Trust Board 1 October 2015

UHL Emergency Performance

Author: Chief Operating Officer paper H

Executive Summary

Context

Whilst performance continues to be an improvement on last year, the difference in performance between this year and last year continues to reduce. UHL remains under pressure because of the continuing and unseasonably high levels of attendance and admissions. We (UHL) need to work more effectively with Leicester, Leicestershire and Rutland partners (LLR) to deliver specific schemes which will reduce our rate of admission and attendance. If we don't achieve this, we will be unable to provide high quality care to all of our patients on the emergency pathway this winter.

Questions

1. What more can UHL do to resolve this problem?
2. What more can our partners do to resolve this problem?

Conclusion

1. The proposed change to the front door is a positive development but more is required to improve performance in time for winter 2015-16.
2. The paper identifies five specific actions that would support LLR in delivering a higher quality of care to patients this winter.

Input Sought

The Board is invited to consider whether internal and system-wide action is sufficient to address the issues raised.

For Reference

Edit as appropriate:

1.The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare [Yes /No /Not applicable]
Effective, integrated emergency care [Yes /No /Not applicable]
Consistently meeting national access standards [Yes /No /Not applicable]
Integrated care in partnership with others [Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed' [Yes /No /Not applicable]
A caring, professional, engaged workforce [Yes /No /Not applicable]
Clinically sustainable services with excellent facilities[Yes /No /Not applicable]
Financially sustainable NHS organisation [Yes /No /Not applicable]
Enabled by excellent IM&T [Yes /No /Not applicable]

2.This matter relates to the following governance initiatives:

Organisational Risk Register [Yes /No /Not applicable]
Board Assurance Framework [Yes /No /Not applicable]

3.Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4.Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5.Scheduled date for the next paper on this topic: 2 July 2015

6.Executive Summaries should not exceed 1 page. [My paper does comply]

7.Papers should not exceed 7 pages. [My paper does comply]

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**1 October 2015**

High level performance review

- (As at week 25) 91.8% year to date (+3.0% on last year)
- Attendance +4.0%
- Admissions +7.1%
- August 2015 90.6% compared to 91.3% August 2014
- September 2015 (up to 23/9) 90.5% compared to 91.6% September 2015
- W/e 20/9/15 had the highest number of admissions ever (1830). Previous high was 1812 (w/e 26/4/15)
- Sunday 13/9/15 had the highest number of attendances ever 702.
- **Performance remains consistently below 95%.**

Over the last 12 weeks performance has deteriorated compared to last year. It is likely that September will be the third consecutive month in which performance is worse than the same month last year. This is worrying as despite the efforts put in, it represents a downward trend in comparative performance just before winter, the most difficult time of year. As previously identified, the two key reasons for this remain the attendance and admissions rate which continue to run much higher than last year. It is very difficult to deliver a consistently high quality service when the Emergency Department at the Leicester Royal Infirmary and the CDU at Leicester Glenfield remain under such pressure.

As stated above, we have recently broken the UHL record for the highest number of emergency admissions in one week and the highest number of attendances. The average number of admissions in September 2014 was 1623 compared to 1708 in September 2015.

Update on UHL plan

We continue to make progress on our internal flow plan. The plan is monitored through the weekly Emergency Quality Steering Group and of the 60 actions, 29 are complete, with the remaining 31 as follows:

1	Not yet commenced	3
2	Significant delay - unlikely to be completed as planned	3
3	Some delay - expected to be completed as planned	7
4	On track	7
	Grand total	20

Key achievements over the last month include:

- Agreement of UHL winter capacity plan
- Agreement of a model of ambulatory care on CDU
- Implemented a new approach to the daily operational meetings to support information flows and recording of actions
- Implemented a frailty flag to identify patients requiring geriatrician input
- Designed an escalation plan for CDU to support continuous flow from the LRI
- Completion of a joint notes audit between GPs, commissioners and UHL clinicians – results attached

LLR KPIs

LLR KPIs were not received in time for the submission of this report. They will be circulated at a later date.

In March and April 2015 an aspirational plan for the health economy based on elements of flow improving by 10% was presented:

- 10% reduction in admissions
- 10% reduction in LOS
- 10% increase in discharges

Comparing April – August 2015 with the previous year, we have achieved:

- 7.1% increase in admissions (17.1% from aspirational target)
- 8% reduction in LOS (2% from aspirational target)
- 8% increase in discharges (2% from aspirational target). However it is important to note that a high discharge rate will partly be linked to a high admission rate. We have not seen an increase in discharges to LPT. UHL discharges to LPT and discharges from LPT remain the same as last year.

Front door improvements

Progress continues with the improvements to the front door interface between the Urgent Care Centre and the main Emergency Department. A weekly meeting chaired by Richard Mitchell is in place reporting into Emergency Quality Steering Group and Urgent Care Board. The aim is to have the front door change in place on 3 November 2015. A verbal update on this will be provided in the Trust Board.

LLR requirements

As detailed in previous months, we need to continue working as a health economy to reduce the level of admissions AND we also need to plan for a higher level of admissions than last year without impacting on elective or cancer performance. Practical steps to deliver this are required and various inititiaves that have been suggested through the Urgent Care Board include:

- If a GP referrals an emergency patient into UHL, we need to guarantee that they have been seen by a GP first
- We require the Primary Care Practitioners to be in place at the Glenfield General Hospital as soon as possible
- We need to be able to guarantee a specific number of patients discharged to community beds every day
- The left shift of activity is essential in Q3 to free up some beds on the Leicester Royal Infirmary site
- We believe a personalised communication campaign may be the best way of communicating the 'choose earlier' message to patients.

Conclusion

The emergency care that we provide remains too variable. Despite huge amounts of effort, time and energy, too many patients wait too long for care on the emergency pathway. It is likely that national emergency performance this winter will be worse than last winter and we want to ensure that our performance does not deteriorate too much. Further work is required on top of the front door change beginning on 3rd November 2015.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the UHL update against the delivery of the new operational plan
- Requests regular **updates** on the LLR wide actions identified and the introduction of the new Front Door.

Urgent Care Board

Title of the report:	ED Case Review - Summary Findings
Report to:	Urgent Care Board
Date of the meeting:	17th September
Report by:	Jane Taylor – Urgent Care Director Julie Dixon – Senior Site Manager
Sponsoring Director:	Toby Sanders
Presented by:	Jane Taylor

1.0 Introduction

The audit took place on the 8th September 2015 and used the retrospective activity from the 15th May (the date identified for the original – postponed audit).

Purpose

To undertake a "deep dive" on emergency admissions and ED attends in response to a request by the Urgent care Board in order to :

- Identify key issues or blocks to current service provision
- Failure to follow pathways
- Gaps in pathways or services provision
- Trends in presentation

Scope

- To include 24 hours of activity on a specified date
- To include all attendances to ED / CDU
- Include all emergency medical admissions via ED / CDU
- Exclude paediatrics

Process

Obtained ED and CDU records and case notes for those patients admitted

In multi-disciplinary / multi agency teams review the ED attendance and where relevant the admission process following the agreed audit pathway

The review team included representation from:

UHL – including ED consultant
LPT
EMAS
LCCCG
WLCCG

GP's
Public Health
CRT
County Social Care
Urgent Care Team

2.0 General Comments and Observations

The audit team completed reviews on 279 attendances (ED and CDU) of which 148 (53%) were admitted.

There were a number of general observations made.

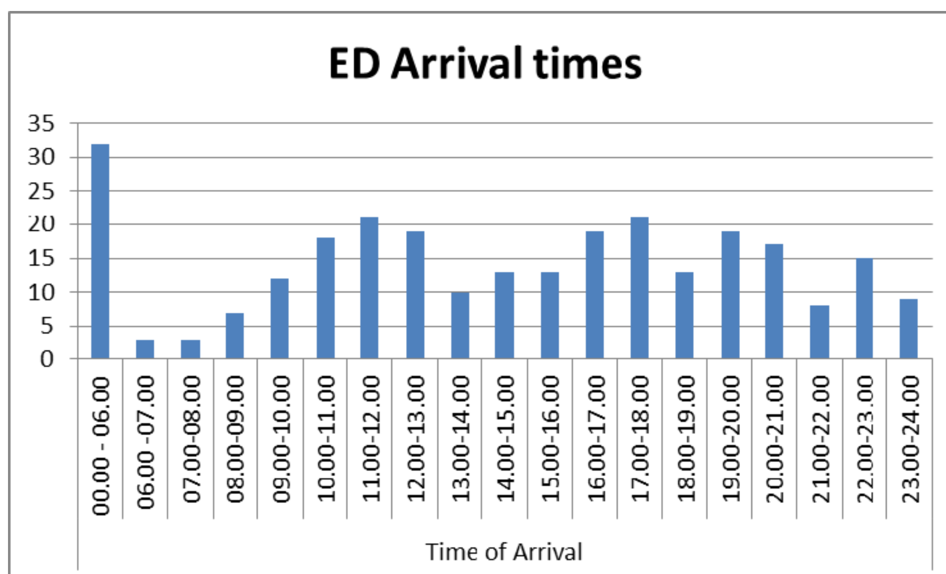
It was difficult to follow the notes – times not consistently recorded on entries, level of clinician not easily identified, and in many instances the notes seemed to stop short of showing the full plan of care for patients. It was apparent that the Cas card needed to be considered in conjunction with the EDIS record to get a fuller picture for each patient as the records are split between the Cas cards and EDIS data. However the assumptions made by the audit team are those based on the physical record. The ability to view the EDIS records on the day was very limited.

3.0 Summary Findings

ED attendances

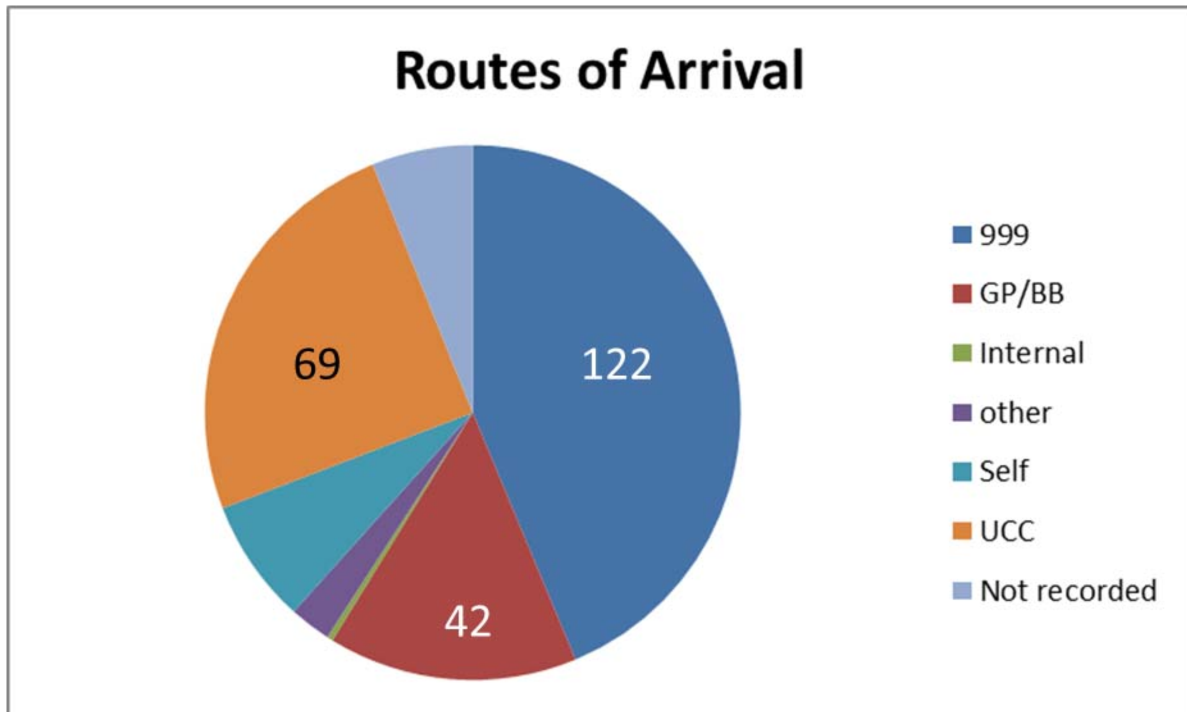
ED arrivals form 2 peaks one between 1100 -1200 and a further peak early evening at about 1800.

The early evening peak is exacerbated by the GP referrals coming through ED. Between 1700 – 2100 there were 15 -GP admits seen in ED.



Of those patients audited – 122 (43%) of attendances were 999 calls of which 76 went on to be admitted. There were 69 patients transferred from the UCC of which 11 were admitted and 52 recorded as discharged home. The 3rd highest group attending were GP /Bed Bureau

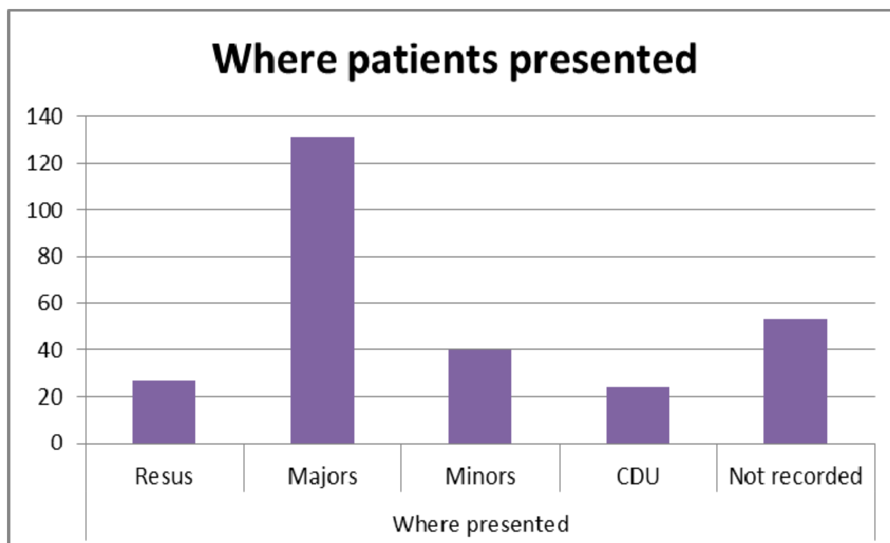
referrals routed through ED, the reason due to lack of AMU capacity rather than clinical need.



With the exception of the Resus and direct access CDU patients, all remaining ED attenders will have been triaged through the 5-6 trolley ED assessment area before allocation to an area.

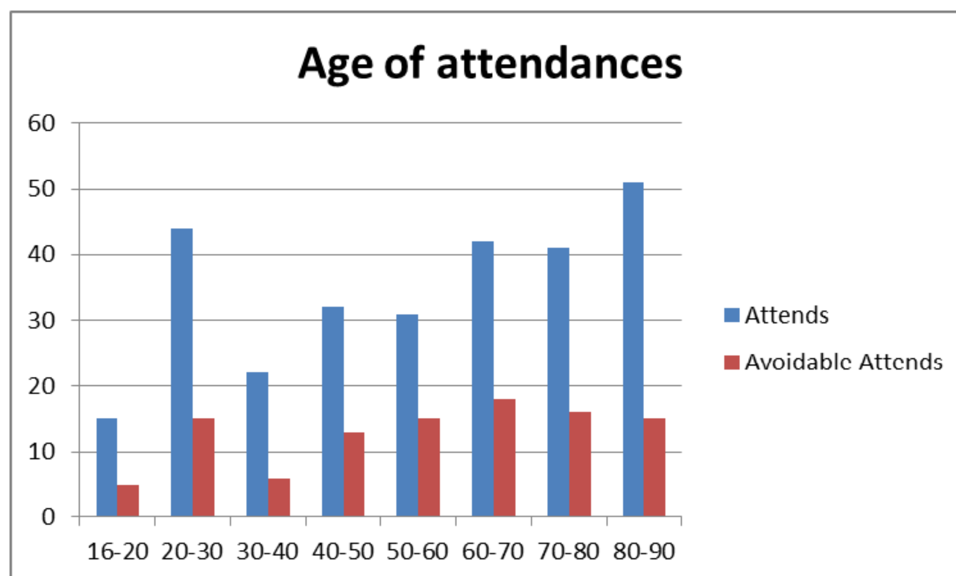
Identifying where the patients were located was a challenge from the Cas cards and the graph below indicates that area was not identified for over 50 patients. A number of patients were seen in ED and then transferred to CDU.

Of patients attending CDU all were admitted with the exception of 1.



Age of Attendees

The chart below shows the spread of ages and identifies the age groups where attendance could have been avoided by using alternative pathways. Of the 279 patients 103 were considered by the teams to potentially have been avoidable attendances.



Avoidable attendances in ED can be identified into process issues and presentational issues.

The process issues include:

- Lack of access to specialty in put via hot clinic or ambulatory pathway – orthopaedics, gynae, Urology, Plastics.
- UCC unable to request X rays
- Lack of capacity on AMU for GP access
- Lack of ability for UCC to refer directly into services
- Failure to signpost / utilise community based services
- Lack of access to community MH teams

The presentational issues include:

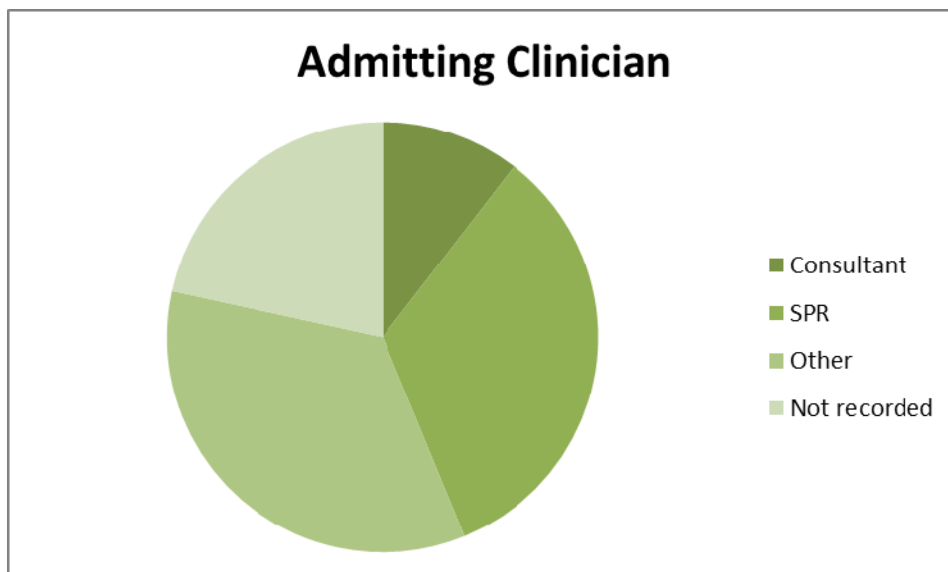
- Old injury
- History days and months old
- Minor Injury
- ED seen as a place of safety – for the vulnerable / older person
- Lack of care plan

Part of the audit sort to identify if alternative medical advice had been sort prior to ED attendance (excluding UCC attendees) 65 patients had consulted their GP prior to attendance of which 19 had referral letters.

Of all patients attending 14 had care plans and of those 6 were under 70, of the 92 patients who were over 70 – 8 had a care plan.

There were no falls identified in the cohort and no FRAT assessments undertaken by EMAS.

Admissions



The pie chart above shows the designation of the admitting clinician.

The written records suggest that only a small proportion of admissions are authorised by consultants as is reflected in the chart above, however electronic records reflect higher levels of engagement and consultation.

There were 148 admissions that were reviewed of which 27 had the potential to be avoidable, with reasons being:

Lack of available advice for a GP
Treatment could have been provided in the community
Community support not sort
Frequent fliers – lack of care plan
Alternatives not considered
Risk aversion (elder patients who live alone)

4.0 Recommendations / Opportunities

The outcomes from the audit are not necessarily surprising, with many of the blocks and barriers previously identified however to drive change and flow the following key issues should be considered as part of a positive impact on ED flow.

- Regular attenders picked up and management plans agreed across agencies.
- Ensure that care plans are in place and available for the vulnerable patients.
- Awareness of community based service and the confidence to use them needs to be explored and myths addressed both for GPs and ED.
- GP letters should be provided for all patients who have been seen and referred or where appropriate patients routed back to the GP.

- Avoidance of streaming back into ED where pathways and access to other services can be achieved, this is particularly diagnostics, hot clinics and Assessment Areas – this is particularly pertinent to UCC.
- Avoidance of GP referrals going through ED unless for clinical need. Direct access to consultant advice, hot clinics and Assessment units which are accessible easily and quickly would avoid attendance were the presentations are not emergencies.
- Use and sharing of FRAT assessments by EMAS
- Records are incomplete and would benefit from a quality audit.

Clear focus and pace is required to address these challenges.