

# UHL Emergency Performance

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Trust Board paper I

## Executive Summary

### Context

This report was written on 17 May 2017 for the 23 May 2017 Executive Performance Board meeting. The Chief Operating Officer will therefore provide a further verbal update at the 1 June 2017 Trust Board.

The new Emergency Department successfully opened to patients on 26 April as planned. However, there was a marked deterioration in both the four-hour performance and ambulance handovers immediately following the move, which has been challenging to recover from. There are four key reasons for this:-

- Embedding the new Standard Operating Procedures (SOPs)
- Staff adjusting to their new environment meaning slower processing than normal
- Staffing in primary care and the interface with paediatrics in particular (iR35 challenges)
- Sustaining meaningful flow out of the Emergency Department

The paper outlines actions in place to improve both four-hour performance and ambulance handover times, including the new weekly ED senior group meeting as part of the UHL Organisation of Care agenda.

### Questions

1. Does the Trust Board agree with the actions outlined in the paper?
2. Are there any other actions that the Trust Board thinks we (LLR) should be taking?

### Conclusion

Our performance is far below an acceptable standard. We must continue to work hard on delivering, embedding and sustaining the key actions for this month to improve performance. Opening additional beds is key to this and we must have more than 826 acute beds on the LRI site in time for winter. We must also make sure that we get maximum benefit from our pre-existing beds and that we maximise the benefits the new emergency floor will give us.

### Our key risks remain:

1. Variable clinical engagement

### Input Sought

The Trust Board is invited to consider the issues and support the approach set out in the report.

# 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: 7 July 2017 TB

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 June 2017

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#### Four hour performance

##### April 2017

- During April we treated on average of 651 patients everyday through ED, Eye Casualty and UCC at the Leicester Royal Infirmary
- April 2017 performance was 81.0% which is slightly higher than the trajectory submitted to NHSI as part of the 17/18 planning submission –see below
- April 2016 performance was 81.2%
- Attendances were 3% up on the same period last year
- Adult emergency admissions are 1% higher than the same period last year

	NHSI Trajectory 4hr Performance	Actual 4hr Performance	Achieved?
Apr-17	80.7%	81.0%	Achieved
May-17	81.9%		
Jun-17	83.8%		
Jul-17	85.1%		
Aug-17	87.9%		
Sep-17	90.0%		
Oct-17	90.1%		
Nov-17	90.2%		
Dec-17	90.1%		
Jan-18	90.1%		
Feb-18	90.3%		
Mar-18	92.2%		

#### Ambulance handover performance

Indicators	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Ambulance Handover >60 Mins (CAD+ from June 15)	6%	6%	6%	9%	7%	9%	9%	11%	17%	13%	6%	6%	6%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	11%	12%	10%	15%	14%	15%	18%	18%	18%	15%	12%	13%	13%

##### May 2017

- Month to date (22 May) 76.6%

The move into the new ED on 26 April 2017 went well and as planned. However, there was a marked deterioration in both the four-hour performance and ambulance handovers immediately following the move, which has been challenging to recover from. There are four key reasons for this:-

- Embedding the new Standard Operating Procedures (SOPs)
- Staff adjusting to their new environment meaning slower processing than normal
- Staffing in primary care and the interface with paediatrics in particular (iR35 challenges)
- Sustaining meaningful flow out of the Emergency Department

To respond to this, the organisation enacted an internal critical incident on 2 May 2017 to maximise capacity by taking a number of key actions:

1. We reviewed the required next step for every LRI medical patient and agreed responsibility for who will take the necessary action.
2. We agreed we would operate with two streaming (VAC) nurses in Adult ED whenever possible and demand requires it to improve the streaming of ambulatory patients attending ED.
3. We agreed we would pilot using Lakeside GPs to assist with front-desk streaming decision-making as well as seeing patients. The rationale is that the primary care stream is being under-utilised and it was felt that senior medical input right at the front would be helpful. This is due to start on fully on 22 May 2017.
4. We agreed we would temporarily relocate GPAU into the new Eye Casualty Rooms with the Blue Zone to increase the space in Majors to full occupancy.
5. Ensure GPAU staffing is available between 0900hrs to 2300hrs 7 days a week
6. Review with the Emergency Floor (EF) project board the option to accelerate the move of GPAU to their permanent residence as part of phase 2 in the next 12 weeks.
7. We agreed to focus on time to be seen by a doctor, as a key barometer as to whether the department is able to function effectively. The Senior ED leadership team are revising the escalation protocols with greater focus on this metric and the actions to be taken when it deteriorates.
8. Linking to point 5, we noted that when there is flow blockage and therefore patients are waiting in Assessment, resources should be moved from Majors to keep wait to be seen down.

Other key points to note are:

- 1) Whilst our performance in hours over the last 10 days has started to show signs of improvement, our performance in the evening and early morning remains poor. We regularly go into the evening in a good position and it deteriorates dramatically out of hours. This is being reviewed as part of the weekly Organisation of Care ED Group meeting chaired by John Adler.
- 2) As detailed in the May paper, we were asked by NHS Improvement to profile our workforce. A paper was presented which indicated some modification was required with nursing shifts but the medical workforce matched the demand profile as long as there were no delays in the wait time to be seen. As with point one above, this will be picked up at the weekly ED group meeting.

- 3) IR35 continues to be challenging, and has restricted the number of GPs currently working in the primary care zone at the Leicester Royal Infirmary. It has not impacted at all on the front door streaming service.
- 4) ECIP have been present in ED over the past 2 weeks both with their ambulance representative looking at ambulance handovers and a wider team undertaking a full walk through of the patient journey. We have had verbal feedback from the latter but awaiting formal written feedback from the ambulance lead. The verbal feedback has been shared with the ED team and forms part of the ED Group weekly meeting (Appendix A shows current actions in place to respond to verbal feedback).
- 5) As detailed in point one, there is now a formal ED Group meeting weekly as part of the organisation of care agenda. This meeting is chaired by John Adler and has senior ED leadership and executive membership. Updates from this meeting will be a key feature for this paper going forward.
- 6) Ambulance handovers have been much improved in the last 10 days (circa 300 lost hours) compared to the first 10 days of the new ED opening (circa 900 lost hours). As of 15 May, our handover time continue to show improvement, with daily lost hours below 30, 0 >2 hour waits and fewer >1 hour waits; the average handover time is consistently below 30 minutes. We continue to work with EMAS to sustain this and improve further.
- 7) We have completed the ward moves between EDU, Ward 7 and Vascular Surgery to enable EF phase 2 to begin.
- 8) The EF Phase 2 governance structure has been agreed, and is now in place and has been communicated. This programme of work will run for 43 weeks. Updates will be provided as per the usual process.
- 9) Red to Green has now been rolled out at the General Hospital and is being supported by Gill Staton and Rachel Marsh.

Outside the ED, it is clear that a key main for the organisation is ensuring meaningful flow from the ED on a sustainable basis. This is one of the workstreams that sits within the Organisation of Care work. Since opening on 26 April 2017, this has remained variable both at the LRI and GGH sites. There needs to be both a 'pull and push' approach for ED which will be improved by good bed availability but also specialty in-reach into the department to ensure that our patients are moved to the right place in a timely fashion.

#### **LLR key actions**

The high impact actions in place across Leicester, Leicestershire and Rutland and tracked through the A&E Delivery Board are attached.

#### **UHL key actions for May and June are:**

- 1) Focus on ED process and wait time to be seen with particular emphasis on addressing the overnight position (1800 to 0200hrs)
- 2) Embed ECIP recommendations
- 3) Organisation of care actions (as detailed above)
- 4) Focus on continued improvement of ambulance handovers
- 5) Continued focus on R2G across the organisation to ensure meaningful flow out of the ED

#### **Conclusion**

Our performance is far below an acceptable standard. We must continue to work hard on delivering, embedding and sustaining the key actions for this month to improve performance. Opening additional beds is key to this and we must have more than 826 acute beds on the LRI site in time for winter. We must also

make sure that we get maximum benefit from our pre-existing beds and that we maximise the benefits the new emergency floor will give us.

**Recommendations**

- Note the contents of the report
- Despite some improvement over the past 10 days, note the continuing concerns about four-hour delays.

## **SUMMARY OF RECOMMENDATIONS FOLLOWING VERBAL FEEDBACK FROM ECIP VISIT 15/5/17**

### **Ambulances**

- CAD+ access in assessment bays and blue zone
- Weekly meetings with EMAS
- Greater direct use of ambulatory pathways
- Fast tracking of crews through walk-in pathway

### **Assessment Zone**

- Simplify pathway
- Calibrate and manage GP capacity
- 1 set of GPs (+/- ED GPSIs)
- Direct to clinician if no wait
- Single assessment/streaming
- Standardise VAC nurse role and ?use as co-ordinator of front door
- Protocol for GPs to request diagnostics
- Review information on patient screens in main receptions

### **Injuries**

- Reduce dwell time between patients (PDSA)
- Use a clinic model – support staff fill cubicles

### **Majors**

- Assigned nurse on NerveCentre
- Review threshold of number of major patients to prompt new arrivals to go straight in, bypassing assessment

### **Clinics**

- Minimise these
- In PED, consider rapid access alternative in CH

### **GPAU**

- Accelerate commissioning of EF2 facility
- Condition-specific ambulatory care list to maximise utilisation when GPAU closed

### **PED**

- Strengthen primary care input - mandate GP working
- Reduce drain of staff from adult ED

**Imaging**

- Dedicated portering for imaging

**Floor leadership**

- Agree “what we are doing when we are in charge”
- Identify key metrics to drive leadership actions
- Have time together as leadership team



Focus Area	Key Actions	Specific milestones/deliverables	Delivery Date	Update	Link to RAP KIAs	AEDB Sponsor	Implement. Lead	Metric	Status	System Support required
ED flow and pathways	Optimise streaming and assessment process in ED	<b>Actions and metrics to be agreed by Ffion Davies.</b> <b>TO INCLUDE:</b> <b>Review of new SOPs following move to new ED</b> <b>Deflections at front door/discharge following assessment zone contact. Meeting UHL/CCGs 3/5 to agree expected numbers of patients.</b> <b>Safe and effective staffing levels?</b> <b>Recruitment to allow RAT 24/7</b>		SOPs clinically signed off 23/3/17 including confirmation that will be RATING consistently from 26/4	KIA1	Richard Mitchell	Ffion Davies	1) Compliance with RAT in the new EF 2) Reduction in volume of breaches 3) UHL deflections/direct booking into City Hubs or other services		ECIP support, Direct booking into City Hubs, Lakeside, EMAS conveyance to UCC
	Improving Ambulance handover time	Milestones to be agreed in discussion with ECIP and EMAS	Mtg W/C 1.5.17	Milestones developed after mtg		Richard Mitchell				
	Consistent floor management 24/7	<b>New set of quality improvement metrics to be rolled out within new ED</b> <b>SOPs for new ED to be reviewed and tweaked in light of learning from move to new ED</b> <b>New Deputy HoS in place - role includes supporting teams to improve consistency of management and performance</b>		Ben Owens continues to support this and we are advertising shortly for some deputy HoS input into ED This action requires further work despite delivery date passing	KIA 1 and 4	Richard Mitchell	Vivek Pillai	1) Reduction in breaches between 2100 and 0700		ECIP support
Minimising Presentations at ED	Improving EMAS ability to access clinical opinion to avoid dispatch of ambulance	CCG to address Hear & Treat levels through contract  <b>Key Areas</b> <b>EMAS use of patient record &amp; DoS</b> <b>EMAS ability to obtain Consultant/Dr advice</b> <b>Audit and refresh of pre hospital alternative pathways for EMAS</b>  Measure of success: UHL, LPT & EMAS to be able to report monthly on the number of patients not receiving an appropriate review and the corresponding registered GP practice SLS to liaise with UHL, LPT, EMAS and Mids & Lancs CSU to understand what care homes data is available for reporting and how each activity is identified e.g. post code, RI code, Read Code or free text DHU 24/7 Home Visiting Service will be required to demonstrate that the patient has been reviewed by a clinician before conveying to acute care Dr Hurwood wrote a brief presentation for the PLT Chairs to include in the March 2017 meetings to remind of options for all clinicians for support to prevent unnecessary conveyance to hospital - this has now been delivered across LLR  <b>IMPROVE EMAS NON-CONVEYANCE</b> <b>USE OF MOBILE DoS - audit and capture of data.</b> <b>USE OF PHEMGEM - to work with Project leads and scope how this fits with EMAS</b>			KIA 2	Tamsin Hooton	Mark Gregory	Hear & Treat as a number and percentage <b>Mobile DoS Usage</b>		
	Care Home Support	<b>Support to on site crews to prevent care home conveyances to hospital &amp; ensure face to face clinical review of patients before conveyance</b>  <b>reinforcing agreed pathways</b> <b>developing feedback loop</b> <b>review current support available to carehomes in hours and out of hours</b> <b>USE OF PHEMGEM -</b> <b>Additional actions to be developed via Care Home network by 1/7</b>		Geriatrician on call support available ad hoc. CCGs have agreed extension to Consultant Connect to enable business case for future model (to include support to paramedics) to be developed. Timeframe for this Nov.	KIA2/3	Rachana Vyas???	Tamsin Hooton/Mark Gregory/Sue Jevons	TBC		Clinical resource to be identified to be located in EOC, may require funding. Rapid response from GP/OOHs/SSAFA or community teams.  DHU 24/7 Home Visiting Service will disseminate support to care homes to understand assessment of patients and appropriate use of 999 resources
Reduce delays within hospitals	Implement the SAFER Patient Flow Bundle and Red2Green days approach to reduce delays for patients in adult inpatient wards across UHL.	Review of the current implementation on medical wards - identifying issues and barriers - lessons learnt Develop a phased implementation roll-out plan for SAFER/Red2Green across all adult inpatient wards in UHL. Strategic support from UEC Team to deliver strategic service improvement Develop educational tools and provide educational support of staff to implement SAFER and R2G. Compile action log of 'key delays' and work with teams to reduce these delays  Red2Green is method of reducing delays by days effectively and improving the patient experience this is being conducted by using discharge lounge and becoming reliant on portering and HCA services. A further cohort of HCA's are being trained and an actions plan will be developed to show progress.	May 2017 June 2017 July 2017 April 2017	Red2Green now in place on 14 medical wards at LRI and 3 medical wards at LGH. Official Launch to 3 Renal wards LGH in May and 13 Respiratory/Cardiology/ Cardiac wards at GH in June. Sustainability plan being written to have a permanent team for implemenation and to support further roll out. Red to green now in place in ESM and RRCV. Full update provided last time. We need to increase the size of the R2G team to support further roll out  Work beginning in other CMGs Detailed SAFER metrics are now published weekly Rapid flow came to EQSG last week and requires additional staff to delive consistently.	KIA4	Richard Mitchell	Gill Staton	1) Increase in the number of discharges before 10 am and 12 noon 2) Increase in the number of medications written day before discharge 3) Reduction in stranded patients 4) Increased usage of the discharge lounge 5)Reduction in length of stay.		Links to discussions about restructuring UHL discharge team/process including PCC and CHC. Needs right level of reporting of R2G issues and especially stranded patients to the AEDB and DSG
	Implement the SAFER Patient Flow Bundle and Red2Green days approach to reduce delays for patients within the community hospital setting	TBC - new HIA					TBC	Nicki Beacher		

Informatics updates for metrics

Data available and reported in EQSG metrics

Data available - pts breaching after 7pm reported in EQSG metrics

EMAS reporting activity breakdown across S&T, H&T

Key metrics and reporting to be identified

From NerveCentre - separate discussion between Richard and Tamsin. Julie Dixon is the lead.

	Rapid Flow	Develop a roll out plan and Standard operating procedure for rapid flow from ED/ assessment units to inpatient wards across UHL. LPT transfer in the morning (8am) process Transport issues - review and improve internal processes around planning for arranging transport to discharge before 12pm TTOs - improve process within ward rounds and ensuring timely TTOs		Rapid flow came to EQSG last week and requires additional staff to delive consistently.	KIA4	Richard Mitchell	Julie Dixon UHL to confirm lead	1) Increased number of patients transferred from the assesment units before 10am. 2) Reduced time of bed request to transfer. KPI's to be developed		
Improving Complex Discharges	Improve daily processes for discharge co-ordination and escalation processes, including interface with CHC	Review daily CHC call to determine whether all stakeholders are accessing call appropriately and monitoring impact of call on CHC delays within the system Monitoring the weekly senior escalation meeting, reviewing process and demonstrating impact on bed day delays			KIA 4 and 5	Tamsin Hooton	Yasmin Sidyot/Claire Hinchley	1. Numbers of DTOCs 2. Number of CHC or fast track patients not completed by 28 days/48 hours		Support from ELR CCG, CSU and social care. Note dependency on sufficient D2A/PoC/P3 capacity to facilitate discharges
	Increase capacity in P2 and P3 to support discharge including discharge to assess	P2: i)Reviewing impact of HTLAH ii)Working with County LA colleagues to improve HART discharges iii)Proposal for additional DRT capacity to make up for shortfall in capacity. City procurement for new providers - to monitor and review the impact of recently procured City Dom Care P3: Evaluation of Peaker Park to develop long term business case Kingfisher business case to be shared with CCG Boards for approval Assessing case management and therapy capacity Scope requirement for possible medical step down by UHL		i) risk on HTLAH procurement not identifying additional providers ii) DRT proposal to AEDB in April P3: Spot purchase of 10 beds in City in place -first patients admitted week beginning 20/3 iii) Evaluate Peaker Park beds, readmissions etc iv) Develop business case for Kingfisher (by 17/5)	KIA 5	Tamsin Hooton	Claire Hinchlkey/Yasmin Sidyot/ Jeremy Bennett	1. Number of patients MFFD awaiting POC 2.Reduction in DTOC		Additional therapy resource required for any increase in beds (staffing and funding). .County to confirm plan B on procurement. Additional case management resources required, could link to development of an integrated discharge team (health and social care), intense engagement with care home market, successful 'patient choice' messages
	Integrated Discharge Team	Commence design phase including use of PDSA to test proof of concept Reccomendations Paper to SDP SLP Commence pre-implementation phase go live with the Integrated Discharge Team	April 2017 May 2017 June 2017 July 2017	Highlight Report from Tiger Team		Tamsin Hooton	Julia Eames/Claire Hinchley - Integrated Discharge team support	TBC	TBC	