Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**6th July 2015**
Board Sponsor:	**Interim Chief Operating Officer**
Paper Author:	**Director of Operations (Emergency Care)**
Subject:	**Urgent Care Transformation**

Executive summary

This report updates the Board on progress within the Emergency Care pathway, detailing performance against the four hour Accident and Emergency standard since the last Board meeting; 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 outcome of the system reset and site moves.

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, 6th July 2015

Urgent Care Transformation

1. Introduction

June has seen urgent care performance 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 can expect. In particular, whilst the overall plan for change has been articulated and covers the key areas, there is a view that there remains a lack of pace and some issues of clinical ownership around the requirements for change across the emergency care pathway from the front door of the Emergency Department, through the wards, theatres and specialist units and on into the discharge facilitating practices at the back door.

Addressing these challenges will require better, more granular and visible leadership all key stakeholders including the individual directorates. The appointment of a new Interim Chief Operating Officer with a strong clinical background is key to improving the dynamics within the clinical body and the directorates. This and the work around the plan previously described but now into full implementation will also be merged with recommendations from ECIST and the CQC so that we continue with one single, coordinated and focussed plan that is driven to agreed timescales and owned by clinical and managerial leaders so that real and demonstrable progress is made.

A risk summit has been convened on 8th July, where progress on urgent care across the health and social care system will be a key focus of the discussion. The Trust continues to see unscheduled care as our biggest concern and priority and we will work with colleagues before, during and after the risk summit on this and update the Board at the next meeting.

2. ECIST recommendations

ECIST fed back to the Trust and were clear that some progress had been made and that staff were supportive and keen for the necessary improvement and were not accepting the position that has been experienced by patients and staff. They set out a range of five “quick win” must dos that they believe can deliver the quantum shift in our current change programme. These include:

1. **Assessment & Streaming**
    - Review and potentially cease TRIAGE and replace with clinical navigation role located in waiting room.

2. **Ambulance Service / PAT**
    - Develop rapid handover for ambulance arrivals through a dedicated ‘team’ approach with a clearly defined SOP. Ensure consistent approach to immediate streaming by initial assessment and timely transfer to the appropriate assessment stream.

- Ensure ambulance arrivals are transferred immediately using clear clinical criteria to the appropriate ambulant flow stream to initiate treatment (e.g. UCC and MATU).

3. **Implement S.A.F.E.R bundle across 2 wards, monitor adherence to the process using tracker.**
    - Urgently carry out baseline audit to identify gaps in ward processes.
    - Develop ward specific bundles with clinical/ medical staff on the wards.
    - Introduce Board Rounds to ensure every patients care plan is reviews everyday by MDT.

4. **Agree to protect the ambulatory care unit to deliver a 'process driven' model service with the agreement that a minimum of 25 patients will be referred/ pulled directly to the service.**
    - Use a simple scoring pro forma to identify patients at RAT/ GP conference call.
    - Ensure staffing is protected to deliver continuity and build effective sustainable models of care.

5. **Implement an escalation trigger tool with agreed actions for individuals and services. Use bed meeting to monitor and hold to account.**

The challenge from ECIST was whether we could deliver these changes at pace. The implementation of the above changes needs to commence and be well progressed within the next two couple of weeks. Teams have therefore being briefed and set-up with this in mind from Monday 29th June. The clinical Directors agreed at the CMB that this would be their focus and that they would work with their teams and describe how they would work differently to bring about change. A further ECIST visit to review progress and support the change programme is scheduled.

3. Care Quality Commission

Formal reporting from the CQC has yet to be received but informal feedback suggests that despite all the work undertaken and planned, the momentum of change in unscheduled care had not been adequately sustained and that there is some disengagement as some staff have commented that they have begun to feel they cannot directly improve the situation to deliver a better service. The implications of this and the normalisation of current delivery were central to the CQC informal feedback. Therefore, whilst they acknowledged the work that has been done, they were also clear that the improvements we have made so far have not gone far enough to address some of the issues we face and that we still have a lot more to do to get to where we need to be. This is something we had already recognised and the formal feedback when it comes will help us refocus our efforts to make the necessary changes to how we do things.

4. Performance

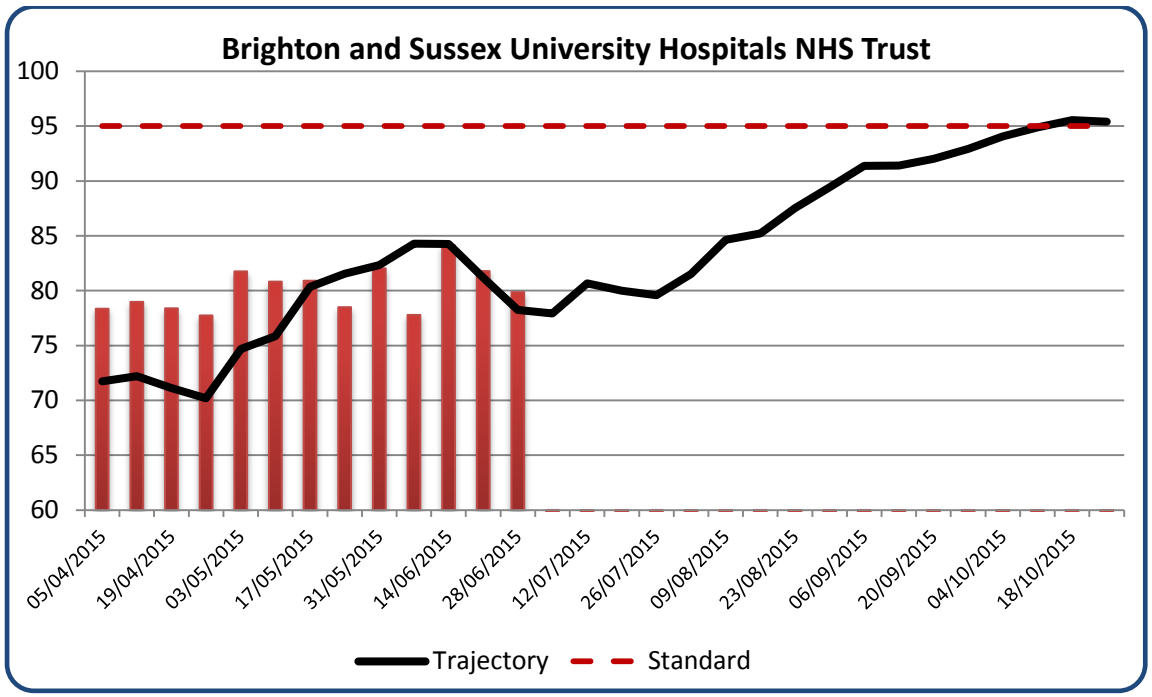
Trust performance around the 4 hour standard is contrasting between our two sites. Whilst PRH have seen a marked improvement in performance with two weeks in a row above 95%, RSCH continues to deliver at a much lower level than that.

Table 1: performance against the four hour Accident & Emergency standard

		Att	Breach	Perf	Att	Breach	Perf	Att	Breach	Perf
01-Jun	Mon	438	90	79.5%	227	86	62.1%	84	4	95.2%
02-Jun	Tue	388	91	76.5%	206	73	64.6%	91	18	80.2%
03-Jun	Wed	420	70	83.3%	214	55	74.3%	91	15	83.5%
04-Jun	Thu	415	96	76.9%	233	86	63.1%	77	9	88.3%
05-Jun	Fri	454	94	79.3%	222	71	68.0%	107	23	78.5%
06-Jun	Sat	435	117	73.1%	241	97	59.8%	98	20	79.6%
07-Jun	Sun	425	103	75.8%	219	93	57.5%	100	10	90.0%
W/E - 07/06/15		2975	661	77.8%	1562	561	64.1%	648	99	84.7%
08-Jun	Mon	501	108	78.4%	273	107	60.8%	95	1	98.9%
09-Jun	Tue	442	69	84.4%	231	69	70.1%	94	0	100.0%
10-Jun	Wed	453	66	85.4%	234	64	72.6%	100	2	98.0%
11-Jun	Thu	452	64	85.8%	231	61	73.6%	113	3	97.3%
12-Jun	Fri	442	72	83.7%	239	71	70.3%	91	1	98.9%
13-Jun	Sat	416	52	87.5%	215	50	76.7%	90	2	97.8%
14-Jun	Sun	451	70	84.5%	216	57	73.6%	138	13	90.6%
W/E - 14/06/15		3157	501	84.1%	1639	479	70.8%	721	22	96.9%
15-Jun	Mon	531	109	79.5%	267	93	65.2%	121	15	87.6%
16-Jun	Tue	447	65	85.5%	231	60	74.0%	88	5	94.3%
17-Jun	Wed	468	74	84.2%	251	74	70.5%	104	0	100.0%
18-Jun	Thu	431	63	85.4%	219	58	73.5%	96	5	94.8%
19-Jun	Fri	461	96	79.2%	239	93	61.1%	102	3	97.1%
20-Jun	Sat	431	83	80.7%	204	80	60.8%	110	2	98.2%
21-Jun	Sun	419	91	78.3%	227	90	60.4%	106	1	99.1%
W/E - 21/06/15		3188	581	81.8%	1638	548	66.5%	727	31	95.7%

Overall this data combines to give us an on trajectory position on our performance trajectory for the last three weeks. It should be noted that all available data suggests that site reconfiguration had no impact on performance.

Table 2: performance trajectory



It is imperative that we continue to work through the Clinical Management Board (CMB) and further empower the Clinical Directors to grip performance and start implementing recommendations from ECIST and CQC and lessons learned during the system reset applied for reconfiguration. This will be done quickly. The dynamic needs to change whereby are issuing considered instructions to clinicians and managers around appropriate actions to manage the day within emergency care. They can then be comfortable being truly accountable for the Trust's recovery and performance moving forward.

A total of 36 patients have experienced waits of over 12 hour breaches from decision to admit since April. This figure has been revised from the previous Board report following a detailed data validation exercise. A full review of each case is in hand so that lessons for the whole system can be identified and actioned. The outcome will be reported to the Quality and Risk Committee in July.

5. System reset

The System Reset work implemented in the lead in to reconfiguration gave some indication of the possible gains and challenges faced by the organisation. We entered a period of System Reset beginning Monday 8th June and spanning the 14 days up to and including the reconfiguration weekend. The aims of the reset were to:

1) Ensure RSCH and PRH were at AMBER status for the reconfiguration weekend
2) Ensure that Target Wards were at their minimal occupancy or where necessary closed
3) Ensure that Core Wards had capacity and flow
4) Ensure that extra capacity was available as a contingent measure during the reconfiguration weekend
5) Ensure that the organisation was briefed, engaged and sighted on the deliverables

In terms of metrics the Trust set out to achieve the following alongside the 5 items above:

a. 6 staffed empty beds in AMU E Bay as contingency beds
b. 6 staffed empty beds on Plumpton Ward as contingency beds
c. No medical outliers on Ansty Ward
d. AMBER status (or less) on both sites
e. Assurance that all comms had been delivered and that the entire organisation was briefed and ready
f. No Medically Ready for Discharge (MRD) patients on the Target and Core Wards
g. No patient waits pending diagnostics, review, referral, therapies or repatriation by 18th June on the Target and Core Wards

Target Wards were those directly affected by the reconfiguration. These were:

- Level 8A East & West
- Level 8 Tower
- Ansty
- Horsted Keynes (medical outliers)
- Twineham and Albourne

Core Wards were identified as a limited number of wards unaffected by the move but key in terms of delivering AMBER status for the Trust. These were:

- Catherine James
- Chichester
- Level 9A

This work was broadly successful for the Trust and the reconfiguration was very successful as a result. However, the work also fed into some of the challenges now outlined by ECIST. In particular it highlighted the need for much more active engagement with partners and the need for a new dynamic if we are to deliver on issues such as markedly reducing MRD numbers and overall ED attends.

6. External engagement

Our broader engagement with system partners has seen us:

- Jointly commission a system capacity review from Ernst & Young that says?
- Work with CCG partners on redesigning the “front door” of unscheduled care
- Improve collaboration with ambulance services, ensuring that our local residents receive high quality coordinated care when they are conveyed by ambulance to the hospital EDs

In addition to these initiatives we are exploring the potential of the NHS England “Five year forward plan” which helpfully sets out new care models and invites systems to apply for additional support via the “Vanguard” project set. We are therefore in the process of submitting a bid, across our local health economy to become a vanguard site and to capitalise on the additional support and learning available from NHS England and peers. This is due for submission by 15th July.

7. Conclusion

In essence, our broader approach is to accept the challenge laid out in the “Five year forward view”, promoting delivery across the following areas:

- **Align leadership and sharpen priorities across the system**

    - The aim is to ensure everyone is agreed on what they are aiming to deliver: What is the overall model of care, which specific patient benefits are you expecting to deliver, and what are the specific changes that will enable these. This provides the operational 'blueprint' for successful delivery.

- **Transform at pace**

    - A comprehensive delivery plan is essential, together with clarity from across delivery partners as to who will actually do what. This requires strong project and programme management support.

- **Unlock innovation**

    - Innovation is required across all areas, and is a strong enabler of front line support for change. Common areas of challenge are IT and Information Governance.

- **Mobilise culture**

    - To shift the culture, there is a need to develop a strong shared purpose, with clinical leaders who will take forward the integration agenda. This is particularly important as:
    - Health systems consist of multiple partners, often with a large geographical spread. A unified purpose and mission is crucial.
    - Innovative ideas often come from the front line clinical staff as they interact with patients on a daily basis. When they are actively involved in cultural shift they are likely to drive the new model and their colleagues along
    - GPs are crucial change leaders, innovators and role models. They will need backfill and support to free up their time to focus on the proposed change.

We believe that this sets out a change programme that is sophisticated enough to draw together the complex set of dynamics that form a whole system approach whilst also being simple enough to deliver that inspirational hook that will help us deliver at pace from the shop floor.

Rick Strang
Director of Operations (Emergency Care)
June 2015