To:	Trust Board
From:	Jeremy Tozer, Interim Director of Operations
Date:	November 2012
CQC regulation:	As applicable

Paper S

Title:	Emergency Department Performance Report

Author/Responsible Director:
Jeremy Tozer

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:

- October has been a challenging month which has seen a significant deterioration in performance to 92.63% for ED type 1 and 2 attendances
- 2 out of the 5 quality indicators have been achieved for the month of October.
- The Trust action plans have been re-evaluated in response to Commissioner concern over the deterioration in performance.
- Progress has been made against the ECIST 14 point action plan.
- Recommendations have been received following a review of the non-elective flow across the Trust. These have been incorporated into the ECIST 14 point action plan.
- Right Place Consulting have been appointed to support the Trust in implementing these recommendations and commenced work with the Trust with effect from 19th November 2012.
- A number of capital enabling schemes are being implemented to support the changes to the emergency flow process.

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 including capital schemes.

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:	**JEREMY TOZER, INTERIM DIRECTOR OF OPERATIONS**
REPORT SUBJECT:	**EMERGENCY FLOWS**
REPORT DATE:	**NOVEMBER 2012**

1.0 INTRODUCTION

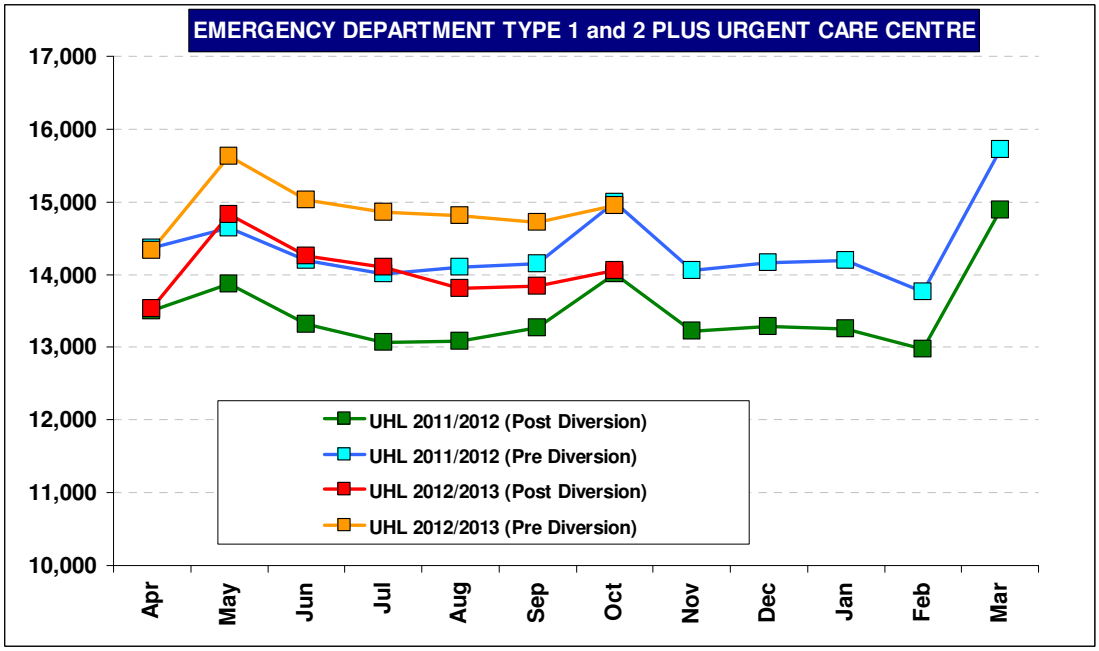
Achieving the emergency 95% target and clinical indicators on a sustainable basis within UHL continues to remain a top major priority for both UHL and the local health economy. Work continues to deliver the actions agreed with local commissioners, the SHA and through the ECIST recommendations in order to improve performance. October has been a challenging month which has seen a significant deterioration in performance in ED - Type 1 and Type 2 performance was 92.6%, the UHL + UCC performance was 94.17%. The Trust only achieved 2 of the 5 ED quality performance indicators which correlate to the process issues within the hospital.

2.0 CURRENT ACTIVITY AND PERFORMANCE

2.1 Attendance rates

In line with reports from previous month's ED attendance rates remain consistently above attendance rates seen in 2011/12 even when pre diversion rates are taken into consideration. October saw 12,576 attendance which is higher than average when compared to a monthly average of 12,306 attendances, however this is 0.3% lower when compared with the same period last year.

Figure 1: ED Attendances April – October 2012

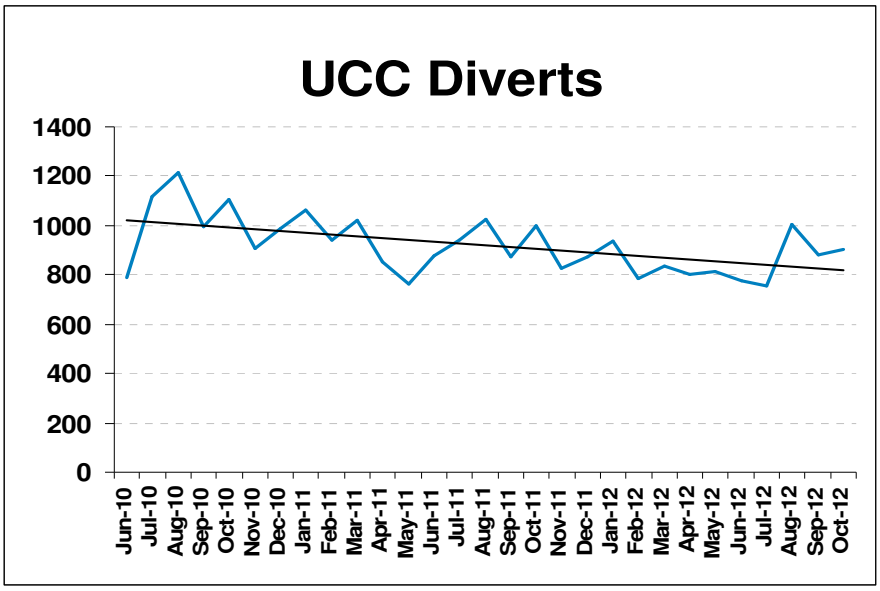


The failure of plans to deliver the reduction in attendances has been raised with the CCG's and will be followed up by the Interim Director of Operations at the ECN meetings.

2.2 UCC Diversion rates

Numbers of patients diverted to the UCC continue to remain lower than the previous 2 years.

Figure 2: UCC Diverts June 2010 to October 2012



The number of patients diverted to the UCC in month remains below 2010/11 levels. When pre and post diversion numbers are compered month on Month for the period April – October 2012 numbers of patients diverted to the UCC have been continuously low with the exception of the month of August where there was a sudden increase in numbers diverted. In percentage terms when the month of October is compared with the previous 2 years there has been a decrease from 7.8% diverted in October 2010 to 6.0% in October 2012. In reviewing monthly percentages over the year April 2012 to October 2012 the percentage deflected is variable ranging from 7.0% in April 2012 to 4.8% in July 2012 (Average deflection 5.8%, median 5.9%).

There is active dialogue with our external partners to review the concept of a 'single front door' aimed to change existing pathways to maximize deflection.

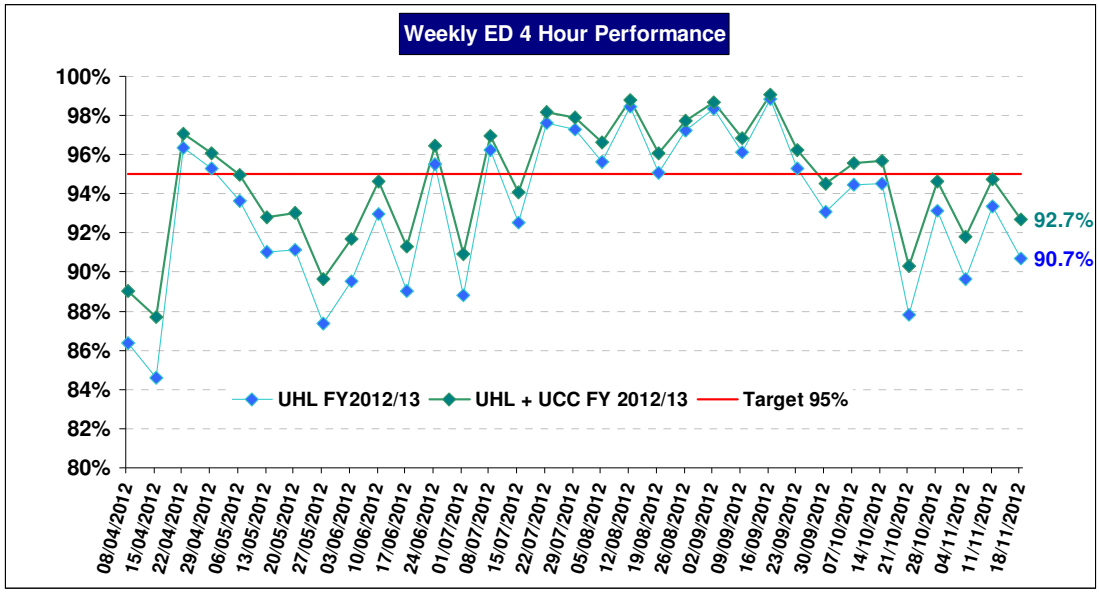
2.3 ED 4 Hour Performance target

The following graph shows the performance of the trust 4 hour target to week ending 4h November 2012. October has been a challenging month which has seen a significant deterioration in performance to 92.6% for ED type 1 and 2 attendances as shown in figures 3 and 4 below:

Table 2 Overall ED Performance October 2012

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	14,052	1,036	92.63%
Urgent Care Centre	Type 3	3,791	4	99.89%
UHL + UCC Total	All	17,843	1,040	94.17%

Figure 3: Overall Weekly ED Performance to Week Ending Sunday 18th November2012



Based on current in year performance to date a range of scenarios have been developed in order to understand the maximum number of breaches per week in order to deliver the 95% target. Given the number of breaches going into early November there are 2 scenarios:

1. To deliver cumulative full year performance will mean no more than 8 breaches a day which will deliver performance at 98.4% every day for the rest of the year. This equates to 952 breaches between 20th November 2012 and the 31st March 2013.
2. To deliver for cumulatively from Quarter 2 to Quarter 4 will mean no more than 20 breaches a day.

Given the Trust's current position and the winter months ahead the second scenario is the most realistic scenario to plan a future recovery trajectory. This will however still provide a real challenge to the Trust.

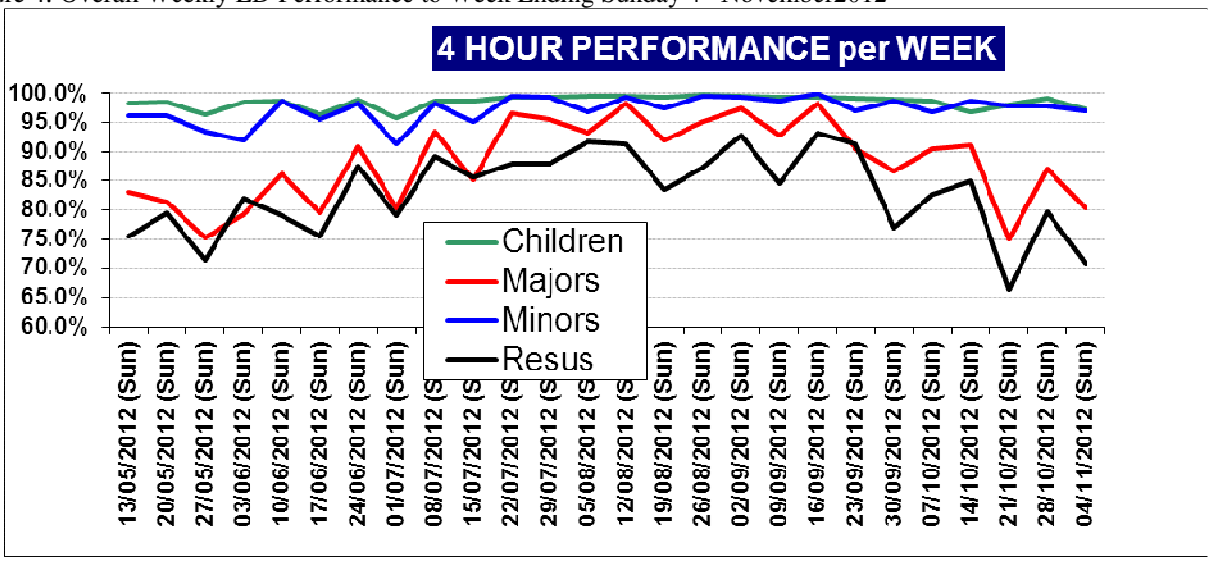
2.4 Breach analysis

The most significant breach numbers appear within the majors area of the department, totalling 973 over a 6 week period from 30th September to 4th November 2012 with an average performance of 85.1% against the 4 hour target. On further analysis poorer performance was seen in the resus area of ED where there were a total of 349 breaches and performance of 76.9%. For further details see table 2 and figure 4 below:

Table 3: Breach analysis by allocation:

	CHILDREN			MAJORS			MINORS			RESUS			TOTAL		
W/E	Att.	Breach	% 4 Hr.	Att.	Breach	% 4 Hr.	Att.	Breach	% 4 Hr.	Att.	Breach	% 4 Hr.	Att.	Breach	% 4 Hr.
30/09/2012	671	7	99.0%	1123	151	86.6%	919	11	98.8%	257	59	77.0%	2970	228	92.3%
07/10/2012	680	8	98.8%	1057	100	90.5%	910	28	96.9%	242	42	82.6%	2889	178	93.8%
14/10/2012	679	22	96.8%	1072	96	91.0%	840	12	98.6%	267	40	85.0%	2858	170	94.1%
21/10/2012	644	12	98.1%	1098	275	75.0%	949	21	97.8%	258	87	66.3%	2949	395	86.6%
28/10/2012	551	5	99.1%	1049	135	87.1%	859	18	97.9%	232	47	79.7%	2691	205	92.4%
04/11/2012	625	17	97.3%	1093	216	80.2%	917	27	97.1%	253	74	70.8%	2888	334	88.4%

Figure 4: Overall Weekly ED Performance to Week Ending Sunday 4th November2012



Although Childrens and the Minors area of A&E are performing better, the Trust needs to strive for a zero breach tolerance in these areas.

The poor performing areas of the Emergency department are the majors and resus areas.

In October there were 1,101 attendances in resus. Should this trend continue for the next two months quarter 3 will show a further increase in activity by approximately 100 attendances. This rise in activity in resus is suggestive of a greater severity of illness of presenting patients. This area needs greater medical and nursing input so it is important that the Trust is able to respond to this increase in resource use without depleting the numbers in the other areas.

Table 4: Quarterly growth in resus activity October 2011 - :

Quarter	
Q3 Oct-Dec 2011	3134
Q4 Jan- March 2012	3141
Q1 April - June	3163
Q2 July - Sept	3213

For the majors area of ED attendance in October ranked the highest along with the month of May 2012 representing 4,702 attendances, which is 5% higher than the

average monthly attendance since October 2011. This again is suggested of an increase in patient acuity arriving at the emergency department.

The top 3 reasons for breaches are summarised as :

- Bed breaches 30%
- ED capacity(inflow) 19%
- Clinical reasons 19%

This picture is consistent with the previous month although the percentage of delays due to bed availability has increased by 10%. Analysis has highlighted that October shows deterioration in the period of time from 'arrival to bed request' as shown below in table 5. Review of historical data shows a similar performance in June which also correlated to a month which saw significant breaches and under-performance of the ED target, as shown in Figure 3.

Table 5: Arrival to time of bed request June – October 2012

	Jun-12	%	Jul-12	%	Aug-12	%	Sep-12	%	Oct-12	%
0-1 Hours	168	4.4%	193	4.8%	165	4.5%	207	5.5%	140	3.6%
1-2 Hours	872	22.6%	946	23.7%	878	24.0%	968	25.7%	804	20.8%
2-3 Hours	1,209	31.4%	1,459	36.5%	1329	36.4%	1357	36.1%	1350	34.9%
3-4 Hours	1,264	32.8%	1,169	29.3%	1172	32.1%	1057	28.1%	1247	32.3%
4-5 Hours	172	4.5%	126	3.2%	69	1.9%	112	3.0%	205	5.3%
5-6 Hours	99	2.6%	54	1.4%	25	0.7%	41	1.1%	73	1.9%
6 Hours+	69	1.8%	45	1.1%	18	0.5%	21	0.6%	45	1.2%

Bed breaches:

The availability of beds at the right time is a key element to allow the flow of patients out from the Emergency Department. Creating bed capacity can be split into two main categories-simple and complex discharges. Simple discharges revolve primarily around hospital process where as complex discharges involve other organisations and services.

The Trust needs to focus on its ward processes to ensure that senior clinicians and nurses are present daily to complete the discharge process. This is a major area of focus moving forward. A new internal procedure has been introduced which is complimented by an increased emphasis on proactive discharge planning increasing our ability to predict capacity issues early.

The table below measures weekly delayed discharges occurring at midnight

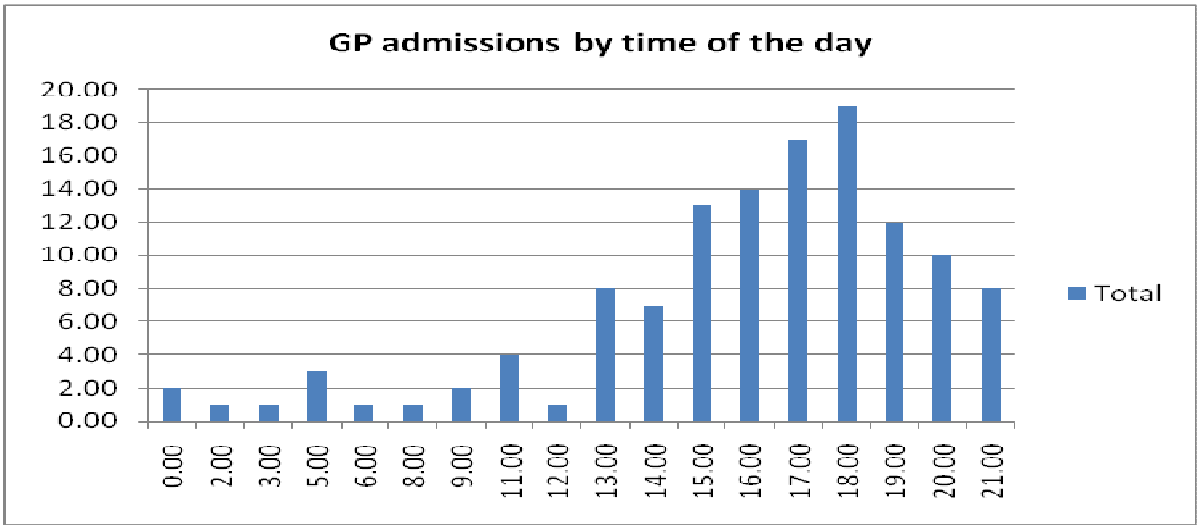
Table 6 The number of delayed discharges from April to September 2012. (October figures as yet are not available)

	City Average	County Average	LLR Average	Total
April	9	13	21	43
May	12	26	38	65
June	14	30	44	88
July	15	31	47	93
August	17	34	50	101
Sept	17	34	51	102

To support the reduction of delayed transfers of care, the Divisional Manager for Women's and Childrens is leading a 'results focussed' piece of work to reduce the above numbers.

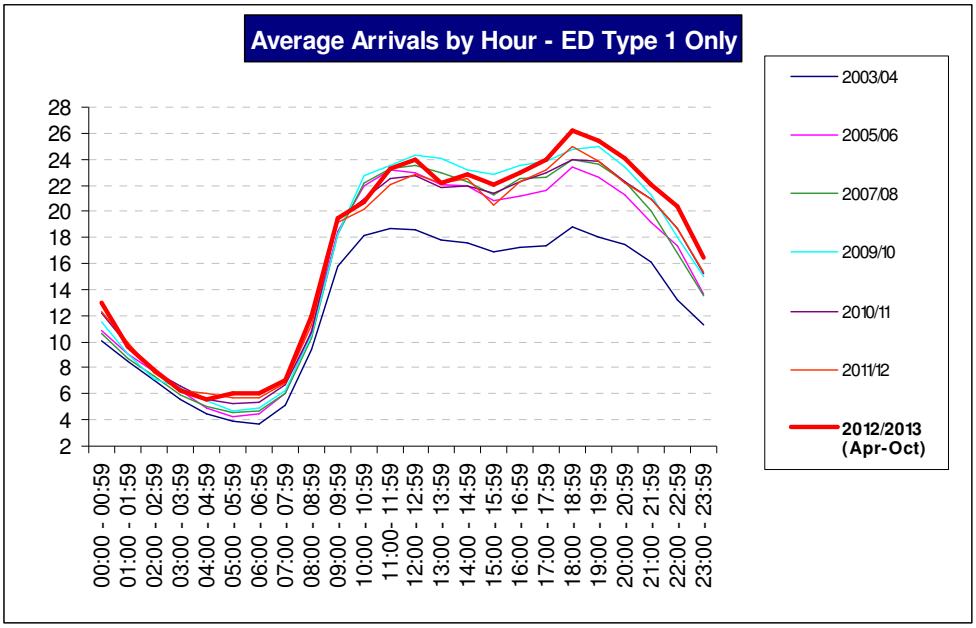
There is considerable evidence that EMAS continue to bring GP admissions later in the day impacting on the high attendance times within ED. The overall timing of breaches can still be correlated alongside the average arrival times to the department and as such are predictable in their nature indicating the need for increased work-force numbers and decision makers to respond accordingly.

Figure 5: Average arrivals by hour of GP Admissions to the ED



There continues to be sustained peaks of attendances which remain focused during the latter part of the evening which may be seen below:

Figure 6: Average arrivals by hour – ED Type 1 – 5 year trend



2.5 ED Quality Performance Indicators

Two of the clinical indicators were met in October as shown in figure 4 below. Time to treatment has seen a further increase reflective of the increasing activity coupled with some of the staffing challenges that the department continues to face. Unplanned re-attendances have shown a further improvement and are at the lowest levels since February 2012. These indicators are important to monitor because they show how effectively the Trust is managing the unplanned patient pathway.

Figure 7: ED Quality indicators January 2012– October 2012

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	TARGET
Left without being seen %	2.4%	3.6%	2.8%	3.0%	2.7%	2.4%	2.1%	2.2%	2.7%	<=5%
Unplanned Re-attendance %	6.1%	6.6%	6.2%	5.9%	5.9%	6.4%	5.6%	5.3%	5.0%	< 5%

TIMELINESS

	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	TARGET
Time in Dept (95th centile)	331	331	319	317	322	240	238	240	298	< 240 Minutes
Time to initial assessment (95th)	34	40	34	31	25	20	15	16	23	<= 15 Minutes
Time to treatment (Median)	54	61	45	49	59	57	53	58	64	<= 60 Minutes

2.6 Staffing Impact on performance

Reduced staffing creates a major problem when inflow is high and does limit the ability of the teams to assess and process patients in a timely manner. In addition the necessary use of bank and agency staff also presents risk, as temporary staff are less familiar with the environment and protocols, even though there is a fully established induction programme for temporary staff within the emergency department.

There has been a significant increase in unfilled shifts in ED in the nursing and medical professions which has led to short staffing. Currently there are 8 WTE consultant posts vacant and a total of 12 WTE at Junior and Middle Grade resulting in a shortfall of 194 shifts potentially unfilled. The nursing shifts requested for October in total were 1,597, of which 382 shifts remained unfilled. This is equivalent to 24% of shifts.

The ability to recruit to posts is impacted by the national difficulties in recruiting to posts within Emergency Departments. Fortnightly recruitment strategy meetings have been established, with Senior HR input, to look at recruitment alternatives and creative recruitment solutions. The department continues to advertise for permanent and locum consultant positions. Recently there has been recruitment drives aimed at attracting qualified nurses and support staff. Retention initiatives also form part of the department's recruitment plans.

3.0 ECIST ACTION PLAN

3.1 Progress continues to be made against the ECIST 14 point action plan. This is updated weekly and presented to the Executive Team as required.

3.2 Since the application of the ECIST action plan a further review of non-elective flow was commissioned by the Chief Executive in September 2012. The review has now concluded and the recommendations have been published and circulated to Board members. These recommendations have been mapped against the ECIST action plan.

3.3 The team who undertook the review, Right Place Consulting, have been appointed to project manage the delivery of their recommendations. They started working with the Trust on 19th November 2012. Their initial focus is on ED process and the acute assessment units.

3.4 On account of the deterioration in performance in October 2012 concerns have been raised again by commissioners about the sustainability of delivering the 95% ED performance target. In response the previously submitted action plans have been updated including a revised trajectory for improvement. These plans will be subject to monthly scrutiny by commissioners who have expressed their intention to levy contractual penalties for each month of non delivery of the target.

4.0 ESTATES SOLUTIONS

In previous reports a number of interim estates solutions had been identified to support process changes across the emergency flow including:

- Relocation of the fracture clinic – this scheme is on target for completion on 23rd November 2012.
- Discharge lounge expansion at the LRI – awaiting final capital funding approval.
- ED enabling schemes – awaiting capital approval. Presented to the Commercial Executive committee 14th November 2012.
- Emergency flow CT scanner – Business case presented to the Commercial Executive Committee14th November 2012.

A more detailed paper describing progress for each scheme has been provided to the Acute Care Division Board in Paper 6.3.

5 IMMEDIATE ACTIONS TO REMEDY PERFORMANCE

To remedy current performance issues 6 key actions will be put in place with immediate effect:

No	Issue	Action	Impact	Status
1	Daily winter SITREP meetings supported by escalation of delays across the system	9.30 teleconference meetings with City, county and LLR CCGs, Social Care, Mental health, Ariva, UCC to discuss . Daily 12.30 meeting to discuss and review delayed discharges.	Escalation of delays Hold external partners to account	Implemented
2	Elderly Frailty Unit/Medical	The move of EFU to AMU/ward 33 short	8 Emergency Decisions Unit	03/12/12

	Assessment Unit and Short Stay Unit integration	stay unit.	(EDU) beds available for ED pathway patients Promotes outflow from ED Consistency in medical staffing cover on AMU Releases consultant PA's to develop more robust speciality in reach	
3	Consultant 7-day in-reach	To facilitate speciality opinion early in the day to facilitate decision making and timely discharge or management.	Standards for speciality opinion agreed Facilitates earlier discharge or transfer from assessment units	17th December 2012
4	Focus on discharge	Emphasis on senior decision makers on daily ward and board rounds	Timely decision making Improved forward planning using the estimated date of discharge (EDD) Discharge earlier in the day Minimising delays and internal waits Escalation of delayed discharges	Initial project implemented.
5	Expand Ambulatory care	Aim to establish an ambulatory care centre in headache and epilepsy which represent a significant number of patients. This will help to free inpatient beds and help flow from ED.	Reduction in avoidable admissions releasing bed capacity and enabling flow Implementation of national best practice tariff pathways	3rd Dec 2012
6	UCC divert	To change the default from ED to UCC with UCC referring back to ED.	Increase and maximize numbers of patients deflected and seen by UCC Reduce ED attendances Reduction in minors breaches	17th Dec 2012

NOTE – timeframes for implementation may change due to Right Consulting

6 RECOMMENDATIONS

Board members are asked to:

- Note the content of this report;
- Note the progress made against the 14 ECIST recommendations and the Note and support the key actions to remedy performance;
- Note the revised trajectory for improvement.