Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	24 August 2015
Board Sponsor:	Chief Operating Officer
Paper Author:	Dr Mark Smith and Simon Maurice
Subject:	Emergency Care and Unscheduled care

Executive summary

This report updates the Board on progress within the Emergency Care pathway redesign, the recommendations arising from the Emergency Care Intensive Support Team (ECIST) visit and their implementation; the initial feedback from the Care Quality Commission (CCQ) unannounced inspection; and the project plans that have developed to improve the performance in relation to the 4 hour standard

Links to corporate objectives	Securing sustained improvements in emergency and unscheduled care is critical to the delivery of the corporate objectives of ***excellent outcomes;*** and ***great experience***
Identified risks and risk management actions	Patient safety and experience; performance against the 4-hour A&E standard; organisational reputation
Report history	Previous reports on Emergency and Unscheduled Care have been made to the Board of Directors monthly in 2014 and 2015.

Action required by the Board

The Board is asked to note the contents of the report and support the direction of this programme of work.

Report to the Board of Directors, 24 August 2015

Urgent Care Transformation

The Trust continues to experience significant difficulties in meeting the four hour A&E standard and following the recent CQC review, ECIST visit and risk summit a major programme of work is underway to make significant and sustained changes and improvements to the whole unscheduled care pathway to ensure that patients are seen promptly, safely and efficiently.

Following the risk summit on 8th July the Chief Executive, Chief Operating Officer, Medical Director and Clinical Directors convened a meeting to discuss the implementation of the ECIST recommendations for the urgent and emergency care pathways and a new model for the acute floor, addressing the ECIST recommendations, was discussed and agreed. This has helped build our 30|60|90 day plan which manages all of this into one plan.

The objective of the new model of care is to ensure that patients who are likely to require inpatient admission and/or specialist care are identified immediately and referred to the appropriate team/location for further assessment and treatment, whilst patients who have had an accident that requires emergency treatment or whose diagnosis or pathway is unclear are directed swiftly through a diagnostic process into the Emergency Department (ED). This model is summarised in the attached document and is based on three fundamental principles, namely (1) there should be no loss of bed capacity on the acute floor, (2) there should be no “exit block” from the acute floor into the hospital, and (3) there should be no scheduled activity taking place on the acute floor.

The under performance of the trust against the 4 hour standard is multi-factorial and is essence is linked to the recommendations of ECIST. The target should be interpreted as a system wide and trust wide target. It is not purely an ED issue. The systems and processes with the trust do not create that pull system which takes patients out of ED and removes exit block. Also with in ED there are issues around performance delivery which relate to systems within the department, poor process issues and a culture that has now become insensitive to the target. Unless the trust tackles the behavioural, cultural as well as these process and practice issues collectively across, the 4 hour target be improved and subsequently delivered. To maximise the opportunity to deliver success we have ensured clinical engagement is paramount to the change process, the projects are clinically led and driven, and that as a trust we commit the right support to create that environment for delivery. Also this work needs to link to our winter planning which we will begin imminently.

This model adopts a ‘front-loaded’ approach to the management of patients. The acute floor will be re-designed with a reduction in the number of ED cubicles but with the introduction of a medical assessment area, a larger surgical assessment area with surgical short stay beds, an acute medical unit including a fragility unit & RACOP, and process changes to improve flow to the wards. The time that a patient spends in the medical or surgical assessment area will still be measured against the national four hour standard to ensure that flow is maintained. This proposed model has been shared widely and will also be discussed with patient representatives.

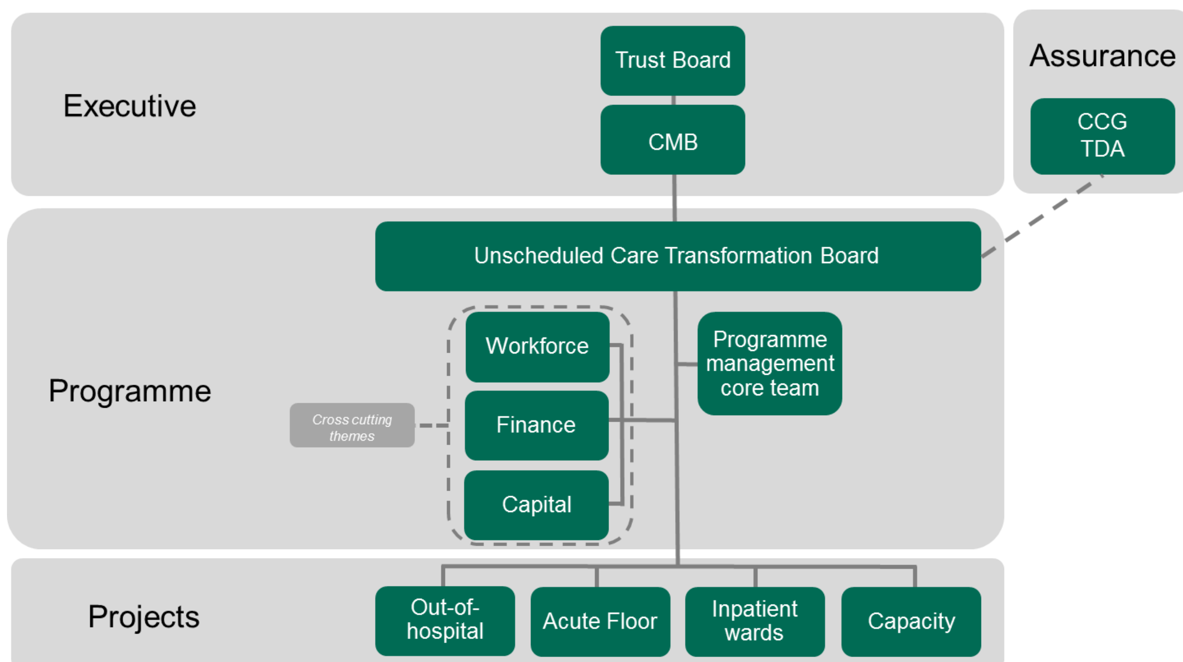
The physical changes and clinical adjacencies on level 5 footprint are illustrated on the attached diagram and highlight:

- An enlarged Surgical Assessment Unit running 24/7 including between 5-6 short stay surgical beds
- Zone 2b dedicated to Medical Assessment and staffed by Acute Physicians

- AMU as a short stay medical assessment ward with dedicated frailty beds for patients with a predicted stay of <48hrs
- An ED for patients who present with undifferentiated issues

Acknowledging the need to demonstrate significant steps to improve performance very quickly a robust governance structure has been implemented which is illustrated below. Weekly project board meetings are being established to ensure:-

- Wide clinical representation
- Clear objectives linked to a wider programme of work
- Action driven to ensure delivery
- A risk log to be used a tool for managing risk and identifying mitigations



The first phase of the acute floor changes must be implemented by the end of September 2015 and the Acute Floor Project Board therefore has the following remit:-

- To develop, agree and implement new clinical pathways and appropriate facilities to deliver best, safest and timely care to unscheduled care patients on the acute floor

- To develop, agree and implement a workforce plan for medical and nursing staffing establishments, skill-mix and workloads

- To agree capacity and physical space requirements for each specialty on the acute floor

- To develop and agree KPIs and time stamps for each area and monitor and evaluate the impact on the national performance targets post implementation

Further work is required to develop a clinical leadership model for the unscheduled care floor and to ensure that robust governance arrangements are in place across the unscheduled care specialties and clinical areas. It is not anticipated that there will be significant changes to the clinical workforce however staff will be kept fully engaged and informed of any

potential implications. Detailed activity modelling is being undertaken to ensure that there is sufficient capacity within ED and the medical and surgical areas assessment areas particularly at peak times; a financial analysis will be undertaken to understand any changes in clinical income as a consequence of these changes.

Minor reconfiguration work may be required on the acute floor on level 5 to enable the proposed changes in processes and flows including clinical adjacencies and to deliver an increase in surgical assessment capacity. Work will also be required to make significant improvements to signage on the acute floor, improve the physical environment for patient and staff, and to bring facilities to compliance standards for gender management and privacy & dignity.

There will be a phased implementation for this change programme and phase one must be completed by the end of September 2015. In the longer term (phase two of the programme) capital works will be required to increase the size and capacity of the resuscitation area on the acute floor and to modernise the existing facilities for the major's area. A design and feasibility study will be required to determine the costs of phase two programme however a nominal figure should be added to the Trust capital programme in anticipation of the need for a longer term estate solution for unscheduled care.

It is recognised that changes to the unscheduled care pathway on level 5 cannot happen in isolation from the rest of the hospital and particular attention and focus is therefore being placed on other elements of the unscheduled pathway. A separate programme will cover these which will implement a range of measures to improve patient care, remove exit block and flow initially within the specialty medicine directorate but then extend during October to cover other specialty base wards. The programme will include:-

- Implementing the SAFER patient flow bundle within selected specialty medicine and digestive diseases wards (prior to rolling out across other wards across the hospital) to improve patient flow.
- Implement changes to discharge processes and pathways including embedding Discharge to Assess (D2A) on all wards, matching therapy provision with the new pathways, and better use of the discharge lounge.
- Implement changes to the configuration of wards in the Barry building and associated staffing changes
- Admission criteria and improved 'pull' to specialty wards
- Removing internal barriers to timely discharge.
- Better co-ordination and utilisation of community services and for some services a system wide look at capacity.

A Capacity Project Board will be established to manage the implementation of additional inpatient capacity within the hospital, including Plumpton and Newhaven wards, ensuring that this is used appropriately and to the maximum benefit of the organisation. This Board will also manage the implementation of other initiatives including Hospital At Home.

It is essential that all these changes are planned and implemented concurrently across the whole unscheduled pathway if the changes to the acute floor are to be successful. To enable this site reconfiguration team are involved, working with COO to enable this coordination. An Unscheduled Care Transformation Board will oversee the whole implementation process and ensure projects are delivering their project milestones and will provide the necessary external assurance to partner organisations including local commissioners.

Recommendation

The Board is asked to note and support the ED programmes of work.

Dr Mark Smith
Chief Operating Officer
August 2015