University Hospitals of Leicester NHS
NHS Trust

To:	Trust Board
From:	Suzanne Hinchliffe, Chief Operating Officer/Chief Nurse
Date:	27th September 2012
CQC regulation:	As applicable

Title:	Emergency Care Delivery

Author/Responsible Director:
S. Hinchliffe Chief Operating Officer/Chief Nurse

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

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

- UHL has delivered the 95% target during July and August.
- In line with Q1, ED attendance rates remain consistently above those seen in 2011/12 both pre and post diversion to the Urgent Care Centre.
- 5 of the 6 quality indicators associated with the ED have been achieved with the exception of unexpected readmissions.
- The Trust action plans remain on target with work progressing on enabling schemes to support the improved performance of the Trust 4 hour target.

Recommendations:
The Trust Board is invited to receive and note this report.

Previously considered at another UHL corporate Committee ? N/A

Strategic Risk Register Yes	**Performance KPIs year to date** Please see report

Resource Implications (eg Financial, HR)
Monthly contractual penalties for non-delivery of target.
Resource implications of implementing ED action plans.

Assurance Implications
The 95% (4hr) target and ED quality indicators.

Patient and Public Involvement (PPI) Implications
Impact on patient experience where long waiting times are experienced

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review ?
Monthly

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT FROM: **SUZANNE HINCHLIFFE**

REPORT SUBJECT: **EMERGENCY FLOWS**

REPORT DATE: **27 SEPTEMBER 2012**

1.0 INTRODUCTION

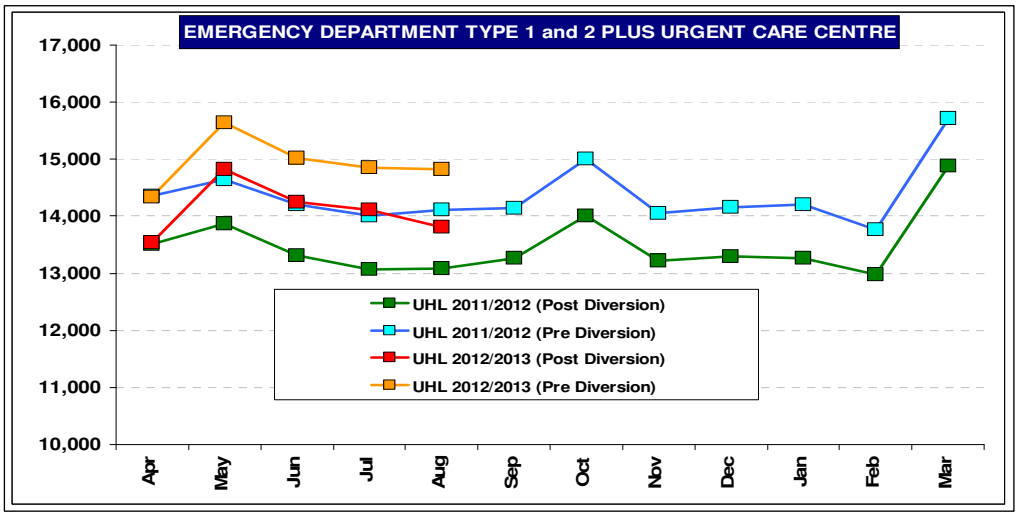
Achieving the emergency 95% target and clinical indicators on a sustainable basis within UHL continues to remain a top major priority for both UHL and the local health economy. Work continues on the actions that were agreed between UHL and CCG partners in order to improve performance from Q2 onwards. Further to this, the trust continues to be mindful of the increasing emergency activity and the impact of this on both overall trust capacity, impact on elective flows and funding streams.

2.0 CURRENT ACTIVITY AND PERFORMANCE

2.1 Attendance rates

In line with Q1, ED attendance rates remain consistently above those seen in 2011/12 both pre and post diversion to the Urgent Care Centre and for August, have realised a 5% activity increase compared with the same period last year – the detail of which may be seen below.

Figure 1: All emergency Attendances April – August 2012

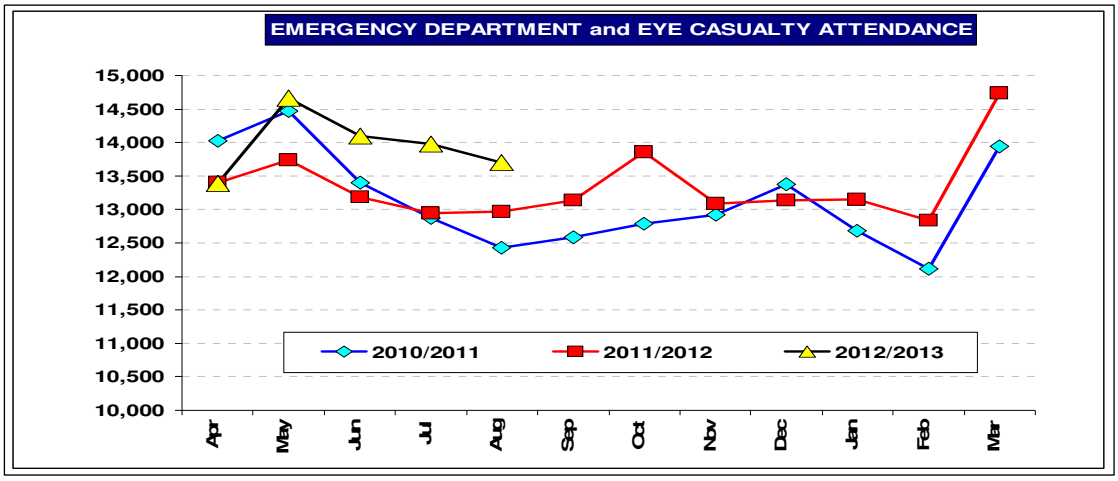


Details regarding overall pre and post diversion numbers may be seen below in Figure 2 coupled with a graph detailing the overall change in attendances for the past three years in Figure 3.

Figure 2: Pre and Post Diversion Activity Comparisons

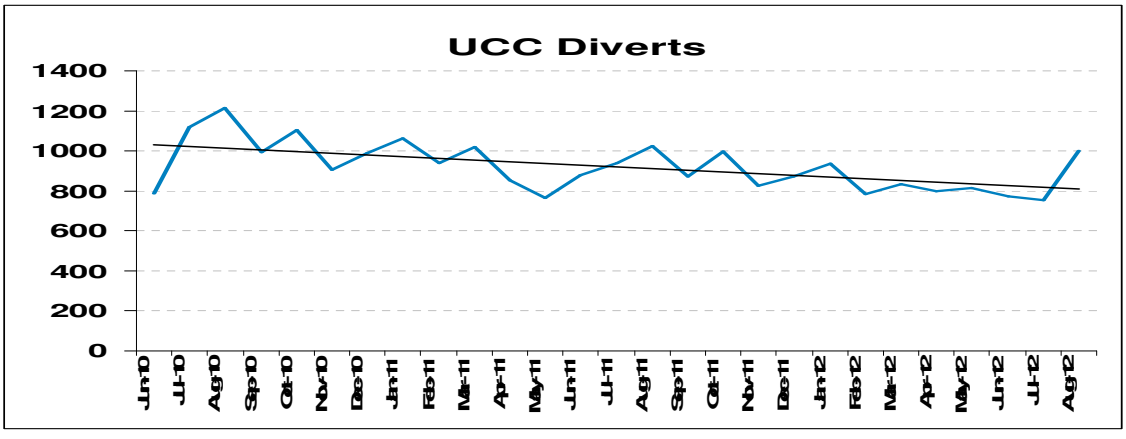
EMERGENCY DEPARTMENT TYPE 1 and 2 PLUS URGENT CARE CENTRE							
	UHL 2010/2011 (Post Diversion)	UHL 2010/2011 (Pre Diversion)	UHL 2011/2012 (Post Diversion)	UHL 2011/2012 (Pre Diversion)	UHL 2012/2013 (Post Diversion)	UHL 2012/2013 (Pre Diversion)	Overall % Change 12/13 vs 11/12
Apr	14,117	14,117	13,507	14,358	13,532	14,332	-0.2%
May	14,574	14,574	13,871	14,636	14,819	15,633	6.8%
Jun	13,509	14,298	13,318	14,197	14,248	15,022	5.8%
Jul	12,983	14,100	13,075	14,014	14,107	14,860	6.0%
Aug	12,544	13,757	13,086	14,109	13,816	14,818	5.0%
Sep	12,726	13,720	13,270	14,142			
Oct	12,918	14,022	14,002	15,000			
Nov	13,057	13,963	13,226	14,051			
Dec	13,500	14,488	13,291	14,162			
Jan	12,830	13,893	13,260	14,196			
Feb	12,263	13,202	12,978	13,762			
Mar	14,100	15,119	14,884	15,719			
Sum:	159,121	169,253	161,768	172,346	70,522	74,665	

Figure 3: Yearly Comparisons 2010 - 2012



Diversions to the UCC in July 2012 are also shown below. The UCC have confirmed there were data quality issues in reporting ED diverts which has resulted in a lower number being reported. This has been rectified for August. However, whilst this has improved the reported overall numbers, these still remain lower that those reported when the diversion programme started – an issue that is being discussed at the Emergency Care Network.

Figure 4: UCC Diverts June 2010 – August 2012



2.2 Trust 4 Hour Performance target

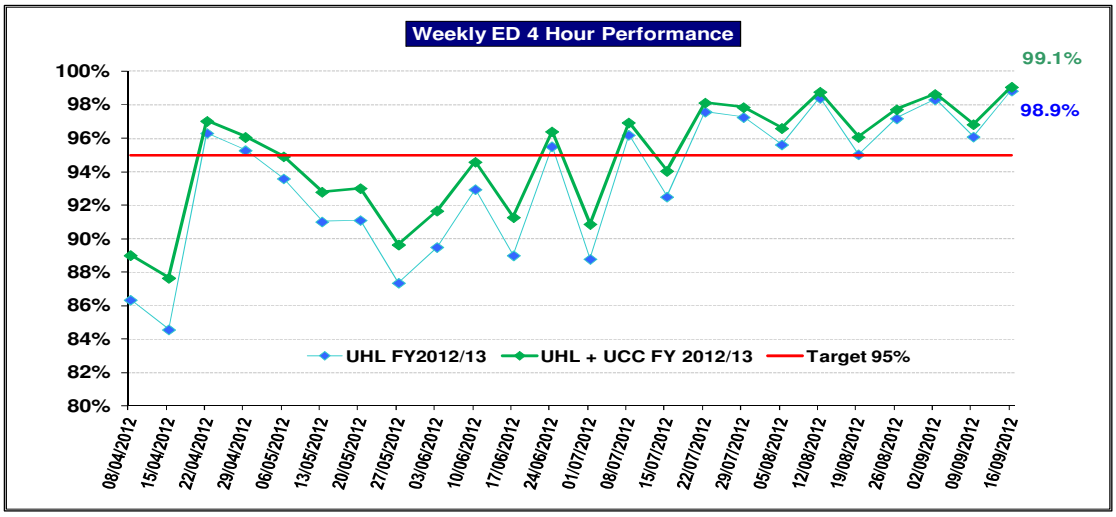
The following graph shows an overview of performance April 2012 to September 2012. With the national trust target set at 95%, current performance has moved the overall trust position from lower quartile in June 2012 to 27th upper quartile nationally in September.

From a cumulative 95% position, with current performance maintained, this will result in the ED, Eye Casualty and UCC position being recovered by the end of September.

In preparation for the forthcoming winter months, performance needs to be maintained and exceeded to ensure delivery of the UHL cumulative position. On current performance data, this will be achieved during December.

The following graph shows the performance of the trust 4 hour target to week ending 16th September 2012;

Figure 5 – Weekly Trust Performance April - September 2012



From a breach perspective, a summary root cause analysis is undertaken on a daily basis and is then subject to the Emergency Flows Steering Group for discussion. Significant changes have been seen in recent weeks showing a reduction of breaches associated with ED process and an increase in breaches recorded as clinical reasons. As such, there are three main contributing factors to the reported breaches in August which may be seen below:

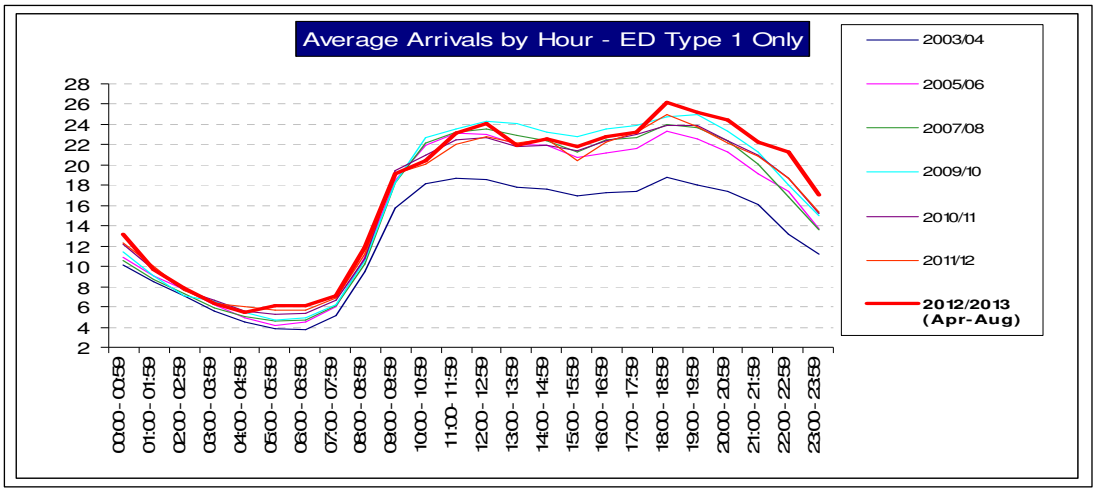
- ED process (inflow, capacity ,staff sickness & late bed requests) 16%
- Bed breaches 17%
- Clinical reasons 31%

Figure 6 – Breach reasons

Delay Reason	12/08/2012 Sun)	19/08/2012 Sun)	26/08/2012 Sun)	02/09/2012 Sun)	09/09/2012 Sun)	16/09/2012 Sun)	Sum:	Cumulative %
Bed Breach	7	30	14	6	19		**76**	**17%**
ED Process	4	30	12	2	18	4	**70**	**16%**
ED Capacity (Cubicle Space)				1			**1**	**0%**
ED Capacity (Inflow)	2	16	3		21		**42**	**10%**
ED Capacity (Workforce)		3					**3**	**1%**
Clinical Reasons	21	35	19	21	25	15	**136**	**31%**
Specialist Assessment		4	1	5	5	2	**17**	**4%**
Specialist Decision				1	2		**3**	**1%**
Investigation (Imaging and Pathology)	4	7	8	9	14	14	**56**	**13%**
Transport	3	5	6	5	3	1	**23**	**5%**
Treatment	2	1		1	10		**14**	**3%**
	43	**131**	**63**	**51**	**117**	**36**	**441**	**100%**

The overall timing of breaches can be correlated alongside the average arrival times to the department and as such are predictable in their nature where increased work-force numbers and decision makers are required. For the month of August however, and the reduced number of breaches, the majority are shown to be related to Monday/Tuesday activity, a shift from the previously reported Thursday. There are however sustained peaks of attendances which remain focused during the latter part of the evening which may be seen below:

Figure 7: Average Arrivals by Hour

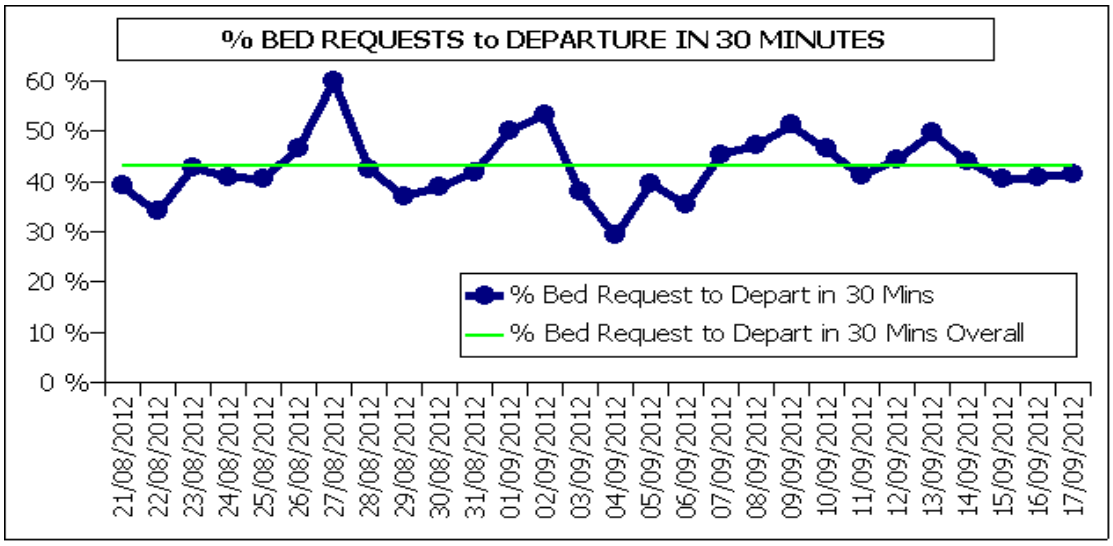


Further to previous discussions at the Trust Board, the timing of bed requests for patients waiting admission and the waiting time post request to transfer may be seen below, where slight improvements are noted in the earlier request of beds for patients requiring admission.

Figure 8 - Time from arrival to bed request

	Jun-12	%	Jul-12	%	Aug-12	%	1st-19th Sept	%
0-1 Hours	168	4.4%	193	4.8%	165	4.5%	127	5.4%
1-2 Hours	872	22.6%	946	23.7%	878	24.0%	653	27.8%
2-3 Hours	1,209	31.4%	1,459	36.5%	1329	36.4%	861	36.6%
3-4 Hours	1,264	32.8%	1,169	29.3%	1172	32.1%	625	26.6%
4-5 Hours	172	4.5%	126	3.2%	69	1.9%	58	2.5%
5-6 Hours	99	2.6%	54	1.4%	25	0.7%	18	0.8%
6 Hours+	69	1.8%	45	1.1%	18	0.5%	9	0.4%

Figure 9: Bed Request to Departure within 30 minutes



The average time from bed request to departure has been slightly variable throughout August, although some improvement is noted in September and additional transfer staff have been arranged to support patient moves.

In support of providing active management to respond to patient or capacity delays, a one page escalation plan has been implemented with early escalation to CBU and divisional managers and ultimately to Director level. Additionally, the use of the ED daily dashboard and live bed state will improve the Trust's earlier response to rising pressures within the system.

2.3 ED Specific Performance Indicators

Since the introduction of the Rapid Assessment and Treatment (RAT) process in ED, time to initial assessment has shown a steady improvement and is now delivering the 15 minute target and overall, 4 of the 5 performance targets as may be seen below.

Figure 10: ED Quality indicators December 2011 – July 2012

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	TARGET
Left without being seen %	2.1%	2.4%	3.6%	2.8%	3.0%	2.7%	2.4%	2.1%	<=5%
Unplanned Re-attendance %	6.1%	6.1%	6.6%	6.2%	5.9%	5.9%	6.4%	5.6%	< 5%

TIMELINESS

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	TARGET
Time in Dept (95th centile)	264	331	331	319	317	322	240	238	< 240 Minutes
Time to initial assessment (95th)	32	34	40	34	31	25	20	15	<= 15 Minutes
Time to treatment (Median)	42	54	61	45	49	59	57	53	<= 60 Minutes

2.4 Discharge Processes and Emergency Activity Trends

With an improving focus on performance, improvements have also been seen in 'take home medications' completed prior to the day of discharge as may be seen below.

Figure 11: % of TTO's Completed Prior to Day of Discharge

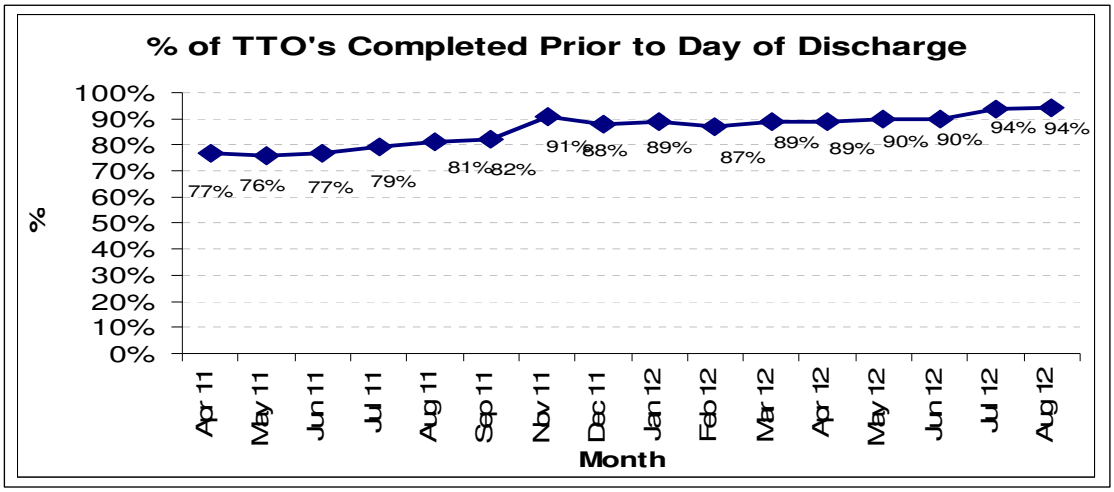
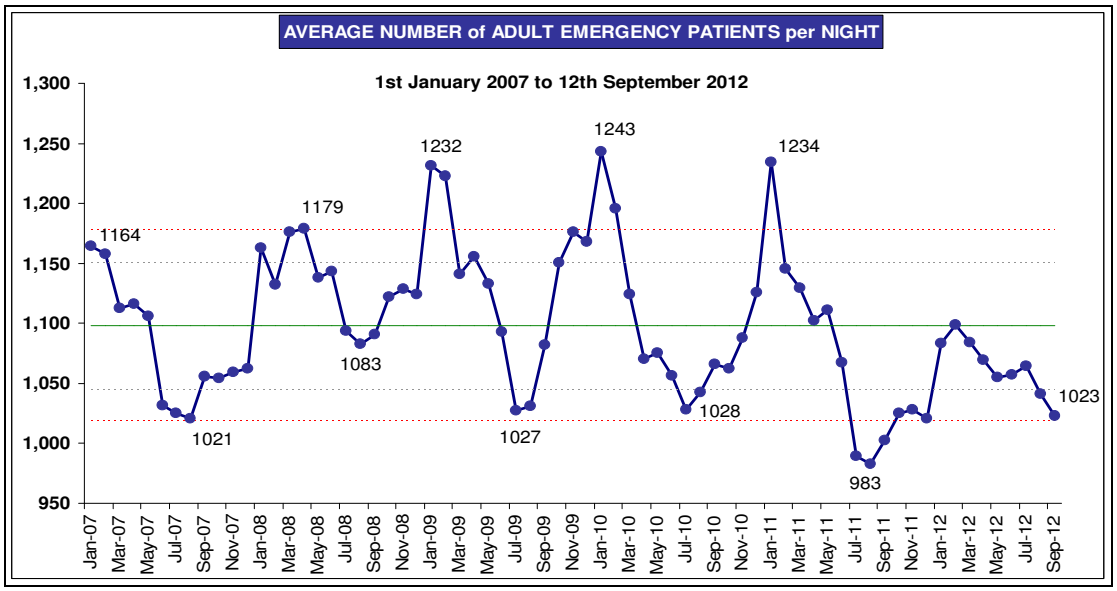


Figure 12: Average Number of Adult Emergency Patients per night

In considering the overall bed base requirements in the trust and changes required for winter, understanding the number of emergency admission patterns and length of stay are key. From the graph below one can see the overall reduction in both key January/February peaks and the recovery period in subsequent weeks. Further detail regarding length of stay shifts are currently being scoped and will be discussed at the cross divisional meeting and agreement reached where support needs to be focussed.



2.5 Discharge Delays

Delayed transfers of care thresholds for 2012/13 have been set at:-

PCT	Vital Sign Target (No. Per 100,000 population)	% delayed target	Population (ONS)
Combined	2.3	1.19%	758070
Leics City	3.2	1.41%	225800
Leics County	1.5	1.04%	532270

Delayed transfers of care are reported to Leicester, Leicestershire & Rutland (LLR) Commissioning Performance Team on a weekly basis using data collated by the UHL Discharge Team.

The Discharge Team carry out a census of all patients whose transfer of care is considered to be a 'delay' as at midnight each day. All delays are then validated with Social Services, Occupational Therapy, Physiotherapy, Leicester City and County Community services, and Equipment services. This validation is carried out by a combination of weekly meetings, email and faxes.

This report measures weekly delays, occurring at midnight each Thursday. Once reports have been circulated and agreed, they are forwarded to the UHL IT Department, who then calculate reporting figures which are sent to the LLR Commissioning Performance Team and reported nationally on unify.

A summary of performance for April-August 2012 may be seen below:

	City Average Monthly Patients Delayed	City Average Monthly %Delay	City Average No of Delays per 100,000 population	County Average Monthly Patients Delayed	County Average Monthly %Delay	County Average No of Delays per 100,000 population	Combined Average Monthly Patients Delayed	Combined Average Monthly %Delay	Combined Average No of Delays per 100,000 population
April	9	1.75%	3.6	13	1.70%	2.3	21	1.72%	2.7
May	12	2.33%	5	26	3.23%	4.8	38	2.88%	4.8
June	14	2.75%	6	30	3.68%	5.5	44	3.32%	5.7
July	15	2.96%	6.5	31	3.83%	5.7	47	3.50%	6
Aug	17	3.20%	7	34	4.13%	6.2	50	3.77%	6.4

Reasons for the delays are summarised below:

Reason	Assessment		Awaiting Public Funding		Availability of non acute NHS Care		Awaiting care home placement		Awaiting domiciliary package of care		Awaiting community equipment		Patient/Family Choice		TOTAL	
	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co
April	10	8	4	5	5	19	10	9	2	3	1	0	2	7	34	51
May	6	14	13	23	20	51	18	60	3	7	7	6	5	23	72	184
June	9	13	10	14	26	48	15	42	3	6	12	14	2	20	77	157
July	10	12	7	14	25	35	13	42	2	9	12	10	9	19	78	141
Aug	12	23	10	20	38	55	23	52	2	8	13	9	5	39	103	206

During this month there has been a significant deterioration in the overall performance for city and county patients. This month has been a 5 week month which is one of the factors contributing to the increase in delays. Delays for availability of non acute NHS care (rehabilitation), care homes and patient choice remain the highest areas of concern

There were 309 episodes recorded as a 'Delayed Transfer of Care' on the weekly sitreps recorded at midnight each Thursday during August 2012, making the combined average of 6.4 delays per 100,000 population since April 2012.

During the month there were 39 internal delays of which 24 are attributed to UHL and 15 attributed to non UHL reasons.

The remaining 270 (87%) delays are mainly due to factors outside of the control of UHL. Main areas of concern include: availability and timely communication regarding the outcome of CHC panels; availability of rehabilitation beds for the increasing number of patients requiring rehabilitation within the city and county and the availability care homes for long term placements. This makes an average combined total of 5.9 delays per 100,000 population since April 2012.

Delayed discharges have been escalated internally at bed meetings and externally at daily teleconferences.

3.0 NON EMERGENCY TRANSPORT CONTRACT

Arriva are contracted to transport all eligible patients between the hours of 5am and 2am, 7 days per week for the trust. Additionally, commissioners have included two UHL ED Transfer resources within the LLR contract, one for 12 hours per day and one 24/7.

Since the transition from EMAS to Arriva, LLR provider Trusts continue to experience problems with the timing of bringing patients to UHL and collecting them following their appointment or discharge. However, since the last report this has not resulted in any rebedding of patients.

UHL continue to meet with commissioners and Arriva on a weekly basis. All daily operational incidents are being directed through the Admissions and Discharge Manager and the Duty Management Team. The Admissions and Discharge Manager is in regular contact with Arriva Operational Management in reporting all daily issues that need attention as they occur. Resolving the above issues is being led by commissioners and is also reported at the monthly Emergency Care Network.

RECOMMENDATION

Trust Board members are asked to receive and note the content of this report.

Suzanne Hinchliffe
Chief Nurse and Deputy Chief Nurse