

## **Priorities for Action 2008/09**

### **Priority 3: Improving Acute Services**

#### **Improving the Patient Experience Unscheduled Care Definitions & Guidance Framework**

**Service Delivery Unit**

July 2008

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## **1.0 INTRODUCTION**

Improving patient access to health services is a top Ministerial priority. During 2007/08 significant progress was made in improving access to Unscheduled Care Services including response times for ambulance services, timeliness of treatment at Emergency Departments and access to subsequent inpatient care. In 2008/09 the aim will be to consolidate this level of performance and standardise performance across individual sites. The Service Delivery Unit will continue to work on the major reform programme to improve access for patients to unscheduled care services. It will focus on the complete patient journey beginning with the ambulance journey, if required, into the Emergency Department, continuing through into the hospital system itself and ending when the patient is discharged (separate definitions are available for the delayed discharge targets).

## 2.0 AMBULANCE SERVICE

### 2.1 PfA Target

Priorities for Action 2008/09, includes the following target aimed at supporting the reform programme and improving access to Ambulance Services across Northern Ireland.

**“From April 2008, the Northern Ireland Ambulance Service should respond to an average of 70% of Category A (life-threatening) calls within eight minutes, with performance in individual Board areas being improved to at least 62.5% by March 2009. By 2011, NIAS to respond to 75% of life-threatening calls within eight minutes.”**

The standard for achieving 70% response within 8 minutes for Category A ambulance calls at regional level will be monitored from 1<sup>st</sup> April 2008. The criteria for achieving 62.5% in individual Board areas will be based on performance during the month of March 2009.

### 2.2 Definitions

The patient’s experience of an Emergency Department attendance can include a journey in an ambulance. In terms of capturing the total emergency care patient pathway, monitoring arrangements have been put in place to capture this part of the pathway. The information required is that which is currently obtained from the departmental KA34 (NI) return.

The following definitions are associated with this part of the pathway:

- **Call Responses**

Advance Medical Priority Dispatch Systems (AMPDS) dispatch codes correspond to the categorisation of calls as defined by the current DHSSPS guidelines and count only those category calls that resulted in an emergency response arriving at the scene of an incident. Emergency (999) calls can be allocated to one of three categories:

- Category A calls are classified as immediately life threatening;
- Category B calls are classified as being serious but not immediately life threatening
- Category C calls are classified as neither serious or immediately life threatening

The PfA target for ambulance response relates specifically to Category A calls.

- **Clock start for response time**

Response time starts when the following details have been ascertained by ambulance control:

- caller's telephone number
- exact location of the incident
- nature of the chief complaint (this may be prior to allocation of the dispatch code)

- **Clock stop for response time**

Response time ends with one of the following scenarios:

- when the emergency response vehicle arrives at the scene of the incident (an emergency response vehicle is any NIAS vehicle crewed by trained ambulance personnel equipped with a defibrillator);
- when an approved first responder equipped with a defibrillator, dispatched by and accountable to the ambulance service arrives at the scene of an incident;
- when a call is received from a general practitioner practice or health centre which has a defibrillator located there and a person trained in the use of the defibrillator.

- **Patient Journeys**

A patient journey should be reported for each patient carried (two patients in one vehicle counts as two). This data item is the same definition as used on the Departmental KA34 (NI) guidance notes

- **Handover**

The handover will be calculated from the time of arrival of an ambulance at an Emergency Department, as recorded on the Patient Report Form (PRF) against the time of registration or triage whichever is earlier. The PRF forms part of the medical record and a PRF for all '999' and GP urgent patients must be completed by the ambulance crew and given to the clinical staff in the Department. Clinical staff within

the Department have a responsibility to ensure that they receive the form, file it in the patients' record, and record the appropriate incident and PRF numbers on their Emergency Department system.

A time of 15 minutes is considered to be reasonable to allow completion of handover at an Emergency Department. Queues at Emergency Departments are not acceptable. A delay exceeding 15 minutes will only be considered acceptable for clinical reasons e.g. ongoing resuscitation of a patient. Where there are recurring delays at a particular site, an investigation will be carried out in collaboration with the Ambulance Trust, the Hospital Trust and the Service Delivery Unit to identify the reasons and develop and agree an action plan for improvement.

## 3.0 Emergency Department

### 3.1 PfA Target

Priorities for Action 2008/09, includes the following target aimed at supporting the reform programme and improving access to Emergency Departments and standardising performance across Northern Ireland.

**“Trusts should ensure that, from April 2008, 95% of patients attending A&E are either treated and discharged home, or admitted within four hours of their arrival in the Department. By March 2009, providers should ensure that this level of performance is achieved in individual hospital sites”**

This 4 hour operational standard applies to all new patients and unplanned re-attenders. Those patients attending the Emergency Department for a planned review should also be seen within four hours; however these patients are not included in the analysis against this target.

The operational standard for achieving the 4-hour target at Trust level will be monitored from April 2008. The criteria for achieving the target at individual sites will be based on performance in the month of March 2009. Therefore on an individual site basis, 95% of all new attendances and unplanned re-attenders who have a completed wait in the month of March 2009 must be admitted, transferred or discharged within 4 hours.

The 95% within 4 hours operational standard recognises that there may be clinical reasons why it would be appropriate to manage a small number of patients in an Emergency Department for longer than four hours.

**Clinical Exception – is defined as a patient who for clinical reasons the Emergency Department Consultant or someone deputising on his/her behalf has deemed it necessary for the patient to remain in the Emergency Department for ongoing treatment. For these patients the clock will continue to run until the patient has been admitted, transferred or discharged. These patients should not exceed 5% of all attendances (new and unplanned) during any month.**

Where a patient is recorded as having waited over 4 hours before being called for treatment, but has left the department without being seen (Did Not Wait), the patient must be recorded as a breach of the 4-hour wait.

Where a patient is recorded as having waited less than 4 hours before being called for treatment, but has left the department without being seen (Did Not Wait), the patient should be recorded as having met the 4-hour target.

### 3.2 12-Hour Breaches

When any patient (irrespective of circumstances and including those awaiting ambulance/private transport) waits more than 12 hours in an Emergency Department, this is classified as a Serious Adverse Incident (SAI) and deemed to have met the criteria for being reported to the DHSSPS, as set out in paragraph 16 of HSS (PPM) 06/2004.

The SAI should be reported to the DHSSPS using the template attached to the Circular Reference: HSC (SQS) 19/2007 '*Reporting and follow-up on serious adverse incidents and Reporting on breaches of patients waiting in excess of 12 hours in the Emergency Department*'.

All SAI reports are to be submitted to the DHSSPS within 72 hours of the breach occurring to [adverse.incidents@dhsspsni.gov.uk](mailto:adverse.incidents@dhsspsni.gov.uk)

### 3.3 Definitions

The following section outlines the key definitions and guidelines in relation to the Emergency Department target.

- **What is an Emergency Department?**

The 4 hour operational standard applies to all Emergency Departments in Northern Ireland, ranging from Emergency Departments with a full range of emergency medical and surgical services (Type 1), to units with a more limited range of emergency medical and surgical services (Type 2) and Minor Injuries Units (Type 3). The full list of current Emergency Departments subject to performance monitoring is as follows:

<b>Trust</b>	<b>Hospital Site</b>	<b>Type of Department</b>
Western Health and Social Care Trust	Altnagelvin Erne Hospital Tyrone County	Type One Type One Type Two

Northern Health and Social Care Trust	Antrim Whiteabbey Mid Ulster Causeway	Type One Type Two Type Two Type One
Southern Health and Social Care Trust	Craigavon Hospital Daisyhill Hospital South Tyrone Hospital Armagh/Mullinure	Type One Type One Type Three Type Three
Belfast Health and Social Care Trust	Belfast City Hospital Royal Victoria Hospital Royal Belfast Hospital for Sick Children Mater Hospital	Type One Type One Type One  Type One
South Eastern Health and Social Care Trust	Ulster Hospital Ards MIU Bangor MIU Lagan Valley Hospital Downe Hospital	Type One Type Three Type Three Type Two Type Two

- **Attendances**

Attendances at Emergency Departments should be allocated into one of the following categories:

a) **New Attendances**

This relates to any patient who presents without appointment to the Emergency Department, the exception to this being unplanned re-attenders (please see below).

b) **Unplanned Re-attenders**

This relates to any patient who returns to the Emergency Department without written instruction, with the same presenting complaint, within 30 days of the initial attendance. (Any patient where the initial intention at first attendance was not to bring the patient back to the ED, but subsequently the patient is recalled by a member of staff to attend the Emergency Department within 30 days should be recorded as an unplanned re-attender)

c) **Planned Reviews**

This relates to any patient given a written appointment, date and time to return to the Emergency Department planned review clinic. A review clinic is defined as any clinic held within the Emergency Department irrespective of where the medical input is outsourced from. The percentage of planned

reviews to any Emergency Department should not exceed 6% of the total attendances.

- **When does the clock start?**

When the patient presents at an Emergency Department via:

- Private transport/public transport/walking, the clock starts at:
  - the registration time or
  - triage timewhichever is earlier.
- The ambulance service, the clock starts at:
  - registration time or
  - triage time or
  - 15 minutes after the recorded ambulance arrival timewhichever is earlier.

- **When does the clock stop?**

- In the case of discharge (where ambulance transport to take the patient home is not required) the clock will stop on completion of the following sequence of events:
  - when the patient's clinical care episode is completed to the point where a safe and effective discharge can occur;
  - medications if appropriate handed over to the patient or carer;
  - written and/or verbal instructions given to the patient or carer

Patients who have to remain in the Department whilst waiting for private transport remain the responsibility of the staff in the unit, even though the waiting time clock has stopped.

- In the case of discharge (where ambulance transport is required to take the patient home) the clock will stop on completion of the following sequence of events:
  - when the patient's clinical care episode is completed to the point where a safe and effective discharge can occur;
  - medications if appropriate handed over to the patient or carer;
  - written and/or verbal instructions given to the patient or carer;

- the ambulance has been requested

The ambulance request time is completed when the ambulance service has **answered** a request call. Patients remaining in the Emergency Department awaiting an ambulance continue to be the responsibility of clinical staff, even though the waiting time clock has stopped.

- In the case of transfer this includes any patient being transferred irrespective of mode of transport to the care of another H&SC organisation, or other public/independent agency. The clock will stop when:
  - the patients clinical care episode is completed to the point when a safe and effective transfer can occur
  - the ambulance has been requested/private transport arranged

Where an ambulance is required, the ambulance request time is completed when the ambulance service has **answered** a request call. Patients remaining in the Emergency Department awaiting transportation continue to be the responsibility of clinical staff, even though the waiting time clock has stopped.

When any patient (irrespective of circumstances and including those awaiting ambulance/private transport) waits more than 12 hours in an Emergency Department, this is classified as a Serious Adverse Incident (SAI) and deemed to have met the criteria for being reported to the DHSSPS, as set out in paragraph 16 of HSS (PPM) 06/2004.

- In the case of admission the clock will stop at the point at which a patient leaves the Emergency Department to go to:
  - An operating theatre; or
  - A bed in a ward as defined below; or
  - An x-ray or diagnostic test or other treatment as a precursor to direct admission to a bed in a ward as defined below

However, leaving the Emergency Department for a diagnostic test or other treatment does not stop the clock if the patient then returns to the Emergency Department to continue waiting for a bed.

- **What is a ward?**

A ward is “a discrete group of funded beds with associated treatment facilities managed by a senior nurse”. This includes observation wards, medical/surgical assessment wards, emergency receiving units (external to the Emergency Department) and short stay admission wards if they meet the guidance set out below on what constitutes a ward. It is recognised that short stay wards will not be identical in every respect to longer stay inpatient wards. However, for patients in these wards to be treated as admitted, the environment needs to be such that the patient experience is similar to that which would be expected in other inpatient wards.

The list below includes minimum criteria for managers and clinicians to take into account when considering whether the patient experience is likely to be similar to that of a patient admitted to an established inpatient ward and therefore whether an environment constitutes a ward within the meaning of this guidance. The list is not meant to be exhaustive - but it is a checklist of things patients could reasonably expect to find in a ward on admission to hospital. These include:

- compliance with Health & Safety, Fire & Disability Access Regulations
- infection control measures
- dedicated staff to that ward with adherence to RCN Policy Guidance on Setting Appropriate Ward Nurse Staffing Levels in NHS Acute Trusts (September 2006) This should include access/identification of a lead person to whom the patient or their carer can bring any concerns or questions
- separate facilities for safe storage of all drugs, including controlled drugs
- the same privacy and dignity as other inpatient wards in the hospital i.e. the ability to screen beds and available private areas for breaking bad news
- dedicated identifiable clean and dirty utility areas
- access to toilet and washing/showering/bathing facilities of the same standard and appropriate number in relation to patient ratio as would be expected in any ward area
- facilities for patients to securely store their belongings
- normal hospital type beds, with sufficient space between beds to allow clinical procedures to take place without compromising privacy and dignity and safe lifting and handling procedures. There must be sufficient space to allow two visitors per bed
- provision of hot meals and appropriate access to refreshments
- no public thoroughfare through the area
- the areas identified should be broadly in line with Health Building, Health Facilities Notes and Health Technical Memorandums

The Service Delivery Unit will decide which areas can be considered as ward areas in each hospital site. For those areas not currently meeting the minimum standards the Trust will be asked to submit an action plan which will detail how areas will be brought up to an acceptable standard. Patients, if not placed in a funded established bed within a designated bed space/on a ward, will be counted as a target breach.

## 4.0 SITREP data collection

### 4.1 Key Action

The key actions for Unscheduled Care Reform included the following medium term action:

*“By 1<sup>st</sup> October 2007, there is a need for Trusts to fully understand in detail the flow of patients into and out of their hospital and the connectivity between elective and non-elective pathways. To this end, Trusts should ensure ongoing SITREP analysis and plan the delivery of services based on this analysis.”*

The timely collection of SITREP data is vital to ensure an understanding of the factors which impact on the delivery of unscheduled care services. Trusts are to provide on a weekly basis the agreed SITREP data for each hospital site with a Type1 / 2 / 3 Emergency Department.

***The Service Delivery Unit has issued separate guidance on SITREP requirements including the detail around the definitions associated with the data to be collected. The SITREP definitions document should be read in conjunction with this document.***

## **5.0 PERFORMANCE MONITORING REPORTS**

The definitions and guidelines outlined in this document will form the basis of all monitoring by the Service Delivery Unit and should also inform internal Trust monitoring. This is detailed below:

### **5.1 Ambulance Service**

- the total number of Category A 999 calls that were responded to and the % responded to within 8 minutes by receiving hospital site
- the total number of Category B 999 calls that were responded to and the % responded to within 18 (rural areas)/21 minutes (sparsely populated areas) by receiving hospital site
- the total number of Category C 999 calls that were responded to and the % responded to within 1 hour by receiving hospital site
- the total number of emergency and urgent patient journeys and the respective incident record number
- the total number of ambulance handovers that occurred and the % which lasted over 15 minutes

### **5.2 Emergency Departments**

- the number of Emergency Department new attendances
- the number of Emergency Department unplanned re-attenders
- the number of Emergency Department planned reviews
- the number and % of patients (new and unplanned re-attenders) who have a total time in the Emergency Department from arrival to admission, transfer, discharge or death in the following time categories:
  - 4 hours or under
  - over 4 hours and less than 12 hours
  - over 12 hours

Outlined below is the minimum set of data which should be available from all operational information systems used in Emergency Departments for the purposes of Performance Monitoring.

### **UNSCHEDULED CARE MONITORING MINIMUM DATASET (Emergency Department waiting times)**

<b>Data Item</b>	<b>Description</b>
EPISODE NUMBER	Emergency Department episode number allocated to patient attendance
ATTENDANCE NUMBER	Attendance number within episode
H+C NUMBER	Unique Patient Health + Care Number
PATIENT DOB	Patient date of birth
PATIENT GENDER	Patient Gender
PATIENT POSTCODE	Patient postcode
GP PRACTICE CODE	Practice Code of GP
DEPARTMENT CODE	Code indicating the Emergency Department attended, e.g., BCH, AMIU
ATTENDANCE TYPE	Indicator whether the attendance is New, Planned Review or Unplanned Re-attenders
INITIATOR	Code indicating who referred patient to Emergency Department e.g. GP, self referral
REVIEW CLINIC	Code indicating the review clinic being attended by patient (where applicable)
ARRIVAL MODE	Indicator how patient arrived in Emergency Department e.g. ambulance, private transport
AMBULANCE ARRIVAL DATE/TIME	Date and Time of Ambulance Arrival (where applicable)
ARRIVAL (or REGISTRATION) DATE/TIME	Date and time of Patient arrival (or Registration)
CLOCK START DATE/TIME	Start time for the waiting time clock depending on Amb arrival/registration/triage time whichever is earlier
PRESENTING COMPLAINT	Text indicating the presenting complaint of the patient
INCIDENT DATE/TIME	Date and time of incident
INCIDENT TYPE	Code for incident type
INCIDENT NUMBER	Unique incident number taken from Ambulance Service Patient Report Form
PRF NUMBER	Unique number taken from Ambulance Service Patient Report Form
ACCIDENT LOCATION	Code indicating the place where incident occurred
ACTIVITY TYPE	Code indicating the type of activity the patient was engaged in when the incident occurred
TRIAGE (ASSESSMENT)	Date and time of Triage (assessment)

DATE/TIME	
TRIAGE TEXT	Text entered by triage nurse
EXAM DATE/TIME	Date and time patient was examined
EMERGENCY DEPARTMENT DOCTOR	Emergency Department doctor who treated the patient
EMERGENCY DEPARTMENT CONSULTANT	Consultant code of Emergency Department consultant
PATIENT GROUP	Code indicating the patient group e.g. accident, medical, cardiac
PRIORITY	Manchester Triage scale value
DECISION TO ADMIT DATE&TIME	Date and time of decision to admit
TRANSFER ARRANGED DATE&TIME	Date and time when all patient transfer arrangements are in place (where applicable)
TREATMENT COMPLETE DATE&TIME	Date and time when patient's clinical care episode is completed
AMBULANCE REQUEST DATE/TIME	Date and time ambulance was first requested
AMBULANCE BOOKED DATE/TIME	Date and time ambulance was actually booked and booking reference number was received by Emergency Department staff.
DATE/TIME TO WARD	Date and time patient leaves Emergency Department to be admitted to a hospital ward.
DATE/TIME TO HOSPITAL	Date and time patient leaves Emergency Department to be transferred to another HSC organisation, or other public/independent agency
HOSPITAL TRANSPORT DATE/TIME	Date and time patient was collected by hospital-arranged transport (e.g. ambulance)
CLOCK STOP DATE/TIME	Stop time for the waiting time clock depending on how patient has left Emergency Department e.g. ambulance, admission or discharge
DEPARTURE METHOD	Indication of how patient was discharged from the Emergency Department e.g. allowed home, admitted to hospital bed etc.
ATTENDANCE DISPOSAL CODE	Korner code indicating Emergency Department Attendance disposal
DEPARTURE MODE	Indicator how patient left Emergency Department
FOLLOW UP DATE/TIME	Date of follow up clinic e.g. plaster clinic, review clinic etc.
ADMISSION WARD	Code for ward to which patient was admitted
SPECIALTY	Code for specialty patient admitted or referred to
TRANSFER HOSPITAL	Code for hospital to which patient was transferred
WAITING TIME RUNNING CLOCK	Showing the patient waiting time from Clock Start time to present time
AMBULANCE TIME RUNNING CLOCK	Showing the ambulance waiting time from Ambulance request time to present time