UHL Emergency Performance

Author: Richard Mitchell, Chief Operating Officer **paper H**

Executive Summary

Context

For the paper to be submitted to Executive Performance Board on time, this paper was written on 22/3/17, before the benefits of the take down of elective surgery were seen. A verbal update on the performance since 22/3/17, when performance has averaged 92%, will be given in the meeting.

Despite a number of plans and initiatives to sustainably improve and maintain our performance against the four hour standard and ambulance handovers, March has been another difficult month.

We know that when we have available beds – by increasing our capacity – both four hour performance and time of ambulance handovers improves. When we reduced our bed occupancy in February for ten days by cancelling electives, we moved from 77.5% four-hour performance, to 91% performance for the period when we had reduced elective work. Performance hovered at around 84% for a period after but has been more difficult since. We called another critical incident on 21 March 2017 and have taken down elective work again.

We have committed to explore all opportunities to remove the imbalance between demand and capacity and the initial plans for doing this includes:

- Delivery of all pre-existing actions including Red to Green and GPAU opening hours expansion
- New actions involving UHL working more effectively downstream to care for step down patients in a non-acute setting
- New actions to increase our bed base at the Royal Infirmary and Glenfield (this is in line with the Sustainability and Transformation Plan/UHL five-year Reconfiguration Plan)
- New actions to transform the hospital pathway for frail, complex patients
- New actions to separate emergency and elective work

April will see the opening of our new ED; work continues in earnest to prepare the environment and familiarise the staff to the new ways of working in the department.

Questions

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

Conclusion

Although the medium-long term aim is to reduce acute beds, in the short term there is evident need for expansion. The proposed location of additional capacity is compatible with our longer term reconfiguration plans. We have 826 beds at the LRI. If we go into winter 2017/18 with 826 beds at the LRI we will have failed - if we do the same thing

over and over again, we cannot expect different results. Whilst we own the risk we currently do not control the risk – this is all about being solution focused.

The pressure on our emergency care system is unrelenting as we move into Spring. It is essential that we urgently reprioritise the work needed to develop:

- New actions to separate emergency and elective work
- New actions involving UHL working more effectively downstream (out of UHL) to care for patients in a non UHL setting
- New actions to increase our bed base

The move to our new ED on 26 April, whilst exciting, a major focus of work for the team to ensure the environment is set up and ready to receive patients; the level of work needed should not be underestimated, especially on top of day-to-day operational pressures we are experiencing.

Our key risks remain:

1. Variable clinical engagement

Input Sought

The 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: March 2017
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: **6 April 2017**

For the paper to be submitted to Executive Performance Board on time, this paper was written on 22/3/17, before the benefits of the take down of elective surgery were seen. A verbal update on the performance since 22/3/17, when performance has averaged 92%, will be given in the meeting.

Four hour performance

2016/17 YTD

- We are treating an average of 653 patients everyday through ED, Eye Casualty and UCC at the Leicester Royal Infirmary
- 16/17 performance YTD is 79.2% and February's performance was 83.8% - best monthly performance since December 2015.
- 15/16 performance YTD was 87.8% and February 2016 was 80.2%
- YTD attendances 5% up on the same period last year
- YTD total admissions are <1% higher than last year (noting the impact of GPAU)

Sustainability and Transformation Fund (STF)

February's STF was not achieved and March's will not be achieved. As we've seen in previous months, struggling to deliver the emergency care STF also impacts on our ability to deliver the Cancer and RTT STF.

	STF Trajectory 4hr Performance	Actual 4hr Performance	STF Achieved?
Apr-16	78%	81%	Achieved
May-16	78%	80%	Achieved
Jun-16	79%	81%	Achieved
Jul-16	79%	77%	Not Achieved
Aug-16	80%	80%	Achieved
Sep-16	85%	80%	Not Achieved
Oct-16	85%	78%	Not Achieved
Nov-16	85%	78%	Not Achieved
Dec-16	85%	76%	Not Achieved
Jan-17	89%	78%	Not Achieved
Feb-17	89%	84%	Not Achieved
Mar-17	91.2%		

March 2017

- Month to date – 1-21 March: 80.52%

Despite a better start to the month, following a reduction of the elective load in February and rebalancing our emergency activity, it is clear that emergency care performance, as measured by four hours and ambulance handovers, has deteriorated over the last ten days, despite a number of agreed improvement actions being in place. Following a

period of continued high occupancy, minimal bed capacity and infection prevention issues, a critical incident was put in place on 21 March.

The key reasons for this position are:

1) Flow out of the department has dramatically worsened
2) Influenza and Norovirus at both Glenfield and the Royal Infirmary restricting access to beds
3) High paediatric activity
4) An 8% increase in attendance during w/c 13 March, compared to the four weeks before
5) The clinical teams are increasingly stretched training and preparing for the move to the new ED whilst running the old ED
6) High Delayed Transfers Of Care (DTOC)

These key reasons are in line with our key themes:

- Imbalance between demand and capacity
- Increasing demand
- Variability of medical leadership
- Transition to new ED

We continue to work on a number of key actions to address the main themes and improve our position, including:

1) We have a five point plan with the objective of rebalancing demand and capacity this year (more details below). In addition, 18 more medical beds will come online at the Royal Infirmary on 12 May 2017 when vascular moves to Glenfield, if we can staff them. Before then, the only way to increase capacity is taking down elective work again and reduction in internal and external delays.
2) Red to green methodology has rolled out to Glenfield and the majority of key wards now have red to green methodology in place. We now need to strengthen the size of the team to roll out this successful approach further.
3) The Chief Operating Officer (COO) meets with the ED consultants every morning, afternoon and evening to understand the position within the department.
4) The requirement to separate, on a day to day basis, the opening of the new EF from day to day running of the department. This is easier said than done, because of staff shortages and the sheer amount of work that goes into moving our busy service to a new environment (further details are included later on in this report).
5) Implementation of twice weekly face to face meetings with our partners, to discuss external delays and how we can strengthen the data available to give us all a true and clear picture of the position across the emergency care pathway.

Rebalancing capacity and demand

As discussed last time, we know that when we have available beds – by increasing our capacity – both four hour performance and time of ambulance handovers improves. When we reduced our bed occupancy in February for ten days by cancelling electives, we moved from 77.5% four-hour performance, to 91% performance for the period when we had reduced elective work. Performance hovered at around 84% for a period after but has been more difficult since. We called another critical incident on 21 March 2017 and have taken down elective work again.

Not only is the cancellation of operations a poor experience for our patients, it is also very costly for us. In February we cancelled circa 450 patients, at a cost of approx. £800,000. This is not a sustainable option moving forward therefore we are prioritising the rebalancing of our capacity and demand – our aim is to align our capacity with expected demand in order to improve the quality of care and performance against our access standards. Whilst we know this will not be easy, it is a must for us.

The initial plan for doing this includes:

- Delivery of all pre-existing actions including Red to Green and GPAU opening hours expansion

- New actions involving UHL working more effectively downstream to care for step down patients in a non-acute setting
- New actions to increase our bed base at the Royal Infirmary and Glenfield (this is in line with the Sustainability and Transformation Plan/UHL five-year Reconfiguration Plan)
- New actions to transform the hospital pathway for frail, complex patients
- New actions to separate emergency and elective work

A verbal update will be provided at the meeting.

Other key actions in March

1. Continuing work with the ED team and the Emergency Improvement Programme (ECIP) to understand how care and performance can be improved between 1800 and 0200

Following the ECIP visit in February, work continues to implement new ways of working based on the recommendations in their report, including: reviewing and improving the bed management model across the Trust; working with partners to reduce the number of inappropriate referrals to ED from GPs; embedding new internal professional standards that focus on swift movement to inpatient beds when they become free; and reviewing how UCC works out of hours.

2. Sustainably staff GPAU for extended periods

Following agreement to extend the hours of this successful service both at the weekend and during the week to 11pm, it has been agreed that this will begin from 26 April, in line with the move to the new ED. For the period of construction of phase 2, GPAU will be based in the new ED, thus maintaining the strong working relationship and flow of patients between the two teams.

3. **Reduce ambulance handovers, including: proactive cohorting in line with the policy, continuation of GP in EMAS Fast Response Vehicle (FRV); and ensuring full usage of discharges lounges at both LRI and GH**

We have seen some improvement in handover times from EMAS. The use of the cohorting process (as outlined above), alongside the actions taken during the System Critical Incident in January will have impacted on this. Handover data (CAD+) is detailed below:

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

The improved position in February is largely due to the ten-day period of cancelled electives and impact of available capacity and increased flow across the hospital. In March we have already had a number of significant handover delays due to increased pressures on our emergency care pathway.

4. **Red to Green**

Red2Green has successfully begun on the wards at Glenfield. The teams, both at Glenfield and the Royal Infirmary, continue to embed the approach with wards through coaching sessions. Morning discharges, TTO's written the day before planned discharge, and earlier use of the discharge lounge continue to be key priorities, alongside the ongoing review of stranded patients with system partners. The team is also looking at how to improve early morning flow from the assessment units to wards, meaning earlier flow from ED.

A new area of focus is the work that has started with both internal colleagues and external partners to improve some of our processes that result in delays to the patient journey.

5. Preparing for the move to the new ED

The new ED was officially handed over to UHL on 6 March from Interserve Construction Limited. Soft commissioning in

the new department continues, alongside key operational activities including staff familiarisation and installing of medical equipment and supplies. The team remain on track to open the new department to patients on 26 April at 4am.

Over the last few months, the clinical teams have been working on developing their new and updated Standard Operating Procedures (SOPs), which outline how teams will work in the new Emergency Department (ED). This work culminated in a walkround of the patient pathways, with the COO and deputy medical directors, led by the ED head of service, lead nurse and service manager. This gave the teams an opportunity to demonstrate new models of care, improved flows, and updated escalation processes for the new environment. This was a useful session, and clearly demonstrates the enormous amount of effort that the teams have put getting these important documents right, so that patients flow through the department as effectively as possible.

6. Preparing for Easter

Working with our system partners, we have submitted our plans for Easter preparedness and assurance to NHS England and NHS Improvement this month. Our response outlines our planning expectations, preparations and actions that each key service within the system will be taking to ensure that services are planned and equipped appropriately to manage demand.

Some of the planning expectations of us and our partners for the period of Wednesday 12 April to Wednesday 19 April outlined in the letter from NHS England and NHS Improvement include:

Acute providers

- All trusts should aim to reduce bed occupancy to 90% by the day before Thursday 13 April
- Weekend discharge teams will need to be in place with the right authority to facilitate swift discharge over the Easter period
- The profile and volume of elective activity should be agreed with regional colleagues regarding the impact it may have on ED performance

Primary care

- CCGs should ensure there is primary care access available on every day of the bank holiday weekend
- CCGs should be assured around commissioning additional primary care capacity (additional GP sessions) for the holiday period
- CCGs should ensure all OOHs services in their area are fully staffed and well sign-posted

NHS 111

- All plans will be assured (and challenged if appropriate) against modelling of predicted call volumes to ensure sufficient capacity in place to respond to demand and challenged where insufficient capacity identified.

Out of hospital urgent care

- All systems that have urgent care centres co-located with their EDs are to have primary care streaming in place 8am-11pm 7 days per week by Easter
- CCGs will need to ensure all other MiUs, UCCs and walk-in centres have sufficient capacity in place to meet demand over the bank holiday period
- CCGs will need to ensure that local Directories of Services (DoS) are up to date and live to ensure all out of hospital urgent care services fully utilised as clinically appropriate, so that the ED is not used as a default

Our system response to Easter is particularly important this year, as it is only one week away from the opening of our new department on 26 April, so we are committed to ensuring our plans are as robust as possible.

7. Working with system partners on key action areas

As highlighted in last month's report, the focus of the Recovery Action Plan has moved to high impact actions. For UHL, they focus on consistent floor management 24/7, optimising the streaming and assessment process, and reducing delays with Red2Green and Rapid Flow. These key areas align with the work being done already, either in preparation

for the opening of the new ED or in improving our flow out of hospital. Following this shift of focus, EQSG now discusses the high impact action areas and progress towards their achievement.

8. Responding to national call to action: 'Getting A&E back on track'

Along with all of the NHS, we received a letter from NHS England and NHS Improvement on 9 March, which outlined a number of key action areas for us to focus on to 'get A&E performance back on track' in 2017. The letter asks us to focus our efforts in the following areas:

- Freeing up hospital bed capacity by both working with adult social care colleagues to ensure patients are moved out of hospital when they are medically fit for discharge, as well as improving timely handoffs from A&E clinicians to acute physicians; ensuring discharge to assess is working effectively; and streamlining continuing healthcare processes. This must all be in place by October 2017.
- Managing A&E demand, in particular by ensuring there is a comprehensive front door streaming model in place, and giving care homes direct access to clinical advice in an attempt to reduce conveyances to hospital.

In addition, the letter states that, given the national importance of improving NHS urgent and emergency care performance, the focus of the 30% performance element of the Sustainability and Transformation Fund (STF) for 2017/18 will be simplified, so that it will focus on A&E rather than requiring providers to focus on multiple objectives. For individual trusts it will be linked to effective implementation of the actions set out above as well as achieving performance before or in September that is above 90%, sustaining this, and returning to 95% by March 2018.

This important letter was discussed at the recent A&E Delivery Group; a further verbal update will be provided at the meeting.

Overall in March

Despite a more-promising start to the month, March has been yet another difficult month, further exacerbated by a high number of infection prevention issues meaning the closing of some ward beds. The critical incident called in the middle of the month highlights this poor position.

Our work on rebalancing demand and capacity is now more critical than ever, as discussions about cancelling electives due to emergency pressures are now common place; this is not good for patients and we need to find a sustainable solution. The plan we have in place now needs to be developed at pace, and tangible, robust actions put in place to help us get to a steady position. The new ED, whilst a really exciting time for our hospitals, will rely on flow across the pathway if it is going to function effectively; this must now be our priority for resolution.

As move to within one month of opening our new ED, the pressure on our staff has increased tenfold to not only provide day-to-day care to our patients, but to support the delivery of the new department so we are operational on 26 April. This is challenging for everyone, and I want to thank them for their hard work and commitment.

Key actions for April

Key actions for the next month (noting they are continuing the themes from last month) include:

1. Developing robust plans to rebalance demand and capacity
2. Successfully moving into our new ED and opening to patients on 26 April
3. Continue to embed Red2Green with RRCV CMG at Glenfield, and with all wards through coaching sessions.
4. Work with our system partners to agree plans and next steps in response to the national letter to get A&E performance back on track

Risks

The key risk is:

1. Variable clinical engagement

Noting that the actions over the last month have reconfirmed, beyond reasonable doubt, that we have insufficient capacity, and that we must take every possible action including increasing our bed base, our key risk remains variable clinical engagement across the emergency care pathway.

It is also important to recognise, again, the three other risks which may increase in 2017-18:

1. We already do not have sufficient capacity to care for all our patients and the gap between demand and capacity (beds) will increase next year unless the best case scenario in contract planning occurs. This strengths the point above.
2. The gap between demand and capacity at GGH will increase in the winter 2017-18 because ward 23A will have vascular patients in it from May 2017. We need to; increase ward capacity at GGH, see a reduction in demand, further increase our discharge rate or reduce the elective work on that site.
3. We now have less than 35 days until the new Emergency Floor (phase one) opens and we need to ensure staff are supported to get the induction they need ready to work from 26 April.

Conclusion

Although the medium-long term aim is to reduce acute beds, in the short term there is evident need for expansion. The proposed location of additional capacity is compatible with our longer term reconfiguration plans. We have 826 beds at the LRI. If we go into winter 2017/18 with 826 beds at the LRI we will have failed - if we do the same thing over and over again, we cannot expect different results. Whilst we own the risk we currently do not control the risk – this is all about being solution focused.

The pressure on our emergency care system is unrelenting as we move into Spring. It is essential that we urgently reprioritise the work needed to develop:

- New actions to separate emergency and elective work
- New actions involving UHL working more effectively downstream (out of UHL) to care for patients in a non UHL setting
- New actions to increase our bed base, if necessary

The move to our new ED on 26 April, whilst exciting, a major focus of work for the team to ensure the environment is set up and ready to receive patients; the level of work needed should not be underestimated, especially on top of day-to-day operational pressures we are experiencing.

Recommendations

- Note the contents of the report
- Note the continuing concerns about 4 hour delays and ambulance handovers in particular and the actions in the refreshed high impact actions that reflect the improvements that can be made within UHL to improve performance.
- Note the continued pressure on clinical staff with increasing demand and overcrowding
- Note the increased pressure on staff as we move towards opening the new ED, recognising the extraordinary efforts by members of the team to go above and beyond to ensure the move goes smoothly.