To:	Trust Board
From:	Jeremy Tozer, Interim Director of Operations
Date:	28 March 2013
CQC regulation:	All Applicable

Title:	Emergency Department Performance Report

Author:
Monica Harris, Divisional Manager, Acute Care Division

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:

- February has been a challenging month but has seen an overall improvement in our in-month position when compared to January (86.13% and 84.94% respectively) but overall the UHL year to date performance has deteriorated from 93.23% in February compared to that of January 92.62%.
- 2 out of the 5 quality indicators have been achieved. Time to treatment has been achieved for the first time in 5 months
- February ED attendance rates showing an overall percentage change in activity of – 0.1%
- The Acute flow is further impaired by poor staffing levels in both ED and Medicine, limiting available capacity. Action plans are in place to improve fill rate of bank and agency shifts with some positive results.
- The top three reasons for breaches are consistent, being ED process, bed breaches and clinical exceptions.
- Early results of work streams 1 and 2 reveal that there are some demonstrable areas of improvement in terms of
  - Ambulance handover time
  - An improved arrival to treatment time suggesting our patients being treated quicker
  - A reduction in conversion rates suggesting that patients are being directed to our ambulatory services or being discharged home rather than being admitted
- Worksteams 4 and 5 are shortly to be introduced which will concentrate on ward management and patient flow
- The CCG collaborative continue to support the internal steps taken by UHL to improve performance through the programme of work to be facilitated by Right Place Consulting.

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Monthly incentive payment for delivery of the 95% target has been extended to all medical wards

Non recurrent funding to support winter pressures 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
NHS Trust

REPORT TO: **TRUST BOARD**

REPORT FROM: **MONICA HARRIS & JANE EDYVEAN**

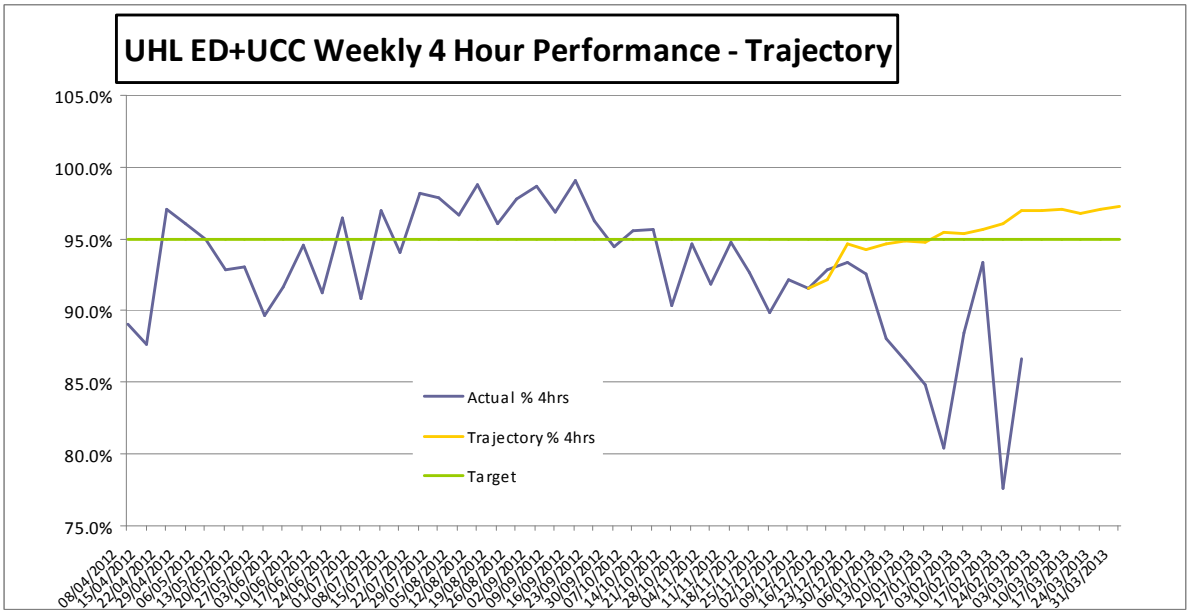
REPORT SUBJECT: **ED PERFORMANCE REPORT**

REPORT DATE: **28 MARCH 2013**

1. Introduction

UHL continues to experience significant problems in achieving the A&E performance target. Our February position shows an overall improvement in our in-month position when compared to January (86.13% and 84.94% respectively) but overall the UHL year to date performance has deteriorated from 93.23% in January compared to that of 92.62% in February.

Achieving the emergency 95% target and clinical indicators on a sustainable basis continues to be a focal area for improvement and remains a major priority for both UHL and the local health economy. 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.



The demand for bank and agency nurses, response to staffing requirements for the new processes in ED, the opening of additional capacity, a decreasing fill rate and an increase in sickness, has resulted in some significant challenges in nurse staffing. February has seen a closure in extra capacity beds due to staffing issues which has 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, an overview of the issues and describes the actions which have been taken to mitigate the impact both in the short and longer term.

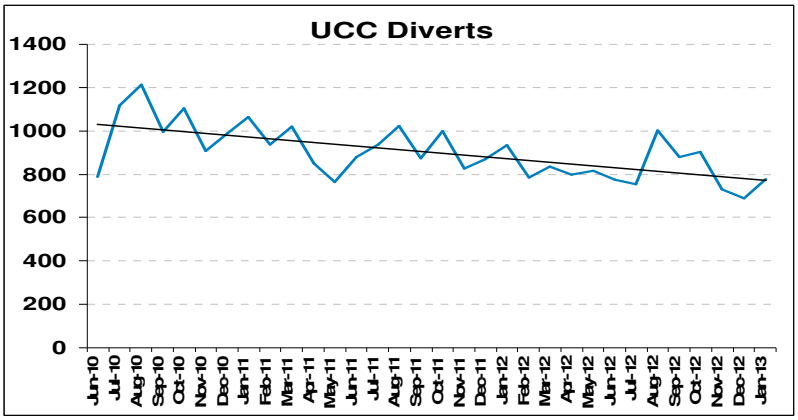
2. Current Activity and Performance

2.1 Attendances rates and Diversion rates.

ED attendance rates for 2012/13 have been consistently above the attendance rates seen in 2011/12 throughout the year even when pre diversion rates are taken into consideration. The downward trend in terms of overall change in activity has been a theme over the past 4 months with February showing an overall percentage change in activity of – 0.1% 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			
Sum:	159,121	169,253	161,768	172,346	153,498	162,392	

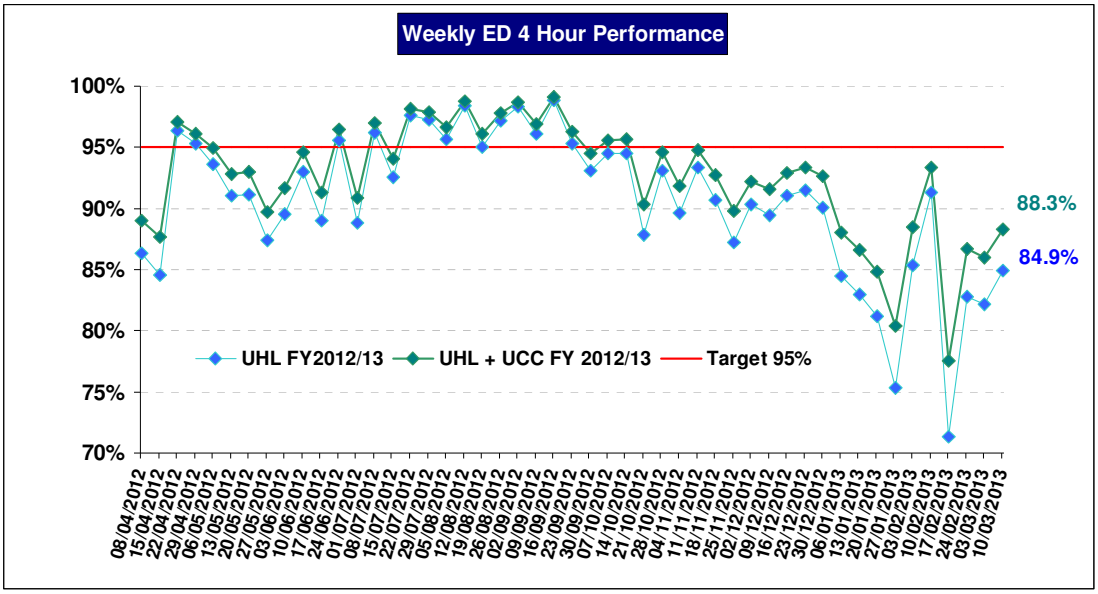
Pre and post diversion attendances in month remained marginally higher than average when compared to the monthly average attendances in February 2011/12 (+ 523 pre diversion and +601 post diversion). Focussed efforts between ED assessment teams and UCC staff continue in order to maximise the numbers of patients diverted to the UCC. Whilst early results from the UCC “single front door” pilot are not available the actual numbers diverted during the month of February are marginally lower than the previous month (769 in February vs 777 in January) the percentage of diversions is marginally higher (5.5% vs%.3%). It is anticipated that these figures will 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, whilst it is early in the trial the impact of which seems positive.

2.2 4-Hour Performance target

Performance against the 4 hour ED target varied significantly throughout February which resulted in a performance of 82.19% for UHL type 1 & 2 attendances and an overall performance of 86.13% when UHL and UCC figures are combined with average daily breach rates ranging from 39 to 133 per day.



A&E 4hr Wait 2012/13

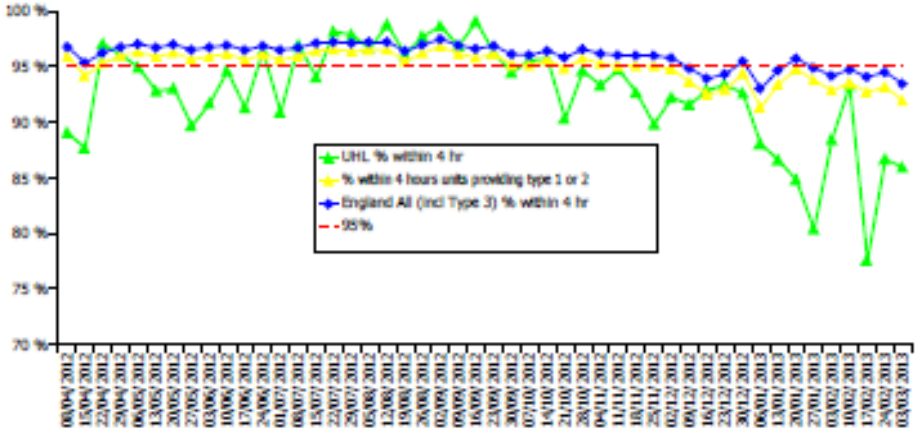
Feb 13

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	12,985	2,313	82.19%
Urgent Care Centre	Type 3	3,730	5	99.87%
UHL + UCC Total	All	16,715	2,318	86.13%

Full Year to Date
Feb 13

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	153,498	14,308	90.68%
Urgent Care Centre	Type 3	41,531	86	99.79%
UHL + UCC Total	All	195,029	14,394	92.62%

As of the 3rd March, UHL was ranked 130 out of 144 Acute Trust for its weekly 4 hour performance of 85.9% and 136 out of 144 over the last 4 weeks, with a performance of 85.9%. Our trend in performance compared to other Acute Trusts, for ED type 1 2 and 3 attendance is shown below:



2.3 February Performance

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

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

The expectation from CCGs remains that our performance will significantly improve following the implementation of the new processes on 18th February 2013. Although embedding the new processes is providing a real challenge to the Trust internally it is agreed that this will improve performance particularly when supported by the outputs of phase 2 of the programme which will concentrate on ward based processes and discharge.

February saw an average of 25.5% patients admitted from the ED which is broadly consistent with previous months. Occupancy levels within base wards remained high, averaging 95.4% for the month of February. Despite the Acute Division exceeding the 30% discharge before 1pm target out of the hospital in January achievement of the improved performance was not sustained in February therefore it could be argued that further pressures have been put on the emergency system as a consequence.

Staffing has provide a challenge for both medicine and ED as agency and bank requests have continued to increase in response to increasing sickness rates, additional capacity and vacancies. February has seen some of our additional capacity being temporarily closed, in order to ensure safe staffing levels, resulting in the reduction of our winter pressure bed-base. This has had a significant impact on the acute flow and has resulted in increased 4-hourly breaches. In response to this incentive payments have been introduced within the ED since 1st March to encourage greater fill rates for vacant shifts with very encouraging

results.137 Bank shifts have been filled over a 5 week period since the introduction of the bonus payment.

2.5 Delay Reasons

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

- ED Process – 31%
- Bed Breaches – 30%
- Clinical Reasons – 12%

The distribution of breaches by area is shown in the table below:

Allocation	Dec-12	Jan-13	Feb-13	1st - 11th Mar-13	Total	Cumulative %
CHILDREN	66	62	73	18	291	4%
MAJORS	815	1770	1402	389	5249	67%
MINORS	127	252	225	38	760	10%
RESUS	313	469	356	101	1545	20%
Sum:	**1321**	**2553**	**2056**	**546**	**7845**	**100%**

The table below provides more detail, and specifies more reasons attributed for breaches. It is worth noting that there has been a sharp fall in the number of breaches attributable to ED process in February despite the fact that this remains the highest cause for breaches. January figures for bed breaches were reflecting the significant pressures in January for beds which is shown in the table below to have settled. Breaches reported for clinical reasons have declined against numbers reported for the previous 2 months.

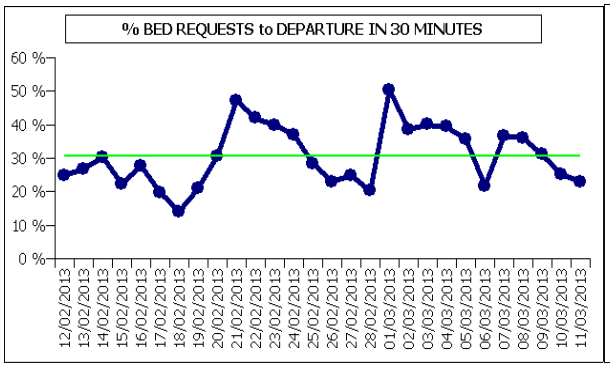
Type 1 Delay Reasons (Excluding "Unknown")

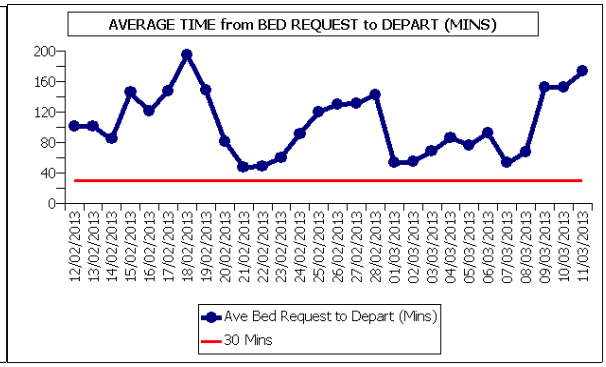
Delay Reason	Dec-12	Jan-13	Feb-13	1st - 11th Mar-13	Total	Cumulative %
Bed Breach	397	866	506	179	2382	**30%**
ED Process	340	1005	519	158	2404	**31%**
ED Capacity (Cubicle Space)	17	88	479	114	706	**9%**
ED Capacity (Inflow)	128	40	51		313	**4%**
ED Capacity (Workforce)	4	8	54		66	**1%**
Clinical Reasons	245	232	189	54	906	**12%**
Specialist Assessment	36	62	40	9	180	**2%**
Specialist Decision	7	5	8	1	29	**0%**
Investigation (Imaging & Pathology)	56	66	64	21	287	**4%**
Transport	73	131	108	7	424	**5%**
Treatment	18	50	38	3	148	**2%**
Sum:	**1321**	**2553**	**2056**	**546**	**7845**	**100%**

ED is experiencing a larger number 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 whilst at other times this can be due to the availability of beds on the rapid assessment, Short Stay units and access to speciality beds, which is a key element to allow the timely flow of patients out of the Emergency Department. The new processes implemented in mid-February are aiming to significantly improve this situation.

The lack of 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 inability of the emergency department to transfer a patient from the department without delay once a bed is available results in lengthy waits for patients. The average wait between the request for a bed and the patient leaving the emergency department continuously exceeds 30 minutes.





2.6 ED Quality Indicators

Two of the clinical quality indicators were met in February as shown below. The time in the department has reduced in February reversing the trend since October 2012, the reasons for which continue to be multi-faceted. It is agreed that as the new emergency processes become embedded and improved outflow is created across the system that performance will improve. Further to this it is known that data capture needs be improved in the assessment bays as the data captured within the clinical quality indicators is not reflective of the success of the new assessment bay processes and the actual time to initial assessment. This will be addressed in March.

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	TARGET
Left without being seen %	2.4%	2.1%	2.2%	2.7%	2.5%	2.5%	2.8%	2.9%	<=5%
Unplanned Re-attendance %	6.4%	5.6%	5.3%	5.0%	5.2%	5.2%	5.5%	5.4%	< 5%

TIMELINESS

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	TARGET
Time in Dept (95th centile)	240	238	240	298	326	344	457	432	< 240 Minutes
Time to initial assessment (95th)	20	15	16	23	24	24	25	33	<= 15 Minutes
Time to treatment (Median)	57	53	58	64	69	68	79	60	<= 60 Minutes

3. CCG Support

There remains continued support from the CCG's to support the Trust in reducing attendance rates. These include 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 be support the work undertaken by Right Place Consulting and recognise the timeframes for processes to transform working practices.

CCGs continue to pursue innovative work to help support the Trust reducing attendance to ED; The project with GPs allocated to ambulance attendances for 999 calls is being expanded and it is anticipated that this will result in an increased impact on attendances. As previously reported the CCG's continue to support and monitor the implementation of the single front door initiative which is being closely aligned and linked with the new assessment processes within ED.

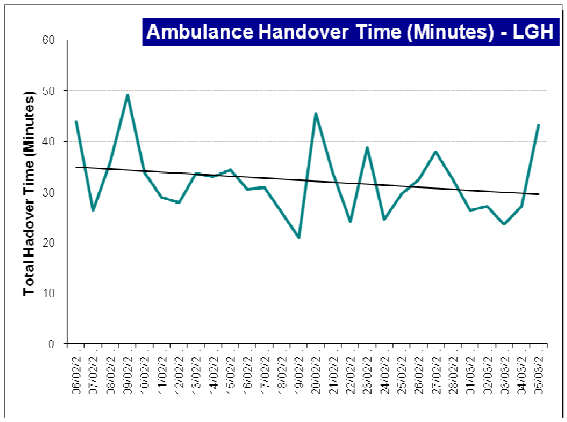
4. REVIEW OF NON ELECTIVE FLOWS

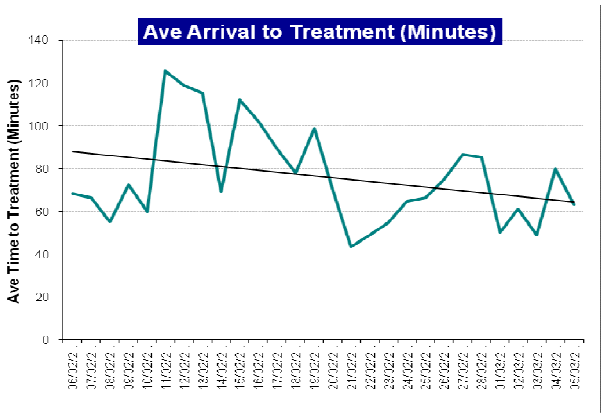
The work undertaken by Right Place Consulting (RPC) continues. The project has been hindered by a shortage of nurse staffing resulting in the inability of teams to fully implement the new pathways. Significant work has been undertaken at all levels of the organisation to minimize the risk of reduced nurse to bed ratios. Incentive payments have been extended to ward staff as well as the ED department. This has resulted in a very positive effect in improving fill rates.

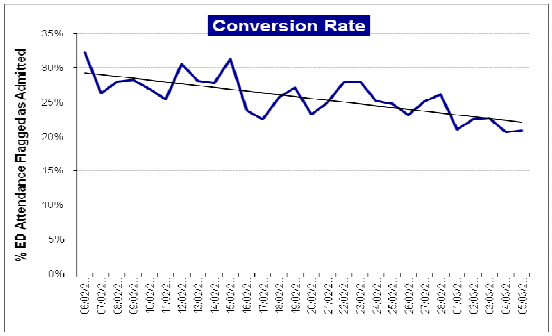
Early March saw several visits from the CCG's to several of our wards; they expressed concern with the level of nurse staffing. Action plans have been put in place and positive progress is being made to mitigate the risks of low nurse to bed ratios.

Early results reveal that there are some demonstrable areas of improvement;

- Ambulance handover time
- An improved arrival to treatment time suggesting our patients being treated quicker
- A reduction in conversion rates suggesting that patients are being directed our ambulatory services or being discharged home rather than being admitted.







Worksteams 4 and 5 are shortly to be introduced which will concentrate on

- Ward management processes, ensuring daily ward rounds, specilaity inreach and the rebasing of specialty beds
- Bed Reconfiguration and flow – concentrating on bed bureau, bed management functions and processes.

Whilst focus is moving to work streams 4 and 5 a core team has been established to provide continued focus on workstream 1 and 2 to ensure that the processes become embedded and staff are provided with ongoing support in the new ways of working.

5.0 ESTATES SOLUTIONS

Various estates solutions are being undertaken to support the relocation of services aligning clinical adjacencies, and supporting the changes in patient flows, ensuring the right clinical staff are in the right place to support the new acute flow. The Key estates solutions are outlined below:

- The conversion of the current Orthopaedic Seminar room to a clinical area to support EMAS handover to the assessment room staff.
- The expansion of the assessment area in ED is nearly completed with will allow greater space to assess patients

RECOMMENDATIONS

The board are asked to:

- Note the contents of this report
- Acknowledge the significant work and opportunity created by the right place consulting work
- Note the on-going support from the CCG and associated incentive for the weekly achievement of performance.

Project Highlight Report

Project Name: *Emergency Care Pathway Implementation Programme (ECP)*

Period:	21st March 2013	**Summary position**	
Author(s): **Tessa Walton**		Last period: A	This period: R

1. Programme Status

Phase 1 - One month post implementation

Following implementation of the revised Emergency Care Pathway, some core elements of the model are in place, however, there are a number of elements, which are not consistently applied or adhered to. Phase 1 was extended until the end of March with support rotas of managerial and clinical teams to help enforce the model on the ground on a daily basis. Staff leave, availability and the inconsistent presence of an acute divisional project support team have meant that these rotas have not had the desired impact.

An objective evaluation has been undertaken by RPC in conjunction with the Interim COO to obtain a detailed view regarding which standards are and are not in place to direct focus. ECIST will be reviewing the model implementation on the 25th March and the outcome of this visit in combination with our assessment to address the key issues.

What is working?

- In the ED Assessment Bay, patients are being seen by a triage nursing team (combination of RN and HCA) on arrival and undertaking a standardised assessment commencing an initial plan to be continued in Majors.
- In the Rapid Assessment Unit (RAU) and Short Stay Assessment (SSA) and Clinical Decisions Unit (CDU) the teams are working well with 2-3 ward and board rounds per day and reviewing new patients within 30 minutes in hours in hours. The discharge home rate has improved significantly in the Short Stay areas at both the LRI and GGH sites (by over 10%).
- The Assessment unit Floor Coordinator roles are working well and the junior doctor allocation to bays has allowed actions to be followed up more proactively following ward and board rounds.
- The Acute Frailty Service is integrating with the Assessment Units and conversion rates have not increased for this cohort of patients, or length of stay. There have been some initial teething problems with streaming of patients from ED on the correct pathway and the Primary Care Coordinator role and teams culturally shifting to work from the EDU to a wider department with new ways of working. These are improving with weekly meetings to troubleshoot issues.

What is not working – key themes:
(Reference Key Performance Indicators Section 4)
Key themes have been identified as compounding reasons for the inconsistent application of the new standards and ongoing poor performance – **Resourcing, Clinical Leadership, Untimely flow onto base wards and Entrenched behaviours.**

- **Poor staffing** in key areas due to vacancies and unfilled bank/agency shifts results in roles and responsibilities being stretched and inconsistent application of the model. An example of this is the Floor Coordinator role on the Assessment Unit – once this post holder has to become one of the staff numbers in the bays, this role is critically stretched impacting on clinical handover and flow management.
- Where **flow to base wards is late**, backlog builds up in the Assessment Units and then ED and during the daytime where there are the most resources patients are not proactively assessed. Due to **inconsistent application** of the standards and limited

clinical leadership on the floor to reinforce the standards, old and localised practices are emerging, e.g. no urgency on the Assessment units to proactively discharge patients, medical teams in the Assessment Bay in ED not considering alternative options to Majors – e.g. UCC/Acute Medical Clinic/EDU etc. This results in overcrowding of the Majors area and reinforces the mentality that all patients need to be there. This is a consequence of the culture to keep hold of patients for as long as possible and not to get patients moved onto the right environment. Furthermore, the delay in implementation of the 'Core Team' rota on the LRI Assessment Units resulted in daily discharge variation between consultants of 14%-68%.

- There has been limited Divisional and Head of Service **medical leadership** to reinforce the models on the ground or tackle/address where the above core issues are arising. Where Divisional or CBU managerial presence has been in place, there has been a limited understanding of the model despite briefings (excluding those directly involved in the process).

Key Next Steps:

- Convene key stakeholders on 22nd March including medical, nursing and managerial to enforce steps to address the core issues:
  - Performance manage where data entry not completed
  - Address escalation (and non-escalation) where standards are not adhered to
  - Exploration of the UCC directly taking more Minors patients within a defined governance structure to release capacity in ED.
- Introduce (22nd March) an external, experienced ED nurse to train and up-skill the Nurse in Charge staff to support the on the ground compliance with the model standards in ED.
- Put in place weekly performance management meeting (week commencing 25th March) with Interim COO, RPC, Deputy Divisional Director Acute Care, Phase 1 Clinical Workstream Leads and Project Managers to review performance information and agree relevant actions accordingly.
- Implement clear action plan to address identified issues with Programme Directors, Divisional Management team and Key Project Stakeholders to reinforce the right standards within the model, incorporating ECIST recommendations when available.
- Finalise KPIs and reinforce requirement to input accurate data with effective performance management where data entry poor.
- Commence Phase 2 to support flow into base wards.

2. Milestone	Target date	Status (R/A/G)*	Estimated date of completion
Implementation completed	28-02-13	R	31-05-13
Evaluation one month post implementation	22-03-13	G	Complete
Agreed Action Plan following Evaluation	22-03-13	A	25-03-13 (incorporating ECIST recommendations when received)
Phase 2 Mobilisation	14-02-13	A	25-03-13

3. Risks and Mitigations:

Description	Risk Rating (RAG)	Mitigating action	Owner	Review date
Significant resistance from key stakeholders.	R	Individual meetings with RPC/ Division/ Executive sponsors taking place. Meeting scheduled on 22nd March to address specific clinical resistance in ED	Jeremy Tozer, Pete Rabey, Ben Teasdale	26/03/13
Nurse Staffing impact on model delivery	A	Review success of latest recruitment drive and potentially run another one ahead of scheduled 3month recruitment plan. Continue incentive scheme for staff to take bank shifts in these areas.	Sue Mason, Jeremy Tozer, HR	26/03/13
Programme momentum will degenerate once programme structure is removed.	A	Ongoing weekly integrated Workstream meetings being held with key stakeholders to monitor progress and address issues. 3 key leads identified to support enforcement	Workstream leads: Ben Teasdale and Catherine Free.	26/03/13
Lack of clinical engagement and inability to obtain consensus on the medical model will impact on implementation of the Emergency Care Programme	A	Specific resistance among individual clinicians is to be addressed on a 1:1 basis following wider key stakeholder meeting	Pete Rabey, Sue Mason, Monica Harris	26/02/13
Easter Break could impact on flow to base wards and staffing to support embedding Phase 1	R	Easter Planning to ensure adequate cover of base wards to minimise impact on flow in Trust.	Jeremy Tozer, Jon Bennett	26/03/13

There is a risk that ongoing poor ED performance will impact the embedding of best practice processes	R	Introduction of ED nurse to support, embed and troubleshoot on the ground to reinforce model put in place from 22/03/13 Leadership support required by the Programme Directors and Accountable Officers to address poor performance against standards	Jeremy Tozer, Pete Rabey	26/03/13
There is a risk that Phase 2 will be delayed in implementation due to immediate capacity pressures and Easter	R	Individual stakeholder engagement continuing. Ensure baseline information re job planning available to mitigate delays in Workstream meetings to progress plan	Programme Directors: Pete Rabey Jez Tozer	26/03/13

R There are significant issues that require immediate remedial action.

A Issues have been identified that will require remedial action if project is to remain within tolerance.

G Project is progressing to plan.

4. Key Performance Metrics:

Please note:

- *The 22.02.13 report, the Trust identified some data quality issues with the conversation rate statistics reported. These have been validated and resolved and a revised position is included in this report
- ** A revised baseline has been agreed to capture performance between 1st April 2012 and 17th February 2013.
- *** It is difficult to draw conclusions from this data, as the data entry/capture is approximately 40% complete.

Measure	** Baseline (Average from 28/01/13-17/02/13)	Last reported 22/02/13	Average 18/02/13-18/03/13	ECP Target
* Conversion Rate	23%	N/A	24.9%	20%
*** Arrival to seen by a doctor in Assessment Bay (Ambulance Arrivals (mins)	N/A	N/A	9	15
Arrival to Treatment in Majors (mins)	81	N/A	76	60
Time to bed request (mins)	167	N/A	199	180
Bed request to leave department (mins)	68	N/A	105	15-30
Arrival to Treatment in Minors (mins)	78	71	85	30
Arrival to treatment in Resus (mins)	43	40	43	30
Discharge Home rate RAU	30%	38%	30%	30%
Discharge Home rate SSA	25%	45%	38%	50%
Discharge Home Rate RAU and Acute Medical Clinic	24%	N/A	49%	60%
Discharge Home Rate CDU	33%	35%	33%	50%
Discharge Home Rate Glenfield Short Stay	58%	N/A	67%	50%