was a mental capacity assessment, where an actor played the role of the patient. Feedback from staff was very positive compared with previous inductions. The department plans to run a joint crash caesarean section simulation with paediatrics and maternity departments. The emergency department has also run a simulation to test its new resuscitation area, enabling staff to test how they would use the room and ensure it was set up correctly, which meant Day 1 ran smoothly.

Royal Bournemouth Hospital holds a bespoke departmental junior doctor induction four times a year. This is a two-day extensive induction, which junior doctors must complete before they are allowed on a clinical shift. It includes practising simulated cases learning from previous serious incidents, near misses or cases based on the Royal College of Emergency Medicine's alerts, Medical Defence bulletins and known high-risk presentations to the emergency department.

In addition, two weeks before starting a post, junior doctors receive a workbook that highlights the top 10 high-risk presentations to the emergency department, including clinical cases, safe handover, dealing with difficult patients, mental capacity and difficult referrals. Juniors work through this booklet as structured written cases and discuss their answers with their allocated clinical supervisor at their first induction meeting in the first week of their post. They discuss learning from previous errors in a discussion around risk during induction. They use simulation to rehearse high-risk attendances.

KLOE E4: How well do staff, teams and services work together within and across organisations to deliver effective care and treatment?

Emergency departments are just one part of the acute care system and clinicians were clear that effective team working across both the trust and the wider health system was essential to ensuring good quality, effective care.

At **Dorset County Hospital**, the emergency department has worked to ensure that there is organisational understanding that the four-hour emergency access standard is about patient flow, crowding and safety. The department reports an exceptional relationship with the acute medicine service, which actively 'pulls' patients.

A dedicated acute physician holds the bleep to enable the emergency department to request early advice. The acute physician completes the post take in the emergency department with the post take team, before they are taken to the ward. Single point clerking was proposed by an acute medical consultant and implemented in October 2016; it has resulted in a 75% reduction in medical patients breaching the four-hour target and has reduced duplicated clerking. The process also enables better training for juniors, as a medical junior is still linked to the patient.

Royal Devon & Exeter Hospital has developed a barometer to evaluate the pressure in the emergency department. This provides a clear action plan to follow when the pressure builds from green to amber and from amber to red. When this happens, there are also clear escalation procedures to follow for patients who are referred to speciality teams where there is a delay in reviewing them. Internal professional standards require that all patients should be reviewed within 30 minutes by a junior and if this does not happen, the registrar is contacted after an hour and then the consultant after two hours.

Salford Royal Hospital has developed a standard operating procedure (SOP) with the ambulatory care unit and the surgical assessment unit. The emergency department now has direct access to these units, as long as the patient has a NEWS score of 4 or less. The SOP is regularly audited to ensure that appropriate patients are sent to other units.

At **Frimley Park Hospital**, an acute physician is based in the emergency department from 10am to 8pm Monday to Friday. This role is designed to facilitate patients' admission to hospital while aiming to increase the number of patients who can be turned around within the department, avoiding an admission. Rather than every medical patient having to be clerked twice, the medical consultant directly post takes selected patients, which ensures that decisions regarding admission or discharge are made as early as possible.

This intervention has resulted in a reduction in the conversion rate and reduced decision to admit time in the department. The department has a surgical assessment unit (SAU) consultant available on weekdays from 2pm to 8pm by direct dial. This allows a senior decision-maker for general surgical problems to be available to review patients early (often when the on-call team is in theatre) and develop management plans in a similar way to the acute physicians. This is now being extended by recruiting two further SAU consultants to enable the service to run from 8am to 8pm on four weekdays.

The emergency department at **Royal Bournemouth Hospital** has developed a simple online comprehensive multidisciplinary weekly rota, which is also available on handheld devices. This allows all staff to easily see who is on duty instead of having multiple separate rotas for junior doctors, consultants, advance nurse practitioners and minor injury nurses. All staff have real time access to a live rota, which ensures that shifts aren't missed due to reading old out-of-date rotas and allows staff to see where there are potential shortages if they are willing to work extra hours or fill in for any short notice sickness. This has also helped the department to plan daily rotas by more effectively utilising the skill mix of different practitioners.

Sunderland Royal Hospital has a Band 8a pharmacist who provides direct input into the emergency department, supports the safe delivery of care around medication/prescribing, facilitates learning from incidents and leads on quality improvements. Examples include supporting the discharge of patients from the department who are on end of life care pathways, developing a prescribing set for the management of hyperkalaemia and supporting procedures such as fascia iliaca blocks in fractured neck of femur. The team feels that the ability to 'parachute in' someone who isn't carrying a clinical caseload, but has the clinical and prescribing skills needed, can often tip the balance in doing the right thing rather than the easiest thing: improving patient experience and quality of care.

At **Luton & Dunstable Hospital** the medical take team is led and delivered by a consultant, and is resident in the emergency department at all times. The team 'gate-keeps' and signposts to alternatives early in the patient's four-hour journey, which avoids a patient from ever reaching an admission zone, wherever possible. By having physicians in the emergency department, all disciplines of staff have a greater understanding, and can achieve a more detailed handover. This also promotes learning, as staff can receive feedback while the patient case is still active.

RESPONSIVE

KLOE R2: Do services take account of the particular needs and choices of different people?

As increasingly recognised, patients with complex mental health needs present a number of significant issues that can be challenging for the emergency department to manage effectively. Clinicians at the workshop shared some examples of how their departments meet the needs of patients who have complex mental health needs.

At **St Thomas' Hospital** many patients in the emergency department are not registered with a local GP, or even known to mental health services in the UK, which means that getting beds for them can be very problematic. However, patients are moved out of the department within 12 hours (from booking-in time) and are cared for on the observation ward.

The needs of patients with a mental health condition were specifically considered in the design of the new observation ward. Ongoing work is looking at the care pathways, and the local mental health group has visited to talk to nurses, and will offer training to increase their skills when providing care for patients with mental health conditions.

Frimley Park Hospital has carried out work over the past two years to increase awareness of mental illness and improve the care of patients with a mental health condition that come through the department. The department has established:

- psychiatry morbidity and mortality meetings
- mental health Cascard templates
- a CAMHS worker based solely at Frimley Park Hospital.

Similarly, At **Luton & Dunstable Hospital**, the acute psychiatry team is based in the emergency department, with offices adjacent to the ED consultants.

Both hospitals have established:

- an emergency department consultant lead for mental health
- regular interface meetings between the emergency department, psychiatry team and the police
- management plans for individual regular and frequent attenders
- at least one mental health education session a year for staff and at every induction.

Taking learning from **Southmead Hospital***, **Bristol Royal Infirmary** has developed an innovative and award winning initiative to address 'High Impact Users' in its emergency department. The local population has a high incidence of homelessness, alcohol and drug addiction and mental health disorders. This initiative has streamlined and personalised the approach for people who are regular attendees with complex needs, allowing the emergency department, ambulance service and GP service to have a consistent approach and make it easier for people to access local services.

***Southmead Hospital** developed local targeted plans for frequent attenders by liaising with GPs and reviewing cases at multidisciplinary team meetings.

Royal Surrey County Hospital has a multidisciplinary approach to frequent and complex attendees that have a high impact on the emergency department. The emergency medicine consultant lead, Inreach GP, mental health liaison and psychiatry teams focus on developing a bespoke care plan for each patient – this is also for those patients with physical health problems, recognising that they often have an unmet mental health need. They are supported in this project by an alcohol liaison team, who were nominated for an award in the Nursing Times, as well as other more innovative practice including the EMERGE project – a group of youth workers who work on a voluntary basis in the department to provide additional support and advocacy for patients aged 10-25 that present with self-harm, overdose or have attempted suicide.

There is 24-hour psychiatric liaison service in the **Royal Devon & Exeter Hospital**, which has a one-hour response time and a 75% success rate in meeting this target. A psychiatric triage tool and observation chart has been devised to ensure that patients are 'risk stratified' to assess their risk of absconding.

KLOE R3: Can people access care and treatment in a timely way?

Clinicians at the workshop acknowledged that there is a national focus on pre-emergency department streaming (by having a GP available in the emergency department), and most departments were streaming to some extent. However, the effectiveness of streaming is variable and depends on the patient demographic of each department.

All clinicians agreed that it is essential to have effective governance arrangements with primary care providers where there is GP streaming, and that it is important for the emergency department to be represented on local A&E delivery boards and to be actively involved in discussion and decisions.

Luton & Dunstable Hospitals have been very successful in streaming high volume/low acuity patients to a GP-led service. The service is located on site, but is separate from the main emergency department. In total, 30% of all attendees are sent to the urgent GP service. As a result of this streaming, the emergency department conversion rate (arrivals to admissions) has risen to around 30%, but the urgent GP conversion rate (consultations to specialty referrals) is less than 5%. As a safety feature, the urgent GP service has the ability to send a patient straight back to the emergency department with "no questions asked" if, for example, a patient deteriorates in the GP clinic or if the GP feels that they are outside of their clinical competency. These cases are all reviewed at a monthly governance meeting, and currently account for less than 0.5% of all cases streamed.

At **Salford Royal Hospital**, a GP works in the emergency department 24 hours a day, seven days a week. Between 10-17% of patients each week are treated by GPs, which reduces the demand on the department.

Once patients are booked in, clinicians use a variety of processes to ensure a smooth patient flow through the department. At the workshop, they agreed that there is not a 'one size fits all' solution.

Royal Derby Hospital has a six bay 'pit stop' that has improved patient flow and the quality of patient care. Doctors are allocated to the pit stop for two hours while nurses are allocated for six hours. There is a standardised ambulance handover and a 'pit stop coordinator' on duty from 11am. One of the benefits of the pit stop is front loading investigations and early decision-making. By pairing trainees with a specialist registrar or consultant, it also provides an education opportunity, with formal allocated time for feedback and training after each two-hour session.

Frimley Park Hospital has developed a five-bedded assessment area into an ambulatory care area within the emergency department. This allows patients who would normally be on trolleys in majors for long periods to be assessed earlier and appropriate investigations organised before they are pronounced "fit to sit". These are not critically ill (ESI 3) and are managed by one to two senior registrars and a Band 6/7 nurse with support from a healthcare assistant. The ambulatory care area runs from 8am to 8pm, with a dedicated team of at least four staff; it is hoped to extend this to 2am.

There is also a medically-run Ambulatory Emergency Care Unit, which is open Monday to Friday 9am to 7pm and Saturday and Sunday 11am to 7pm. GP-expected patients are streamed off to be seen there. This firstly reduces the number of patients coming through the emergency department, and secondly ensures the aim of staff is to ambulate patients rather than assume that they require an admission. This model of service delivery has now also been implemented at Wexham Park Hospital.

Emergency department staff at **Royal Bournemouth Hospital** visited Ipswich Hospital to look at its successful early warning trigger tool, with a view to learning from it. Royal Bournemouth has now developed and modified its own internal escalation trigger tool. Every hour, the nurse co-ordinator inputs various parameters, including staffing levels, the number of patients in various parts of the department and incoming ambulances, to produce a score. Having collected the data for two years, the scores now align to trigger levels, which are regularly updated on the front page of the trust's intranet and are linked to defined actions on the escalation plan. This has greatly improved the effectiveness and communication of the live pressures in emergency department to the rest of the trust.

Some hospitals have developed specific clinical pathways to reduce admissions and improve patient flow.

Manchester Royal Infirmary has developed a chest pain pathway (Troponin-only Manchester Acute Coronary Syndromes Models (T-MACS)). The model identifies patients as low, medium or high-risk with a single blood test, which speeds up the diagnosis of acute coronary syndromes and allows appropriate early discharge of low-risk chest pain patients.

Clinicians at the workshop agreed that it was often difficult to discharge patients back to care homes following an admission. Frail elderly assessment teams could help to facilitate this and give feedback about individual care providers that were causing delays.

WELL-LED

KLOE W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Effective leadership is essential for departments working under pressure. Clinicians felt it important that clinicians should lead by example and are visible and accessible to all staff. They believe that leaders play a key role in succession planning, and place great importance on identifying and nurturing the leaders of the future.

> At **Frimley Park Hospital** the matron chooses to work weekly clinical shifts. All staff have free access to the senior team to raise any concerns.
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> Similarly, at **Royal Devon & Exeter Hospital** Band 7 nurses have been rostered to work Friday through Monday nights to improve clinical leadership on these shifts.
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> At **Luton & Dunstable Hospital**, all the consultants insist on being approached by junior doctors on first name terms, and they have completed multiple training programmes in Human Factors. This allows the hospital to develop a culture of accessibility without fear.

KLOE W3: Is there a culture of high-quality, sustainable care?

Culture was a key area for discussion at the workshop. Clinicians were clear that it is essential to have a supportive culture that encourages a single cohesive team. They acknowledge that it can be difficult to change the culture of a department, especially when it is working under pressure, but that it is an essential component of leadership. Engaging frontline staff and empowering them to drive improvement are the most important aspects of bringing about this change.

> **The Royal Bournemouth Hospital** uses project management software to keep doctors, nurses and managers up-to-date with risks, new policies, education and safety alerts in the emergency department. Staff can engage with it at home, at work or on their phones or handheld devices. This has greatly improved communication between staff, especially as not all nurses or healthcare assistants have a trust email account or cannot access it outside work.
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> The hospital has also developed a suite of electronic staff feedback forms. These encompass safety concerns, near misses, good ideas and positive event reporting as well as allowing the department to say #Thank you to any member of staff. This has changed the culture of reporting in the trust into one of positive learning from both good outcomes, near misses or harm. In addition, the hospital has implemented the Happy App – a staff wellbeing portal that measures the live 'mood' of the department. This gives all members of the department a voice and allows senior members of the team to be responsive to staff concerns, praise and good ideas.

St Thomas' Hospital has worked hard to improve culture, and a key element to this is the daily 8am handover, which has extended the routine clinical handover into a standardised session attended by all relevant members of staff. This is a multi-disciplinary meeting, held away from the department and incorporates:

- generic messages or allocations for the day
- a celebratory element
- guest speakers
- clinical handover.

The emergency department had to demonstrate to the trust the importance of this meeting to its culture and effectiveness, to ensure that the its nursing hours were not changed to be in line with the rest of the trust, to enable nursing staff to attend.

To implement a culture of safety, **Royal Derby Hospital** engaged with the East Midlands designated Academic Health Science Network to carry out a survey of the safety environment using real-time patient safety clinical triggers. They have re-audited areas of poor performance (such as visibility of local management teams) to ensure a focus on continuous improvement before the department is formally re-audited in 2018.

The hospital also addressed the psychological support of members of emergency department team by implementing psychological support systems such as 'Trauma Risk Management (TRiM)' to help staff following traumatic events, as well as team social activities, Monday morning breakfasts provided by the department, and specific areas designated as no 'doctor-only' or no 'nurse-only' areas.

Southmead Hospital has a number of activities aimed at increasing team wellbeing and cohesiveness.

- The emergency department consultants pay for an annual BBQ and disco at a campsite, which all staff and their families are invited to, where they can camp and have breakfast in the morning.

- The ED Float Group tours the local area at weekends in December on a float made and maintained by ED staff. ED staff and their relatives go with the float collecting money for the hospital charity.

- There are annual away days for consultants, matrons and ward managers, which alternate between having a strategic and operational focus. There are also away days every six months for Band 6 and 7 staff.

At **Addenbrooke's Hospital**, a team of people from within the emergency department provide private and confidential support, encouragement and guidance to staff through an 'ED Listeners' scheme. The ED Listeners are available to all members of staff regardless of specialism, grade or employment type. The principle aim of the ED Listeners is to provide on-site peer support in times of need and to offer advice on additional 'expert' support when the need is identified. The ED Listeners are represented at debriefs following an incident in the department, so that staff know they have access to ED Listener support after an incident. While not a counselling service, the ED Listeners can arrange access to external counselling services if they are unable to offer appropriate support locally.

Clinicians told us that a good indicator of the culture of an emergency department is the level of engagement with other specialities in the hospital, which links back to KLOE E4 and multi-disciplinary working.

KLOE W5: Are there clear and effective processes for managing risks, issues and performance?

While the day-to-day impact of winter pressures and other surges in demand are felt at the front door and affect the safety of the department, the ability to manage escalation is a reflection of how well-led the department and hospital is. Escalation policies and how they are implemented vary across departments, but having an effective escalation process, which works both in and out of hours, was seen as the number one priority for many. Clinicians feel it is imperative that dealing with surges in demand is viewed not just as the responsibility of the emergency department; rather it should be seen as the responsibility of trusts as a whole, and potentially the wider health system.

Both **Luton & Dunstable Hospital** and **Ipswich Hospital** use predictive modelling and dashboards to monitor activity to inform how they use the escalation process. The dashboard triggers a RAG score for the emergency department, which is shared hourly with the operations centre and the director on call. The dashboard has been changed following feedback from nursing staff to give an accurate reflection of the status within the department.

In addition, at Luton & Dunstable Hospital, the medical shift leaders are required to use their clinical experience to predict the need for a bed for every patient within one hour of their arrival. This allows the patient flow team to accurately estimate the bed requirements up to four hours in advance, and well before a formal referral to a specialty has been made.

At **Royal Surrey County Hospital** there is a weekly Emergency Care Steering Group chaired by the Chief Executive and regularly attended by the other executive team members. Its focus is on anything related to emergency care, but this isn't limited to just the emergency department only; it links in with trust-wide projects to improve patient flow, including acute medical and frailty pathways. This has allowed a direct and continuous relationship with the executive team to understand and respond rapidly to the needs of the emergency department and its development, and cascading and integrating this throughout the trust.

KLOE W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Clinicians felt that the Friends and Family Test is not the most effective way of collecting feedback from patients about their experience in an emergency department as the response rate nationally is poor. Some trusts use other ways to collect feedback such as through social media, although this has limitations. However, the clinicians all felt more could be done locally to learn from patient feedback and to share the positive patient feedback about their experience.

Royal Derby Hospital holds patient experience meetings for the emergency department, which include representatives from nursing, the head of reception, volunteers, the trust's patient experience team, and two patient representatives. The group was instrumental in developing an 'ED Passport'. This is an anonymous document (it only includes the hospital number) that states the patient's management plan, and gives them the opportunity to state their priorities. This had been very useful in making staff aware what was important for the patient, for example, asking "Do my relatives know about my admission?"

The **Royal Devon & Exeter Hospital** has monthly 'care rounds', when an emergency department supernumery consultant or a member of the hospital's senior management will select a number of patients at random to talk to and ask about their experience of attending the department, including what they think needs to improve. The wider team receives 'hot feedback' at the 4pm handover so that they are aware of emerging issues.

KLOE W8: Are there robust systems and processes for learning, continuous improvement and innovation?

There was a collective view that to be rated as good and outstanding, organisations should have a culture that promotes continuous quality improvement. Clinicians believed it was right that staff should regard quality improvement as an intrinsic part of all their jobs. The consensus at the workshop was that quality improvement can only happen if leaders are fully committed to it and set aside the necessary time and resources.

Bristol Royal Infirmary has developed an embedded quality improvement workstream that takes place consistently and includes all members of the emergency department. There are 10 teams, allocated yearly, comprising clinical staff of all grades and nursing staff, including matrons and clerical staff. They are tasked with a quality improvement audit and have a year in which to audit, implement a change and re-audit the outcomes. The hospital has a dedicated Clinical Audit and Effectiveness Manager and publishes an annual report outlining the progress of each quality improvement [ED Page 16] and noting the audits that are in progress, those that are completed and abandoned audits.

Royal Bournemouth Hospital has a 'Staff Vision and Innovation Day', which is held off site. As well as giving feedback about performance, and patient and staff feedback, they discuss all the good ideas from members of staff, including new ideas, innovations, QI projects and priorities for the next year. This annual meeting is attended by all grades of staff and allied members of the team.

Continuous improvement and service development at Western Sussex Hospitals NHS Foundation Trust (**St Richard's Hospital, Chichester** and **Worthing Hospital**) has become the focus of service delivery, and is aligned to the trust's strategic direction. The focus of trust activity is 'patient-first' and performance metrics are designed around that objective, with strategic themes aimed at sustainability, workforce, quality improvement and systems. All continuous improvement projects in the emergency department (including reducing time to triage, falls, and nursing vacancy rates) are supported and coached by divisional directors, and a culture of continuous improvement is embedded across all staff.

There is visible input and coaching from the executive level leaders, and all staff feel that they have a voice and are empowered to drive forward high-quality care. All staff (clinical and non-clinical) attend daily 15-minute huddles on the emergency department, to review performance and solve problems.

Luton & Dunstable Hospital has allocated development days for nurses and doctors, where each grade looks at specific audits. Nurses and doctors are assigned an area of responsibility, which allows them to feed learning points back to improve the quality of care. On these 'personal development' days, medical staff are expected to perform audits, review their x-rays and missed pathology, undertake and participate in teaching, and senior trainees are involved in management activities.

If you would like further details about the examples from emergency departments, please contact the trusts using the details below.

Hospital name and NHS trust	Attendees at the workshop
Cambridge University Hospitals NHS Foundation Trust **Addenbrooke's Hospital** Email: communications@addenbrookes.nhs.uk	Vazeer Ahmed Andy Bailey
City Hospitals Sunderland NHS Foundation Trust **Sunderland Royal Hospital** Email: media@chsft.nhs.uk	Kate Lambert Hannah Stoker
Derby Teaching Hospitals NHS Foundation Trust **Royal Derby Hospital** Email: dhft.communications@nhs.net	Dan Boden Sam Bagshaw Lee Doyle
Dorset County Hospital NHS Foundation Trust **Dorset County hospital** Email: communications@dchft.nhs.uk	Andrew Brett Kevin Samarasingha Emma Joslin Jennifer Frampton
Frimley Health NHS Foundation Trust **Frimley Park Hospital** Email: communications@fhft.nhs.uk	Nick Payne Bethan Graf Glyn Barnett Cheryl Meineke
Guy's and St Thomas' NHS Foundation Trust **St Thomas' Hospital** Email: press@gstt.nhs.uk	Katherine Henderson James Hill Anneke Biginton
Homerton University Hospital NHS Foundation Trust **Homerton University Hospital** Email: mark.purcell@nhs.net	Jean Lyon Maeve Clarke Claire Charley
The Ipswich Hospital NHS Trust **Ipswich Hospital** Email: Jan.ingle@ipswichhospital.nhs.uk	Nadine Darlow Andy Willis

Luton and Dunstable University Hospital NHS Foundation Trust **Luton and Dunstable Hospital** Email: communications@ldh.nhs.uk	Dave Kirby
Manchester University NHS Foundation Trust **Manchester Royal Infirmary** Email: comms@mft.nhs.uk	Craig Ferguson Cath Bartlett Gillian McAllister
North Bristol NHS Trust **Southmead Hospital** Email: press.office@nbt.nhs.uk	Leilah Dare
Royal Devon and Exeter NHS Foundation Trust **Royal Devon and Exeter Hospital** Email: rde-tr.RDEComms@nhs.net	Lewis Jones
Royal Surrey County Hospital NHS Foundation Trust **Royal Surrey County Hospital** Email: rsc-tr.Communications@nhs.net	Lori Anderson Karen Butler
Salford Royal NHS Foundation Trust **Salford Royal Hospital** Email: communications@srft.nhs.uk	Angela Coumbarides
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Royal Bournemouth Hospital** Email: communications@rbch.nhs.uk	Farhad Islam
University Hospitals Bristol NHS Foundation Trust **Bristol Royal Infirmary** Email: communications@uhbristol.nhs.uk	Rebecca Maxwell
Western Sussex Hospitals NHS Foundation Trust **St Richard's Hospital, Chichester and Worthing Hospital** Email: communications@wsht.nhs.uk	Mark Witcomb

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