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To:	Trust Board
From:	Suzanne Hinchliffe, Chief Operating Officer/Chief Nurse
Date:	30th August 2012
CQC regulation:	As applicable

Title:	**Emergency Care Delivery**

Author/Responsible Director:
S. Hinchliffe Chief Operating Officer/Chief Nurse
P. Walmsley, Head of Operations

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 for the first month of Q2.
- Improvements have been seen in the performance of the 5 quality indicators associated with the ED 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: **30 AUGUST 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. Despite internal action and wider health community plans a number of challenges and associated risk to delivery of the target remain. To counteract this and mitigate the risk, 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 is mindful of the increasing emergency activity and the impact of this on both overall trust capacity, impact on elective flows and funding streams. Further to an executive time out and subsequent discussion on the 10th July, Executive responsibility for the trust 4 hour performance transferred to the Chief Operating Officer/Chief Nurse with immediate effect.

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 July, have realised a 6% activity increase compared with the same period last year.

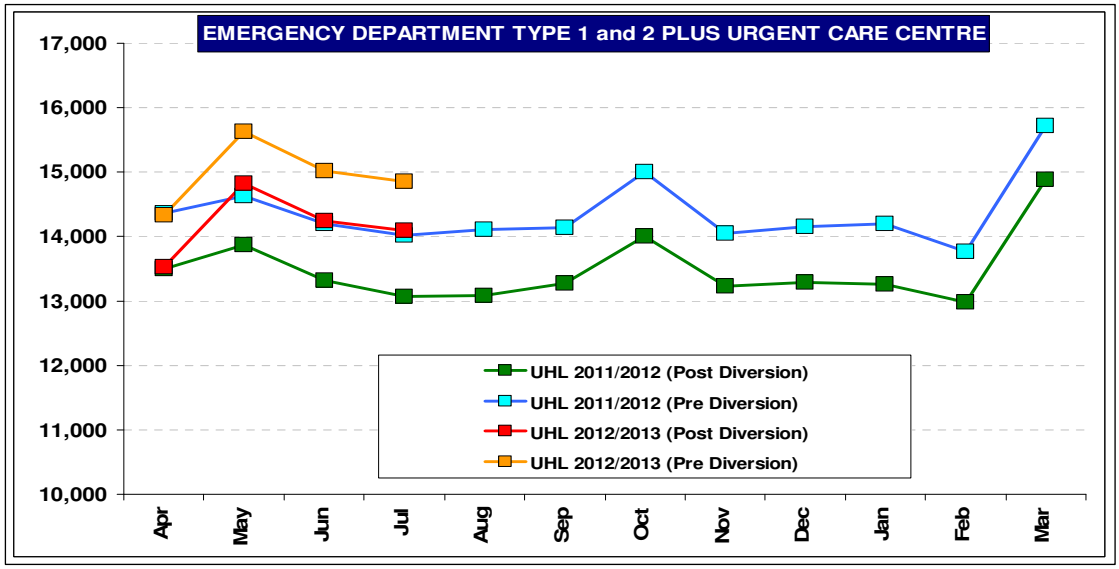


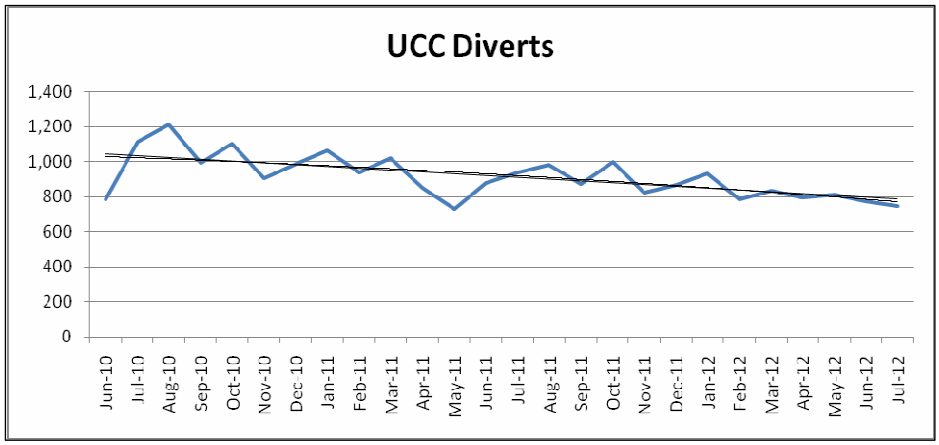
Figure 1: All emergency Attendances April – July 2012

Detail pertaining to the overall breakdown of pre and post diversion activity for the past two years and overall % change may be seen below;

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	14,100	14,853	6.0%
Aug	12,544	13,757	13,086	14,109			
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	56,699	59,840	

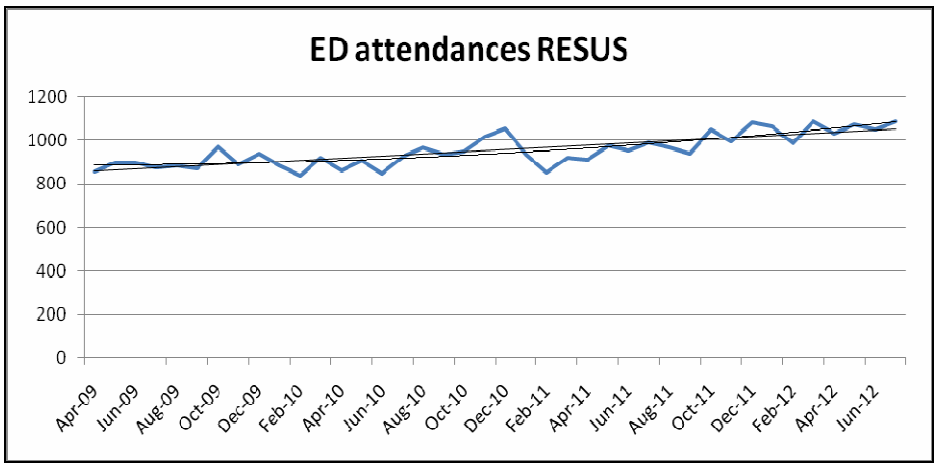
Table 1All emergency attendances April 2010 – July 2012

Diversions to the UCC in July 2012 are also noted to be lower during July than the same period in the previous two years, showing an average monthly divert of 800pcm compared to 1000pcm when diversion processes initially commenced.



UCC Diverts June 2010 – July 2012-08-22

From a care perspective, activity increases may be seen within the resuscitation area and incremental increases in minors, returning to levels pre UCC divert.



ED Resuscitation Attendances April 09 – Jun 2012

2.2 Trust 4 Hour Performance target

The following graph shows the performance of the trust 4 hour target to week ending Sunday 5th August 2012.:

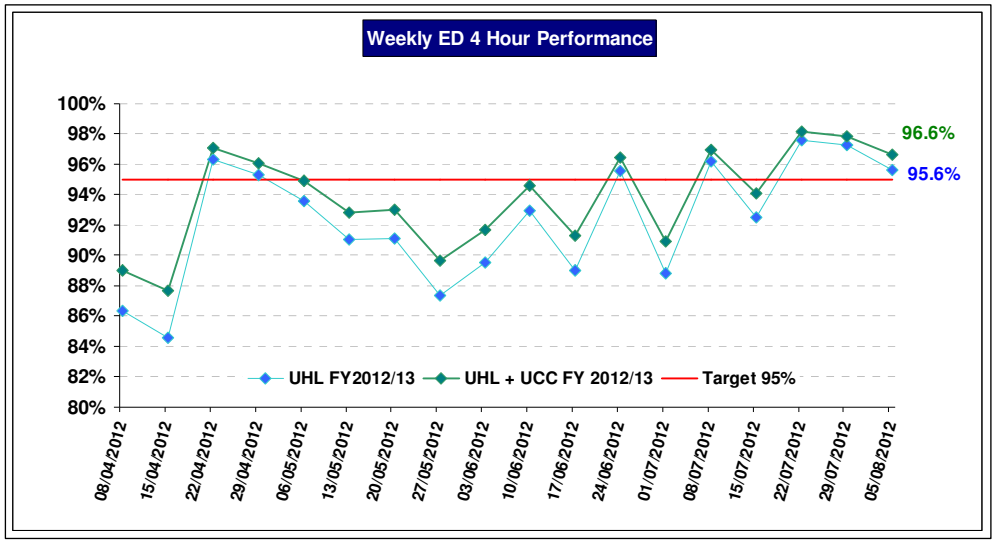


Figure 2: Overall Weekly 4 hour Performance to Week Ending Sunday 5th August 2012

Although the overall achievement of the trust 4 hour performance has improved to achieve the 95% target since the middle of July and has continued into the month of August, the ED remains vulnerable to fluctuation in attendances, dependency and the management of attending patients within the ED, in addition to a constant focus being required on managing the patient journey through the assessment, ward areas and finally through to discharge.

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.

There are four main contributing factors to the reported breaches:

- ED process (inflow, capacity ,staff sickness & late bed requests) 47%
- Bed breaches 18.6%
- Clinical reasons 9.6%
- Ambulance delays 6.4%

The distribution of breaches by hour over previous weeks indicates that the majority of breaches continue to occur overnight and most significantly between Tuesday and Friday. Key to the continued improvement in this area is the ability to:

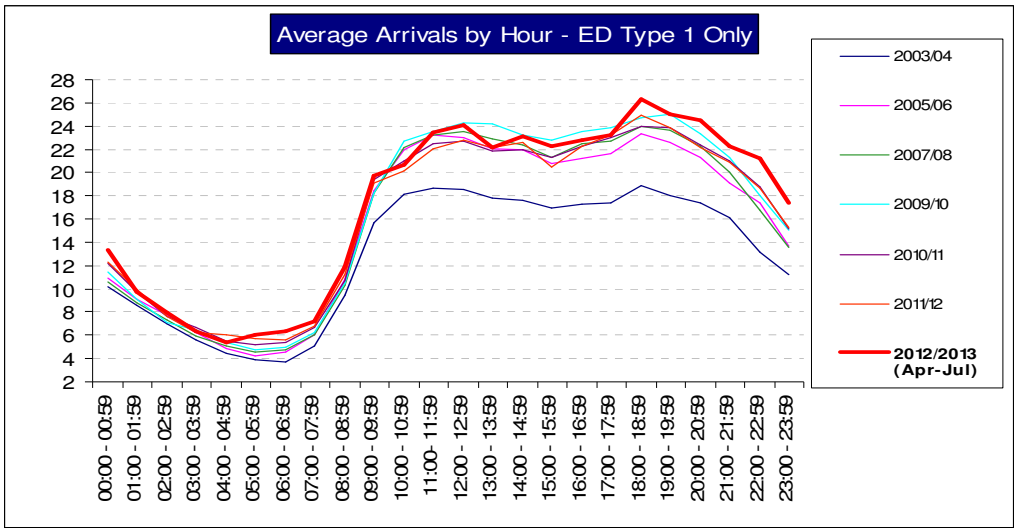
- Effectively manage ED inflow, expediting diagnostic tests and early referral to assessment wards
- Ensuring capacity through the immediate availability of both male and female beds within the assessment units and movement to base wards where continued admission is required, and,
- Effectively driving the discharge process to maintain optimum capacity and appropriate length of stay.

A summary of hourly breach times may be seen below:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00:00 - 00:59	0.8	1.3	1.8	1.3	2.0	0	2.0
01:00 - 01:59	0.3	0.8	2.8	1.5	2.5	0.3	1.3
02:00 - 02:59	0.8	2.3	2.3	2.5	3.0	0.3	1.0
03:00 - 03:59	0.3	1.8	3.0	1.5	5.0	0.5	0
04:00 - 04:59	0.3	1.5	3.0	0.8	4.5	0.8	1.0
05:00 - 05:59	0	3.0	1.5	0.5	3.3	0.8	1.0
06:00 - 06:59	0.3	1.5	0.5	1.5	2.0	0.8	0.8
07:00 - 07:59	0	2.0	0.5	0.8	1.8	0	0.3
08:00 - 08:59	0.8	0.8	0.3	0.5	1.5	0.5	1.0
09:00 - 09:59	0	0.3	0.5	0.5	1.0	0.3	0
10:00 - 10:59	0	0.5	0.3	0	0.5	0.5	0.3
11:00 - 11:59	0.3	0.3	0	0.3	0	0	0
12:00 - 12:59	0.3	1.3	0	0.5	0.5	0	0
13:00 - 13:59	0	1.0	0	0	0	0	0.3
14:00 - 14:59	0.3	0	0.5	0	0.8	0.3	0
15:00 - 15:59	0	1.8	0.5	0.3	0.5	0.3	0.5
16:00 - 16:59	0	1.0	0.3	1.3	0.8	0	0.5
17:00 - 17:59	0.5	0.3	0.8	1.3	0.5	0	0.3
18:00 - 18:59	0.5	0	0.3	2.3	0.5	0.5	0.3
19:00 - 19:59	0.8	0.3	0.5	1.3	0.3	0	0.3
20:00 - 20:59	0.5	0.3	0	1.3	0.5	0.3	0
21:00 - 21:59	0.8	0.8	0	1.0	0.3	1.0	0
22:00 - 22:59	1.8	1.5	0.5	3.8	0	0.8	0
23:00 - 23:59	1.8	0.8	0.3	1.5	0.8	0.5	0.8

Table 2: Average Type 1 ED Breaches per Hour – 4 Weeks Mon 2nd July to Sunday 29th July

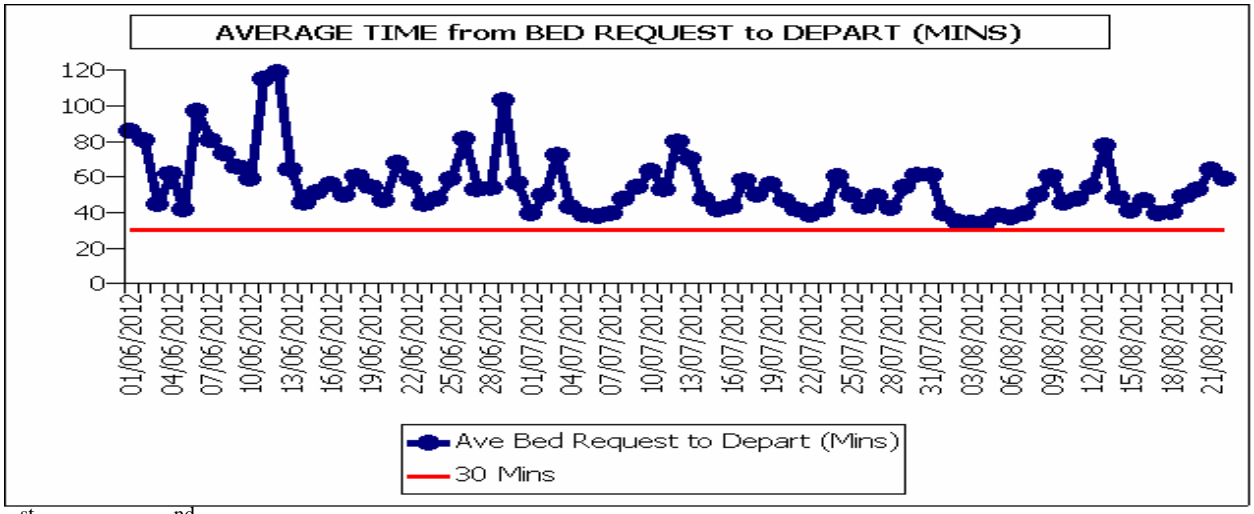
The overall timing of breaches can be correlated alongside the average arrival times to the department and as such are predictable in their nature where increased work-force numbers and decision makers are required.



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.

	Jun-12	%	Jul-12	%	1st-22nd Aug	%
0-1 Hours	168	4.4%	193	4.8%	112	4.3%
1-2 Hours	872	22.6%	946	23.7%	620	23.9%
2-3 Hours	1,209	31.4%	1,459	36.5%	939	36.1%
3-4 Hours	1,264	32.8%	1,169	29.3%	831	32.0%
4-5 Hours	172	4.5%	126	3.2%	59	2.3%
5-6 Hours	99	2.6%	54	1.4%	21	0.8%
6 Hours+	69	1.8%	45	1.1%	16	0.6%

Time from arrival to bed request



1st June to 22nd August 2012

The average time from bed request to departure has been variable throughout July although some improvement is noted 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 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. This process is also supporting the achievement against the 95th centile for the time spent within the Department. The median time to treatment continues to remain within target.

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	TARGET
Left without being seen %	2.3%	2.1%	2.4%	3.6%	2.8%	3.0%	2.7%	2.4%	2.1%	<=5%
Unplanned Re-attendance %	5.4%	6.1%	6.1%	6.6%	6.2%	5.9%	5.9%	6.4%	5.8%	< 5%

TIMELINESS

	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	TARGET
Time in Dept (95th centile)	240	264	331	331	319	317	322	240	239	< 240 Minutes
Time to initial assessment (95th)	42	32	34	40	34	31	25	20	15	<= 15 Minutes
Time to treatment (Median)	42	42	54	61	45	49	59	57	52	<= 60 Minutes

Figure 6: ED Quality indicators December 2011 – July 2012

3.0 PATIENT CONVEYANCE

From July 1st 2012, Arriva took over the Non Emergency Patient Transport Contract from EMAS. This was awarded by the PCT in December 2011 following a two year Tender process managed by the PCT.

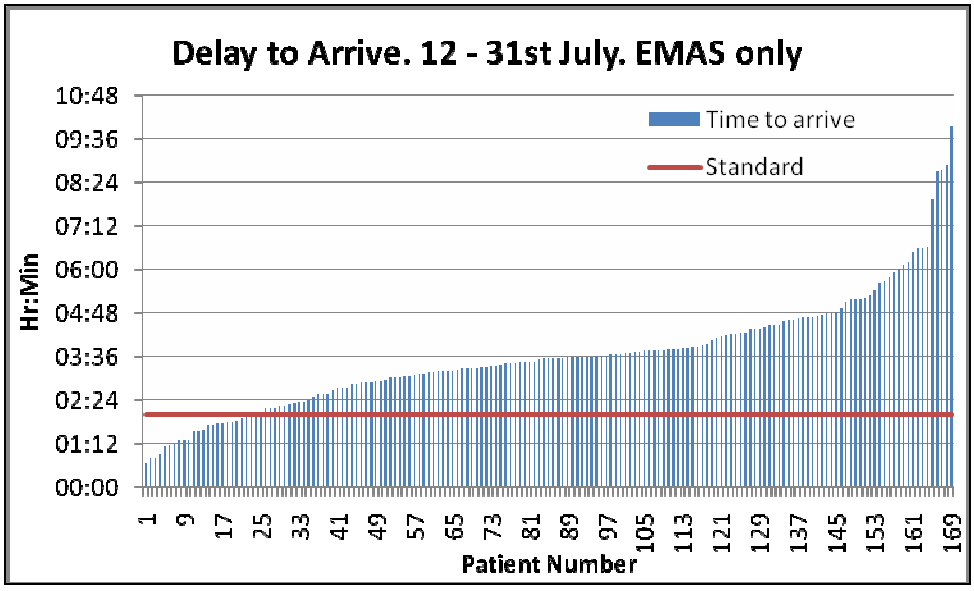
Arriva are contracted to transport all eligible patients between the hours of 5am and 2am, 7 days per week for the trust. Additionally, commissioners have included two UHL ED Transfer resources within the LLR contract, one for 12 hours per day and one 24/7.

Since the transition from EMAS to Arriva, LLR provider Trusts have experienced significant issues including the inability to make contact, book journeys and make patients ready via the Arriva Call Centre due to the volume of calls. This was primarily due to the number of patients and staff contacting Arriva to confirm that their future booking had been transferred from EMAS to Arriva. In addition, UHL experienced a number of issues with the timing of bringing patients to UHL and collecting them following their appointment or treatment. This has led to a number of reported incidents from staff due to patient delays and the effect on clinics. It has also led to a number of re-beds as follows:

w/c 2 July (wk1 of contract)	24
w/c 9 July (wk2 of contract)	8
w/c 30 July (wk5 of contract)	11
w/c 6 August (wk 6 of contract)	8

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. All areas are encouraged to report all Incidents via Datix, which in turn are being reported to UHL as well as to LLR Commissioners on a monthly basis. An overview of all issues occurring and actions taken are reported to the Head of Operations.

In addition to the above, a review is currently underway regarding the timing of EMAS patient conveyance arranged via Bed Bureau with a particular focus on improving arrival times to enable improved capacity planning and clinical management of the patient.



An analysis of referral to arrival time for medical patients from the 12th July to the 31st July (above) shows that the majority of patients arrive between 2 and 5 hours after the patient is booked on to the Ambulance system. The current 'standard' is for a 2 hour journey from referral to arrival at the ED. This leads to a level of unpredictability in terms of arrival time, an issue being discussed at the ECN who are currently reviewing a bid for additional ambulances to improve this service.

4.0 UPDATE ON ACTION PLANS

Following the ED Summit held on 26th June 2012 progress has been made against the UHL plans to improve ED performance and to provide assurance of delivery against the 95% trust target and quality indicators from Q2. Progress has been made in a number of areas in both the short and medium term action plans and may been seen attached (Appendix A and B). In particular to note, two paediatric consultants have been appointed and a locum ED consultant effective from September with further adverts currently in progress to fill remaining ED consultant vacancies. An active recruitment campaign has taken place for nursing staff though to date has only secured one appointment.

To support the wider emergency flow process the clinical support division have been active in recruiting to radiography positions and are in the process of appointing a locum consultant radiologist with emergency department expertise. In addition additional therapists and pharmacists have been recruited to extend the hours of and support the discharge process to maximise opportunities for freeing up bed capacity.

5.0 INTERIM ENABLING SHCEMES

In support of improving the emergency flow of patients 7 schemes have been identified which will support the longer term vision of the emergency floor. These include:

- Relocation of the existing fracture clinic and the conversion of the fracture clinic to an Emergency Clinical Decisions Unit
- Improvements to the assessment area
- New CT scanner dedicated to the Emergency Department
- Creation of an additional resuscitation bay
- Expansion of the discharge lounge facility (LRI)
- Creation of additional bed capacity within existing medical wards
- Relocation of Odames Day Case ward.

Each scheme is at a different stage of development and capital approval with the first scheme to complete being the relocation of clinic 5 activity (including the move of hypertension services to the Glenfield site).

6.0 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. The Trust were recognised for implementing a number of initiatives including the development of Acute Medicine, investment in ANPs and the development of the Frail Elderly Care service. Recognition was also given to the recent development of the Ambulatory Emergency Care Service, the pilot of timely assessment at the front door and the focus on recruitment to speciality in-reach to ED.

The review also highlighted a number of areas for further development which are subject to response plans currently being developed by the Acute Division.

7.0 RECOMMENDATION

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

Suzanne Hinchliffe
Chief Operating Officer/Chief Nurse

Appendix A

UHL Top 10 impact actions – Short term (within 6 weeks) – Commenced 4ht July

	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	Doug Skehan	6 weeks Delivery date subject to agreed tendering process. Slippage likely	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 Delivered: Focus going forward on developing urgent gastroenterology clinics and a headache pathway. Ratification work completed for urgent and next day clinics. Draft criteria developed. Full list of all urgent/fast clinics being published to GP	Marina Muirhead, GP Urgent Care Leads	2 weeks Complete	Increase in calls to GP hotline % admissions subsequently deflected GP hotline in place
3	Appropriate staffing across the Trust    	7 day cover of therapists Completed Transformation bid outcome awaited as additional staff taken on at risk.	Shona Campbell,	Within 3 weeks	Aligned to other issues within this list
		Use of bank staff Complete	Phil Walmsley		
		Additional porters for patient movement Complete	Shona Campbell		
		ED consultant to cover overnight Recruitment on-going and out to agency though subject to job market challenges. Job planning review complete.	Doug Skehan		

		Additional medical consultants to increase acute clinics and AMU Appointments made with start dates to be confirmed	Doug Skehan		
		Additional surgical consultant to cover ED Action removed by Cross Divisional agreement	Doug Skehan Shona Campbell		
		Phlebotomists to provide full weekend service Weekend cover in place. Review of additional cover underway.	Phil Walmsley		
		Additional specialist discharge nurses to maintain discharge flow Complete			
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 Selective rota complete. Review of job plans in ED undertaken	Doug Skehan	3 weeks	Increase in DCC by consultant Increase in ED presence in ED
5	Time to specialty assessment, specifically for Trauma patients 	Improve flexibility by having two orthopaedic registrars on call, one based in the ED Dedicated registrar cover available. Discussions underway regarding a more efficient/effective referral pathway for spine and Cauda Equina Focussed work on orthopaedic referrals to AMU in progress	Andrew Furlong	1 week	Decrease in time to specialty assessment for trauma patients
6	Surgical pathway for ED 	Implement a clear pathway to allow surgical patients to go to the ward before all investigations are back	Andrew Furlong	2 weeks	Decrease in time surgical patients await results in ED

		Clinical lead identified by planned Care Division. Awaiting confirmation of a lead from ED			
7	Pharmacy waits 	Additional dedicated pharmacy cover for ED/AMU/EFU to reduce delays (as above in 3) Additional pharmacy support to AMU complete, home delivery options and improved availability of prepacks being taken forward by the Acute Care Division	Shona Campbell	2 week	Decrease in patients awaiting medication
8	Imaging/diagnostic delays 	Imaging to provide 7 day service Radiographer recruitment underway. Locum consultant identified.	Shona Campbell	6 weeks Revised to 12 weeks Agreed with CCG	Decrease in patients awaiting diagnostics tests
9	Trust wide escalation 	Immediate revision of the internal escalation process Review and sign off by Emergency Flows Steering Group 24/08/12	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 - complete 2. Expand discharge to assess model – awaiting CCG confirmation 3. Increase discharge lounge capacity Business case to Commercial Executive for review	Doug Skehan Phil Walmsley Doug Skehan	6 weeks Discharge Lounge timescale impacted by outcome of Commercial Executive Estimated delivery Autumn. More actions needed 2012	Increase in Discharge before 11am rate

 Delivered/On Target  Partially delivered  Not delivered

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) Rev: Dec 2012	3 areas identified. Estimated capacity = 12 beds. Proceeding to tender (single tender action agreed)
2.	Admission avoidance process at ED front door	Explore the option of a portable facility to improve assessment space in ED RAT process implemented. Development/refurbishment of assessment area requires feasibility study. Preliminary architects visit completed.	Doug Skehan/CCG	24/09/12 (12)	Will increase space at the front of ED allowing for more assessment and linking to the UCC 'bounce back' concept. Resources to be agreed.
3.	Lack of Clinical Space	Review of non-clinical accommodation adjacent to wards to become clinical accommodation Review of R&D embedded space underway	Doug Skehan	22/10/12 (16) Revised timescale to be advised	May identify accommodation that can be used for clinical accommodation currently used for non-clinical purposes. Issues in relocation of non-clinical services from clinical space
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 with support of commissioners. 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). Part of wider reconfiguration plan discussions.
6.	Slow processes concerning medical short stay patients	Move the short stay ward closer to AMU Complete	Doug Skehan	9/07/12 (1)	Makes better use of the Short Stay facility. Move ward 33 to Ward 37 Complete
7.	Lack of Clinical Space for the EDU	Move outpatients 5 initially and then clinics 1-4, as part of the emergency floor development.	Doug Skehan	27/08/12 (8) November 2012	Allows expansion of EFU, EDU and development of Psych assessment facility. Needs support from PCT/LPT re clinic accommodation out of UHL.

					Dependent upon relocation of fracture clinic. Movements have started but timescale extended
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. Target date of November being discussed. Specification being written. Awaiting CCG feedback.	Phil Walmsley/ Caroline Trevithick/ Rachel Bilsborough	30/07/12 (17)	
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. Business case to Commercial Executive for review	Doug Skehan	13/08/12 (6)	
11.	Lack of senior medical input post 01:00 in ED 24/7	Increase Senior Decision Makers (SDM) overnight.	Doug Skehan	16/07/12 (6) Revised date to be agreed	Recruitment ongoing.
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 in progress until April 2012. Awaiting outcome of transformational funding bid. Cost and benefit analysis to be completed.
13.	Patients having operations cancelled due to lack of ITU capacity	Expand on current Critical Care capacity.	Doug Skehan	23/07/12 (3)	Commissioners to source external review of critical care capacity and management.. Phase 1 recruitment underway. Discussions ongoing with commissioners
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 admission avoidance options	Increased number and specialty urgent clinics	Phil Walmsley/ Marina Muirhead	30/07/12 (4)	Review to expand portfolio in progress..
16.	Need to make best use of	Agree specification and cost of	Phil Walmsley	31/12/12(26)	.

	current bed capacity	pan trust/LLR Patient management system			
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)	Review of elective activity management in progress.
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 limited in its capability, so impact will be limited. Current e bed state improved and in place.
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.

Delivered/On Target Partially delivered Not delivered