Ealing Hospital NHS Trust

Paper 11a

Support to implement a real time admissions and discharge system in Ealing Hospital NHS Trust

Project initiation document

16th May 2013

Document purpose

The purpose of this document is to provide a firm foundation to support initiation of *a real time admissions and discharge system in Ealing Hospital NHS Trust*.

This project initiation document outlines the initial view of the scope, objectives, and governance for the project as well as a high level outcomes plan for the project.

Version control

Date	Version no.	Reviewed by	Comments
07/05/13	v1	KA	1st Draft
16/05/13	v2	KA	Procurement & risk section

Contents

Figures

Tables

1 Background

Shaping a Healthier Future relies on treating patients in the appropriate care setting for their condition. The Out of Hospital (OOH) strategy delivers increasing OOH capacity and capability reducing demand on acute hospitals. The Acute Reconfiguration strategy centralises capability and capacity where it is needed. Running together these strategies complement each other in meeting demand and delivering the change.

Measures have been developed to understand how the care system is responding to changes. The strategy Implementation monitoring will guide and support decision making at CCG, Provider and Implementation Board levels.

Real time information from A&E and wards would help the system change within the hospital and outside it, so an approach to monitor and improve the effectiveness of Shaping a Healthier Future in real time is now required. This approach in the first instance will incorporate:

- The ability to identify patients in the Acute setting that could be treated elsewhere.
- Support to program, project and change management of the implementation of such an approach.
- Development of reporting, suitable for Ealing Hospital NHS Trust (EHT) and NHS Ealing CCG (ECCG).

These benefits enable patients to have the ***right care***, to be flowed to the **right setting**, at the **right time**. Both EHT and ECCG need to work closely together to maximise the right care, right setting, right time benefit to patient streaming.

2 Procurement process

On the 7th of March 2013, Solent Supplies (our procurement specialists) on behalf of NHS NWL, ECGG and EHT advertised an Invitation to Tender (ITT) to procure the services of a supplier who could develop a system allowing a practical, real-time, objective measure of patient activity attending Ealing Acute Hospital. The framework used was the Health Trust Europe framework.

The submission deadline for this work was 21st of March at 12PM.

The ITT was advertised for over the recommended 10 working days for the suppliers to submit their proposals. Running concurrently, we also gave suppliers 8 calendar days to ask any clarification questions in respect of the ITT whilst they compiled their proposals.

On the 21st of March, Solent Supplies sent to the Strategy & Transformation team the submissions received, which was one proposal from Finnamore/Oak group.

This was distributed to our panel members to evaluate over the next 8 Calendar days.

The panel members that took part in the evaluation of this work are:

- Dr Mark Spencer - Medical Director NHS NWL & GP in Ealing CCG
- Daniel Elkeles - Chief Accountable Officer-CWHH CCG's
- Thirza Sawtell - Director Strategy Transformation Team
- Kevin Atkin - Deputy Director Strategy Transformation Team
- Dr Arjun Dhillon - GP Ealing CCG
- Peter Buckman - Finance Lead Ealing CCG
- Dr William Lynn - Deputy Chief Executive Ealing Hospital

The panel invited Finnamore/Oak group to present on the 4th of April 2012 (attendees as above).

The panel judged the proposal and clarifying presentation on the scoring basis provided as part of the ITT.

The panel scored that the proposal met all of the requirements and Finnamore/Oak group became preferred bidder prior to contract signature.

3 Project definition

3.1 Purpose

Purpose

To introduce a real time structured review tool that can help build the best definition of 'right care, right setting' into the flow of patients supporting the ability to:

- Improve patient care by streaming patients to the most appropriate level of care within the health economy.
- Manage the flow of patients between levels of care within the acute.
- Support effective discharge planning.

Objectives

- Work with clinicians and executives to ensure a buy-in to the implementation of a structured survey at A&E first and on the wards.
- Engage all key Hospital and CCG stakeholders to agree a phased implementation plan.
- Develop the reporting requirements through discussion with the EHT and ECCG staff.
- Implement the structured survey in A&E in a phased way, providing training, mentoring and change management support.
- Use the information collected to develop useful reports to EHT and ECCG.

Outcomes

The outcome will be the installation of a functioning structured survey tool complete with staff engaged in its use and information used in regular reporting for the benefit of patient flow and commissioning of appropriate services.

3.2 Key deliverables

- 100% of admissions through A&E assessed in MCAP.
- Based on the doctor's care plan the structured survey tool will allow clinicians to:
  - Determine the correct level of care based on service requirements.
  - Identify and summarise the number of patients within the hospital, where an alternative setting would be better suited.

  - Identify and summarise the reasons for why these patients are not in their alternative setting, breaking the reasons down into those that are system-based, and those that are hospital based.
- This information will be made available to EHT and ECCG.

3.3 Scope

3.3.1 Organisations involved

The organisations involved with this project are:

- Commissioners: NHS Ealing CCG (ECCG).
- Acute: Ealing Hospital NHS Trust (EHT).
- System level: The Strategy and Transformation team (S&T).

Whilst the following organisations are important for continuous improvement, to ensure a rapid and focussed implementation of the structured survey toolset, these specific organisations are out of scope for this project:

- The local mental health Trust (West London Mental Health Partnership Trust).
- Local authorities (Ealing Council and social services).

3.3.2 Time period

The duration of the consultant support for this project is 12 months from the kick off meeting dated Friday 26th April 2013. The licence for the use of the structured survey tool commences for 12 months from the date of the signature of a licence agreement with The Oak Group.

3.3.3 Boundaries and interfaces

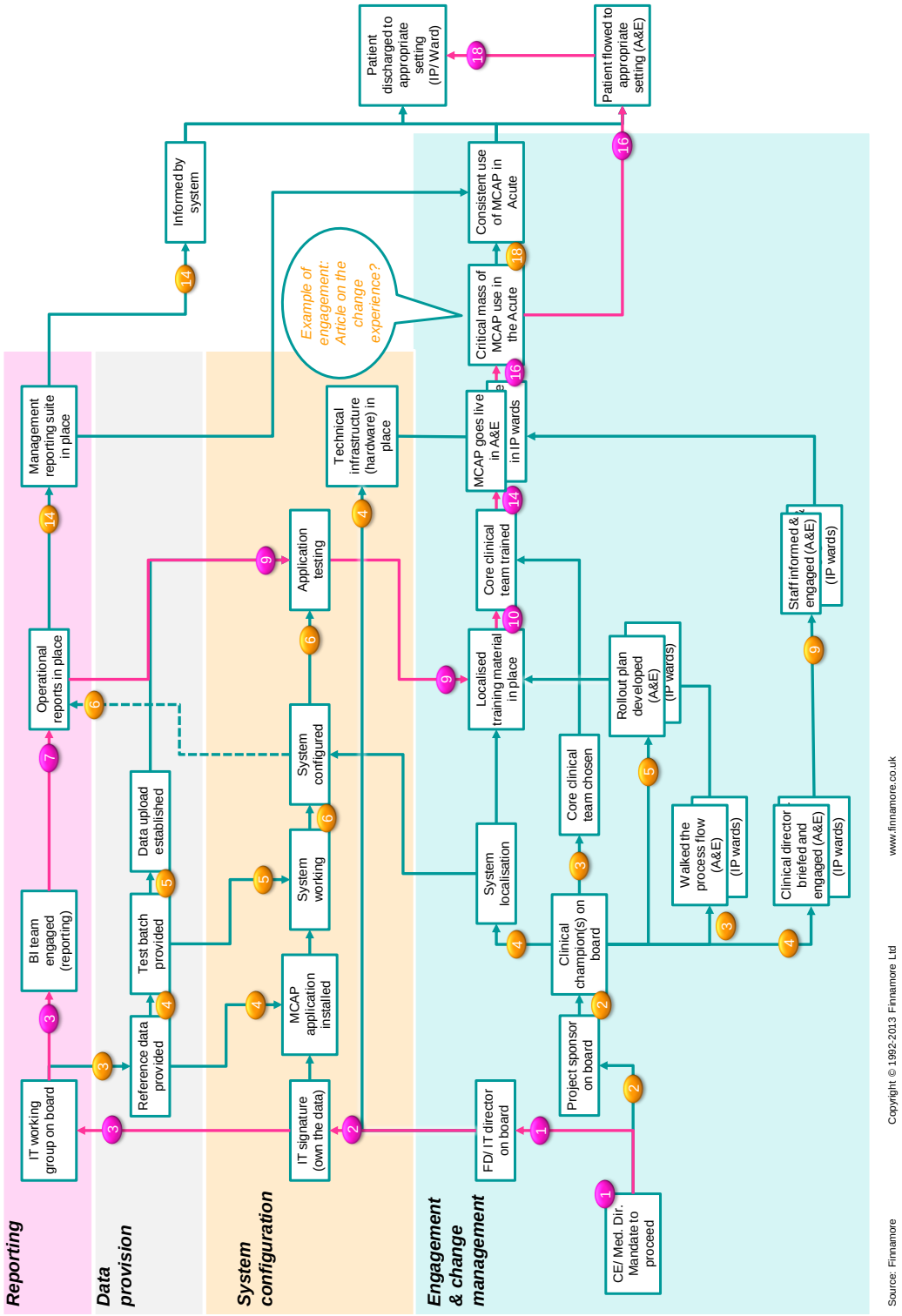
The structured survey tool will draw information where possible to enable automatic population of MCAP fields from the following database systems:

- EHT IT systems:
  - The hospital patient administration system (PAS).
  - Symphony A&E record system.
  - EPRO bed management system.
- The structured survey database will be held on servers managed by Carelink, communication with Carelink will be through a dedicated N3 connection.
- Communication between Carelink and the Data Management Interface Centre (DMIC) will allow pseudo anonymous reporting to ECCG, and benchmarking reports to be created for EHT.

3.4 Initial milestone plan

The initial critical path of outcomes schematic is shown below.

Figure 1 : Initial critical path of outcomes



It is assumed the project is in mobilisation from Friday 26th April until Friday 10th May. Week 1 of the critical path thus starts on the following week. The critical path of outcomes for the successful delivery from the initial project plan above is summarised below.

Table 1 : Initial critical path of outcomes

Week	Critical path outcome	Week commencing
1	Decision to proceed	13/05/2013
2	IT signature (authority to proceed)	20/05/2013
3	IT working group on board Business intelligence team engaged (reporting)	27/05/2013
7	Operational reports in place	24/06/2013
9	Application testing complete (system and user) Local training materials in place	08/07/2013
10	Core clinical team trained	15/07/2013
14	MCAP goes live in A&E and select IP wards	12/08/2013
16	Critical mass of MCAP use in the Acute Patient flowed to appropriate setting (A&E)	26/08/2013
18	Patient discharged to appropriate setting (IP ward)	09/09/2013

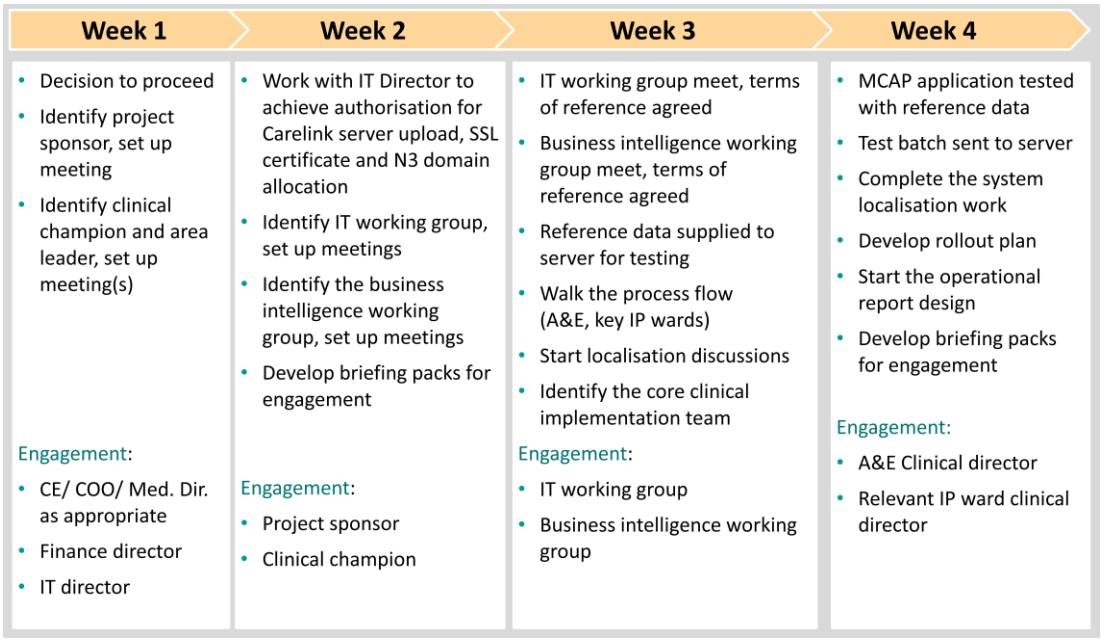
Key milestones within the project are anticipated as follows.

Table 2 : Likely key project milestones

Week	Key milestones	Week commencing
2	Clinical champion(s) on board	20/05/2013
3	Core clinical team identified	27/05/2013
4	System localisation completed	03/06/2013
5	Rollout plan developed (A&E/ IP)	10/06/2013
9	A&E staff informed and engaged	08/07/2013
10	Core clinical team trained	15/07/2013
11	Key IP ward staff informed & engaged	22/07/2013
12	Go live in A&E	29/07/2013
14	Go live in first key wards Management reporting suite in place	12/08/2013

Specific actions summarised for the initial 4-week plan is also included below.

Figure 2 : Initial 4-week plan



3.5 Initial list of dependencies

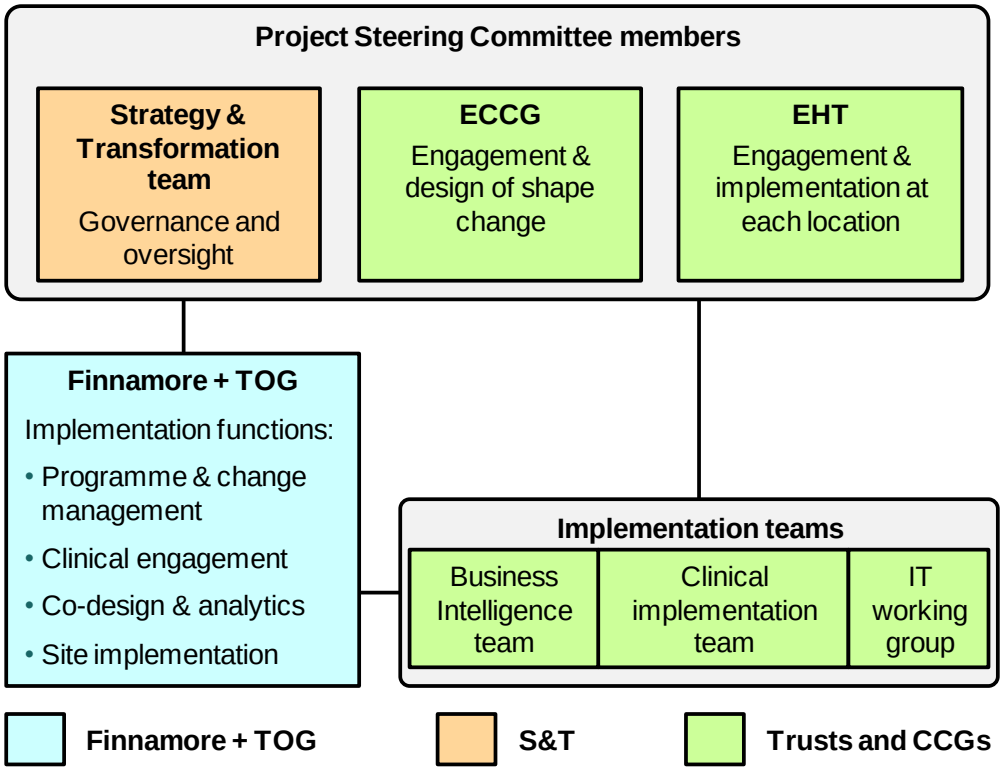
- Commitment and ownership of the process by key stakeholder groups.
- Access to key individuals and groups for inputs into the process and for decision making.
- Clear understanding of roles and responsibilities for individuals and groups.
- 'Open book' agreement between organisations.
- Timely access to data and information.
- For the project team:
  - Mobile phone accessible work space
  - Administration support (to book meetings, etc)
  - Passes, access to printers, etc. as required.
- It is likely that other dependencies exist, and the relative priorities of these competing activities will need to be resolved to enable a successful implementation of the structured survey tool.

4 Governance

4.1 Project governance structure

Shown below are the proposed project governance arrangements.

Figure 3 : Proposed governance arrangements



4.2 Outline terms of reference

Table 3 : Terms of reference

Title	Steering committee	Clinical implementation team	IT working group	Business Intelligence working group
Purpose	Oversight of shape change, engagement and support.	To design and implement MCAP in A&E and wards	To co-design and to set up : the localised MCAP system, the data feeds and the EHT hardware.	To co-design and set up the operational and management reports
Membership	**ECCG:** Chair, COO, project lead **EHT**: CE, COO, Director of Nursing, IT Director **S&T:** Deputy Director **Finnamore**	**EHT**: Clinical champion, Clinical leader, core clinical group **Finnamore**	**EHT**: IT champion, Clinical champion, IT support team **TOG**: Potential IT consultants, VP, Operations **Finnamore**	**EHT**: Head of performance improvement, IT champion, Clinical champion, BI team members as needed. **ECCG**: Project lead **Finnamore**
Chair	EHT Chief Executive	Clinical champion	IT champion	Head of performance improvement
Mode of working	Review updates from the project teams, steer direction	Walking the process in A&E & Wards, localisation of MCAP, engagement building	IT system mapping, setting up data flows, localisation of MCAP, application testing.	To co-design operational then management reporting requirements
Frequency	Monthly review	Daily working, weekly reviews	Daily working, weekly reviews	Daily working, weekly reviews
Quorum	TBC	TBC	TBC	TBC

5 Benefits

Patients

- Improved patient care through flowing to the most appropriate setting for their care, faster.
- Receive higher quality care with an appropriate mix of services.

Caregivers

- Improved patient flow (right patient, right setting, right time).
- Aware of the alternative available local care setting options.
- More senior clinician involvement at the right time.
- Improved clinical focus on their patient.
- Rapid, consistent assessment through internationally agreed protocols.

Ealing Hospital Trust

- Care givers can immediately identify patients who do not need to be admitted or who are able to go straight back to core services (GPs, DNs, etc).
- Avoiding admissions and readmissions gives better patient care and will free up beds.
- Data will evidence where external causes require 'non-qualified' patients to be admitted or to remain in the hospital.

Commissioners (benefits for all patients in Ealing)

- Understand the requirements and capacity for alternative services quickly.
- Information to plan the longer term transition of care settings through appropriate commissioning.
- Measureable proof (on a daily/ weekly/ monthly basis) to manage improvements.
- Greater consistency across geography, service and time for all patients

6 Assessment of benefits

We propose to report to the steering committee on a monthly basis. The oversight will vary depending upon the project stage:

Table 4 : Project oversight by Steering Committee

Project stage	Steering committee oversight
Engagement & Co-design - weeks 1-11	Status against agreed milestone plan • System configuration & localisation • Data provision • Report development • Process mapping • Go live date and relevant plans
Go live - weeks 12-16	Status and when data starts to be recorded operational reports (and fine tuning) • % of A&E admissions being reviewed by MCAP • Non-qualified rates by staff, specialty and location Vs number of admissions or reviews • Status of number of staff trained on MCAP • Status of management report development • Select ward length of stay tracking
Operating period - weeks 17+	Operational and Management reporting • Non-qualified patient rates by staff, specialty and location • Non-qualified patient rates by required setting of care • Reason code reporting showing internal and external causes • Select ward(s) length of stay tracking

7 Project risks

#	High level risk	Example consequence	First order mitigation measures
1	Insufficient commitment and priority to the work by clinical leads and senior managers	Delays as meetings, interviews and other events are poorly attended or postponed.	Clear leadership from project sponsors, highlighting the priority this project takes with a request for clinicians to make themselves available as required. Guidance for peers to support/ back fill each other as necessary to ensure project progression without impacting on patient care. The use of experienced project managers and site leads to ensure issues are identified and resolved quickly.
2	Procurement of a new Carelink server, N3 client domain address or SSL security certificate is delayed	Delay the implementation of MCAP within EHT.	Clear leadership from the IT director with appropriate escalation to ensure rapid procurement and assignment of N3 domain address and security certificate take place. We are experienced in setting up the N3 domain address and can help guide you through this process.
3	Ineffective project or change management.	Lack of discipline and focus, leading to wasted time.	The use of experienced project managers with directorial oversight in leading and managing the assignment. In addition we will deploy a clinician to support discussions on the clinical criteria used by MCAP, helping to resolve any change management issues that arise.
4	Insufficient resource available to do the work.	Project delays due to lack the resource required to meet deadlines.	Finnamore and The Oak Group will commit named staff members sufficient to perform the work. Likewise named resources from EHT and Ealing CCG staff will enable sufficient resource to be identified and ring fenced.
5	EHT IT infrastructure unable to support MCAP .	Problems with uploading to MCAP from the hospital PAS, patient details not found in MCAP, or access to MCAP is slow	Hardware requirements of use of MCAP are relatively light. There will be a clear scoping of hardware and software requirements with the IT director and The Oak Group. The use of a dedicated N3 connection with a dedicated carelink server to ensure responsiveness is maintained. Regular data pushes set up from the hospital PAS to ensure timely updates to MCAP prior to patient reviews taking place.

8 Implementation Cost

This resource is provided over a number of months to ensure the successful implementation of MCAP within EHT.

A resourcing example is included below showing the likely spread of days across the period. This will be flexed as necessary but be limited to the total days.

Table 5 : Example resource breakdown by activity type

	Set up		Live (months)							10-12	Totals	
Work breakdown (days)	**0**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7-9**		**Days**	**£k**
Implementation support	7	23	23	7	1.5	2	1	1	2.3	1.5	**68**	**99**
Information and reporting	3	17	19	4	4	0	0	0	0	0	**47**	**56**
System	3	3	3	0	0	0	0	0	0	0	**9**	**61**
Project mgmt & direction	2	3	3	2	2	2	1	1	2	2	**19**	**33**
Total days	**15**	**46**	**48**	**13**	**7**	**3**	**1.8**	**2**	**4.5**	**3**	**142.8**	
£k	**18**	**58**	**123**	**19**	**9**	**5**	**3**	**2**	**2**	**2**		**249**
										Total	**143**	**249**

The total cost to implement at Ealing Hospital including change management, training and the system licence/connectivity to required systems for 1 year is £249,000.

(Any expenses to be charged at cost & capped at 8% of total fees).

Note: This is being funded from the Strategy & Transformation budget in 13/14.

9 Communication and stakeholder plan

Engagement is crucial for the successful deployment of any structured survey tool. The adopted approach is demonstrated below in the following figures.

Figure 4 : Example engageement approach

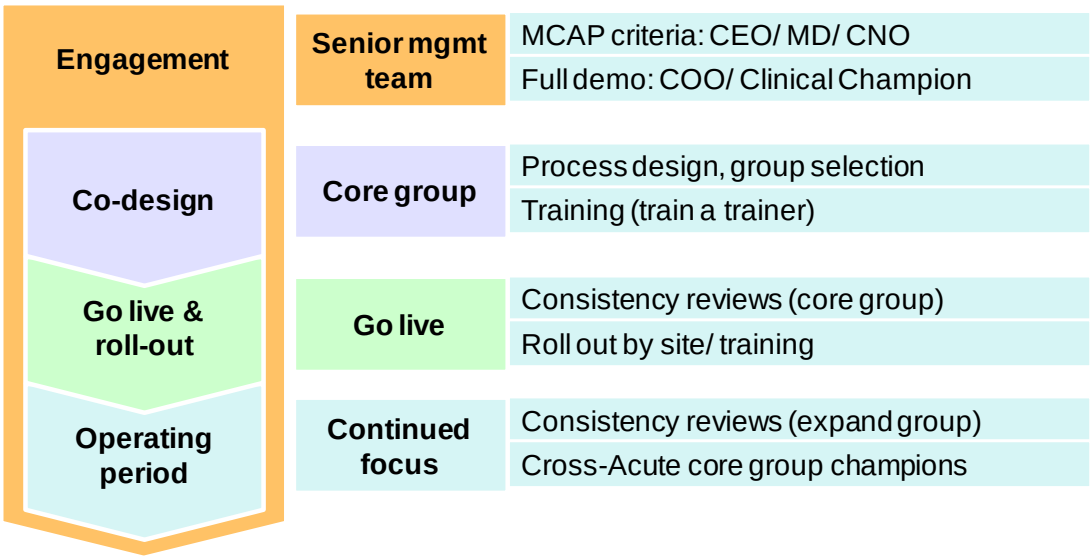


Figure 5 : Example clinical engagement workflow

Engagement and communication with specific stakeholders will be required. An initial stakeholder map is included below for EHT.

Table 6 : Initial engagement map for EHT

Role	Engagement outcome and role required
Chief Exec/ MD/ FD +[CNO/ COO]	• Mandate to proceed (CE/ MD/ FD) • Support with blocks • ID who to work with • Change readiness assessment • Key forums to be engaged with
IT Director	• N3 connection approval • PAS upload facilitated • Mechanism to integrate with hosp. systems and hardware • Ongoing support (at the hospital end)
Clinical Champion • Deputy nursing director? • A&E consultant? • From health science network specialties? Clinical safety to be on side	• Buy-in to the process • Co-design 1. Local A&E flows 2. Ward flow (one of each type? PN) 3. Reason codes • Core team selection & support to this team • Consistency review support • Core team leadership • Roll-out plan development (co design)
Head of performance improvement	• Regular report generation • Access to the MCAP system database • Information governance issue resolution
Finance Director	• Budget sign off for the project AND the IT investment • Engaged in the principles
A&E Director (if not already covered)	• Awareness of what is happening • Engaged (i.e. not blocking) • Ideally support • Getting consultants to allow the change to take place
Core nursing group	• Buy-in to the process • Buy-in to the process flows • Appropriate training • Regular consistency support
A&E staff (and ward staff as relevant)	• Informed of the changes • Have the ability to have their questions answered • Do they need support in the transition?

Whilst this map will ensure the core people are involved in the programme, it is likely that additional engagement exercises will be needed with existing committees and working groups.

To enable the benefits of this system to be fully realised the information obtained should be used to support commissioning appropriate services by ECCG. The following roles and individuals have initially been identified for ECCG.

Figure 6 : Initial engagement plan for ECCG

Role	Engagement outcome and role required
CCG Chair • Mohini Parmar CCG operations exec • Jo Murfitt	• Mandate to proceed • How information will be used (message management) • Support to engage the Acute • ID of CCG stakeholders to engage and work with • Support on any blockages
CCG clinical lead • Arj Dhillon?	• Engagement and support • Message management • Reporting requirements
CCG operations lead • tbd	• Engagement • Reporting requirements • Acute dialogue guidance
CCG Finance • Peter Buckman	• Engagement • Potential support on blocks • Potential negotiation positions

As the project progresses it is likely that these roles may change or evolve.

It is proposed that members of ECCG will be included on the project steering committee.

Other stakeholders may well be involved outside of ECCG and EHT. Engagement may be needed with the following additional groups:

- BEHH/ CWHH executive.
- Shifting settings of care working groups.
- CSU and BIU groups.