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<b>Meeting:</b>	<b>Brighton and Sussex University Hospitals NHS Trust Board of Directors</b>
<b>Date:</b>	<b>31st May 2016</b>
<b>Board Sponsor:</b>	<b>Dr Mark A Smith Chief Operating Officer</b>
<b>Paper Author:</b>	<b>Andrew Stenton Interim Deputy Chief Operating Officer - Emergency Care</b>
<b>Subject:</b>	<b>Urgent Care Transformation</b>

### Executive summary

This report updates the Board on progress within the Emergency Care pathway, describing progress in the Level 5 Plan and *Right Care, Right Place, Each Time* programme; together with the introduction of a single clerking process on the Acute Floor and changes to the configuration of wards within the Barry Building – all of which are designed to improve patient flow and the standard of patient care.

The report further describes performance against the 4-hour Accident and Emergency standard since the last Board meeting and the challenges to performance on both the Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) sites.

<b>Links to corporate objectives</b>	Securing sustained improvements in emergency and unscheduled care is critical to the delivery of the corporate objectives of <b><i>excellent outcomes</i></b> ; and <b><i>great experience</i></b> .
<b>Identified risks and risk management actions</b>	<b><i>Patient safety and experience; performance against the 4-hour A&amp;E standard; organisational reputation.</i></b>
<b>Report history</b>	Previous reports on Emergency and Unscheduled Care have been made to FPPC and Trust Board monthly in 2015 and 2016.

### Action required by the Trust Board

The Board is asked to note the report and the on-going work to make sustained improvements to the urgent care pathway; performance against the 4-hour Accident and Emergency standard and the challenges and risks to performance.

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## Report to the Board of Directors, 31st May 2016 Urgent Care Transformation

### 1. Introduction

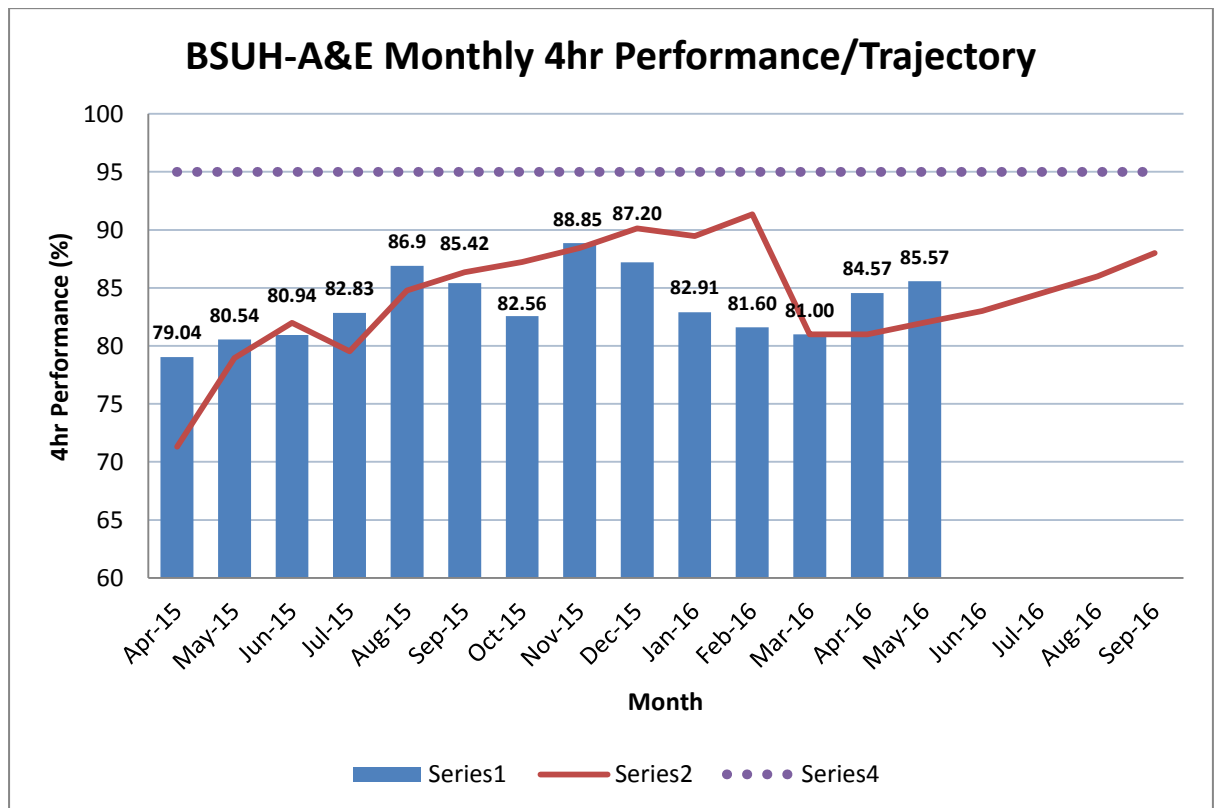
Emergency Care performance is under significant external scrutiny allied to the absolute priority given to it by the Trust as seen in previous Trust Board reports and the annual plan for 2015/16. After inviting the national Emergency Care Intensive Support Team (ECIST) to review its emergency care pathway, there was an unannounced 48-hour visit followed by a recent full inspection by the Care Quality Commission (CQC). In addition to these forensic visits, the Trust has also reviewed its performance and recovery plan with the NHS Trust Development Authority (NTDA) at our regular Integrated Delivery Meetings (IDMs).

The broad message is that whilst there are areas of good practice and care for patients across the emergency care pathway, the Trust still has to improve to secure the levels of performance that patients should expect.

### 2. ED Performance & Challenges

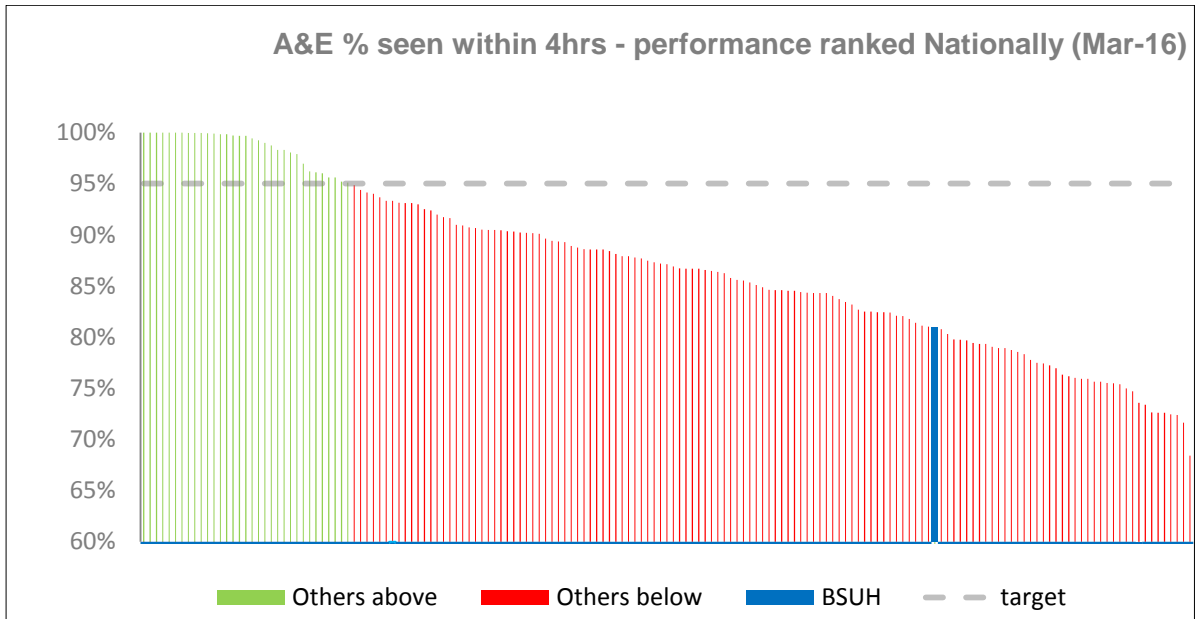
#### 2.1 ED Performance

Performance against the 4-hour standard is showing some improvement, recovering to 84% in April against 81% in March. May performance is for the period to 15th May.



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The chart below illustrates the rank the BSUH occupies nationally in March 2016.



Discussions are being finalised regarding the 2016/17 trajectory of improvement for the Accident & Emergency 4-hour standard. Delivery of this trajectory is also dependent on partners within the local system delivering on a range of initiatives including a reduction in delayed transfers of care on 15/16 levels and reductions in the number of patients conveyed to ED by ambulance.

## 2.2 Medically fit patients

The Trust continues to experience a rise in the numbers of patients who are medically fit, but who require some form of additional service or support in order to be discharged. In some cases this will be nursing, residential care or a package of care in the community.

This is being addressed through a joint piece of work between providers and facilitated by Brighton and Hove CCG. This work will identify and address the root cause of delays to patients' discharge through a joint programme of work between BSUH, Social Services and Community Health. This will help resolve issues for particular patients with non-standard requirements and improve the interfaces for patient pathways more generally.

## 2.3 12-hours Breach Position

The validated 12-hour breach position for the period 1 August 2015 to 30 April 2016 is as follows:

Month	Aug-15	Sep-15	Oct- 15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
12-hour breaches (validated)	10	2	34	2	1	8	6	6	12

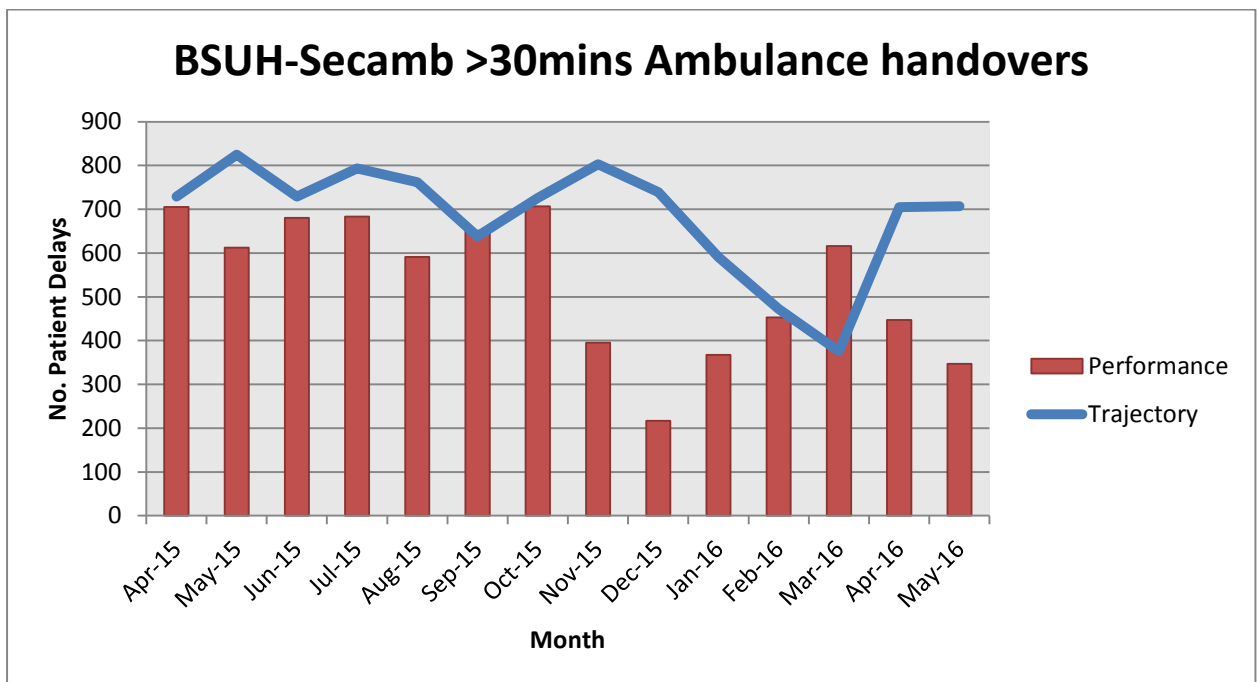
In line with TDA requirements all 12-hour breaches must be reported as a Serious Incident (SI) and a Root Cause Analysis (RCA) undertaken within

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agreed timeframes. An initial RCA must now be completed within 24-hours and shared with senior clinical staff to prevent reoccurrence.

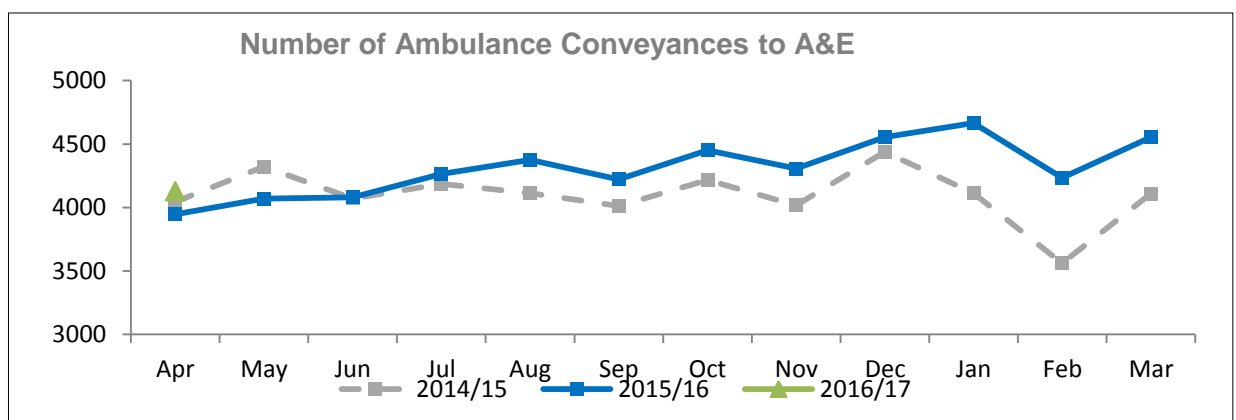
Additional analysis is being completed by the Quality and Safety Team on the cluster of 12-hour breaches in October 2015 to ensure that all potential lessons have been identified and changes made. NHSI is being updated on this work at our monthly IDM meetings.

## 2.4 SECamb Handover Trajectory



In line with improving 4-hour standard performance, Ambulance turnaround has improved in April and the first part of May. This is an area where the Trust, SECamb and the CCGs will continue to focus with the support of the Emergency Care Intensive Support Programme (ECIP).

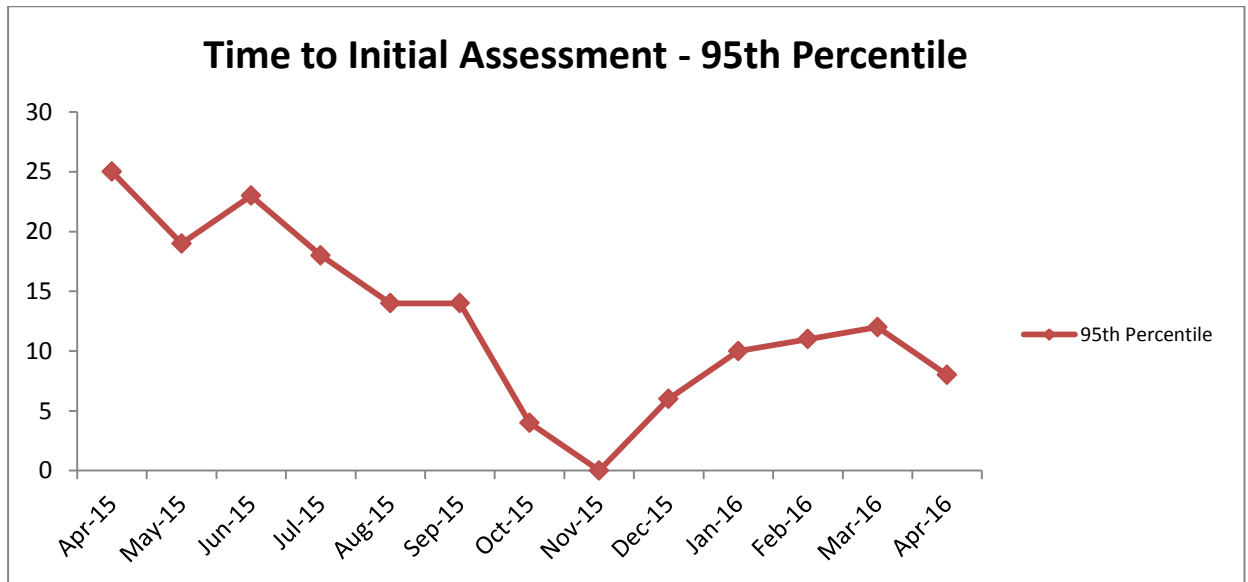
Inevitably, achieving continuous improvement in Ambulance Handover is affected by the volume of patients being brought by Ambulance and any clustering of attendances. Overall conveyances are increasing into A&E, year on year.



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## 2.5 Time to Initial Assessment

This national indicator measures the time from arrival by ambulance to the start of a full assessment by a clinician. The national standard is that such assessments must begin within 15-minutes. This remains a focus for the Urgent Care team, to consolidate the significant improvement over the last year.



## 2.6 RSCH ED Challenges

- Attendance at the front door of RSCH appears flat for the main department but continues to rise in the UCC:
  - Average attendances for UCC remain elevated for April and have been higher still in the first two-weeks of May with the exception of the days of the Junior Doctor's Industrial Strike Action.
  - Average attendances in the Main ED are similar to those in February and March. However, there have been extraordinary spikes in demand during May. One day reaching 172 patients against an average of 128. This places significant pressure on the department and the rest of the site.
  - Ambulance attendances remain static at a weekly average of 644.
- The flow out of the department continues to be a challenge, which is directly linked to the number of daily discharges and those that happen later in the day.

## 2.7 PRH ED Challenges

- The average weekly attends in April were comparable with previous months at 667 per week.
- Ambulance attendances fell slightly in April but remain at an average of 135 per week.

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### 3. **Progress of Level 5 Plan**

- Work is beginning to redevelop the entrance area at RSCH to allow an improved ambulance handover and assessment process. The initial focus has been to improve patient dignity. Overall, these changes will result in a rapid definition of a plan for each patient and ensuring that they are directed to the most appropriate location.
- RACOP has been relocated from SAU to increase the space available for surgical assessment and has improved flow out of the Emergency Department.

### 4. **Rapid Transfer Improvement Event**

Analysis of flow within the site have highlighted that there are significant delays for some patients in accessing beds, even after the bed has been allocated. As a result a workshop was held, led by Clinical Directors from the Acute Floor and Specialist Medicine.

The workshop - which involved representatives from all relevant areas - analysed the cause of delays and significantly reduced the steps in the process to move patients to allocated beds from ED and AMU onto the wards.

The workshop utilised Rapid Transfer Improvement methodologies to agree changes to the process of allocating beds and then transferring patients. Specific actions on short timescales were allocated to individuals and are being tightly managed to ensure that the required benefits are achieved.

The Rapid Transfer Improvement Workshop methodology will be utilised elsewhere for process improvement, given the significant engagement around this initial event.

### 5. **Escalation Process**

The revised escalation process has been trialled during times of significant pressure ensuring that communication and command and control activities have been tested. As a result the process is being slightly modified to clarify actions. The procedure and action cards will then be formally launched.

Our partner organisations' are updating their plans to respond when BSUH is at a higher level of escalation.

### 6. **Transfer of non-urgent patient transport (PTS)**

From 1 April, the Sussex-wide PTS service transferred from South East Coast Ambulance Service (SECamb) to a new provider (Coperforma). The transfer has resulted in a reduction in responsiveness of the service to our patients and staff. This has caused significant delays for many patients. In Renal Dialysis and Radiotherapy some patient's courses of treatment have been disrupted.

BSUH have contracted two private ambulance companies to support inpatient discharge and has used taxi firms where appropriate to reduce the disruption to patients.

BSUH has continued to work closely with the CCGs to resolve the issues and a remedial plan has been agreed between Commissioners and Coperforma. An independent investigation is underway to establish the cause of the difficulties following implementation of the contract and suitability of the remedial plan.

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Locally within BSUH, transport delays are being registered on DATIX and complaints and staff concerns are being logged with responses to individual patients.

In the meantime:

- BSUH have four Coperforma staff on our sites to help smooth the continuing issues.
- BSUH staff are being trained to use the Coperforma software to allow direct access, rather than relying on telephone booking alone.
- Members of staff are escalating issues to embedded Coperforma staff and through Directorates.
- Further escalation takes place to the Deputy COO (Emergency Care) where excessive delays are being experienced.
- The DCOO takes part in a weekly conference call and regular meetings with Commissioners and Coperforma to help resolve the operational problems being experienced.

### 7. **Junior Doctors' Industrial Action**

A further two day strike took place on 26 and 27 April between 08:00 am and 05:00 pm on each day. This is the first action where Junior Doctors withdrew all provision, including emergency cover. Consequently our plans required cancellation of the majority of elective activity. As a result senior clinicians were allocated roles normally fulfilled by their teams, such as managing the emergency response to deteriorating patients.

The plans put into place worked well and A&E performance was maintained. The strikes have been treated as incidents, managed by a HICC (Hospital Incident Control Centre) with dedicated telephone lines and gold command structure.

A subsequent 'After Action Review' (AAR) has taken place which highlighted areas for improvement should a future strike take place. Initial contingency planning has been undertaken to consider potential future scenarios for junior doctors' industrial action. From a governance perspective, plans, AAR and scenarios continue to be managed through the Senior Management Team (SMT) meetings.

BSUH awaits formal feedback from the talks between the NHS and BMA, the recommendations from which are subject to a BMA referendum.

### 8. **Recommendations**

The Board is asked to note the report and the on-going work to make sustained improvements to the urgent care pathway; performance against the 4-hour Accident and Emergency standard; and the challenges and risks to performance.

**Andrew Stenton**  
**Interim Deputy Chief Operating Officer (Unscheduled Care)**  
**May 2016**