Trust Board paper E1

To:	Trust Board
From:	Dr Kevin Harris, Medical Director
Date:	26 July 2012
CQC regulation:	As applicable

Title:	**Emergency Care Delivery**

Author/Responsible Director:
Dr Kevin Harris, Medical Director

Purpose of the Report:
To provide an overview and update of Emergency Care Delivery.

The Report is provided to the Board for:

Decision		Discussion	x
Assurance	x	Endorsement	

Summary / Key Points:
UHL has committed to consistently achieving the 95% target from Q2 and this objective remains the focus of executive attention within the Trust. The CCGs will levy the fines as permitted within the contract should there be non delivery of the ED target therefore it remains imperative that performance is both achieved and sustained.
Performance remains variable from day to day and has been impacted by higher levels of ED activity in May and June 2012. Performance against the quality indicators is improving particularly time to initial assessment.
An ED Summit was held in June resulting in a revised action plan jointly agreed with CCG leads being submitted to the SHA. This is subject to weekly monitoring. Further to the Summit the Trust received a further visit from the ECIST Team. The six recommendations largely focused on clinical leadership and engagement have been incorporated within the revised SHA Action plan.

Recommendations:
Trust Board members are asked to receive and note this report.

Strategic Risk Register Yes	**Performance KPIs year to date** See report

Resource Implications (eg Financial, HR)
Contractual penalties for non-delivery of target
Resource implications as a consequence of implementing SHA action plans

Assurance Implications
Yes against the 4 hour performance trajectory and ED quality indicators

Patient and Public Involvement (PPI) Implications
None

Equality Impact
N/A

Information exempt from Disclosure
No

Requirement for further review?
Monthly as agreed by the Trust Board

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**Trust Board**
REPORT FROM:	**Kevin Harris, Medical Director**
REPORT SUBJECT:	**EMERGENCY CARE DELIVERY**
REPORT DATE:	**26 JULY 2012**

1.0 INTRODUCTION

Achieving the emergency 95% target and clinical indicators on a sustainable basis within UHL remains a top major priority for both UHL and the local health economy. The complex and dynamic inter-relationships both within UHL and the interface with the wider health community continues to pose a series of challenges and associated risk to delivery of the targets. To counteract this and mitigate the risk, a revised series of actions have been agreed between UHL and CCG partners in order to improve performance from Q2.

UHL is committed to consistently achieving the 95% target for Q2 and this objective remains the main focus of executive activity within the Trust. The financial implications of non-delivery of the target are well understood. UHL will therefore work to avoid contractual penalties that may be levied by CCG's.

2.0 CURRENT ACTIVITY AND PERFORMANCE

2.1 Attendance rates

ED attendance rates for the first quarter are above attendance rates seen in 2011/12 even when pre diversion rates are taken into consideration. In May 2012 there was an overall increase in attendance rates of 6.8% and 5.8% in June 2012 against 2011/12 activity levels. Activity trends are in line with the previous financial year for both pre and post diversion activity.

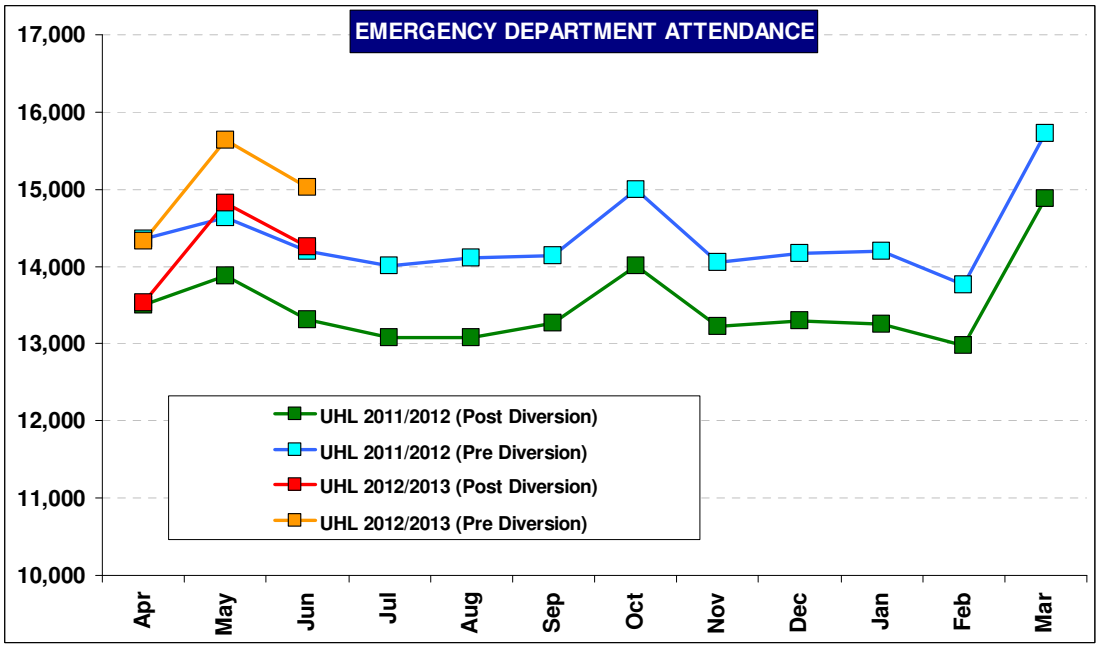

Figure 1: ED Attendances April – June 2012

2.2 ED 4 Hour Performance target

Sustainable achievement of the 4 hour ED target remains a challenge for the Trust, with performance continuing to fluctuate on a daily basis as shown in table 2 below:

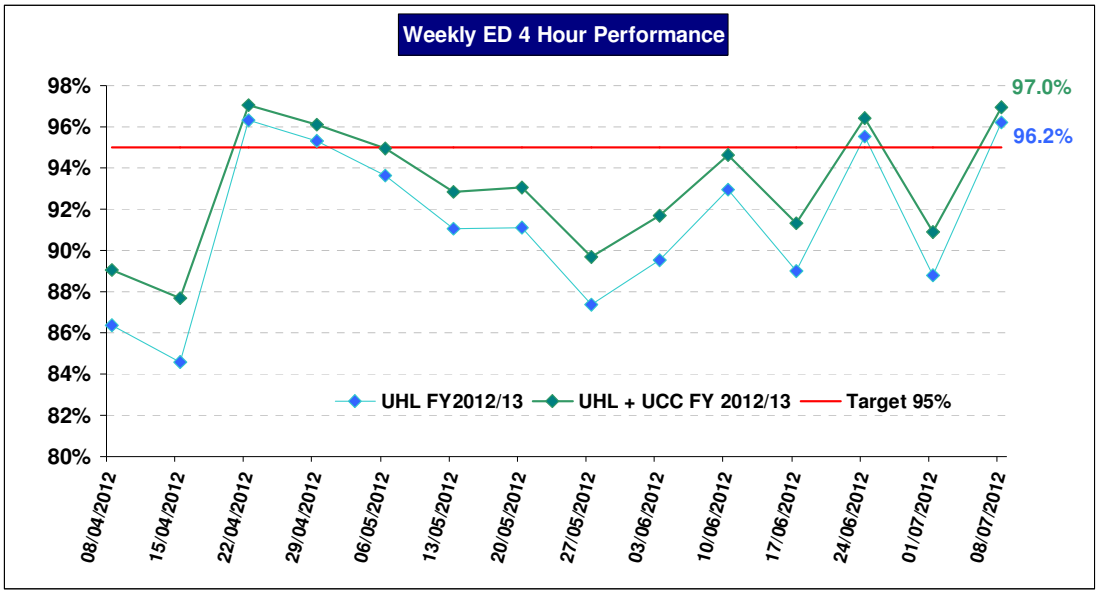

Figure 2: Overall Weekly ED Performance to Week Ending Sunday 8th July 2012

Contributing factors demonstrated through detailed breach analysis are ability of the ED to process patients and create outflow at peak times of demand and bed availability. High patient inflow and the associated processing capacity account for 26% of breaches and bed availability 23%. Escalation plans are being implemented to manage demand and capacity and to improve management of outflow from ED.

An on-going issue remains the timing of presentation to the department of GP ambulance attendances and the peak time for ED type patients to present as shown below.

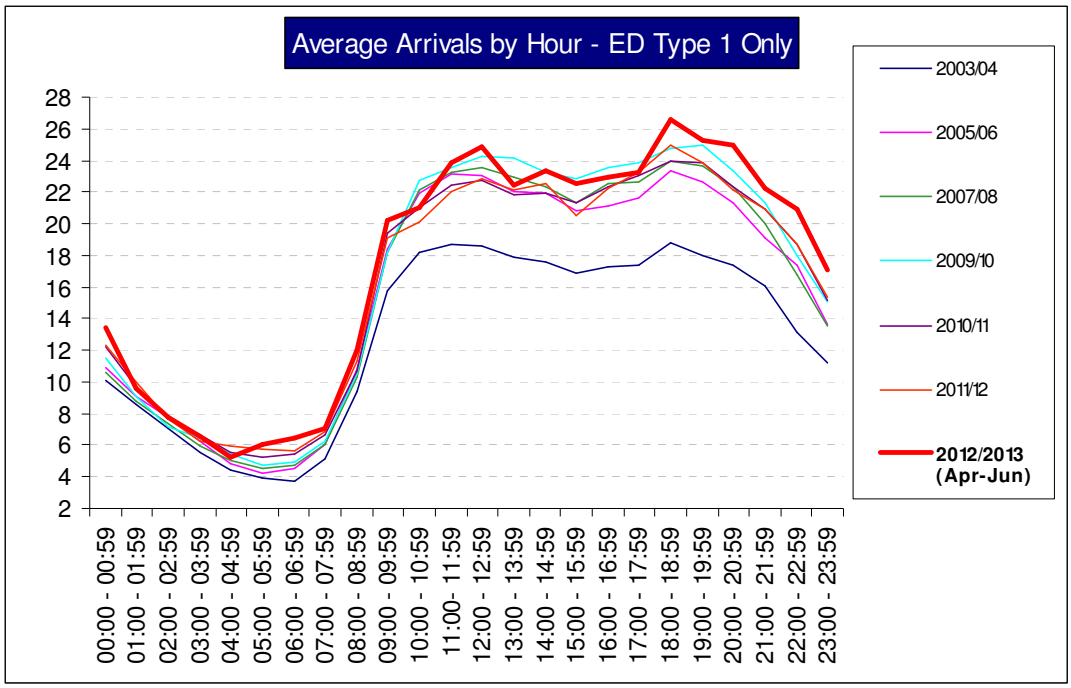

Figure 3: ED Type 1 Arrival time profile

Work is on-going with CCG colleagues to remedy this through improved ambulance response times for Bed Bureau patients identified as requiring admission post GP home assessment.

2.3 ED Performance Indicators

Since the introduction of the Rapid Assessment and Treatment (RAT) process in ED time to initial assessment has shown a steady improvement towards the 15 minute target. The median time to treatment remains within target.

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	TARGET
Left without being seen %	2.0%	2.3%	2.1%	2.4%	3.6%	2.8%	3.0%	2.7%	<=5%
Unplanned Re-attendance %	5.7%	5.4%	6.1%	6.1%	6.6%	6.2%	5.9%	5.9%	< 5%

TIMELINESS

	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	TARGET
Time in Dept (95th centile)	288	240	264	331	331	320	317	322	< 240 Minutes
Time to initial assessment (95th)	48	42	32	34	40	34	31	25	<= 15 Minutes
Time to treatment (Median)	43	42	42	54	61	45	49	59	<= 60 Minutes

Figure 4: ED Quality indicators November 2011 – June 2012

3.0 THE ED SUMMIT

An ED summit was held on 26th June. As previously reported the meeting was led by the CCGs with input from all health and social care organisations across LLR including UHL. This reflects the continuing commitment and priority across the Health Community to achievement of the 95% ED target both in the short term and to ensure that this delivery is sustained long term.

A follow up meeting was held with UHL to agree a joint plan to remedy ED performance and to provide assurance of delivery against the 95% ED target and quality indicators from Q2. Proposals put forward within CCG's plans were reflective of UHL's plans submitted for the ED summit; however requests for additional funding by UHL were not supported. Funding for additional community resources were supported by CCG's. The outputs of discussions and the agreed action plan submitted to the SHA can be found in appendix A.

3.1 IMMEDIATE ACTIONS

A number of immediate measures were identified for action in June. These have been implemented, however challenges remain in achieving the desired increase in staffing within ED to align provision of staffing to demand and guaranteed outflow to all admissions areas with a predetermined meaningful hospital response to aid ED if this is not the case 24/7.

3.2 Top 10 Short Term Actions (timeframe 6 weeks)

From the action plan submitted to the SHA, immediate attention has been focussed on 10 identified priorities detailed in Appendix B. Progress has already been made against many of these actions and reflected against each action.

A further range of actions identified in June for short term delivery continue to be progressed:

- Plans for the development of a viewing area within resuscitation to be converted into a low dependency resuscitation bay to allow 7 patients to be treated within resuscitation are being drawn up. Out of hours mortuary technicians would need to be employed to allow 24/7 use of mortuary viewing room. This scheme forms part of a number of estates issues to increase ED capacity described in appendix B
- Task and finish groups have been set up to identify ways in which additional capacity can be provided through more efficient flexing of EDU/EFU beds. The focus of the task and finish groups will be to prevent unnecessary admissions and prevent breaches through the identification of alternative patient pathways, identification of clear standard operating procedures (SOP), protocols and procedures to support the pathway and identify key performance indicators. These groups are to deliver the required outputs within the next month.
- Gastroenterology and headache (neurology) have been identified as priorities for the fast track development of Same Day Emergency Medicine ambulatory pathways
- Locum ED Consultants via locum agencies are being appointed where possible to bring ED up to establishment. In parallel work is being progressed to review current job plans using models from other ED's to inform decision making.

3.3 Medium term measure (timeframe 12 week)

The action plan agreed with the SHA (appendix A) will be managed and monitored through the Emergency Flows Steering Group. As the short term 10 point actions are delivered attention will become focussed on early delivery of the SHA action plan. Further to this the following previously agreed actions will continue to be progressed:

- Appointment of two paediatric emergency medicine consultants and APNPs who in combination with existing post holders would provide a more integrated paediatric emergency service. Funding and job plans have been agreed.
- Appointment of a project manager whose primary objective is to deliver improvement in Post-Graduate Education, creating a brand ensure improved future recruitment of medical staff to ED.
- Moving fracture clinic to clinic 5, releasing the space currently occupied by fracture clinic to be used for the emergency process. This will allow the clinical model of expansion of the EFU and physicians at the front door to be delivered.

The Trust is conscious that the required timeframes for action are short however this is imperative given the need to deliver sustainable performance from Q2 onwards. At all times UHL governance will ensure consistency and fit with the longer term vision of UHL (supported by the Health economy), to establish an "emergency floor". Delivery of an emergency floor in its entirety cannot be realised until 2013/14 and will encompass cross community and divisional emergency specialities (including the frail elderly) to support the assessment, deflection and admission of patients - adult and paediatrics. Work has been commissioned to develop this clinical model in greater detail as a precursor to the development of the business case that will be required later in the year. The vision and clinical model will be developed by early September2012.

4.0 KINGS COLLEGE VISIT

A team from Kings College were due to visit UHL on 12-13 July 2012. Owing to emergency pressures within London and the South East this visit was postponed. A view will be taken on the future timescale for re instating this visit.

5.0 ECIST VISIT

The Emergency Department and medical assessment units at the LRI were visited by the Emergency Care Intensive Support Team (ECIST) on 26th and 28th June 2012. Recommendations from the visit highlighted 6 key areas for action:

- Consultant led RAT process to provide rapid assessment, initiation of diagnostics and signposting at the front door. This will improve timeliness of decision making by junior doctors and will enhance education.
- Elimination of breaches in Minors through the enhancement of see and treat service, reviewing the minor illnesses seen in the majors area of the department and reviewing the opportunities for access to diagnostics for the Urgent Care Centre (UCC).
- Consultant team working to ensure effective and consistent leadership on all shifts and the development of clinically led escalation plans.
- Managing patient throughput on base wards including daily consultant ward rounds and the consistent application of effective board rounds.

- General physicians complimenting the way in which the Acute Physicians work through the development of speciality in reach and the extension of community in reach into the short stay unit.
- Developing Ambulatory care including the continued development of case management of frail elderly and care plans for patients from nursing homes, maximising opportunities for use of 40 discharge to assess beds.

These actions have been incorporated into the actions agreed with the SHA to ensure delivery.

6.0 RECOMMENDATIONS

Trust board members are asked to:

- Note the content of this report
- Endorse the action plan submitted to the SHA
- Support the view that the visit from Kings should be indefinitely deferred

Appendix A

UHL Medium- term plan – Delivery throughout Q2-Q3

	Issue identified	Solution proposed	Accountable lead	Timescale	Comments
1.	Lack of ward Space	Identify and agree funding to convert non clinical ward space to clinical	Doug Skehan	5/10/12 (18)	3 areas identified. Estimated capacity = 12 beds. Estimated cost £180k
2.	Admission avoidance process at ED front door	Explore the option of a portable facility to improve assessment space in ED	Doug Skehan/CCG	24/09/12 (12)	Will increase space at the front of ED allowing for more assessment and linking in to the UCC 'bounce back' concept. Needs funding agreeing with commissioners
3.	Lack of Clinical Space	Review of non-clinical accommodation adjacent to wards to become clinical accommodation	Doug Skehan	22/10/12 (16)	May identify accommodation that can be used for clinical accommodation that is currently used for non-clinical purposes..
4.	Split paediatric admissions process	Develop a model for a single front door paediatrics process	Pete Rabey/CCG	1/10/12 (13)	Needs to be completed before winter. Part of LLR strategy
5.	There is a need to protect day case activity from demand by emergency patients	Explore the option to expand Day Case Capacity on the LGH	Doug Skehan	24/09/12	e.g. Odames Daycase activity to move to LGH (Potentially releasing Odames as an inpatient ward)
6.	Slow processes concerning medical short stay patients	Move the short stay ward closer to AMU	Doug Skehan	9/07/12 (1)	Makes better use of the Short Stay facility. Move ward 33 to Ward 37
7.	Lack of Clinical Space for the ED	Move outpatients 5 initially and then clinics 1-4, as part of the emergency floor development.	Doug Skehan	27/08/12 (8)	Allows expansion of EFU, EDU and development of Psych assessment facility. Needs support from PCT/LPT re clinic accommodation out of UHL.
8.	Lack of privacy and dignity in UCC assessment process at ED front door.	Move security personnel out of current ED facility to increase assessment facility for UCC	Doug Skehan	27/08/12 (8)	Will require relocation of security in nearby facility.
9.	Inability to move medically fit for discharge patients out of acute beds	Develop a step down facility on the LGH site in conjunction with the commissioners and LPT	Phil Walmsley/ Caroline Trevithick/ Rachel Bilsborough	30/07/12 (17)	Will need clear identification of patients and clarity on who is responsible for the clinical management of patients in this facility. Needs funding agreeing with commissioners

10.	Patients who are fit for discharge are unable to use the discharge lounge due to their need for a bed/stretcher	Develop a business case for the expansion of the discharge lounge	Doug Skehan	13/08/12 (6)	This will be an expansion of the current estate. Costs of around £250,000 (Revenue of £100,000 and capital of around £150,000). Needs funding agreeing with commissioners
11.	Lack of senior medical input post 01:00 in ED	To try to add to Senior Decision Makers (SDM) overnight.	Doug Skehan	16/07/12 (6)	Recruitment will remain an issue as we currently struggle to fill vacant posts.
12.	Patients waiting longer than necessary for access to theatres	Identify funding for additional Emergency capacity (theatres)	Shona Campbell	16/07/12 (2)	Successful Flory bid but stopped in April 2012. Needs funding agreeing with commissioners
13.	Patients having operations cancelled due to lack of ITU capacity	Expand on current Critical Care capacity	Doug Skehan	23/07/12 (3)	Agree to have a CCG discussion regarding need for enlarged CC capacity in July. Any agreed change will need to be agreed as part of ongoing discussions over CC capacity.
14.	Slow discharges post bank holiday and weekends	7 day working and normal functioning over bank holiday weekends.	Phil Walmsley	(5)	Need sustainable 24/7 services in and out of UHL
15.	Lack of admissions avoidance options	Increased number and specialty urgent clinics	Phil Walmsley/ Marina Muirhead	30/07/12 (4)	Can expand portfolio but need to agree which specialities will be of most use and also agree ongoing funding arrangements for new clinics.
16.	Need to make best use of current bed capacity	Agree specification and cost of pan trust/LLR Patient management system	Phil Walmsley	31/12/12(26)	Start-up costs will be high and need to be clear about source of funding. Needs to link in to the Managed Business Partner process at UHL as well as linking to LPT
17.	Need to make best use of current bed capacity	Patient tagging to track progress in system for 1st patient on theatre list	Elaine Ryan	5/10/12 (18)	Need to get this process agreed as practical and acceptable from patient and staff perspective
18.	Greater focus on use of technology to improve patient flow	Increase use of patient centre regarding discharge information and EDD	Phil Walmsley	23/07/12 (3)	Patient centre is very limited in its capability, so impact will be limited.
19.	Need to increase speed of patient process	Explore the option of increasing point of care testing against improve laboratory turnaround time	Shona Campbell	30/07/12 (4)	Currently being assessed by CSD division. May not be needed

UHL: Top 10 impact actions – Short term (within 6 weeks)

	Issue identified	Solution proposed	Accountable lead	Timescale	Impact measures
1	ED capacity	Relocate fracture clinic & clinic 5 to create a general medical assessment & triage unit, expanding current EDU and EFU capacity from 8-12 to 16-24 Focus on admission avoidance schemes	Doug Skehan	6 weeks	Decrease in Breach reason; waiting for bed Increase in % discharged from unit Decrease in max time in ED
2	Increase in GP referred patients	Wider promotion of the GP hotline and associated 'admission avoidance' clinics Focus on developing urgent gastro clinics and headache pathway	Marina Muirhead, GP Urgent Care Leads	2 weeks	Increase in calls to GP hotline % admissions subsequently deflected
3	Appropriate staffing across the Trust	7 day cover of therapists Use of bank staff Additional porters for patient movement ED consultant to cover overnight Additional medical consultants to increase acute clinics and AMU Additional surgical consultant to cover ED Phlebotomists to provide full weekend service Additional specialist discharge nurses to maintain discharge flow Work in progress. Weekly reports to Emergency Flows Steering Group	Shona Campbell, Shona Campbell Doug Skehan Doug Skehan Doug Skehan Shona Campbell Phil Walmsley	Within 3 weeks	Aligned to other issues within this list
4	ED consultant presence in ED	Increase Direct Clinical Contacts for consultants, review of job plans for ED/AMU, selective rota of those suited in acute medicine Impact of future increases in DCC's being evaluated	Doug Skehan	3 weeks	Increase in DCC by consultant Increase in ED presence in ED
5	Time to specialty assessment, specifically	Improve flexibility by having two orthopaedic registrars on call, one based in the ED	Andrew Furlong	1 week	Decrease in time to specialty assessment for trauma patients

	for Trauma patients	Dedicated registrar cover available already. Discussions underway regarding a more efficient/effective referral pathway Focussed work on orthopaedic referrals to AMU			
6	Surgical pathway for ED	Implement a clear pathway to allow surgical patients to go to the ward before all investigations are back Clinical lead identified by planned Care Division	Andrew Furlong	2 weeks	Decrease in time surgical patients await results in ED
7	Pharmacy waits	Additional dedicated pharmacy cover for ED/AMU/EFU to reduce delays (as above in 3) Creative solutions to pharmacy demands eg healthcare at home, home delivery options and improved availability of prepacks to be presented to cross Divisional meeting 13/7/12	Shona Campbell	2 week	Decrease in patients awaiting medication
8	Imaging/diagnostic delays	Imaging to provide 7 day service Imaging agreed as a priority for the internal waits programme. Andy Rickets identified as the lead. Agreed that Assessment Units should have the same turnaround times as ED including reporting. Potential ED Locum Radiologist identified	Shona Campbell	6 weeks	Decrease in patients awaiting diagnostics tests
9	Trust wide escalation	Immediate revision of the internal escalation process For review and sign off by Emergency Flows Steering Group 20/7/12	Phil Walmsley	1 week	Increase in response time
10	Outflow	Policy to be implemented that ALL discharges are to be morning discharges unless otherwise stated as per ECIST recommendation 1. Increase discharge coordinators 2. Expand discharge to assess model 3. Increase discharge lounge capacity	 Phil Walmsley Doug Skehan Doug Skehan	6 weeks	Increase in Discharge before 11am rate

Summary of Emergency Department Developments

Acute Division

July 2012

1. Introduction

1.1. The acute floor is seen to provide many benefits resulting from clinical and diagnostic adjacencies allowing better access to a variety of specialist clinicians improving processes around access and decision making which otherwise will be difficult to replicate within the current footprint.

1.2. There is much support for the acute floor, but it will take a significant time to realise. Work is actively being undertaken to prepare for this development, a formal group has been established and a project Manager appointed.

1.3. ED performance is a major concern for the division and the Trust but with robust action plans to support the necessary systems and process changes an equivalent change in our capacity is also required to support and sustain improved performance

1.4. It is the aim of the current estates strategy to try to reap the benefits of the acute floor earlier, whilst incrementally moving towards our end vision.

1.5. The aim of this paper is to update executive team of the plans and the rationale for change.

2. The program of work

2.1. The program of work is extensive in support of the emergency department (ED) from CBU's other divisions, involving the corporate transformation agenda to the local CBU improvement plans. This work is essential for the achievement of the ED performance. Key projects include

- Hidden waits
- Bed Management
- Discharge Planning
- Creation of the emergency floor

2.2. A peace of work has been commissioned to support the development of the clinical model that will inform the development of the business case for the emergency floor, which is due to be completed by the end of the year and involves all divisions.

Appendix C

Project	Plan	Rationale	Benefits
Extend Emergency Decisions Unit	Convert Fracture clinic to relocate and extend the current EDU Enabler: relocation of fracture clinic	A new 20 patient EDU to be created. The area will comprise of both beds and chairs and minimize the patients admitted to AMU. The area will take sometime to develop fully, initially the minimum amount of work will be undertaken to allow early opening with a design program which will later include a psychiatric assessment facility and relocation of the ambulatory services. This incremental approach is to enable benefits to be realised early.	Reduction in admissions to inpatient beds Reduced breaches, and release senior clinical time resulting from the improved management of psychiatric patients Relocation of ambulatory care will lead to more effective multi-disciplinary working, effective streaming and reduced admission from the clinic through use of clinical pathways onto EDU
Extend the Elderly Frailty Unit (EFU)	The space vacated by EDU will be used to expand EFU Enabler: relocation of fracture clinic	The existing Elderly Frailty unit (EFU) as part of a wider reaching whole Health care economy based project to avoid admission and readmission of elderly frail patients. Current facility is not big enough to meet the demand as a result patients are being admitted to the AMU	Reduction in admissions to AMU
ED Assessment Area	Phase 1 Short term Convert two rooms Phase 2 Extend front of ED Enabler: planning permission, funding and process redesign,	Full benefits of will allow the full benefits of RAT/STAT (rapid assessment and treatment) to be realised, limited by space constraints Expansion and dedicated staffing of this area will allow early intervention, initiation of appropriate investigations and streaming to appropriate area. Later developments will	Faster decision, (consultant led) making minimize assessment time and processing of patients. Reduce clinical risk by minimizing the number of patients in the majors area at anyone time.
		It is believed that the above three initiatives will the biggest impact on reducing the number of breaches	
Expansion of resuscitation	Enabler: Conversion of a viewing room in resuscitation	To increase capacity of resus to meet demand	Improve patient flow Patient in the right place seen by the right clinician
Convert non clinical areas on wards to Clinical areas	Wards 34, 36, 37, 38, Enabler: relocation of admin staff	Aimed at ensuring there is a planned and flexible and cost effective way to increase bed base to ensure occupancy remains at an acceptable level which will allow flows to be maintained within the acute areas. LOS and active discharge planning has been a key area of process change but lack of acute beds resulting in a reduced patient flow has resulted in increasing the number of ED breaches.	Reduced bed base occupancy in AMU supporting patient flow
Recruitment	Improved recruitment strategy	The ED has adopted an aggressive recruitment policy regarding attracting ED training grades which has resulted in the highest fill rate	Full establishment to enable shifts to be filled at 100% enabling

	Enabler: Education Strategy	at ST4 level of any region in the country. The ED is actively trying to attract ED specialist registrars from out of region on 1 year out of program experience in a variety of areas (Education, Leadership, Geriatrics and Pre-Hospital Care – these will replace locums in out of hours, nights and weekend shifts in a highly cost effective way. The same aggressive approach is being applied to consultant recruitment with the recent appointment of an ED consultant with dual certification in ED and ITU and recent adverts for Paediatric subspecialty ED Consultants	timely assessment and reduction of breaches Implement 24/7 consultant cover and improved senior decision making out of ours
Education	Improved teaching of deanery Trainees Enabler: A £464,000 SHA grant	ED has an active plan to drastically improve the quality of teaching delivered in the ED. A £464,000 SHA grant underpins an extensive project plan led by a newly appointed Postgraduate Education Lead with 2 dedicated PA's and a soon to be appointed Project manager. The specific intention is to transform Leicester ED into a nationally recognised teaching and training centre able to proved excellent core training and deliver additional/subspecialty training in Ultrasound, Leadership, Medical Education, Research, Geriatric Emergency Medicine, Intensive care, Paediatric Emergency medicine and Pre-Hospital Emergency Medicine	Improved 24/7 covers of senior decision-makers supporting processes within the department in support of improved assessment time. Build reputation to improve future recruitment prospects and possible branding.