University Hospitals Dorset
NHS Foundation Trust

Internal Professional Standards

EMERGENCY & URGENT CARE PATHWAYS

(Version 5.1)

October 2022

CONTENTS

1. Background

1.1. This document outlines the guiding principles and Trust-wide Internal Professional Standards (IPS) for emergency patient flow as recommended by NHSI and ECIP.

2. Purpose

2.1. We all want the NHS to be at its best when we need it most. Access to life-saving emergency services is therefore vital in every sense. The NHS must determine priorities that will allow it to make best use of specialist skills and limited resources. The Clinical Review Standards reflects public perceptions of quality of care and has become a key measure of a hospital's standing in its community. UHD has therefore looked to balance this key performance indicator with Royal College guidance and clinical evidence regarding the speed with which senior decision-makers can assess and treat individuals who may need emergency admission. This policy sets out the Internal Professional Standards that will serve to fulfil the organisations and professionals' clinical responsibilities.

2.2. This document has been written to share the Internal Professional Standards to:

- Ensure UHD provides high-quality emergency and urgent care pathways.
- Identify the requirement for individual departments to develop procedures to meet the overarching IPS for an emergency care pathway.
- Support a clear escalation process with specific triggers.

3. Scope

3.1. This document relates to the following staff groups who may be involved in the assessment and delivery of care of emergency patients attending UHD. Staff will be both based in the Emergency Department (ED) and in other Trust teams where those teams have responsibility for caring for, providing diagnostics for or receiving emergency patients from the ED.

- Nursing Teams
- Support workers
- ED coordinators
- All Clinical & Medical staff across Care Groups & specialties
- Clinical Site Teams
- Management
- Porters
- Ward clerks / discharge coordinators
- Allied Health Professionals
- Radiographers
- Healthcare Scientists (path, cardiology, respiratory etc.).

- Hospital Operations

4. Location

4.1. This standard operating procedure for internal professional standards relates to the operational management of emergency patients across the whole Trust.

5. Governance

5.1 Monitoring of the standards will be managed by a newly formed 'Clinical User' Group (*Appendix 1*) which will be made up of clinicians and management colleagues from all specialties that will meet every two months to review compliance and share good practice and learning from incidents.

6. Guiding Principles & Trust Internal Professional Standards:

Statement of Intent:

The patient journey across UHD has become increasingly complex and there are many reasons for this. The recent external review has strongly recommended developing and aligning our principles of Acute and Emergency Care across our sites to enable a high quality of care for our patients. We describe these principles below which can be used for the benefit of patients at the beginning of their journey into UHD.

Signed by:

Ruth Williamson, Matt Thomas, Isabel Smith, Rob Howell, Daniel Webster & Tristan Richardson on behalf of the *Office of the Chief Medical Officer*

And UHD Chief Executive Siobhan Harrington

7. The Ten Principles for Effective Emergency Care: *The overarching principle, is right care, right place, right time*

1. **Timely assessment-** An emergency department (ED) decision making clinician will see new patients on or as close to arrival as possible in the ED.

2. **Think home-** If a patient is likely to be able to go home, this is the priority. The ED team will not admit to hospital, or transfer to SDEC just to avoid a breach of the UEC Standards.

3. **Move to correct specialist care-** Specialties will have arrangements in place for sufficiently experienced staff to assess emergency patients in a timely way and must not insist on ED based investigations that do not contribute to the immediate management of the patient.

4. **ED will refer patients to the most appropriate speciality** after initial assessment, who will attend the patient. If subsequently it is considered that an alternative specialty would provide more appropriate care, it is the responsibility of the first specialty to initiate necessary care, facilitate discussions and onward referral if necessary.

5. **Patients referred from primary care** (or any other clinical service) should be routed directly for specialty assessment via the Emergency Admissions Team. If this does not occur and the patient attends the ED, the patient will be transferred to the specialty considered most appropriate by the ED team unless immediate medical intervention is required. This includes patients where primary care has been unable to contact speciality but the patient attends with a written referral.

6. **Patients will only be sent to the ED** as a result of advice by specialty teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. In this situation, the ED team will continue to provide immediate clinical support to patients within the resuscitation area, but they remain the responsibility of the specialty for on-going management of the current clinical problem. Timely communication is the responsibility of both the speciality teams and ED.

7. **Timely specialist review of returning patients** Discharged inpatients that return to ED within 72 hours of discharge with the same condition and are stable, or at any point with a complication of surgery or a procedure will be seen by the specialty team in their own admission/SDEC areas. The ED team will continue to provide clinical support to unstable patients within the resuscitation area.

8. **Right place for transfers of care -** Except for specific agreed clinical pathways, patients requiring clinical review/admission in another UHD site will not be transferred to the other ED.

9. **If there is a failure for different specialties to agree** on accepting a patient, the ED consultants have the authority to admit any patient to the speciality that they consider best able to meet that patient's clinical needs.

10. **The patient should always be at the centre of all decision making**

8. Emergency Department

Owner	Standard	Target	Measurement Points	Measure	Level
ED	Time to clinical handover and release of ambulance crews	Average Time	Arrival to first non-ambulance location	KPI	15 mins
		Cumulative Time Lost in Handovers over 15 mins	From SWAST	IPS	< 4 hours
		30 min ambulance breach	From SWAST	IPS	<4
		1-hour ambulance breach	From SWAST	KPI	O
ED	Time to triage (walk-in)	First meaningful clinical assessment (not FDS). <15mins	Arrival to Nurse Assessment / Triage	KPI	95%
ED	Time to clinician seen	Within 60mins	Arrival to first clinician seen	IPS	80%
ED	Time to Senior Review (majors)	Within 60mins	First clinician seen to senior review	IPS	75%
ED	Time to decision - Majors	Within 90mins	First clinician seen to referral or diagnosis which is earlier	IPS	90%
ED	Time to decision - Minors	Within 30mins	First clinician seen to referral or diagnosis which is earlier	IPS	90%
ED	Time to bed booked (from arrival for all predicted admissions)	Within 90mins	Nurse assessment to Bed Booking / APM	IPS	60%
ED	Time to ECG	Within 10 minutes	For patients presenting with Chest Pain	IPS	100%
PATH	Pathology tests	Percentage of results available on EPR within 1 hour of receipt	Lab receipt to EPR publication	IPS	95%
RAD	X-Ray for ED patients	Completed within 30 mins of receipt Daytime	Request on ICE to arrival at imaging	IPS	90%
		Completed within 30 mins of receipt Night-time	Request on ICE to arrival at imaging	IPS	50%
		Reports viewable in EPR within 1 hour of imaging	Imaging complete to publication	IPS	75%
RAD	CT Imaging	Completion within 1 hour	Request on ICE to	IPS	75%

	Imaging for ED Urgent scans e.g. Head & Neck, CT Brain and others not for speciality follow up	of receipt	arrival at CT		
		Report available on EPR within 1hr of imaging	Imaging complete to publication	IPS	75%
CST	Transfer to inpatient areas	Bed will be made ready within 60mins of booking	Bed booking / APM request to Bed Ready time	IPS	80%
		Patient will leave the department within 60mins of “Fit for Ward” i.e. ED care complete	Time from bed ready or referral (whichever is later) until Bed Ready time (in development)	KPI	95%
TRUST	Speciality review *Where no capacity exists within the Trust – patients MUST NOT routinely be held in ED*	Speciality will review referred patients within 4 hours	Time from referral to clerking by speciality team (retrospective dip test)	IPS	90%
TRUST	Total time within the department	Total mean time within department for all closed episodes	Attendance to left department for closed episodes in 24hr period	KPI	200 mins
		Patients waiting 12hrs within the department	Attendance to left department in 24hr period	KPI	<5%

9. Admission Units

Standard	Target	Level
All patients attending should have observations performed within 15 minutes of arrival	15 minutes	100%
All patients attending should have investigations initiated (blood tests, CXR) within 30 minutes of arrival (unless completed in ED)	30 minutes	100%
All new patients should be reviewed by a member of the speciality team within 4 hours of arrival	1 hour	100%
Time to be seen by a Consultant –Within 14 hours from arrival on admissions unit - overall (or 8 hours for those admitted between 0800-1800) 100%	14 hrs	100%
All patients within SDEC should be seen and discharged within 4 hours of arrival (unless they require additional diagnostics such as CT scanning and additional treatment such as blood transfusion)	4 hours	80%
Moves to inpatient areas should be complete within 60 minutes of bed allocation	1 hour	90%

10. Document management

The table below will be completed by the Author:

Approval:	**Ruth Williamson & Medical Directors**		
Owning department:	Medical Care Group		
Author(s):	Michelle Higgins GM, and Bruce Hopkins Snr Matron		
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Appendix 1

University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset
Internal Professional Standards Clinical User Group
Terms of Reference

V0.1 Draft

The UHD Internal Professional Standards Clinical User Group brings key stakeholders together to facilitate a collaborative approach to the delivery and continual improvement of the emergency service provision to our patients. Working together to ensure the service is patient centered, evidence based and focused on delivering transformational change.

1. Membership and attendance

1.1 The core members of the Emergency Clinical User Group shall be:

- Medical Director Medical Care Group
- Medical Director Surgical Care Group
- Deputy CMO / MD??
- Clinical Director ED
- Lead ACP ED
- Clinical Director Acute Medicine
- Clinical Lead ED
- Clinical Lead Acute Medicine
- Senior Matron ED
- Senior Matron Acute Medicine
- General Managers all CG's
- Head of Nursing & Professions Medical CG
- Clinical Lead Orthopaedics
- Clinical Lead Urology
- Clinical Lead General Surgery
- Clinical Lead Gynaecology
- Clinical Lead Acute Medicine
- Clinical Lead, ITU/Anaesthetics
- Clinical Lead Pathology
- Clinical Lead Radiology
- Senior Matrons surgical Specialties

By invite:

In Attendance:

- Other clinicians and managers at the request of the committee

- UTC GP Lead?
- ED PA (notes)

1.2 The Chair and Co-Chair of the IPS Clinical User Group shall be the XX . The Chair of the committee reserves the right to delegate chairing of the meeting to any standing member with appropriate notice.

1.3 If a Clinical User Group member is unable to attend a meeting, they shall send their apologies in advance to the Group PA and arrange for a colleague to represent in their place.

1.4 Members of the IPS Clinical User Group are expected to attend at least two-thirds of the number of meetings in any given financial year. An annual attendance record shall be prepared by the PA and any issues concerning poor attendance of a User Group member shall be considered by the Clinical Lead and acted on as appropriate.

2. Secretary of the Board

2.1 (Quarterly Meetings) The ED PA will ensure that the agenda for the User Group meeting is circulated to all members one week in advance of a scheduled meeting and that action notes from meeting are circulated no later than two weeks post the meeting.

3. Quorum

3.1 The quorum necessary for the transaction of business, for decisions primarily affecting the ED and a given specialty, shall be the Clinical Lead IPS (or delegate), one member from the relevant care group, (or Deputy) and one member of the specialty groups.

3.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the IPS Clinical User Group.

3.3 Where a Clinical User Group meeting:

(i) is not quorate under paragraph 3.1 within 15 minutes from the time appointed for the meeting; or

(ii) becomes inquorate during the course of the meeting,

The members present may determine to adjourn the meeting to such time, place and date as may be determined by the members present.

4. Meetings and minutes

4.1 The Clinical User Group shall meet quarterly on *dates to be confirmed*.

4.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Clinical User Group no later than one week before the date of the meeting. Supporting papers shall be sent to members and to other attendees, as appropriate, at the same time.

4.3 Due to the frequency of the meeting all of the above will be standardised as much as possible, minutes will be kept to a minimum whilst the main record will be an action log recorded by the PA.

4.4 The record of the minutes shall include:

(i) the names of:

(a) every member of the IPS Clinical User Group present at the meeting;

(b) any other person present; and

(c) any apologies tendered by an absent member of the Clinical User Group

(ii) Actions agreed at the meeting

5. Decisions of the IPS Clinical User Group

5.1 The Emergency Clinical User Group will make formal recommendations for discussion and or approval at Divisional Governance Boards

5.2 Decisions of the Emergency Clinical User Group shall normally be made by agreement rather than by formal vote.

6. Duties

The Clinical User Group aims:

6.1 To deliver the best outcomes for our patients: Ensuring that patients access safe, timely and clinically effective Emergency Services.

6.2 Delivery of the Urgent and Emergency Care Standards working collaboratively with local and internal stakeholders to achieve and maintain all standards.

6.3 Improve trust-wide multi-professional specialty engagement to the urgent/emergency care pathways

6.4 Provide assurance that IPS, quality and governance national standards are fully adhered to and evidenced

The IPS Clinical User Group shall:

6.5 Determine service needs required to provide the best or excellent outcomes for patients

6.10 Provide the IPS Operational Board members with updates on progress against the agreed objectives and timescales

6.11 Hold each other to account for the delivery of agreed work programmes to improve resilience across the service.

6.12 Communicate changes/ improvements within their areas: Each member of the is Emergency Clinical User Group responsible for timely and effective briefing of all staff in their area of responsibility.

7. Conflicts of interest

Emergency Clinical User Group members shall comply with the UHD Code of Conduct and declare any conflicts of interest in relation to agenda items.

8. Review

The Emergency Clinical User Group shall, at least once a year, review its own performance, membership and terms of reference to ensure it is operating at maximum effectiveness.

9. Authority

9.1 The Emergency Clinical User Group has the authority to deal with the matters set out in paragraph 5 above.

9.2 The Emergency Clinical User Group may seek any information it requires from any employee of the Trust in order to perform its duties.

Appendix 2 — Emergency Department Agreed Triages

General Medicine
Acute and chronic diarrhoea
Chronic pancreatitis (normal amylase as per lab reference range)
Diabetic foot ulcers
Fractures for conservative management (single or simple)
Infected DVT in IV drug user
Intractable non-traumatic back pain without acute MRI evidence
Lower limb cellulitis
Mental health patients awaiting further psychiatric evaluation
Painless jaundice
Post-operative respiratory complications (i.e pneumonia, PE)
Pregnant patients with a medical complaint, after ED discussion with Obstetrics team – may be suitable for SDEC after Medical Consultant discussion if >22/40, otherwise transfer to Poole if admission required
Proven constipation without obstruction
Pyelonephritis without obstruction or complicated urinary tract
Upper GI bleeding

Older Persons Medicine
>85 years or 75-85 years with clinical frailty score $\geq$ 6
Head injury (if meets frailty criteria as above)
Isolated traumatic chest injuries if $\geq$ 80 years (joint care with General Surgery)
Spinal fracture (if meets frailty criteria above)

Oncology (transfer to Poole)
Back pain secondary to cancer
Malignant spinal cord compression (suspected or confirmed)
Patients under active treatment
Issues relating to immunotherapy treatment

Paediatrics
<18 years with oncological problem, complex special needs or Cystic Fibrosis
Children aged <16 years

Maxillofacial Surgery (Poole)
Periorbital cellulitis
Neck and facial cellulitis

Obstetrics & Gynaecology (Poole)
Anaemia related to PV bleeding
Hyperemesis gravidarum
Lower abdominal pain in women
Vaginal bleeding

All Specialities
Unplanned readmissions with the same complaint within 72 hours of discharge (ideally direct admission to relevant ward)
Patients needing IR procedures from Poole (or external to UHD) must have a consultant to consultant discussion to be accepted (spec to spec, not IR)

Emergency Medicine (Poole)
All head injuries that require admission for observation but do not meet OPS criteria and do not require Neurosurgical transfer (i.e Traumatic Subdurals)

General Surgery
Abdominal pain of unclear source, regardless of need for surgery or unremarkable CT findings
Acute pancreatitis
Anaemia related to PR bleeding
Biliary colic
Critical limb ischaemia not requiring vascular intervention
Ileus
Painful jaundice
Post-operative wound sepsis
PR bleeding
Pregnant patients <22/40 with a surgical complaint, after ED discussion with Obstetrics team
Significant mechanism/force of trauma causing torso injury with negative CT scan
Traumatic pneumothorax
Trunk and groin abscess

Vascular Surgery
Bleeding AV fistula
Critical limb ischaemia
Non-diabetic foot ulcer
Symptomatic abdominal aortic aneurysm (including not for operative intervention)

Urology
Acute scrotal pain
Acute urinary retention
Haematuria
Obstructive uropathy
Pyelonephritis with proven obstruction
Renal colic

Orthopaedics
Acute diabetic foot infection requiring surgical drainage (Poole)
C-spine injuries requiring hard collar immobilisation
Cauda equina syndrome (suspected or confirmed)
Falls with confirmed/suspected fracture (unless meets OPS criteria)
Hip pain with clinical suspicion of fracture but negative x-ray
Upper limb cellulitis
Necrotising fasciitis of limb
Septic arthritis (suspected or confirmed)
Significant mechanism / force of trauma causing neck/back injury with negative CT scan
Spinal fracture (unless meets OPS criteria)
Patients with fractures that are cause for admission as unsafe to go home (even if for conservative management) i.e Humeral / fracture, Pubic Ramus

Triage document – 25/10/22
Lead Dr M Wheble, Consultant Acute Med