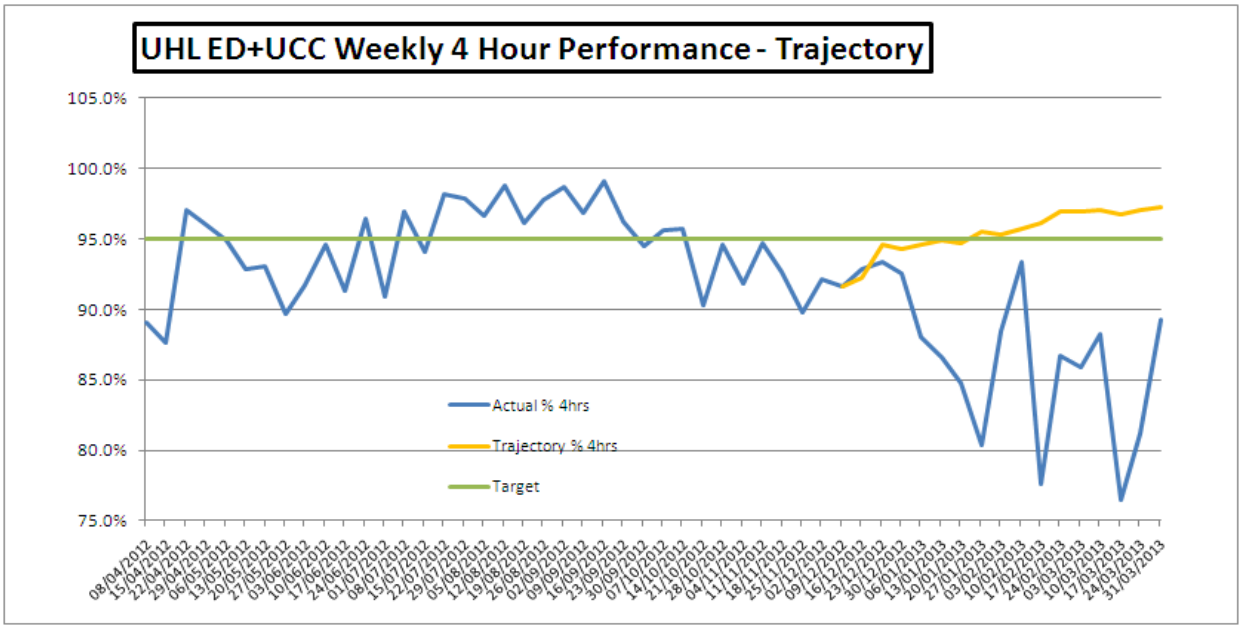
Trust Board Paper Z1

REPORT TO:	**ACUTE CARE DIVISIONAL BOARD**
REPORT FROM:	**JEREMY TOZER – INTERIM DIRECTOR OF OPERATIONS**
REPORT SUBJECT:	**ED PERFORMANCE REPORT**
REPORT DATE:	**25 APRIL 2013**

1. Introduction

Significant pressures remain on the emergency care system across LLR resulting in a continued deterioration in performance over the last month. UHL has achieved a year end performance of 89.79% against the Emergency 4hour target and when combined with the UCC the year end position is 91.93%.

Concerted efforts have been made in conjunction with Commissioners to manage demand and support new ways of working including additional resources to stream patients and manage flow. A revised trajectory for achieving the 95% performance has been agreed with CCGs for the early part of 2013/14. Despite support for recovery plans and agreement to a trajectory for improvement in performance with commissioners, UHL remains behind plan in delivering the agreed performance improvement.



Contractual discussions as we move into the new financial year include planning assumptions for the Marginal Rate Emergency Threshold (MRET). As an incentive for the Trust a risk share has been agreed with CCG to assist with managing emergency activity. The risk share has been designed to incentivise activity below plan and the Trust will benefit financially to any emergency under performance.

The demand for bank and agency nurses, in response to staffing requirements for the new processes in ED, the opening of additional capacity, a decreasing fill rate and an increase in sickness, continues to provide daily challenges in medical and nurse staffing. March has seen the extension of use of extra capacity beds. This is in response to issues associated with high demand for acute hospital beds coupled with a lack of consistent flow across the

emergency pathway. These factors have significantly impacted on our ability to maintain the four hourly target and our performance has consequently deteriorated.

This report provides details for the current level of performance for March 2013, an overview of the issues and describes the actions which have been taken to mitigate the impact both in the short and longer term.

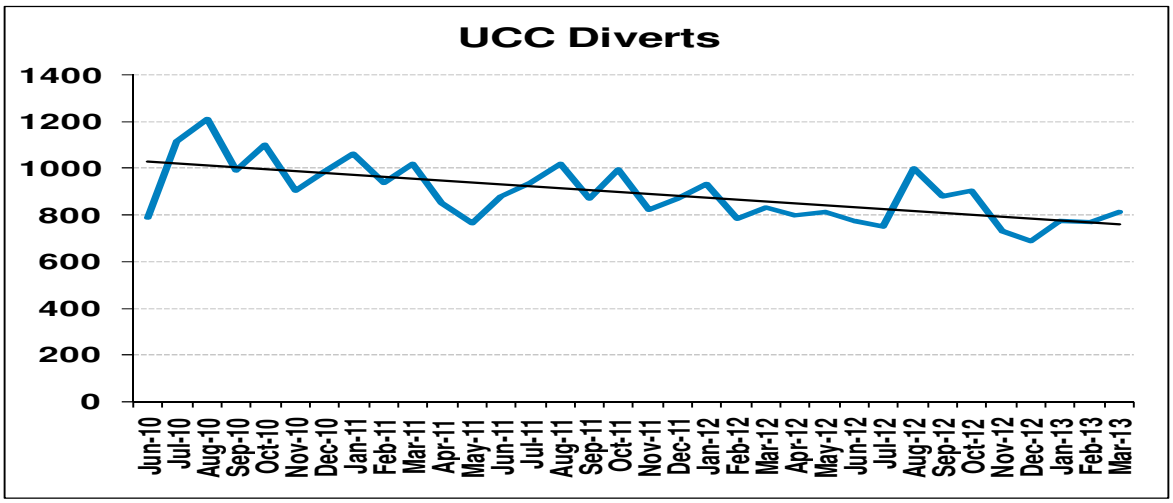
2. Current Activity and Performance

2.1 Attendances rates and Diversion rates.

ED attendance rates for 2012/13 were consistently above attendance rates seen in 2011/12 throughout the year until February 2013 even when pre diversion rates are taken into consideration. The downward trend in terms of overall change in activity has continued in March with reported figures showing a further overall percentage change in activity of –2.8% as shown in the figure 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	14,107	14,860	6.0%
Aug	12,544	13,757	13,086	14,109	13,815	14,817	5.0%
Sep	12,726	13,720	13,270	14,142	13,839	14,719	4.1%
Oct	12,918	14,022	14,002	15,000	14,051	14,955	-0.3%
Nov	13,057	13,963	13,226	14,051	14,201	14,933	6.3%
Dec	13,500	14,488	13,291	14,162	14,150	14,839	4.8%
Jan	12,830	13,893	13,260	14,196	13,751	14,528	2.3%
Feb	12,263	13,202	12,978	13,762	12,985	13,754	-0.1%
Mar	14,100	15,119	14,884	15,719	14,459	15,274	-2.8%
Sum:	159,121	169,253	161,768	172,346	167,957	177,666	3.1%

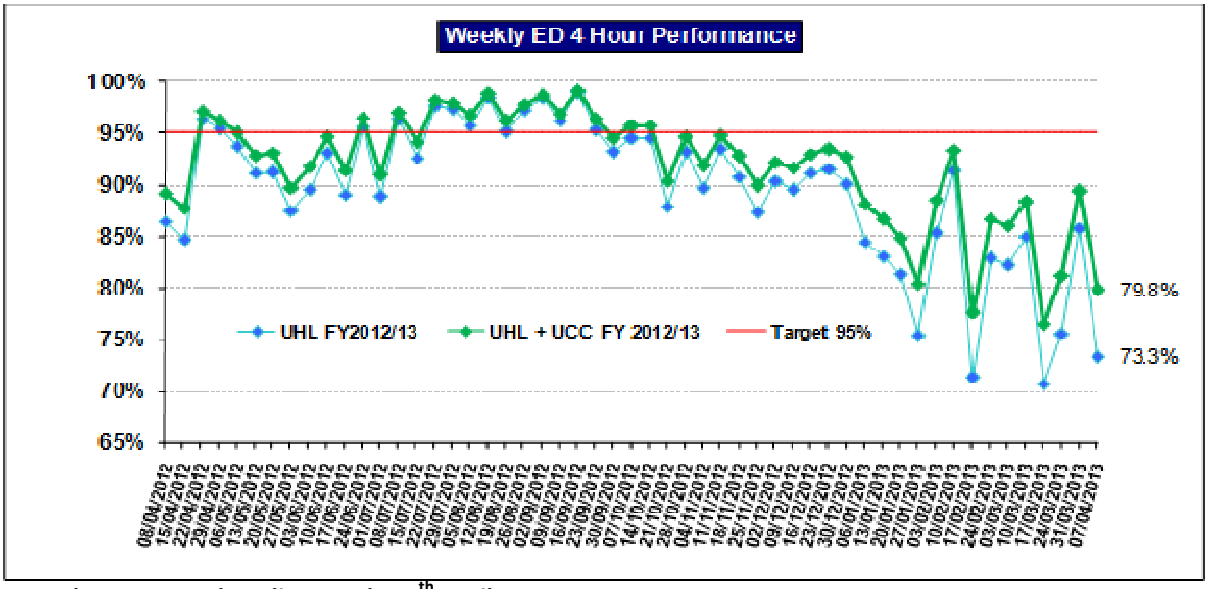
Focussed efforts between ED assessment teams and UCC staff continue in order to maximise the numbers of patients diverted to the UCC. Whilst early results from the UCC "single front door" pilot are not available actual numbers diverted during the month of March are marginally higher than the previous month (769 in February vs 815 in March) but within normal variance. It is anticipated that these figures will continue to improve going forward.



In addition to this work stream significant work continues to be undertaken by the CCGs to review all ambulance requests by a GP, to prevent attendance, and ensure GP review of patients referred from nursing and residential care.

2.2 4-Hour Performance target

Performance against the 4 hour ED target varied significantly throughout March which resulted in a performance of 73.3% for UHL type 1 & 2 attendances and an overall performance of 79.8% when UHL and UCC figures are combined.



ED and UCC to Week Ending Sunday 7th April 2013

Emergency Department 4hr Wait 2012/13

Mar 13

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	14,459	2,840	80.36%
Urgent Care Centre	Type 3	4,228	11	99.74%
UHL + UCC Total	All	18,687	2,851	84.74%

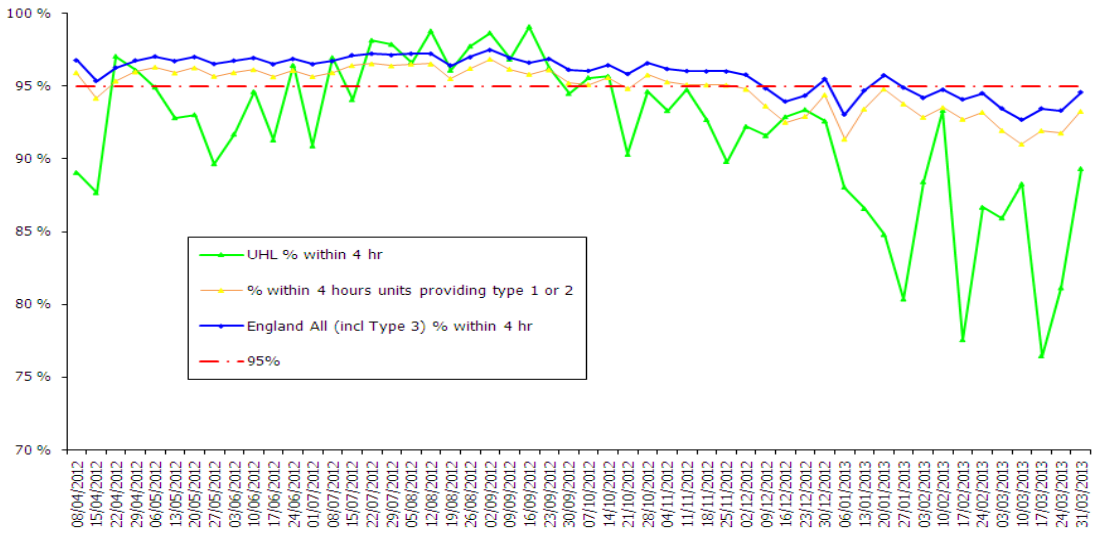
Quarter 4

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	41,195	7,773	81.13%
Urgent Care Centre	Type 3	11,640	21	99.82%
UHL + UCC Total	All	52,835	7,794	85.25%

Full Year to Date

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	167,957	17,148	89.79%
Urgent Care Centre	Type 3	45,759	97	99.79%
UHL + UCC Total	All	213,716	17,245	91.93%

As of the 31st March UHL was ranked 115 out of 144 Acute Trust for its weekly 4 hour performance of 89.3% and 134 out of 144 over the last 4 weeks, with a performance of 83.7%.Our trend in performance compared to other Acute Trusts, for ED type 1, 2 and 3 attendance is shown below:



2.3 March Performance

Our actual performance against the agreed trajectory has fallen short of the required target as shown below in the table.

Week Ending	Actual % 4hrs	Trajectory % 4hrs	Attendances	Breaches
09/12/2012	91.6%	91.6%	4,129	347
16/12/2012	92.9%	92.2%	4,204	299
23/12/2012	93.4%	94.6%	4,110	272
30/12/2012	92.6%	94.3%	4,068	301
06/01/2013	88.1%	94.6%	4,169	498
13/01/2013	86.6%	94.9%	3,929	527
20/01/2013	84.8%	94.8%	3,593	546
27/01/2013	80.4%	95.5%	3,898	765
03/02/2013	88.4%	95.4%	4,217	488
10/02/2013	93.3%	95.7%	4,138	276
17/02/2013	77.6%	96.1%	4,152	931
24/02/2013	86.7%	97.0%	4,089	545
03/03/2013	85.9%	97.0%	4,381	616
10/03/2013	88.3%	97.1%	4,360	511
17/03/2013	76.5%	96.8%	4,261	1003
24/03/2013	81.1%	97.1%	4,247	801
31/03/2013	89.3%	97.3%	3,972	424
2012/13		91.9%	213,167	17,225

The expectation from CCGs remains in regards to the transformational project with Right Place Consulting that our performance will improve going forward, particularly with the commencement of Phase 2 to look at ward processes and discharge arrangements. Embedding the new processes continues to provide a real challenge to the Trust particularly at times of such high demand and lack of continuous patient flow across our emergency processes.

In March an average of 24.5% patients were admitted from the ED which remains broadly consistent with previous months (range 23.1 – 26.1). Occupancy levels within base wards remained high, averaging 94.15% for the month of March. The Acute Division only exceeded the 30% discharge before 1pm target out of the hospital in the first week in March. Performance for the remainder of the month was variable and fell below the 30% expected target which has added further pressures into the emergency system as a consequence.

Staffing has provide a challenge for both medicine and ED, agency and bank requests have continued at high levels in both Medical and nursing in response to increasing sickness rates, additional capacity and vacancies. To manage the acute flow additional capacity beds that were closed in February were reopened and plans to reduce additional capacity beds were put back. Despite the additional bed capacity problems remain with flow across the system which gave rise to a major internal incident on 15th March 2013The use of incentive payments for nursing staff has been extended to continue to support fill rates for bank requests and to maintain skill mix across the department.

2.5 Delay Reasons

The top cause this month for breaches is the ED process which remains consistent with those reported in previous months. The top three reasons for breaches are summarized as

- ED Process – 31%
- Bed Breaches – 29%%
- ED Capacity – 19%

The increase in % reasons attributed to ED capacity is associated with the continued high numbers of patients in the department associated with ED processing time and bed breaches. Reflected in this picture is the fact that the department has consistently had several patients awaiting admission at any one time during a 24 hour period and this as a result has severely impacted on the ED process.

The distribution of breaches by area is shown in the table below which demonstrates that the 70% of breaches occur not surprisingly within the majors area. It should be noted that the number of minors breaches are consistent. New processes and improved coordination should help to reduce these potentially avoidable breaches:

Allocation	Jan-13	Feb-13	Mar-13	1st - 9th Apr-13	Total	Cumulative %
CHILDREN	62	73	47	22	204	3%
MAJORS	1770	1402	1633	628	5433	70%
MINORS	252	225	235	85	797	10%
RESUS	469	356	389	152	1366	18%
Sum:	**2553**	**2056**	**2304**	**887**	**7800**	**100%**

The table below provides more detail, and specifies more reasons attributed for breaches. It is worth noting that there has been an increase in the number of breaches attributable to ED process in March linked in part to ED overcrowding as a result of no outflow. The number of bed breaches is reflective of the significant pressures on beds whilst those reported for clinical reasons have declined against numbers reported for the previous 2 months again.

Type 1 Delay Reasons (Excluding "Unknown")

Delay Reason	Jan-13	Feb-13	Mar-13	1st - 9th Apr-13	Total	Cumulative %
Bed Breach	866	506	616	279	2267	**29%**
ED Process	1005	519	760	129	2413	**31%**
ED Capacity (Cubicle Space)	88	479	563	350	1480	**19%**
ED Capacity (Inflow)	40	51			91	**1%**
ED Capacity (Workforce)	8	54			62	**1%**
Clinical Reasons	232	189	183	64	668	**9%**
Specialist Assessment	62	40	41	12	155	**2%**
Specialist Decision	5	8	15	7	35	**0%**
Investigation (Imaging and Pathology)	66	64	46	24	200	**3%**
Transport	131	108	64	16	319	**4%**
Treatment	50	38	16	6	110	**1%**
	2553	**2056**	**2304**	**887**	**7800**	**100%**

ED has to cope with very high numbers of patients in the department at times for a number of reasons. At times this is due to internal delays in patients awaiting medical review (see section 2.6 below) whilst at other times this can be due to the availability of beds on the rapid assessment and Short Stay units and access to speciality beds, which is impacted by timeliness of discharge throughout the day.

The early availability of beds on base wards to allow flow from the Rapid Assessment and Short Stay units has impacted on the availability of beds at the time of request. This coupled with the ability of the emergency department to transfer a patient from the department without delay once a bed is available results in lengthy waits for patients, particularly when the department is at full capacity. There is a feeling that the increasing numbers of acute frailty patients being admitted to the RAU and SSU are impacting length of stay and discharge rates from these areas. Work is underway to provide the evidence as to whether or not this is the case.

Further analysis of timeliness of discharge in the department

	Nov-12	%	Dec-12	%	Jan-13	%	Feb-13	%	Mar-13	%	1st-9th Apr-13	%
0-1 Hours	176	4%	189	4%	194	5%	231	6%	265	6%	75	6%
1-2 Hours	762	19%	865	19%	686	16%	673	17%	718	17%	193	16%
2-3 Hours	1320	32%	1510	34%	1214	29%	1095	28%	1102	26%	271	22%
3-4 Hours	1465	36%	1459	33%	1452	34%	1181	30%	1243	29%	312	26%
4-5 Hours	236	6%	270	6%	448	11%	416	11%	453	11%	157	13%
5-6 Hours	86	2%	104	2%	157	4%	193	5%	221	5%	87	7%
6 Hours+	59	1%	71	2%	112	3%	177	5%	299	7%	123	10%

2.6 ED Quality Indicators

The two clinical quality indicators that were met in February continued to be met in March as shown below:

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	TARGET
Left without being seen %	2.1%	2.2%	2.7%	2.5%	2.5%	2.8%	2.9%	3.3%	<=5%
Unplanned Re-attendance %	5.6%	5.3%	5.0%	5.2%	5.2%	5.5%	5.4%	5.3%	< 5%

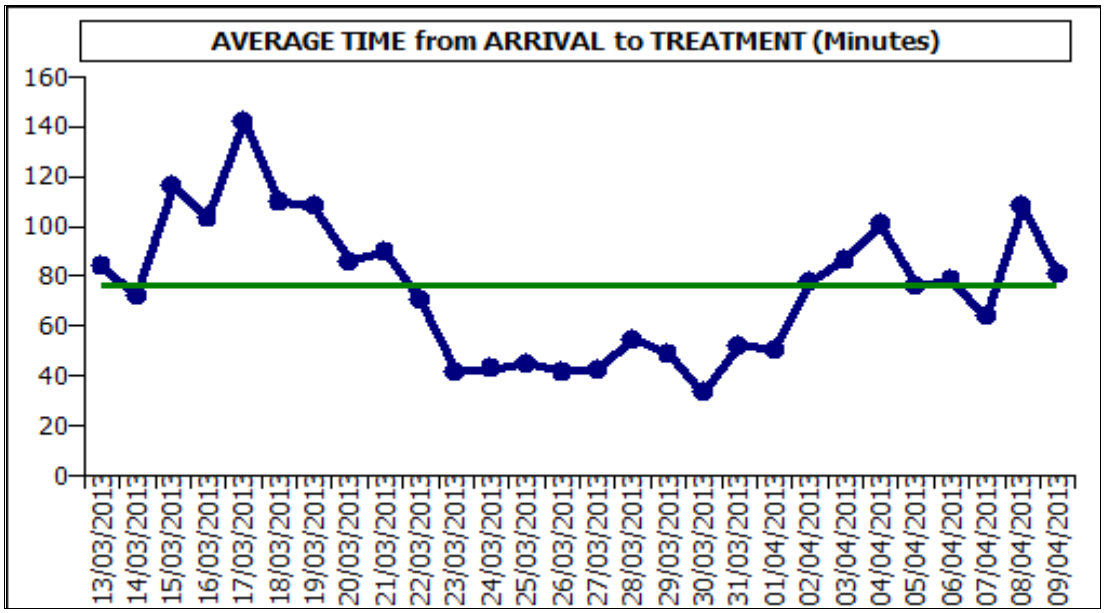
TIMELINESS

	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	TARGET
Time in Dept (95th centile)	238	240	298	326	344	457	432	483	< 240 Minutes
Time to initial assessment (95th)	15	16	23	24	24	25	33	45	<= 15 Minutes
Time to treatment (Median)	53	58	64	69	68	79	60	47	<= 60 Minutes

The time in the department has risen to 483 minutes against a 240 minute target. When these figures are split between discharged patients and admitted there is a difference in overall time spent within the department with the latter being significantly longer for those awaiting admission. Waiting times to be seen by a doctor and for a treatment plan to be in place is recognised as an issue overnight particularly when the numbers ion the department at the time of handover are high.

Average Time to Treatment (Minutes)

28 Days from Wednesday 13th March to Tuesday 9th April 2013



It continues to be recognised that as the new emergency processes become embedded and improved outflow is created across the system that performance will improve. This will be addressed through the second phase of the work undertaken with Right Place Consulting. Previously reported data capture accuracy in the assessment bays continue to be worked on to ensure that the data within the clinical quality indicators is reflective of the success of the new assessment bay processes and the actual time to initial assessment. It should be noted that this is imperative owing to the contractual penalties to be introduced in 2013/14 where handover is not completed within the requisite time.

3 CCG Support

There remains continued from the CCG's through a variety of activities to support the Trust in reducing attendance rates, improving diversion, providing improved access to primary care placements as a means to reducing delayed transfers, and the enablement of improved access to health and social care to prevent admission. Similarly the CCG's continue to fully support the work undertaken by Right Place Consulting and recognise the timeframes for processes to embed and for working practices to truly transform.

To reaffirm the direction of travel and to assess what further could be done to improve the Trust's emergency performance a further visit from the Emergency Care Intensive Support Team (ECIST) was requested for 15th March 2013. There were a number of changes that the team recognised had been implemented since their last visit. Further to this a number of key recommendations were made that are being taken forward.

Further support has been sought through an independent review of the ED processes by Paul Saines. The department has been commended on the standard of assessment bay processes and some areas highlighted as quick wins. Feedback focussed on the need to redefine the role of the tracker, refocusing the role of the Nurse in Charge and Doctor in

Charge and making minors breaches a never event. Further recommendations were made for consideration by the Division.

CCGs continue to pursue innovative work to help support the Trust reducing attendance to ED; The project with GPs allocated to 999 calls is being expanded and it is anticipated that further impact on attendance will be seen. As previously reported the CCGs continue to support and monitor the implementation of the single front door initiative is being closely aligned and linked with the new assessment processes within ED.

4. RECOMMENDATIONS

The board are asked to:

- Note the contents of this report
- Acknowledge the continuing pressures in the emergency system resulting in a further deterioration in performance, particularly associated with flow and capacity;
- Note the on-going support from the CCGs to alleviate pressures across the Health Economy;
- Note the impact of the revised trajectory for improvement for 2013/14 and the contractual incentives;
- Note that future reports will include commentary on the metrics for assessment unit processes to reflect the whole emergency process.