Meeting:	**Brighton and Sussex University Hospitals NHS Trust Board of Directors**
Date:	**25 January 2016**
Board Sponsor:	**Chief Operating Officer**
Paper Author:	**Chief Operating Officer**
Subject:	**Urgent Care Transformation**

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, which are designed to improve patient flow and the standard of patient care.

The report further describes performance against the four 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.

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 report and the on-going work to make sustained improvements to the urgent care pathway; performance against the four hour Accident and Emergency standard; and the challenges and risks to performance

Report to the Board of Directors, 25 January 2016
Urgent Care Transformation

1. Introduction

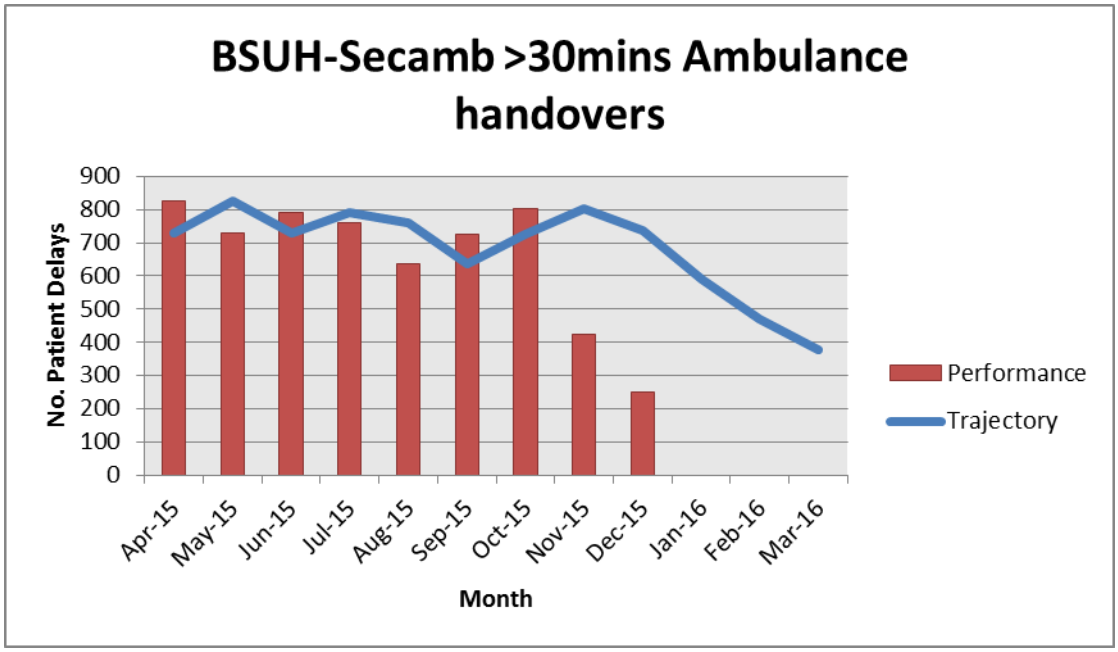
Emergency Care performance is under significant external scrutiny allied to the absolute priority given to it by the Trust as seen in previous board reports and the annual plan for 2015/16. After inviting the national Emergency Care Intensive Support Team (ECIST) to review its emergency care pathway, there was also an unannounced 48-hour visit and review of emergency care 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 (TDA) at our regular Integrated Delivery Meeting (IDM).

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. Progress of Level 5 Plan

Work is continuing to make significant and sustained changes and improvements to the whole unscheduled care pathway to ensure that patients are seen promptly, safely and efficiently.

In December, a new standard operating procedure was agreed between BSUH and SECAmb for ambulance handovers at the RSCH in Brighton. This was reviewed two-weeks after implementation and to date a significant improvement in handover times between SECAMB and ED at RSCH has been seen.



In February, it is proposed that medically expected patients and patients assumed to be destined for medical admission will be streamed from the front door to Zone 2b, which will facilitate review and ward rounds by the medical team; the time that a patient spends in

Zone 2b will be measured against the national 4-hour standard. Majors patients will be streamed to Zone 2a.

The Surgical Assessment Unit (SAU) is functioning seven-days-a-week but is not yet operational on a 24/7 basis. A revised design for SAU has been developed, however an alternative location has yet to be found for the Rapid Assessment Clinic for Older People (RACOP) which is currently located within the SAU.

Work has continued on the re-design of the Urgent Care Centre (UCC) to significantly improve both patient flow and patient experience; a final design for the UCC is close to being agreed and it is anticipated that works will commence in early 2016. Work will also shortly be starting on the re-design of the ambulance entrance at RSCH to establish additional assessment cubicles.

A new daily acute floor meeting is being introduced in February at which senior clinicians and nurses from all the acute floor specialties will meet to discuss a plan for the day and highlight any particular problems, issues or challenges. This will also facilitate more collaborative cross-speciality team working on the acute floor.

3. Right Care, Right Place, Each Time

The multidisciplinary project team - led by Dr Sarah Doffman, Clinical Director for Specialist Medicine - continues to rollout *Right Care, Right Place, Each Time* across the Trust and by December roll out of the programme has extended to 21-wards across the organisation. The remaining wards and directorates will be completed by the end of January.

At the end of December 2015, there was a significant improvement in the number of early patient discharges, which created better patient flow with most wards having empty beds on a daily-basis. This has had a positive impact on the national four-hour performance standard.

Average length of stay has also fallen across all clinical areas and this was accompanied by an improvement in the 'stranded patient' metrics; this has had an impact on community bed availability as patients have needed less rehabilitation as inpatients as a result of reduced deconditioning.

Christmas proved to be a difficult period for sustaining the improvements in patient flow, however the on-going commitment, dedication and focus from all members of the MDT to undertake daily board rounds has enabled the Trust to recover sooner than in the same period in previous years.

The project group continues to support innovative ways of working, for example the use of pharmacy technicians and prescribers in clinical areas. Work is underway on the implementation of a discharge planning tool and use of the whiteboards, which are due to go live in February.

4. Single-Clerking Process

In early February, further changes will be introduced to the existing multiple-clerking process, which is inefficient and causes delays. A new single-clerking process will be implemented on the acute floor and this will have a number of benefits including a decision

to admit being made much sooner, a better experience for patients who are currently asked the same repeated questions during the current clerking process, and a better experience for junior doctors. A new standard operating procedure and associated documentation for single-clerking have been drafted and agreed by senior representatives of the key specialties and successfully piloted over the Christmas period. It is proposed to implement this new way of working in February to coincide with the change-over of junior doctors.

5. Specialty Medicine Site Reconfiguration

In January changes were made to the configuration of wards within the Barry Building to improve the standard of care given to patients, to help improve patient flow, and strengthen the clinical directorate leadership structure and capacity.

- Baily Ward relocated to Bristol Ward to become the Diabetes, Endocrine, General Medicine Ward (19 beds)

- Bristol Ward relocated to Bailey Ward to become Care of the Elderly Ward, Acute Complex Discharge ward (14 beds)

Baily ward will become the new complex discharge ward taking over this function from Overton ward once works have been completed on Overton to enable acutely unwell patients to be cared for there.

6. Emergency Care Improvement Programme (ECIP)

The Emergency Care Improvement Programme (ECIP) is a clinically led programme that offers practical help and support to the 27 urgent and emergency care systems across England that are under the most pressure. It supports rapid and sustained improvements in quality, safety and patient flow. The programme focuses on improving care for patients, with a particular focus on improving system performance across the winter months, when emergency departments are working under additional pressure.

The success of ECIP will be measured against better patient outcomes and experience as well as improvements to the emergency care 4-hour waiting time standard.

ECIP is providing additional clinical support in ED whereby an ED Consultant and an Acute Physician from the ECIP team are reviewing some of the Trusts ED and acute pathways. Also a member of the ECIP team is working with the Trust to help develop our escalation trigger tool and escalation policy.

Senior clinical staff have received a presentation showing the approach to escalation taken by another Trust. This used readily available real-time information to identify points at which action was required to avoid deterioration in the smooth flow of patients through the organisation. In effect this simple tool provides an early warning and triggers specific actions by identified individuals. As a result of this presentation BSUH is receiving support to develop its own version; working with its Clinical and Managerial team. An initial version will be launched in February with an expectation of further development during the year.

6. ED Performance & Challenges

6.1 Revised 4-hour Standard Trajectory

Please refer to *Appendix 1*.

6.2 12-hour Breach Position

The validated 12-hour breach position for the period 1 May to 31 December 2015 is as follows:

Month	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct -15	Nov-15	Dec-15
12-hour breaches (validated)	13	4	3	10	2	34	2	0

6.3 12-hour Breach Analysis (November - December 2015)

There were two 12-hour breaches for the month of November with both occurring at the RSCH. The validation of the breaches was undertaken by the Matron for the ED and an ED Consultant. The review of the patient's notes post breach identified that one was as a result of no capacity in the Trust to accommodate the patient and the second patient breach was for clinical reasons i.e. a patient whose condition was deteriorating and required further resuscitation.

There were no reported 12 hour breaches for December.

6.4 New 12-hour Breach Policy

The Trust is a significant outlier nationally in the numbers of patients who wait in the Emergency Department for more than 12-hours after a decision that they should be admitted. Whilst significant effort has historically been applied to avoid such excessive delays, there has not been a systematic approach to notify senior staff of delays for specific patients, nor of mobilising external resources. As a result, the Trust has put into place a new process from 13 January, whereby Directorate Clinicians and Managers will be notified of patient delays well before the patient has been delayed by 12-hours. If the Directorate is unable to resolve the issue causing the delays, then further escalation takes place to senior management with regular updates. At 10-hours CCG senior staff are informed, who will escalate to NHS England. All will receive regular updates until the issue is resolved.

All 12-hour delays are subject to a Root Cause Analysis and are reported to NHS England through established procedures.

6.5 SECAmb Handover Trajectory

Performance against the Ambulance Handover Standards deteriorated over the Bank Holiday period as a result of poor flow in the Hospital. This results in patients being held in the 'cohort' area managed by Ambulance Staff. There remains in place an agreement regarding the supervision and management of these patients jointly by SECAmb and our own clinical staff such that safety can be maintained. In recent

days the Trust has begun recovering from the effect of the Bank Holidays with improved flow. As a result there have been fewer and shorter delays to ambulance handover.

6.6 RSCH ED Challenges

- Attendance at the front door of RSCH appears flat, and in keeping with expected seasonal variation:
    - Average attendances in the UCC for December were 640 per week compared to 680 per week for November.
    - Average attendances in the Main ED for December were 920 per week compared to 893 per week for November.
- The restrictions on using agency nursing staff have created additional challenges for the department i.e. managing high ED attendances and caring for those patients conveyed by ambulance. There have been times when the department has been up to 5-trained staff down, which has impacted on the service being able to cover all areas of the ED and in particular the area designated as the 'cohort'.
- The flow out of the department continues to be a challenge, which is directly linked to the low number of daily discharges and discharges which happen later in the day.
- The Trust has invoked the Full Capacity Protocol at times of extremis.
- There are some specialty review time issues which the Acute Floor Directorate are addressing and the planned reconfiguration and pathway changes will facilitate a more timely response and review of patients.
- Overall, Trust 4-hour performance remains a challenge, and sits at 85 – 86%. Detailed analysis shows the major contributing factor for this 'admitted patients' breaching in the early evening and then at 22.00 hours, when the hospital runs out of in-patient beds.
- The RSCH 4-hour performance as an average for December was 82%.
- The UCC maintained over 95% for December with achievements of over 99% as the average for some weeks.
- There are efficiencies that need to made within processes owned by ED, such as timely return of blood tests, and these form part of the work within the Acute Floor project to clarify these 'marginal gains' and improve efficiency.
- There are middle grade medical staff issues within the ED resulting in gaps in rotas which are covered by ED Consultants and by increasing SHO cover using locum agencies. The middle grade issues are national and the ED and Acute Floor Directorate are working on new ways of working to cover the needs of the department.

- The ED is down by 6 WTE Consultant posts. The Consultant rotas are covered until February and the service has advertised for vacant posts. To ensure core shifts are covered, the service has realigned Consultant shifts on Mondays and Fridays to support pre and post weekend demand challenges on both Trust sites. There has been some interest in the locum Consultant and substantive consultant adverts and the department is to interview for Clinical Leads for both the RSCH and PRH with applicants for both posts.

6.7 PRH ED Challenges

- PRH attendances are slowly increasing, both walk-in and ambulance attends. The average weekly attends in December were 683 per week.

- The performance for December was on average 92%. This is a drop from the performance which was sustained for November 2015. The 3 days post-Christmas saw 50 4-hour breaches due to acuity and bed availability for medicine.

- ED medical staffing is an issue with shift times and seniority with an ED Consultant led service from 09.00am to 05.00pm, Monday to Sunday. Detailed analysis has demonstrated the need for additional ED medical workforce presence to support the continued high attendances in the evenings. This has in part been addressed by the introduction of GPs into the department to support what is deemed to be primary care work in a similar model to that in the UCC at the RSCH. In addition, the department now has an ED SHO covering the period of 04.00pm until 02.00am.

- As detailed above in the RSCH challenges, the reduced ED Consultant numbers will have an impact on the ability to staff the ED at PRH with Consultants and plans/models are being worked through to ensure that there is appropriate support for the service.

- Medical reviews overnight are also an issue, yet to be fully resolved due to the difficulty in filling the Medical Registrar rota at PRH but there has been a slight improvement in December due to escalation.

- The service is working closely with the children's directorate to ensure a high standard of paediatric safety is maintained following new identification of potential risks. PRH attendances are slowly increasing, both walk in and ambulance attends.

- Staffing is an issue, both in terms of shift times and specialty. Detailed analysis has demonstrated the need for evening work, and also Primary Care presence. To that end the Rapid Access Medical Unit (RAMU) is being transformed into a minors service with Primary Care, Acute Medicine, ENP and HRDT function, all allied with streaming at the front door.

7. Junior Doctors' Industrial Action

All clinical directorates put in place plans to ensure they were able to continue to deliver their critical activities and maintain patients safety during the strike action on the 12 January. A command and control structure was put in place and the HICC (Control Room) was set up for the day. Because of this planning the Junior Doctor's Strike on the 12 January did not impact on patient safety and disruption to patients was kept to a minimum. The largest impact was on out-patient activity where patients had their appointments rescheduled for non-strike dates.

The strike planned for 26th to 28th January has been suspended, however planning continues for the full walk-out on the 10 February. Command and control and the HICC (Control Room) will be instigated for the ensuing strike dates and the Communications Team will liaise with staff and the public regarding the strike. A debrief questionnaire has been sent out so that we can incorporate any learning from the strike on the 12 January into planning for subsequent strike dates.

8. Recommendation

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 four hour Accident and Emergency standard; and the challenges and risks to performance.

Dr Mark Smith
Chief Operating Officer
January 2016

Appendix 1:

Revised 4-hr Standard Trajectory