University Hospitals of Morecambe Bay
NHS Foundation Trust

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Scope: Trust Wide	**Classification:** Organisational
Author / Title: Andrew Higham, Clinical Director, Medicine	**Responsibility:** Medicine Division
Replaces: Version 2.1, Urgent and Emergency Care Pathways, Corp/Proc/033	**Head of Department:** Andrew Higham, Clinical Director Medicine
Validated By: Clinical Directors Group Medicine DPDG Medicine DGAG	**Date:** 14/09/2016 03/11/2016 30/11/2016
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Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 1,2,3,4,5,6,7	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** 2,3,5

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

References Checked by ……Joanne Phizacklea…… Date……14.12.16…..…

To be completed by Library and Knowledge Services Staff

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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

Long waiting times in the Emergency Department (ED) (often experienced by those awaiting admission and hence acutely unwell patients) not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness. We have an operational standard of 95% for patients being seen and discharged within 4 hours and we use this to ensure patients are being treated promptly.

2. PURPOSE

The purpose of this Procedure is to:

- Establish standards within the emergency care pathway to ensure patients receive timely access to specialist clinical care.

- Support the 'floor management process' to ensure patients receive a definitive clinical decision within a maximum of 150 minutes re: appropriate transfer of care either home or admission.

- Set 30 minute response time for specialties to ED.(This is the time taken to respond to a referral)

- Set 30 minute dispersal time if specialty response cannot be achieved due to other clinical pressures. This would result in the patient being transferred to the assessment unit after discussion with receiving ward/assessment unit if physiologically stable.

- Where a specialist surgical review is required in ED by an in-patient team then please refer to the detailed paragraph 7 below.

- Ensure Situation, Background, Assessment, Recommendation (SBAR) framework is used for referral and further embedding maximum 30 minute response time to ED request from specialties. ED will commence necessary treatment and order investigations if urgent and appropriate prior to transfer to the ward.

- Eliminate disputes between specialties that result in what has become known as specialty “ping pong”.

- Support the delivery of the 4 hour emergency care quality standard.

- Inform teams of escalation process for specialties that do not respond within agreed timeframes.

3. SCOPE

All Clinicans, Nurses and support staff that are involved in the coordination of patients within the Emergency Department and across the hospital site. This excludes mental health patients in the Emergency Department with no clinical conditions.

4. PROCEDURE

4.1 Duties

Duties of staff within the Trust are to follow this procedure and in line with Duties of a Doctor guidance from the GMC[1].

4.2 Emergency Department

- New patients will be seen within 15 minutes of arrival at ED. All patients will be assessed on arrival by a suitably qualified nurse who will triage patients, assess their needs ensuring they are comfortable and informed.

- Patients will then be seen by an appropriately skilled decision maker (FY2,SAS,ST3+ or Consultant) within 60 minutes in line with the national Emergency Care Quality indicator of 'Time to Treatment'

- Within 150 minutes a definitive decision should be made by the ED physician. There should be no more than 30 minutes to dispersal from this decision (unless continuous instability).

- This will be supported by the floor management process that will include 2 hourly Board Rounding for a maximum of 10 minutes – led by the Nurse in Charge and Consultant/Senior Doctor in Charge. This is designed to monitor each patient to prevent any patient's waiting longer than 150 minutes for a definitive decision.

- In minors, ED should be aiming to achieve 90% dispersal home in 120 minutes through effective implementation of 'see and treat'.

Note: Patients referred from outside e.g. by a GP, will not be sent to the ED, they should be directed to the appropriate assessment unit/ward. Patients, who arrive with a referral letter from a GP but unknown to the clinical teams, will be triaged and assessed by senior ED coordinator and doctor if appropriate and then to the specialty and providing the patient is stable, transferred to the appropriate Assessment Unit/ward. ED should not be used as a waiting area for this group of patients.

4.3 Specialty Response

- For Surgical specialties, the following arrangements will be in place:

I. In hours on both RLI & FGH site, 0830 to 2030 the specialties will respond within 30 minutes either by phone or in person to assess and formulate plan of care and next steps.

II. For General surgery, this may be a SpR at level ST3 or above or SAS doctor however if scrubbed in theatre then the intermediate grade FY2, CT, ST1, 2 will respond.

III. For Orthopaedics (between 0830h-1730h), this may be a SpR at level ST3 or above

or SAS doctor however if scrubbed in theatre then the intermediate grade FY2, CT, ST1, 2 will respond

IV. For all other specialties (Urology, ENT, Maxillofacial Surgery & Ophthalmology) an intermediate grade doctor FY2,CT,ST1,2 will respond or contact can be made with the Specialty Consultant on-call directly.

V. Out of hours RLI, 2030h to 0830h an intermediate grade doctor - at FY2/CT, ST1, ST2 level will assess emergency patients within 30 minutes. At FGH 2030h to 0830h an RMO will respond.

- If the acute clinical team is committed elsewhere both in or out of hours and cannot meet this standard, a senior emergency medicine physician will ensure a 'physiological safety status check' has been performed and the patient will be admitted to the relevant assessment unit/ward following communication with the ED admission team and the receiving ward. The ED referral process should be standardised to SBAR.

- If the ED physician refers to a specialty for admission and the specialty cannot respond in 30 minutes, the patient will be assessed by a senior ED specialty doctor - SpR at level ST3 or above or SAS doctor and admitted to the relevant assessment unit/ward within 30 minutes providing appropriate SBAR discussion has occurred with the relevant team. If the receiving specialty feels care could be given by a more appropriate specialty, the accepting team will undertake the onward referral. It will not be ED responsibility to coordinate onward referrals. ED will ensure a safety check has been performed prior transfer. However, major trauma/spinal injuries must not be passed onto T & O for them to liaise with the major trauma centre. This should be done in line with the Major Trauma Pathway ED to ED.

- In cases where the specialty assesses the patients and refers onwards to a different specialty the onward specialty **must respond within 30 minutes.** However, the patient must be prescribed appropriate first line treatment whilst further assessment takes place.

4.4 Specialty Disputes

The ED physicians choice of specialty for referral is to be discussed with the referring specialty (if there is a dispute, the on call specialty Consultant should be contacted) and for the safety of patients and in line with professional codes of practice and for medico-legal purposes, the admitting team should be able to decide which patients come under their care. It is important not to delay or prevent the patient assessment, and following discussion, the acceptable response from the referred to specialty should be to see the patient without delay.

If a dispute arises, the on call specialty Consultant should be contacted and a senior discussion must take place. Contact will be attempted once only. If there is no response, the ED Senior Clinician will make the final decision on where the patient should go. The patient will be transferred providing they are physiologically stable as assessed by the senior ED coordinator and doctor if appropriate. Unless clinically essential, once a decision to admit is made the patient will not be re-reviewed in ED but referred to the appropriate specialty. Staff in ED will pre-empt patients' needs anticipating bed requirement giving

acute units and CSM time to prepare the bed.

4.5 Escalation Process

4.5.1 The 150 minute standard:

At 120 minutes or after 60 minutes of commencement of assessment by a decision maker (Doctor or Nurse Practitioner) with no plan in place to discharge/or refer to a appropriate specialty the ED nurse in charge contacts:

4.5.1.1 In hours:

- The Doctor in Charge of the department to ensure that the team reaches an appropriate clinical decision.

- At 150 minutes the nurse in charge will arrange a plan with the CSM.

- Waits over 6 hours are escalated to Divisional Management team if the problem remains unresolved.

4.5.1.2 Out of hours & weekends:

- The Doctor in Charge of the department to ensure that the team reaches an appropriate clinical decision.

- At 150 minutes the nurse in charge will arrange a plan with the CSM who will contact the Duty Manager on Call only if problem remains unresolved.

- Waits over 6 hours are escalated to GOLD on call if the problem remains unresolved.

- In the extenuating circumstances of a very long stay in ED >6 hours, it is essential the time the decision to admit to a specialty **and** the time the specialty accepts the patient is clearly documented in the patients notes and to the Duty Manager on Call as these situations are reportable to the Department of Health.

- Please refer to escalation flow chart for ED patients which is included in the Trusts escalation policy the most up to date version can be found on heritage.

4.5.2 30 minute specialty response standard:

- Where specialties do not respond via phone or in person within 30 minutes or where disputes between specialties continue, they will be escalated to the consultant on call for that specialty and the 3 times daily bed meetings.

- Shortfalls in delivery against these standards will be escalated where necessary to the relevant Clinical Director who will actively contribute to delivery.

4.6 Watershed Medical Conditions

The table below offers some guidance for the ED team for times where there is a dispute as to which team will admit and assess the patient.

Specialty	Watershed condition(s)
Orthopaedics	• Elderly frial patients with back pain, with no spinal fractures, with comorbities should be admitted to medicine. • Elderly frial patients failing to mobilise and who do not have fractures, in whom cauda equina has been excluded either clinically or with MR should be admitted to medicine. • Fracture neck of femur but with significant co-morbidities- always Orthopaedics • Fall with hip pain and unable to weight bear with no fracture, CT then refer if hip fracture reported to T&O, if no fracture on CT then should admit to medicine. • Pubic ramus fracture and failing to mobilise as sole reason not for discharge should be admitted onto a rehab ward and opinion requested from Orthopaedics if appropriate • Limb soft tissue infection / abscess
General Surgery	• Biliary colic & Acute Cholecystitis (if appropriate for surgery) • Acute (or acute on chronic) pancreatitis • Acute Appendicitis (See O&G note – Gynae review first unless obvious clinical diagnosis i.e. sepsis, pyrexia & peritonitis) • Acute Diverticulitis / intra-abdominal sepsis • Bowel Obstruction • Groin / retroperitoneal abscess (including in patients known to drug inject unless obvious clinical vascular complications in which case direct to Vascular Surgery at RPH) • Breast Abscess (initially General Surgery & refer on to Breast team) • Abdominal pain cause not determined – surgical opinion if felt to require admission Consider • Lower GI Haemorrhage
Urology	• **Suspected Renal Colic** Convincing history/previous history of stones **and** dipstick haematuria – analgesia and send for urgent CT-KUB. If evidence of obstructing ureteric stone – refer to urology. If not – refer on appropriately. • **Urinary Retention** Convincing history of painful retention – analgesia, catheterise, measure residual, check U&Es. If normal Cr and suitable send home with catheter pack and bring back to Urology Hot clinic. If normal Cr but can't manage catheter at home discuss with on call

	urology consultant. If abnormal Cr – refer to urology. • **Suspected Pyelonephritis or UTI** Refer to medicine – as this is not a surgical condition requiring urological surgical input. All patients admitted with suspected pyelonephritis or UTI should have an US within 24 hours and if there is any sign of obstruction, a ward referral should be made to Urology. • **Visible Blood in the Urine** Only needs catheterisation if the patient is in retention, and then this should be with a 3 way catheter for irrigation and the patient referred to urology. If the patient is not in retention – send home to drink copiously and refer to Urology Hot clinic. • **Suspected Testicular Torsion** Needs senior ED doctor review and immediate telephone consultation with on call Urology Consultant. • **Suspected Epididymo-Orchitis** Treat with Cipro 500mg bd 2 wks and Doxcycline 100mg bd 7d (if sexually active) and send home to bed rest unless unable to tolerate oral antibiotics or abscess suspected – then refer to urology.
Vascular Surgery	• Please note that this is now a regional service and referral for all urgent / emergency vascular problems is direct to the Vascular on-call team at Preston (**NOT** to the General Surgery on-call team). • Non-urgent problems should be referred to the regional vascular team for outpatient review
Obstetrics & Gynaecology	• Women of child bearing age with abdominal pain are referred to O&G initially unless they have ongoing general surgical problems
ED observation on AMU	• Head injury overnight stay
Acute medicine/medical specialties	• Acute dysphagia –likely to need endoscopy • Fall and “unwell” but no hip frcture on CT scan and unable to weight bear then admit to medicine. • Overdose with estimated LOS over 24 hours • Fall and fracture of upper limb where effective discharge not possible -to consider Med unit 2 wards including Ripley (RLI) or Abbey View, WGH or Millom (FGH) • Fall and fracture of lower limb where safe discharge not possible and likely co-morbidity requiring elderly medicine input • Leg ulceration & immobility – consider onward referral to vascular or T&O as appropriate • Diabetic foot sepsis – consider onward referral to vascular or T&O as appropriate • Diarrhoea AND Vomiting (likely infectious cause NOT surgical) • Patients with known Inflammatory Bowel Disease & symptom flare/ relapse (unless Peritonitis in which case surgical review

	first) • Jaundice or cholangitis Consider • Lower GI Haemorrhage (unless cardiovascularly unstable in which case refer to General Surgery initially)
Elderly Care /Geriatrics	• Frail /co-morbid Elderly patients who are unlikely to be fit enough for surgical intervention (inpatient surgical opinion can be sought for these patients) • Patients with known palliative / terminal diagnosis • Frail elderly & Bed or pressure sores (refer for Orthopaedic or General Surgery Specialty inpatient opinion later if required as appropriate)
Children and young people	• In general, before the 16th birthday, admission should be to the children's ward, and after 16 to an adult ward. The 3 main exceptions are as follows: • Pregnant girls should always be discussed with the on call obstetrics and gynaecology team, and will be admitted to maternity or gynaecology as appropriate. • Young people over 16 with a chronic condition (e.g. neurodisability) for which they have been under the care of a paediatrician and are currently in transition to adult care should be discussed with the paediatric on-call team as they will often be more appropriately cared for on the children's ward. • During periods of severe pressure on adult beds, those aged 16-17 should be discussed with the consultant paediatrican to see if admission to the children's ward could be appropriate. Even if these patients are given a bed on the children's ward, their clinical management would remain the responsibility of the adult medical team or surgical team.

5. ATTACHMENTS	
Number	**Title**
1	Equality and Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
	RCP Toolkits
G50	UHMB escalation/de-escalation policy and action plan http://uhmb/cs/tpdl/Documents/G50.doc
Obs/Gynae/Guid/104	Handover and SBAR http://uhmb/cs/tpdl/Documents/OBS-GYNAE-GUID-104.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	General Medical Council (GMC) Duties of a doctor [Online] Available from http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp (Accessed 19/08/2015)
2	
3	

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document	
Name	**Job Title**
Paul Grout,	Deputy Medical Director
Shahedal Bari	Deputy Medical Director
Ameeta Joshi	Clinical Director, Surgery & Critical Care
David Birch	Clincal Director, Womens & childrens
Robin Procter	Clinical Director, Core Clinical Services

10. DISTRIBUTION PLAN	
Dissemination lead:	Andrew Higham
Previous document already being used?	Yes
If yes, in what format and where?	Watershed Conditions & 10 Steps to Improving the Emergency Care Pathway. Used within the ED
Proposed action to retrieve out-of-date copies of the document:	Withdraw all hard copies within ED Replace electronic versions with revised SOP
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING Is training required to be given due to the introduction of this procedural document? *Yes / No Please delete as appropriate		
Action by	**Action required**	**Implementation Date**

12. AMENDMENT HISTORY				
Revision No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
0.1	February 2015	All	Draft for comment	
0.2	February 2015	All	Additional comments received from Clinical Directors & Ian Sturgess	
0.3	March 2015	All	Additional comments from CD surgery.	
1.1	January 2016	Page 1	Review Date extended to 01/04/2016	April 2016
1.2	August 2016	Page 1	Review Date extended to 01/10/2016	October 2016
1.3	Sept 2016	Page 1	Review Date extended to 01/12/2016	01/12/2016
2	Nov 2016	All	Full review by clinicians. Reformatted into latest Trust template.	01/12/2019
2.1	Oct 2017	Page 3	BSF Page Added	Dec 2019
2.2	August 2018	Page 8	Amendment to section 4.6	01/12/2019
2.3	28/08/2018	Page 10	Section 4.6, Children and Young People added	01/12/2019

Appendix 1: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Urgent and Emergency Care Pathway			
Lead Assessor	Marie Spencer			
What is being assessed?	Urgent and Emergency Care Pathway			
Date of assessment	05/12/2016			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☒	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?

Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	Impact (Positive / Negative / Neutral)	Comments ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Positive	
Disability (Including physical and mental impairments)	Positive	
Sex	Positive	
Gender reassignment	Positive	
Religion or Belief	Positive	
Sexual orientation	Positive	
Age	Positive	
Marriage and Civil Partnership	Positive	
Pregnancy and maternity	Positive	
Other (e.g. caring, human rights)	Positive	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	Equal access to services across the organisation.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.