7. Improving patient flow: Implementing internal agreements and standards

A Timely Emergency Care Collaborative how-to guide for health services

OFFICIAL

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Institute for Healthcare Improvement

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.
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Introduction

The Timely Emergency Care Collaborative (TECC) aimed to reduce delays for patients needing emergency care in Victoria through improving hospital-wide patient flow.

The project involved 14 teams from hospitals across Victoria, as well as a team from Ambulance Victoria. The Victorian Department of Health delivered the project in partnership with the Institute for Healthcare Improvement.

The project ran from December 2022 until the end of June 2024. Almost every team showed significant improvements in the timeliness of emergency care, as measured by emergency department lengths of stay.

The project set out with a change theory of how to improve hospital-wide patient flow. This change theory was developed by drawing on international evidence, local and international expert input and the ideas of the participating teams.

Through the results of testing and the insights from participating teams, the change ideas that were found to be most impactful (feasible to implement, demonstrated improvement) were identified as 'high-impact change ideas'. These ideas have been written up as a series of 'how-to guides'.

This guide is one of a series outlining each of these high-impact change ideas. All guides are available from Emergency care <https://www.health.vic.gov.au/patient-care/emergency-care> or by contacting TEC2@health.vic.gov.au. A summary of the overall change theory from the TECC can also be found on the Emergency care webpage <https://www.health.vic.gov.au/patient-care/emergency-care>.

The change theory and learnings from the TECC project continue to inform other departmental projects including the Timely Emergency Care (TEC) 2 Program.

Problem this change idea addresses

The ways in which healthcare staff interact within a health service can affect patient flow. If there is a high level of variation in these professional interactions, this can create an environment where safe, timely and effective patient care can be adversely affected. A lack of shared understanding about how individuals and services interact can also lead to:

- frustration and finger pointing, reinforcing professional and service silos
- limited clinical engagement, ownership and perceived value of improvement efforts
- difficulty orienting new staff or vocational staff to organisational ways of working
- lack of shared accountability for patient flow and risk across the organisation
- difficulty managing performance – opportunities for improvement are not apparent, leading to a focus on where the symptoms of poor flow manifest (rather than identifying the lack of flow alignment).

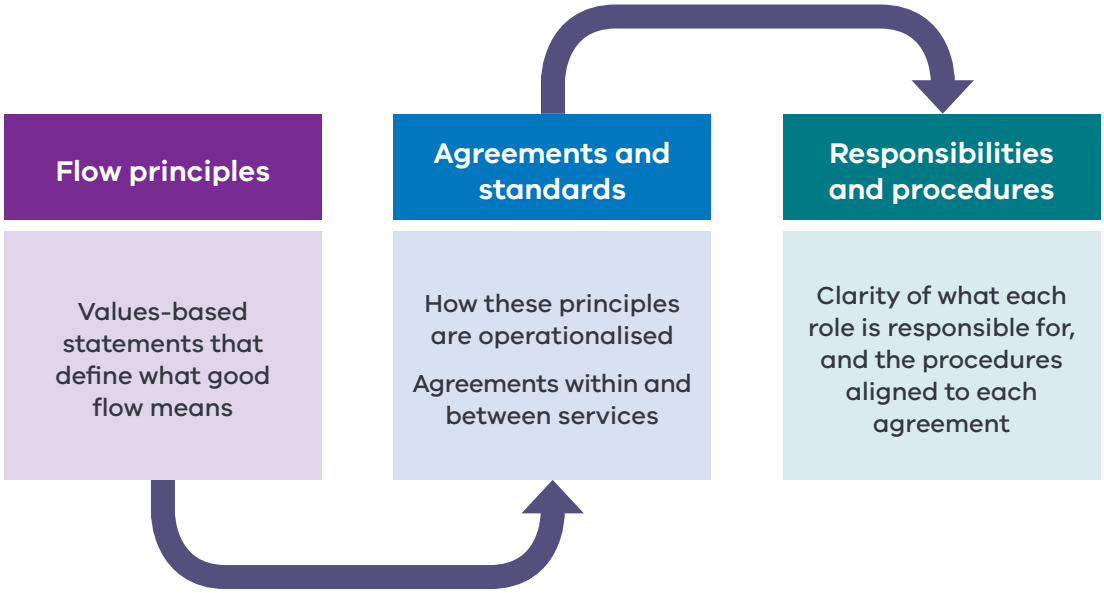
Overview of the change idea

Internal agreements and standards (IAS) (also known as internal professional standards) are a clear, unambiguous description of the values, agreements and behaviours expected in an organisation.

IAS communicate 'the way we do things here, all day, every day'.

Many organisations have principle-based statements that define good flow and timely care. Common examples of these often reference 'right care, right place, right time' – or similar statements. Developing and communicating flow principles signal to everyone in the organisation, as well as to patients and carers, that there is a collective responsibility for patient flow and providing timely care. But they don't always define what this looks like in practice. This is where IAS can provide clarity and alignment across the system (Figure 7.1).

Figure 7.1: Relationship between flow principles, internal agreements and standards, and roles and procedures



Evidence

Analysis in the UK of the top performers based on the Urgent and Emergency Care dashboard found that those with the lowest ambulance handover delays were consistently found to have embedded internal professional standards cultures. Hospitals with internal professional standards were also consistently in the top quartile of performance against key patient flow metrics such as:

- emergency department (ED) length of stay
- conversion (admission) rates from ED
- total time to treat
- percentage of patients with same day discharge
- percentage of patients with a length of stay under 2 days
- bed occupancy.

In Victoria, the Department of Health has regularly engaged with health services to understand factors that contribute to variation in timely emergency care performance. The presence of clearly stated, regularly communicated and supported patient flow standards and expectations was a common factor seen in hospitals with the lowest ED lengths of stay.

Developing and implementing internal agreements and standards

IAS are most powerful when they:

- centre on patient care
- are developed and agreed by clinical leaders
- are openly supported by the executive team.

Every clinical service and specialty should have IAS that fit with each other. If an organisation is in the process of developing these or refreshing existing agreements and standards, then it is best to take a phased approach by identifying and working on a priority interface that is currently impacting on patient flow and timely care.

Bring together clinical directors and heads of nursing and allied health professional leads from across the health service or hospital site. Together, create a local set of standards that translate into professional standards which they, themselves, are empowered to be the champions and advocates for.

Roles and responsibilities

The following roles need to be in place to develop and successfully implement IAS:

Chief operating officer (or equivalent)

- Responsible for operational oversight of development and implementation phases
- Ensures project support and resourcing (for example, project manager, analyst, communications)
- Monitors performance

Medical director or chief medical officer

- Responsible for clinical and risk oversight
- Project lead for signing off each clinical service's IAS and escalation framework, including ensuring consistency, equity and parity
- Attends weekly huddles and addresses barriers to ensure progress
- Daily point of contact for the project team, where required to manage issues
- Provides updates to the CEO and board
- Point of final escalation for performance management of compliance with IAS (refer to 'Escalation' below).

Chief nurse or director of nursing and allied health lead

- Responsible for quality and risk oversight
- Critical friend for CMO for reviewing each service's IAS and escalation framework

Other roles needed to support implementation

- Project management support
- Supports staff engagement
- Project management oversight (such as a GANTT chart of activities)
- Communications (staff engagement)
- Data analysis (performance)
- Divisional heads of operations, medical, nursing, allied – for engagement and design input
- Consumer/patient representatives for design review

Implementation pathway

Table 7.1 has a suggested pathway for setting up IAS, as well as the recommended roles. This should be adapted to align to local expectations, engagement and capacity.

Table 7.1: Suggested pathway for establishing internal agreements and standards

Set up

Critical action	Week(s)	Lead
Review the current state of IAS and prioritise a critical interface for timely care – to form phase 1	1	COO CMO or medical director Chiefs or directors of nursing, allied health
Allocate the executive role Review the current IAS/SOPs/streaming/direct access documentation for priority interface Define the project outcome for phase 1	1	As above
With divisional leaders, undertake a full review of the current IAS actual practice	1–2	Clinical lead(s) Project manager

Develop

Critical action	Week(s)	Lead
Undertake significant staff engagement exercises to get input into the IAS Coordinate engagement events and a range of mixed media staff comms encouraging collaboration and feedback. Strong focus on culture – 'this is the way we want to work'; 'creating a safe and calm hospital'	2–4	Clinical lead(s) Project manager Comms support
Collaboratively design IAS for priority interface Define metrics to be monitored / methods of audit Include qualitative and quantitative measures chosen collaboratively on the metric checklist	2–4	Clinical lead(s) Project manager Analyst
Daily huddle – align on activities, identify issues to progress that may need escalation	1–4	Clinical lead(s) Project manager
Weekly huddle – report on progress, management of risks and issues	1–4	CMO or medical director Clinical lead(s) Project manager
Define performance management pathways	4	CMO + COO Chiefs or directors of nursing, allied health Clinical lead(s) Project manager

Implement

Critical action	Week(s)	Lead
Announce formal deployment of IAS	5 and ongoing	CMO + COO Clinical lead(s)
Daily meetings to review implementation and resolve issues and lack of alignment (drop back to weekly)	Ongoing	Clinical lead(s) Project manager
Daily and weekly metric monitoring and reporting	Ongoing	Clinical lead(s) Project manager

Next steps

Critical action	Week(s)	Lead
Initiate next priority interface (phase 2)	6	CMO + COO Director of nursing Director of allied health

CMO = chief medical officer; COO = chief operating officer

Managing and improving internal agreements and standards

Building IAS into daily work

Discuss and promote standards throughout the organisation. Leaders (consultants, senior nurses, allied health leaders) should role model the standards in their routine and daily interactions to reinforce them as core behaviours and values.

Integrating IAS into daily huddles and handovers as a point of reference for how the day is going and what needs to be planned reinforces the IAS as defining 'the way we do things here'.

Staff orientation

New staff should be oriented to their work using the IAS. They should understand what they mean in relation to individual roles and responsibilities.

Fractional staff or visiting medical officers should also receive a briefing on the IAS relevant to their roles. If IAS are well integrated into huddles and handovers then this will make it easier for visiting clinicians to be reminded of the local expectations. Consider opportunities to make the IAS easily accessible (reference cards on lanyards, posters beside computers).

Continuous improvement

Part of clinical governance processes should include regular reviews of IAS and identifying opportunities to:

- update IAS
- strengthen clarity of roles and responsibilites of IAS
- improve communication
- improve performance management and escalation processes.

Escalation

Identify steps of escalation when IAS are not being upheld that align with organisational governance procedures. Local management of non-compliance should be undertaken in the first instance to identify system issues or the need further educate about IAS. Ongoing issues with non-compliance should be escalated to the CMO or medical director.

Factors for development and deployment

Lessons learned from organisations that have set up IAS have highlighted that the key to success is not simply in writing down the IAS but in the following enablers:

- **staff engagement** (through staff forums/workshops) and meaningful listening so all staff have a shared understanding of risk resulting from care delays across the acute patient flow journey
- **clinical and operational collaboration** to champion, lead and review IAS
- **effective daily management** including clear performance management and escalation processes, ongoing clinical advocacy and audit, review and continuous improvement practices
- **CMO/director oversight** with the support of clinical directors, the chief operating officer and the director of nursing to maintain conversations to support real improvements
- **consistent leadership messaging** that clearly states that the organisation's IAS are vital to having a safe and calm hospital for patients and staff, and for delivering timely care
- **project management support** for clinical leads including data analytics support
- **ongoing communication** throughout the development and as part of deployment
- **monitoring and reporting mechanisms** developed in parallel so there is continual performance oversight by the executive and boards.

Acknowledgement

With thanks to Jon Scott and Tim Whittlestone for their expertise and advice in developing this guide. The content in this guide has been adapted, in part, from the references provided at the end of this chapter.

Case study: North Bristol NHS Trust, England

North Bristol NHS Trust in England identified acute admission to specialty beds as a priority interface for their organisation where they chose to develop internal professional standards (IPS). The image below shows the IPS that were agreed and implemented.

Alongside the IPS there were also defined responsibilities (standard work) for implementing and managing the standards.

6. Roles and responsibilities

6.1. Consultants will be expected to work within the IPS and share this with their junior doctor trainees 1 role modelling the behaviours which are expected.

6.2. ED referring clinicians and "Middle Grade" Specialty doctors responding to referrals will be expected to work within the IPS and escalate concerns if standards are not being met.

6.3. ED nursing staff are expected to be aware of the IPS and escalate concerns if standards are not being met.

6.4. Operational managers are expected to be aware of the IPS and support the escalation of concerns if standards are not being met.

6.5. Specialty Leads are expected to respond to "on the day7Je scalation about a patient's care where there is disagreement.

6.6. Clinical Directors are expected to respond to concerns about standards of behaviour of individuals in relation to the standards.

IPS were then defined in terms of what this means for frontline staff. These were defined as a set of procedures (refer below). Alongside the procedures were cultural values/ norms that were expected of everyone – 'be nice' and 'professionalism'.

7. Procedures

- The following standards must always be met using respectful clinical conversations, with colleagues being generous, calm, team players, open, trusting, courteous, civil and caring towards one another, to enable better outcomes for patients.
- Patients will only be directed to arrive to the ED by Medicine) Neurosciences and Musculoskeletal (NMSK), Anaesthesia, Surgery, Critical Care and Renal (ASCR) and Women's and Children (WACH) divisional teams, if the patient's clinical condition requires immediate clinical intervention best delivered in a resuscitation environment. All other patients will normally be seen in designated assessment areas.
- Patients will receive an initial nursing assessment within 15 minutes of arrival to ED.
- An ED decision-making clinician will see new patients as close to arrival as possible in the ED and within 60 minutes.
- Patients in ED requiring Specialty assessment will be referred to the Specialty after agreement with the ED Senior Decision Maker.
- Patients will be referred to Specialty team decision-makers within 2.5 hours of arrival if they need a specialist review.
- Specialties will have arrangements in place to receive referred patients in designated specialty assessment areas and to assess them wrthin 60 minutes of referral from ED.
- In situations where there is a delay in transfer to the designated specialty area, arrangements should be made for consultant "post-take" review in ED.
- Registered ED nurses who know the patient, will transfer them to a ward area and handover to a registered nurse, leaving the ward with the ED trolley within 15 minutes of arrival.

Chapter references and further reading

IPS for ED, SSU, Acute Medical Unit (AMU), Inpatient Wards and Clinical Support Services (Pharmacy, Imaging, Pathology, Clinical Technology)

NHS England (n.d.). *Rapid improvement guide to: Making internal professional standards work for you*. Available at: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-making-internal-prof-standards-work.pdf

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North Devon Healthcare NHS Trust (2019). Trust wide internal professional standards for acute patients – the North Devon Way, December: IPS for ED, Specialty Services and Inpatient Wards.

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