University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper M (revised)

TRUST BOARD – 7 MAY 2015

Emergency Care Performance Report

DIRECTOR:	Richard Mitchell, Chief Operating Officer
AUTHOR:	Richard Mitchell
DATE:	7 May 2015
PURPOSE:	a) To update the Board on recent emergency care performance b) To update on Board on progress against the LLR action plan c) To update the Board on the findings from the recent Dr Sturgess visit
PREVIOUSLY CONSIDERED BY:	Emergency Quality Steering Group, Urgent Care Board and System Resilience Group
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☒ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Healthwatch representatives on UCB and involved in BCT workstream.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	None undertaken but will be in respect of new pathways within BCT.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED * For decision ☒ For assurance ☐ For information ☐	

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do** ♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together** ♦ **We are passionate and creative in our work*** tick applicable box

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

Review of 2014-15

- 2014-15 full year four hour performance was 89.1% compared to 88.4% the year before – 23rd greatest improvement out of 142 NHS providers with 110 provider's four hour performance deteriorating last year (national context).
- Over 7000 more patients were admitted (8% increase) last year compared to the year before.
- There were 76 days of +95% performance compared to 63 days the year before.
- Seven months of +90% compared to four months the year before.
- March 2015 performance finished at 91.1%.
- **Performance remained consistently below 95%.**

April 2015

- Performance in April 2015 (as of 28/4/15) is 92.7% compared to 87.2% in April 2014.
- **Attendances up 3.7% (18,341 v 17,684)**
- **Admissions up by 7.0% (6,622 v 6,188) compared to April 2014.**

Dr Sturgess visit

Dr Ian Sturgess revisited UHL for eight days in March 2015 focussing on both the Leicester Royal Infirmary and the Glenfield General Hospital. His full report is attached, with key findings below:

- UHL staff should take pride in what they have already achieved and have confidence in their ability to continue to make and sustain progress.
- Patient safety and experience have been improved by the changes.
- Continued risk of a 'supply side driver' due to local optimism within UHL.
- Better understanding across UHL that maintaining flow is an organisational issue and not just a concern for the Emergency Department.
- The wider health system needs to accelerate demand side management and utilise expertise from systems which are delivering demand control.

From the report we have identified 42 key recommendations which will be included in the reworked UHL component of the Leicester, Leicestershire and Rutland Urgent Care Board (LLR UCB) action plan. The recommendations relate to:

- Base Wards
- Acute medical Unit/ Short Stay
- CDU at Glenfield
- Cardio-Respiratory Base Wards
- Neurology
- Stroke
- Acute Frailty Pathway
- Oncology/ Haematology
- Paediatrics

We continue to work with health partners on delivering permanent improvements to the emergency pathway and as such we are pressing for the following five ambitious and deliverable goals for LLR in 2015-16 to be the focal point for activity:

1. 10% attendance reduction
2. 10% admission reduction – UHL very much has a role to play in this
3. 10% reduction in medical length of stay
4. 10% improvement in LPT supported discharge
5. Improvement in CDU and ED productivity and grip

These are all very much in line with BCT but need to happen quicker than the current plans. Detailed modelling has shown that delivering anything less than all five of these will result in another winter of poor patient experience and extreme pressure on staff.

The five key risks identified in the last Trust Board report remain.

Conclusion

To achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy stops overall improvement.

Concerns remain about the rising level of admissions and plans to resolve this. We must therefore set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are rapidly met.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the findings from the second Sturgess visit
- **Note** the UHL update against the delivery of the new operational plan
- Seek **assurance** on UHL and LLR progress

Dr Ian Sturgess
IMP Healthcare Consultancy

9th April 2015

Mr John Adler
Chief Executive
University Hospitals Leicester NHS Trust

Dear John

Re: Feedback Report on Emergency Care Pathway at UHL.

Thank you for inviting IMP Healthcare Consultancy Ltd to return to review progress against some of the key recommendations within our report of November 2014.

In November it was noted that there had been 'early green shoots' of improvement occurring within UHL and a concern expressed at that time was that unless the demand side was more effectively managed by the wider system, there was the potential for a 'supply side driver' to develop. There has been further definite improvement, the 'green shoots' are now 'tender green stems', these need to be nurtured and developed further to become hardy stems and beyond. However, emergency admissions have continued to rise and there is little evidence of impact of the 'demand side' controls having much impact as yet. The risk of a 'supply side driver' due to local optimisation within UHL remains and the wider system does now need to accelerate the demand side management utilising expertise from systems who are delivering demand control. This will require enlightened system level leadership to 'take the challenge' of working with external urgent care systems that have a track record of delivering reduced admitted demand. The present systems within LLR have not to date delivered demand management. A relatively local system based in Corby appears to have demonstrated considerable success in managing demand and there are valuable lessons or opportunities for collaboration with this model of primary care and delivery of an urgent care centre process which appears to manage a level of patient acuity above that seen within the urgent care centres within LLR.

In conversations with a wide range of staff across multiple departments, there does appear to be a developing 'belief' and 'drive' that UHL can improve its processes further and there is early optimism. The conversations concerned the 'view of the possible' as opposed to the 'challenge of the impossible' which is a very significant cultural shift. There is now a clear understanding that maintaining flow is an organisational wide issue not just an Emergency Department issue. Resilience is still some way off and fragility remains although at a significantly reduced level to previously. UHL ought to be developing an increasing level of pride in what it has already achieved and in its confidence to continue to improve. There is no doubt that patient safety and experience will have been improved by the changes already achieved and there is so much more to be gained.

There will not be a specific section in the Emergency Department within this feedback since the emphasis continues to need to be on 'afterload', downstream

flow, and 'pre-load', demand management. The Emergency Department are aware that streaming of 'stable' GP referrals direct to assessment units, a more robust urgent care centre process, a 5 team 'assessment bay' function, 60 minutes maximum to 'treatment', 150 minutes to decision, 'situational awareness' supported by 2 hourly 'board rounding' focussed on these timelines and effective escalation will deliver. An 'increase' in activity that is not out with 'common cause variability' is not a reason for these timelines to drift. An escalation process, effectively delivered, based around an over-crowding 'index' with adjustment for the 3 main additional variables which can cause the ED to become challenged, namely, extent of resus cases, volume of children's cases and exit block, should ensure consistency of delivery. The escalation needs to be triggered early rather than waiting for over-crowding to occur. The EY modelling of the impact of each patient over a certain level within the majors area on journey times is impressive, as is the modelling of the number of assessment teams, inflow, exit block and even including the impact of the numbers of porters available..

There has been a strong focus on getting 'simple' discharges more timely and there is a need for this to continue. However, as a significant risk to the system, the extent of focus on the 'frailty' pathway has waned and this explains why the potential significant number of empty beds across the system has not materialised. The stranded patient metric and the 'direct return home rate' for patients aged 75 and over have not significantly improved as yet. It was disturbing to see the presentation of the 'improved delayed transfer of care' metric at the urgent care board. It was immediately apparent that this 'improvement' was as a result of a 'change in counting' with no evidence presented on how patient journey times had been improved. The LLR system was effectively 'managing the reporting' rather than 'managing the flow', essentially 'hitting the target but missing the point'.

The prevention of the adverse impact of deconditioning, a process that converts patients who could have simple discharges in to those with complex discharges and, most importantly, results in significant harm, needs to become the highest priority. It is understood that an 'integrated frailty programme' is being developed across Leicester Partnership Trust and UHL. Prevention of deconditioning, the 'Home First' principle with 'discharge to assess' for post discharge home based care needs assessment would deliver improvements in patient outcomes, particularly remaining at home, with a marked reduction in dependency on bed based solutions of the order of 150 beds or more. Programme management to support the 'acute frailty programme' is not visible and as such, the likelihood of delivering the quality and cost improvements necessary across LLR have been compromised.

A few of the high level improvements are identified below and where others have been observed at the 'day to day' level, these will be identified in the specific sections in the body of the feedback.

1. Programme management. This has been particularly well received by the clinical leaders driving the improvements. How programme management is to be continued is clearly a decision for the organisation, yet it will remain a crucial element of the ongoing improvements.
2. Governance. The Gold:Silver:Bronze process is more robust and the organisation has a far better understanding of what causes the challenges across

the patient's journey and then focusses on how these can be resolved. The daily discharge teleconference call at 11 am has become more structured and is 'supportively challenging' and includes key elements of the wider system to take away specific actions. Peer to peer reviews of key processes has as yet not become fully embedded. Peer review of long length of stay patients, board rounds and one-stop ward rounds need to be consistently delivered.

3. Clinical Leadership has continued to grow with both 'primary and secondary' leaders becoming more visible and designing and testing new ways of working to reduce variability.
4. Communication Strategy/Social Movement. This is gathering pace and now needs to spread across the wider system. The 'Exit Block' video was excellent. Celebrating more success stories, eg the Oncology 'attending model', ambulatory emergency care, the Assessment Bay, etc as well as 'individual stories' of 'what I achieved today' would strengthen the social movement further. If these can be supported by patients telling the story of an improved process, then this becomes more compelling.
5. The '4 questions' patients should be able to answer are visible as posters and there is visible re-enforcement of these principles with the 'No decisions about me without me' 'credit card' sized plastic cards.
6. Use of improvement techniques. Rapid cycle tests of charge continue to be used and the methodology appears to be well liked by the clinical teams. This could be further strengthened by building capacity and capability in improvement methodology.
7. The Medicine Consultant 'Safety' rota ensures early review of any patients waiting a bed in ED and outlier reviews after the 0800 Gold meeting. As flow continues to improve the need for this process will disappear as outliers and overnight wait for beds in ED are abolished.

OBERVATIONS AND RECOMMENDATIONS

Acute Medical Unit/Short Stay

- There has been a reduction in the variability of processes within the AMU although significant variance remains.
- Currently approximately 50%% of GP referred patients are going direct to AMU/AMC clinic, the aim is to increase this further.
- The Ambulatory Emergency Care programme has progressed and will be starting to have significant impact on flow. There remain considerable further opportunities with consistency of Consultant input, increasing the direct GP referred attends through the AEC area, direct transfer of ED referrals from the Assessment Bay utilising the AMB Score for patients who would otherwise be referred to bed based assessment.
- Use of iPads for 'order comms' and updating of Nerve Centre appears to have assisted in reducing some constraints in the system.
- The Acute Medical Clinic, which provides the AEC process, also has capacity consumed by patients who could be managed elsewhere, namely in other routine clinics and for follow up patients, a virtual space. Managing these patients in alternative settings would free up the AMC for more AEC.
- Short Stay on Ward 33 is delivering between 8-12 discharges per day.

- The patients transferred to the Short Stay Unit have a 'Short Stay Pathway' form completed.
- There are inconsistencies in Consultant rostered cover such that for 50% of the week, if not more, there is not Consultant cover from early morning. This impacts on the rate of morning discharges.
- Short Stay did not report a significant delay in the writing up of discharge letters and discharge prescriptions.
- Pharmacy cover out of hours and at weekends does appear to be affecting discharge timeliness from the Short Stay unit.
- The Consultant 'Safety Rota' to review patients awaiting a bed in ED first thing in the morning and reviewing outliers is good practice. This rota will become unnecessary when there is consistent delivery of no 'waiting for beds' in ED in the morning and no outliers.

Recommendations

1. Complete the Standard Operating Procedures/Internal Professional Standards for the AMU and then clearly define roles and responsibilities with monitoring against these standards, reported daily. 3-4 key process metrics could be summarised at the commencement of each day.
2. Continue the 'Safety Rota' until there are consistently no 'waiting for beds' in ED and no medical outliers.
3. Senior review of all GP calls. If rigorously applied, up to 25% of all GP calls can be managed by a non-same day attendance route, either advice, community based options, next hot slots in routine clinics etc.
4. Ambulance/Transport service to convey those GP referrals that do need to attend within 1 hour of GP request for transport
5. Ensure consistent Consultant cover of the AMC/AEC area.
6. Aim for 20-25% of the Medical take being managed through an AEC process, consider renaming the Acute Medical Clinic to align it with AEC.
7. Ensure that only patients who would otherwise have attended either via ED or as a bed based same day acute assessment are seen in the AEC area.
8. Continue to increase the proportion of GP referrals arriving direct in to the AEC area, aiming for 80-90% of GP referrals not going via ED. Only those with physiological instability need to go via ED.
9. Ensure consistent 7 day early morning Consultant cover, with appropriate support, of the Short Stay Unit to facilitate morning discharges.
10. Process map and optimise the dispensing of discharge prescriptions across the AMU and Short Stay for out of hours and weekends.

Medical Base Wards

- There has been some Peer to Peer reviewing of Board Round processes.
- There is an improved focus on expected date of discharge and clinical criteria for discharge although this is not fully embedded.
- The daily discharge review meeting at 11am is much more robust than last year aiming to ensure timely preparation of discharge letters/prescriptions, pre-booking transport, encouraging the use of the discharge lounge, etc. There is improved engagement with LPT and Social Care to sup[port discharges.
- Consistent peer review of 'one stop' Ward rounds is not consistently in place

- Peer review of long length of stay patients has not been consistently delivered.
- There remains risk averse behaviour relating to discharge home

Recommendations

1. Re-implement the Peer review processes, particularly for the 'long length of stay' reviews but importantly for the Board Rounds and One Stop Ward rounds.
2. Put in place simple 'standard operating procedures' or 'internal professional standards' on 'long length of stay reviews', Board Rounding and One stop ward rounds against which Peer to Peer review aims to manage the variance. The SAFER care bundle from ECIST is a useful starting point.
3. Re-enforce the 'Home First' principle'.

Acute Frailty Pathway

- This flow-stream does not appear to have been prioritised to the extent recommended in the feedback report in November 2014.
- There is no specific programme management for this flow-stream.
- There have been improvements in some cross organisational working to support discharge.
- The acute frailty front door process appears to have stalled due to lack of availability of Consultant Geriatricians. The system remains dependent on the Acute Frailty Unit, through which probably less than 50-60% of older people with frailty with acute medical problems actually pass through.
- As a consequence, the potential extent of reductions in the stranded patient metric and the expected rise in direct discharge home from UHL for patients aged 75 and over has not materialised.
- It is by optimising this flow-stream that the system will be able to release considerable numbers of beds across the system, both acute and community.

Recommendations

1. Ensure a focus on the frailty pathway to minimise in-hospital deconditioning as recommended in the November feedback.
2. Provide programme support to this flow stream to support the delivery of the expected reductions in occupied beds.

Neurology

- Neurology has implemented a 7 day attending model.
- Daily Consultant Neurology Board Rounds are in place.
- Run Chart shows a mean discharge rate of 22-24 per week from July 2014 to March 2015 compared to 15 per week throughout last year.
- An AEC Neurology rapid cycle was tested and was perceived as successful, aim has been to implement this for the week beginning 23rd March 2015. Bed occupancy restricted this PDSA.

Recommendations

1. Continue PDSA cycles of AEC Neurology area on Ward 24.
2. Continue to reduce 'admit for investigation' patients. This is deliverable through ambulatory care or through standard outpatient processes.
3. Further develop the in-reach process to AMU, as Neurology AEC expands, the numbers of neurological cases admitted to AMU should be reduced significantly.

4. Ensure that the direct emergency admits or AEC patients attending the Neurology ward are assessed in accordance with the Keogh standards.

Stroke Medicine

- It was reported that there remain variances on the discharge/transfer rate from the Acute Stroke Wards dependent on which clinical team is 'attending'.
- There are considerable differences in discharge rate between the community stroke units with ward 3 at the Leicester General Hospital having the lowest rate.
- It is reported that there is a difference in the case-mix between the community stroke units with the Leicestershire County units taking a mixture of stroke and non-stroke patients whilst Ward 3 remains solely a stroke unit. In addition, the early supported specialist stroke discharge service is much more mature in Leicester City area with the potential that the remaining in-patients have a much higher dependency.
- There remain considerable issues relating to complex discharge (both generic and stroke specific) and the CHC process across the system. If this latter issue were resolved, the need for community stroke beds would considerably reduce.

Recommendations

1. Analyse Stroke bed resource utilisation across patient journeys to understand the differential between community stroke units and Ward 3.
2. Minimise system delays with regards to discharge processes for complex patients, this is a generic recommendation.

Oncology/Haematology

- Oncology has implemented an attending model for the in-patient wards with a reduction in a length of stay and very positive feedback from trainees and nursing staff. This has not been implemented in Haematology.
- Oncology have recommended a 'ward based team' approach with Doctors in training being shared across Oncology and Haematology.
- Community based transfusions for patients' with predictable transfusion needs has not progressed as extensively as it could have done.

Recommendations

1. Implement an attending model in Haematology.
2. Implement the shared ward based Junior medical staff as proposed by Oncology.
3. Ensure that the community based transfusion programme is implemented in full to release Haemato-oncology day unit capacity.

Paediatrics

- Presently 'two' of the Paediatric Consultants provide Children's Assessment Unit (CAU) cover.
- Consultant presence not mapped to 80th centile of presentations (commencing at 0800 hrs)
- Staffing levels on CAU not consistently robust.
- There are 'legacy issues' regarding clinical risk.
- Lack of HDU facilities for Children – partly due to long term patients who could be managed in the community if there was service for them.

- 10% (high) of admissions are in children < 1 week old. It was reported that this may be due to a combination of early discharge post-partum and Community Midwifery cover. Community midwives are visiting on day 5 as opposed to day 3 which can result in children who have not 'attained 'stable breast feeding becoming dehydrated, weight loss, at risk of hypoglycaemia and competencies re phlebotomy etc for monitoring of jaundice.
- Rule of 1/3rds of children to CAU, 1/3 can be out in < 1 hour potentially a primary care stream, 1/3 out in < 8 hours, and 1/3 very ill. Same tariff for all on CAU attendance – ward attendance tariff
- Paediatric bed occupancy persistently (including summer) above 90%, issues with complex dependent children with long term neurological problems
- There is a recognition of the need to build relationships with ED
- Number of recently appointed Paediatricians and Paediatric Emergency Consultants

Recommendations

1. Building a robust CAU rota – this is currently 70% plus in place aiming for Consultant presence until at least 2100 hrs.
2. Continue to develop a 'mutual aid and support' process across Paediatric AD and CAU.
3. Robust staffing for CAU based around the 85th centile of children's attendances and not the average.
4. Co-location of CAU with Children's ED in the new build, the processes to be tested before move into the new build.
5. Develop a Primary care stream – currently UCC GPs within Paediatric CAU, aim will be to train up to manage the 1/3 with LOS < 1 hour

Cardio-Respiratory At the Glenfield Hospital

Clinical Decision Unit

- There are 25 beds on the CDU with 2 new assessment bays, a number of trolleys and chairs and 15 short stay beds.
- With an average of 48 daily attendances over the preceding 26 weeks with an 85th centile of approximately 55 per day, if assuming a 12 hr bed turn rate, this requires 27-28 chairs/trolleys/beds for assessments, investigations and initial treatment.
- The number of short stay beds is insufficient to meet the short stay demand.
- There is approximately a 60/40 split between respiratory and cardiac cases. Although there are a number of cases with 'general medical or acute frailty problems' masquerading as cardio-respiratory cases.
- There are 24 beds on the Coronary Care Unit.
- There is one Consultant Respiratory Physician, and during the two weeks of the return visit, an ad hoc Consultant Cardiologist process covering the CDU.
- There is a proposal to test the use of the AMB score to identify the potential ambulatory cases attending the CDU.
- The Consultant Respiratory Physicians cover the CDU from 0800 to 2000 weekdays and 0800 to 1300 hrs at weekends which results in the majority of the weekend take only being reviewed on a post take next day process rather than an in-day review process. This will result in fewer short stay discharges.

- The observed Consultant Cardiologist cover was sporadic and was 'fitted in' after Coronary Care Unit ward rounds.
- CDU has EDIS in place and is able to report on timelines across the assessment process.
- Time to initial assessment (nursing) is longer than the recommended time frame of 15 minutes.
- 'Time to treatment', ie commencement of medical assessment, is considerably longer than a 60 minute standard.
- It is not clear what % of patients have a Consultant assessment within 4 hours (6 hours for the Keogh standard) of arrival (0800 to 2000 hrs). The 14 hour out of hour standard will be breached at weekends.
- It was reported that a number of cross sectional imaging is shifted to an on-call radiology rota as there does not appear to be sufficient capacity during normal working hours to deliver timely diagnostics. There can be delays in return of reports from the out of hours radiology as the on-call radiologist covers both the Glenfield and the General out of hours.
- Junior Doctors from CDU are required to provide 'medical cover' for the injection of contrast out of hours which reduces 'assessment capacity'.
- Drugs to take home prescriptions out of hours appear to require the faxing of the relevant section of the in-patient prescription chart, after pulling off the relevant section, to the Pharmacy at the LRI. This causes considerable delays in drugs to take home turnaround time for patients on the CDU.
- In conjunction with all assessment units, the complexity of the process to generate discharge summaries for zero length of stay patients consumes a significant amount of 'assessment team member'.
- With this 'consumption' of assessment team member time it is debatable whether there are sufficient Junior medical staff covering the CDU.
- There are times when there are considerable backlogs of patients awaiting assessment and senior reviews despite there being empty beds on the Glenfield site. This results in an over-crowded CDU with the attendant risks. If times to assessments and senior review could be improved, particularly for patients with the potential rapid turnaround, the over-crowding within the CDU would be markedly reduced and the need for 'stopping' the take to the CDU would be abolished.
- In patients with non ST elevated Myocardial infarction without on-going instability, there are at times delays beyond the strict evidence based benefit of early angiography and proceed of 72 or 96 hours.
- For patients with STEMI after primary PCI, there appears to be a standard 3 day length of stay for uncomplicated cases. There is some published and operational evidence that this can be safely achieved after a two day length of stay, with only the first 24 hours being in a monitored bed, for potentially 70% of primary PCI STEMI patients.

Recommendations

1. Across the 'medical' assessment units, there is a need for standardisation workforce plans utilising demand;capacity analysis, reduction/elimination of non-added value tasks using 'expected' rates of assessment per hour, reviews per hour and 'discharge tasks'. The work done within the Emergency Department on this area by Professor Tim Coats could assist in this standardisation process.

2. The volume of patients for effectively one Consultant to see is excessive and constitutes a potential clinical risk. There is a need for 2 Consultants 12 hours per day 7 days per week, one Cardiology and one Respiratory. This is probably achievable within current staffing levels following a job plan review.
3. Implement a door to nurse standard of 15 minutes, a 'door to doctor' standard of either 30 minutes or 60 minutes, and a 'door to Consultant review' of 4 hours (for 0800 to 2000 hrs.
4. Implement an evening weekend Consultant review process, from 1600 hrs to 1900 hrs in the first instance, for both Cardiology and Respiratory. Ideally, there should be two Consultant present for 12 hours a day for 7 days per week.
5. Test through PDSA cycles, the impact of a 'front door' physician in the CDU providing 'early senior assessment' as within the ED at the LRI with streaming to 'ambulatory care', utilising the AMB score in the first instance, aiming to achieve rapid turnaround of this stream of patients. Diagnostic and pharmacy support to achieve this fast turnaround will also need to be tested.
6. Out of hours pharmacy provision or 'take home' pack extension to current provision would aid in supporting early discharge from the CDU and short stay.
7. Removal of the need for an assessment team doctor to supervise contrast administration.
8. Diagnostic radiology, particularly cross sectional imaging, demand:capacity analysis for the non-elective pathway at the Glenfield and the General is required with an improvement programme to minimise delays.
9. Rationalisation of discharge documentation for zero length of stay patients.
10. Cardiology to consider the safety and efficacy of a 2 day length of stay for uncomplicated primary PCI patients.
11. A 'frailty/complex' discharge support process is required and its need will increase over time. LPT will need to consider the provision of the Primary Care Co-ordinator support process to the Glenfield.

Cardio-Respiratory Base Wards

- There is considerable variability in the 'board round' process both within and between the two specialties.
- Consultant led Board rounding does not occur 5 days per week. Well scripted, focussed Board rounds take 30 minutes or less for a 24 bedded ward.
- The Respiratory Board round observed was Consultant led, focussed on discharge, clinical criteria for discharge were not 'visible' to the whole team but did appear to 'in the mind' of the lead Consultant.
- This Board round only included the patients under that Consultant (approximately 75_80% of the ward) whilst the remaning patients had near identical 'diagnosis' profiles. Effective use of EDD and clinical criteria for discharge would allow Board rounding of all patients.
- There are 'predicated' length of stay for a variety of respiratory conditions appeared to be being used. The risk is 'regression to the mean'.
- Historically there has been an 'audit' of EDD which found that EDD did not match actual discharge date. This has been interpreted as undermining the concept of EDD. However, if an EDD is set assuming 'zero delays' and is based on clinical need alone, then this 'audit result' is very encouraging. The purpose of setting an EDD assuming 'zero delays' is to assist in the identification of the 'constraints' in the system that prevent the system delivering the EDD.
- Board rounding is more variable on the cardiology base wards.

- The extent of one-stop ward rounds is variable across the cardio-respiratory base wards.

Recommendations

1. Implement the use of EDD and CCD, using the assumed non-delays principle, to drive the case management delivery.
2. Implement daily structured Consultant led Board Rounds on all wards utilising the SAFER bundle from ECIST.
3. Identify the blocks to 'one stop' ward round delivery and rectify aiming to achieve one-stop ward rounds on all wards.

Concluding Comments

There has been clear improvement in emergency care flows at UHL despite limited evidence of demand control from the wider system. There is still more to do and there was clear evidence of improved engagement in the principles of improving flow and safety and the recognition that this is 'everyone's responsibility'.

It is becoming increasingly crucial that the wider LLR system puts in place effective demand management as the continued improvement which will occur at UHL risks becoming a very significant 'supply side driver'.

The spring and summer months are an opportunity to really drive and deliver the further improvements which UHL now has the capability to achieve.

Yours sincerely

Dr Ian Sturgess FRCP (Lon)