Meeting:	**Brighton and Sussex University Hospitals NHS Trust Board of Directors**
Date:	**29th March 2016**
Board Sponsor:	**Mark A Smith Chief Operating Officer**
Paper Author:	**Andrew Stenton Interim Deputy Chief Operating Officer (Unscheduled Care)**
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 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 four hour Accident and Emergency standard; and the challenges and risks to performance

Report to the Board of Directors, 29th March 2016
Urgent Care Transformation

1. Introduction

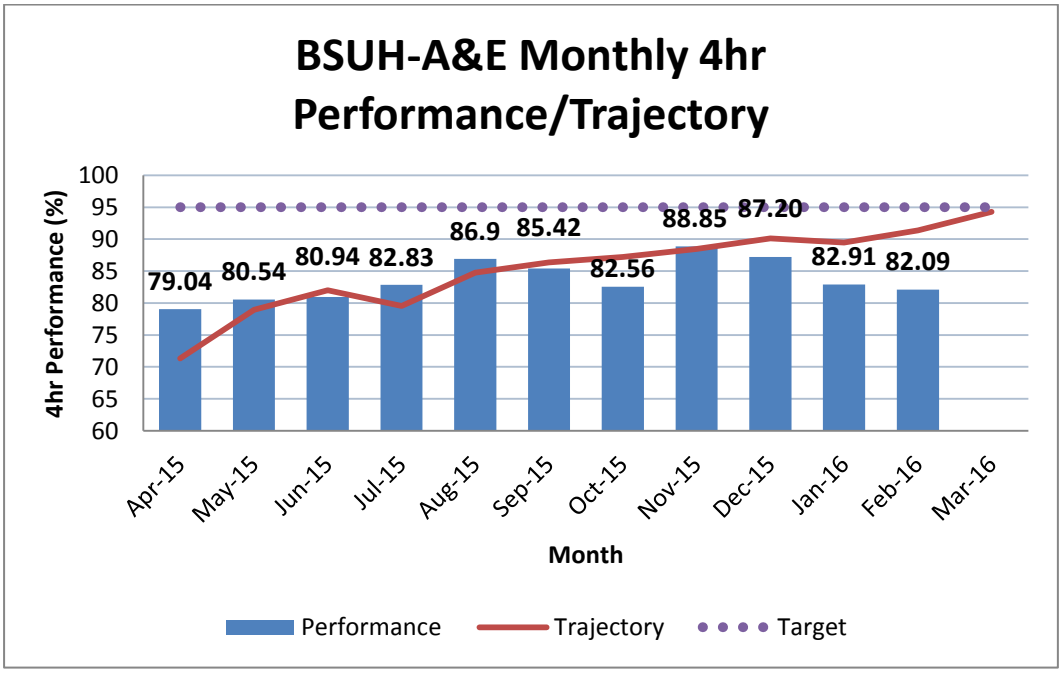
Emergency Care performance is under significant external scrutiny allied to the absolute priority given to it by the Trust as seen in previous FPPC reports and the annual plan for 2015/16. After inviting the national Emergency Care Intensive Support Team (ECIST) to review its emergency care pathway, 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. ED Performance & Challenges

2.1. ED Performance

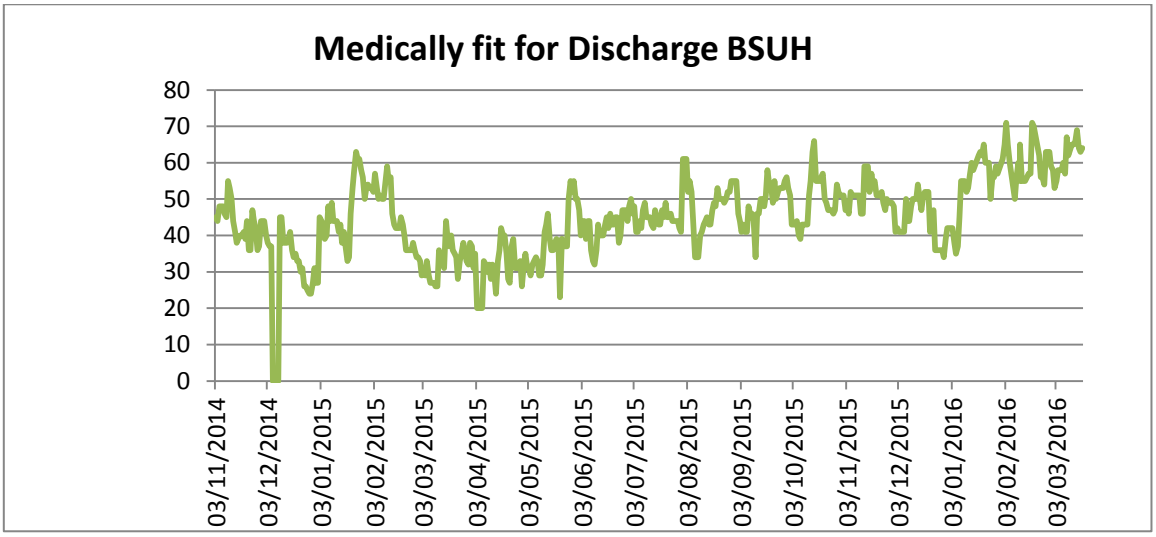
There has been deterioration in performance against the 4-hour urgent care standard during January and February. The Trust had been tracking the required trajectory until December 2015. Since then performance has deteriorated and remains at approx. 82%. During March performance has deteriorated to around 80% in the first two weeks.



Discussions are currently progressing regarding a re-setting of our trajectory for the 4 hour standard as part of the 2016/17 planning round.

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.



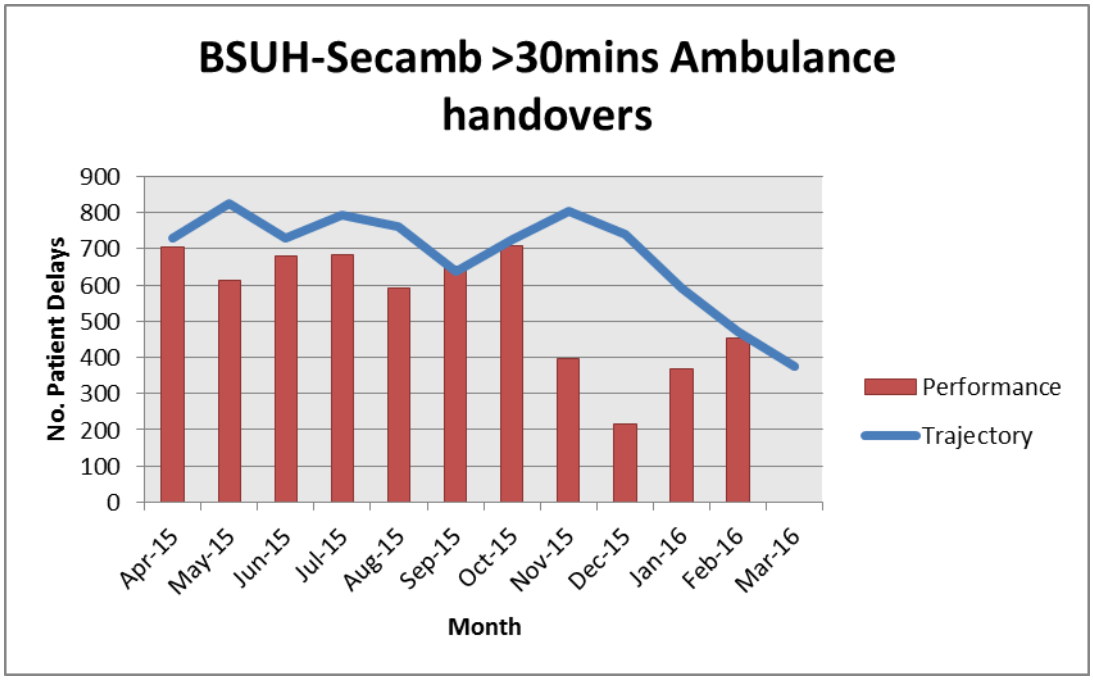
2.3. 12-hour Breach Position

The validated 12-hour breach position for the period 1 June 2015 to 29 February 2016 is as follows:

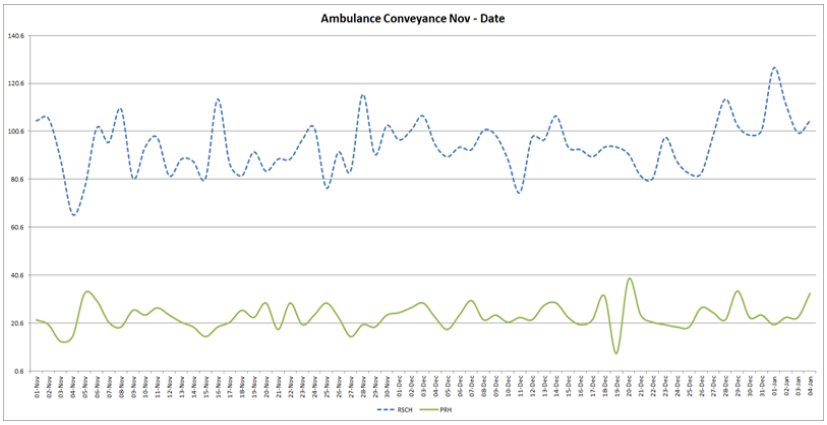
Month	Jun-15	Jul-15	Aug-15	Sep-15	Oct - 15	Nov-15	Dec-15	Jan-16	Feb-16
12-hour breaches (validated)	4	3	10	2	34	2	1	8	0

2.4. SECAmb Handover Trajectory

Performance against the Ambulance Handover Standard has been disappointing recently as a result of poor flow in the hospital. This results in patients being held in the 'cohort' area managed by ambulance staff. The Ambulance Service has found this increasingly difficult in recent weeks as demand has been high.

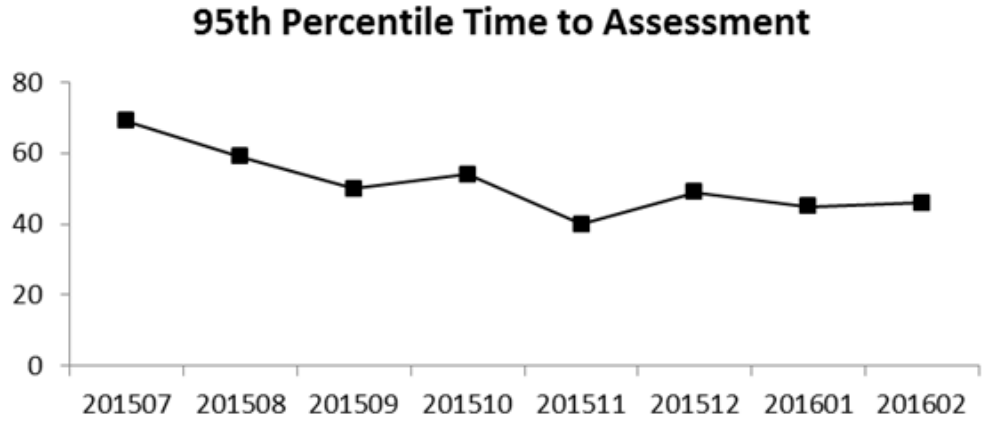


There is evidence from the chart below that the downward trend in patients conveyed has not continued in 2015/16.



2.5. Time to Initial Assessment

This national indictor 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. Historically, Trust data on this measure has been inconsistent. This has made monitoring, management and reporting difficult. As a result clinical leaders within the Emergency Department have devoted time to resolving the data issue. Since completing this work, the measure has shown improvement.



2.6. RSCH ED Challenges

- Attendance at the front door of RSCH appears flat for the main department but continues to rise in UCC:
    - Average attendances in the UCC for February 2016 were 735 per week compared to 693 per week for January.
    - Average attendances in the Main ED for February were 911 per week compared to 932 per week for January
- 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 frequently during recent weeks in order to maintain flow in ED.
- Performance in UCC has fallen, averaging 94.2% in February.
- Recent analysis confirms that bed occupancy is a major driver of performance in the Emergency Standards. When occupancy is higher than 90% performance in the A&E standard falls significantly.

2.7. PRH ED Challenges

- PRH attendances as a weekly average increased in February. The average weekly attends in February were 681 per week compared to 652 for January.
- The emergency admissions however have continued to increase with the average per week rising from 236 in February compared to 217 in January.
- The performance for February improved to 93% on average for the month from 89.8% in January.
- 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.

3. 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. To support the significant change programmes underway in the acute floor directorate a transformation team has been which includes a new lead nurse and service manager.

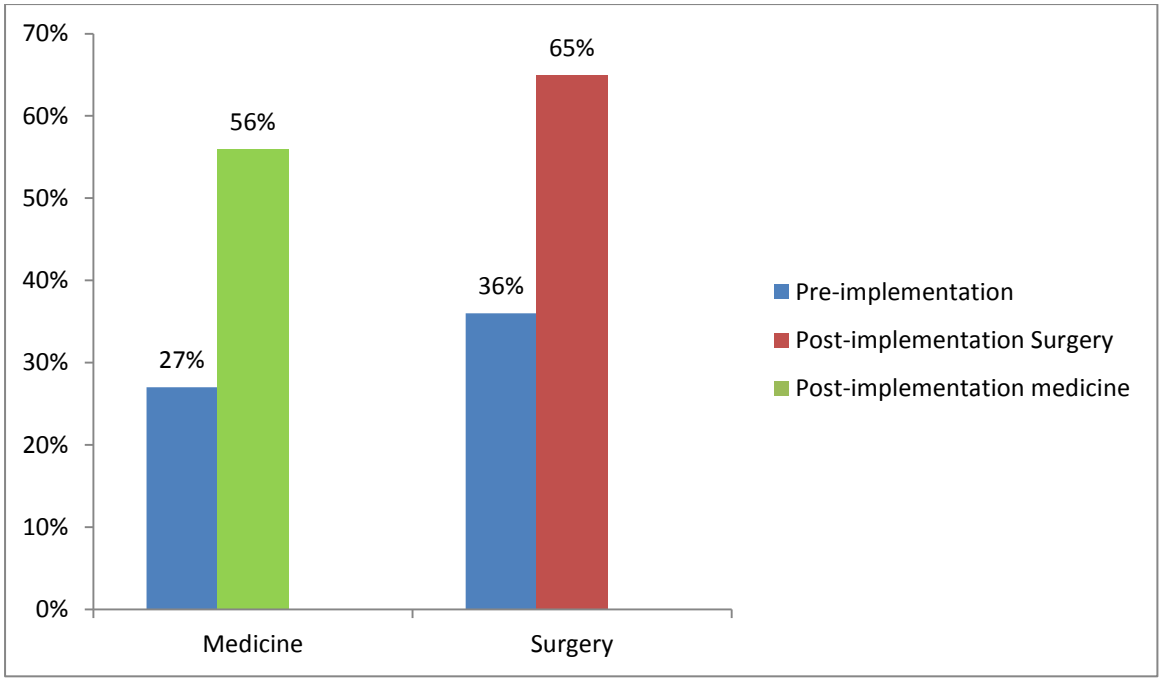
3.1. Single-Clerking Process

From 3 February changes were introduced to the initial medical assessment processes as patients arrive in the 'Majors' within ED. This change stops the wasteful process whereby junior medical staff 'clerk' patients as part of the initial assessment, only to have elements of this repeated by junior staff from specialties. Clerking is the process of obtaining a medical history and physical examination of the patient. It is a vital, but time consuming process. So eliminating the need for a subsequent clerking improves use of medical time and importantly reduces the frustration that patients feel at answering the same questions multiple times.

A new clerking booklet has been introduced, which ensures that all of the information required by specialties is available at the initial clerking. This has freed medical assessment time and allowed junior medical staff from all specialties to assist in the initial assessment process in A&E. A further benefit is that senior decision makers (Registrars and above) are brought closer to the 'front door' by this process. As a result the timeliness of decision making has been improved somewhat.

An element of the single clerking changes has been the introduction of an early morning meeting of the medical and surgical teams working on the emergency floor each day. This 15-minute standing meeting allows a joint understanding of the challenges for the day and assists the clinical specialties to work better as a team.

Four weeks after the launch of single clerking, there is consensus that single clerking is the right thing to do for patients and the quality of care we are providing feels better. Initial data shows that approximately half of patients are getting a DTA within 3 hours and 45 minutes. Generally, doctors feel part of a wider team and are reporting greater satisfaction as a result of reviewing their clerking with the senior doctor. Overall, nurses are pleased that senior reviews are happening earlier and find the paperwork easier to navigate.



Percentage of patients who had DTA within 3h 45min pre and post implementation of Single Clerking

Work continues on a number of other initiatives on the acute floor including:-

- Further development of the single clerking model to navigate patients to correct ward of admission
- On-going review and development of workforce models including nursing
- Surgical Assessment Area to function 24/7 – a plan has been developed to relocate RACOP to an alternative location in the Barry Building during April 2016.
- On-going development and training to support whiteboards, live dashboard and real time bed states across both sites of the hospital
- Re-development of the Urgent Care Centre (works are expected to start in June 2016) and the building of four additional assessment spaces in ED (works are expected to start in April 2015)
- Development of an assessment area in the Acute Medical Unit

4. Right Care, Right Place, Each Time

The initial Trust wide rollout of Right Care, Right Place, Each Time principles came to its completion at the end of February 2016.

The multidisciplinary project team - led by Dr Sarah Doffman, Clinical Director for Specialist Medicine – has now moved to providing much more focused support at Ward and Consultant level, in order to embed the principles and different ways of working into each ward and clinicians' "business as usual", working alongside teams to identify any issues with performance, or informing conversations regarding ideas for different ways of working.

The key principle is the continued focus with each ward on the daily MDT board rounds; proactively ensure that each patient has a clear care plan, including an agreed clinical planned date of discharge, and that every day a patient is in our care is a progress step forward towards that date.

4.1. SAFER-Start

The Trust has continued to see some particularly difficult and challenging days for everyone.
Recognising these difficult times, and the need to take a different approach, we have continued to host MADE events (Multi-Disciplinary Accelerated Discharge Events) on selected inpatient wards once a week, throughout March. Locally these events are known as SAFER-Start.

With attendance internally from; Senior Nurses, Therapies, Doctors and externally from; SCT, Adult Social Care, Brighton and Hove CCG, Mid-Sussex CCG, GPs and Voluntary Sector, these events take a whole system approach to review and identifying accelerated discharge options, or different care pathways, i.e. utilising services such as Voluntary Sector, in order to identify patients who can be discharged from acute care in a safe, timely way.

These events alongside with the on-going commitment, dedication and focus from all members of the MDT to undertake daily board rounds has meant that throughout January, February and March we have continued to see some sustained improvements; reduction in our average length of stay maintained, accompanied by in the continued improvement for our 'stranded patient' metrics. In addition we are continuing to see improvements with discharging our patients earlier in the day, "home for lunch" allowing patients to settle in their new surrounding in daylight hours, and supporting flow of emergency and elective patients awaiting admission.

4.2. Six Promises

To support the communication of the Right Care, Right Place, Each Time aims to both our clinical staff, but also very importantly our patients, we have developed an 'Our Promise to You' poster which will be displayed in all patient areas. With this poster we make our patients 6 promises regarding their care and what they can expect from us, with the hope that by sharing this we will encourage conversation, forward planning and challenge from our patients and their visitors.

4.3. Discharge Module

The project group also continues to support innovative ways of working, for example we now have a discharge planning module on our PAS system; this will support the Consultant teams with the identification of each patients planned date of discharge and the interventions required to achieve that, within 24hrs of a patients' inpatient admission assessment.

4.4. Real-time bed state

In addition staff engagement and training also continues with use of the electronic whiteboards, over the next month or 2 the Trust will move to a 24/7 "real live" bed state and live dashboard, significantly improving our patient flow, patient safety and relative/ visitor experience.

5. Escalation Process

A draft Escalation Process is now being consulted upon, along with action cards. This process will ensure that deterioration in available capacity triggers an escalation in response. That response is more significant than in previous versions of the policy. Further work is required to design the response of Community and Social Services to escalating pressure within the system. All of this redesign is supported by ECIP expertise.

6. Junior Doctors' Industrial Action

A 48 hour Junior Doctors' strike took place on 9th and 10th March. This followed on from single days of action on 12 January and 10 February. On all of these occasions the BMA undertook limited strike action by withdrawing those Junior Doctors who were not providing emergency care. A control room was staffed and an incident command structure put into place. All Directorates submitted plans to cover duties. Elective capacity was reduced in both Non-Admitted and Admitted arenas.

As a result of careful planning disruption to patient care was kept to a minimum. Cancelled appointments have been re-booked.

A further 48 hour strike takes place 6/7 April.

7. 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

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