Transition Regulatory Approach – NHS Trust level urgent and emergency care conversation

Trust level urgent and emergency care relationship management questions

These questions have been set out to develop a consistent approach to carrying out and recording relationship management conversations about urgent and emergency care at trust level. The KLOEs covered are the same as in the trust level TMA conversation, except for E4 and C1 which are not covered. Please structure your conversations with providers in whatever way you see fit. This may mean, for example, covering the Well-led discussion questions first.

The prompts contained below reflect key issues covered in CQC's recent 'Patient FIRST' publication. Whilst trusts are not mandated to use Patient FIRST, they should be able to demonstrate how there is executive level support to the emergency department and patient flow through the hospital.

You should request a copy of the trust's winter plan and any escalation plans as part of the conversation. Any other document requests should be on an exception basis only.

A risk score should be allocated to each KLOE as follows. An MRM should be triggered for any trust scoring a 1 or 2 for any KLOE:
1 = Very High – Issues require immediate attention
2 = High – Issues require attention
3 = Medium – Some issues require attention
4 = Low – Few issues require attention
5 = Very Low – No issues currently identified

Frequency of calls

Please schedule a trust level urgent and emergency care relationship management conversation by 2 November 2020. It is especially important in the run up to winter that we have a clear sense of the issues and challenges in all trusts and how they are responding. Risk scores and information from these conversations will be used by the Pressure Resilience Oversight Group to inform our decisions throughout winter around further regulatory action, including focused winter pressures inspections.

Overarching question (displayed in tool) and prompts	Any related guidance
S1: How do systems, processes and practices keep people safe and safeguarded from abuse? • Has a structural review of the emergency department been undertaken to understand how IPC and social distancing measures can be ensured? (For example, isolation areas, Aerosol Generating Procedures (APG) areas, negative pressure rooms, areas for safe donning and doffing of PPE, signage) • Has a full capacity protocol assessment for all areas of the emergency department been carried out? If social distancing is likely to be compromised, does this link to the trust's escalation plan?	RCEM Best Practice Guideline: Emergency Department Infection Prevention and Control (IPC) during the Coronavirus Pandemic (June 2020) COVID-19: infection prevention and control Patient FIRST – Infection control and social distancing
S2: How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe? • Have emergency department staffing models been developed for the next 12 months, and how are these being supported by the trust? • If children attend the emergency department, is there a Paediatric Emergency Consultant (PEM) and a minimum of two registered children's nurses per shift? If not, what mitigating actions are being taken to ensure safe and effective care?	RCEM Workforce Recommendations (2018) Safe Staffing for Nursing in Accident and Emergency Departments – Draft Evidence Review NHSI Safe, sustainable and productive staffing in urgent and emergency care (June 2018) RCPCH – Facing the Future – standards for paediatric care (2018) CQC Brief Guide: Staffing emergency departments that treat children Patient FIRST - Staffing
R2: Do services take account of the particular needs and choices of different people? • Has the trust supported any changes to the emergency department that specifically cater to the needs of children and young people, and those with mental health needs? Is there support to continue these changes where they have shown to improve the patient experience?	

R3: Can people access care and treatment in a timely way?
• How is the trust ensuring that issues relating to patient flow are consistently and rapidly escalated?
• How are senior executives ensuring early involvement in flow issues?
• How has the trust been involved in developing alternative pathways for patients with non-time critical presentations? These may be:
  ○ External to the trust – GPs, CHS, 111, pharmacy, ambulance, UTC, MH services)
  ○ Within the trust – UTCs, MH services, speciality review – any patients under a specialty team that can avoid attending the ED, for example for post-op complications, should)
• Have there been any initiatives with external partners (community services, health visitors, school nurses) to safely reduce demand for emergency care from children and young people?
• Are there policies and strategies to enable early and dynamic discharge planning? What has the trust done to understand and remove delays in moving patients through pathways of care (examples may include Same Day Emergency Care (SDEC), speciality review, ward discharge teams, support services such as pharmacy, testing and transport)
	RCEM – Tackling Emergency Department Crowding (2015)
	
	RCEM and RCPCH Position Statement – Winter pressures in children's emergency care settings (2019)
	
	RCPCH – Facing the Future – standards for paediatric care (2018)
	
	Patient FIRST - Flow
	
	Patient FIRST – Reduced patients in emergency departments

W1: Is there leadership capacity and capability to deliver high-quality, sustainable care? • Do trust leaders understand the challenges to quality and sustainability in the emergency care pathway during this period? Can they identify the actions needed to address them?	
W3: Is there a culture of high-quality, sustainable care? • Has there been any impact on the culture of the trust in supporting the emergency department in response to the pandemic?	
W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management? • How are the board going to monitor progress against the escalation / winter plan? • Are the board assured that the trust's escalation / winter plan is going to be effective?	
W5: Are there clear and effective processes for managing risks, issues and performance? • How are the board kept aware of risks and issues in the emergency department, particularly related to seasonal demand, in a timely manner?	

W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services? • What role do trust senior executives have on the A&E Delivery Board / Emergency Care Delivery Board? Has it continued to function during the pandemic? Has it signed off the local system level escalation / winter plan and are the board assured that the local system plan is going to be effective?	.
W8: Are there robust systems and processes for learning, continuous improvement and innovation? • Are there any examples of innovation and learning in the urgent and emergency care pathways in response to the crisis, that the trust wants to share?	