Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**30th March 2015**
Board Sponsor:	**Amanda Fadero, Director of Strategy and Change**
Paper Author:	**Rick Strang, Director of Operations (Emergency Care)**
Subject:	**Urgent Care Transformation**

Executive summary

This report updates the Board on progress within the Emergency Care pathway. Following the discussion at the Board meeting in February, a detailed analysis of the reasons for breaches of the four hour Accident and Emergency standard was undertaken and is described in the report.

Performance against the four hour standard remains below the required level of 95% however the Trust has seen some improvement over recent weeks.

Links to strategic objectives	Best and Safest Care √
Identified risks and risk management actions	Patient safety and experience; performance against the 4-hour A&E standard; organisational reputation
Resource implications	To be worked through within the Directorates
Legal implications	Not applicable
Report history	Previous reports on Emergency and Unscheduled Care have been made to the Board of Directors monthly in 2014 and 2015.
Appendices	None

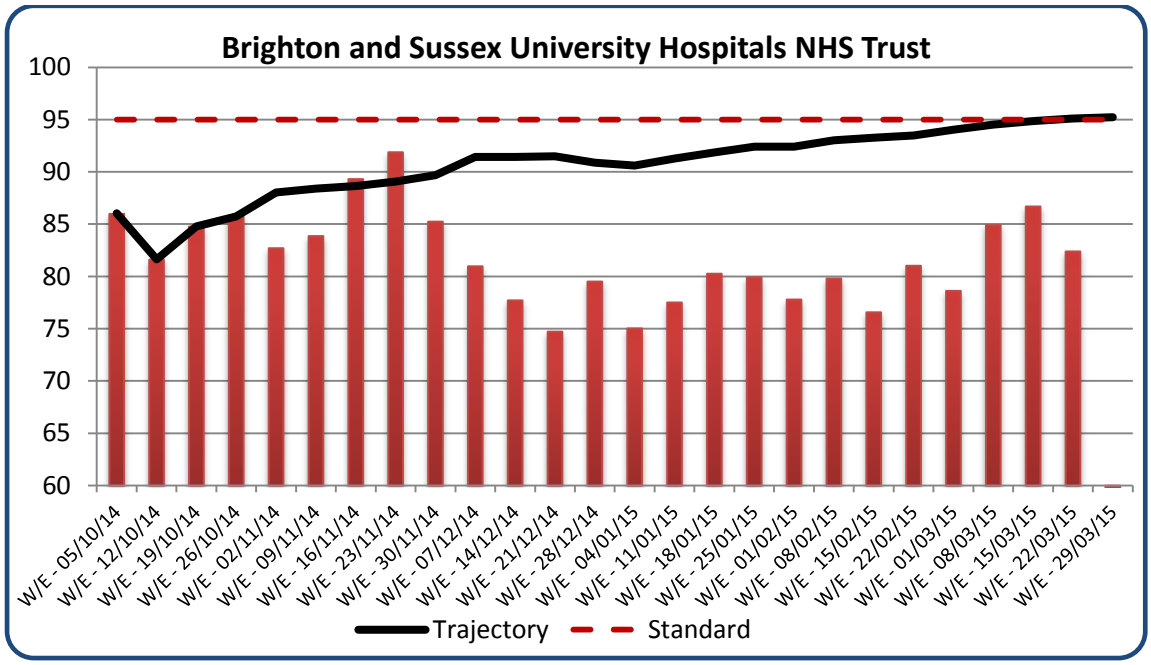
Action required by the Board

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

Report to the Board of Directors, 30th March 2015

Urgent Care Transformation

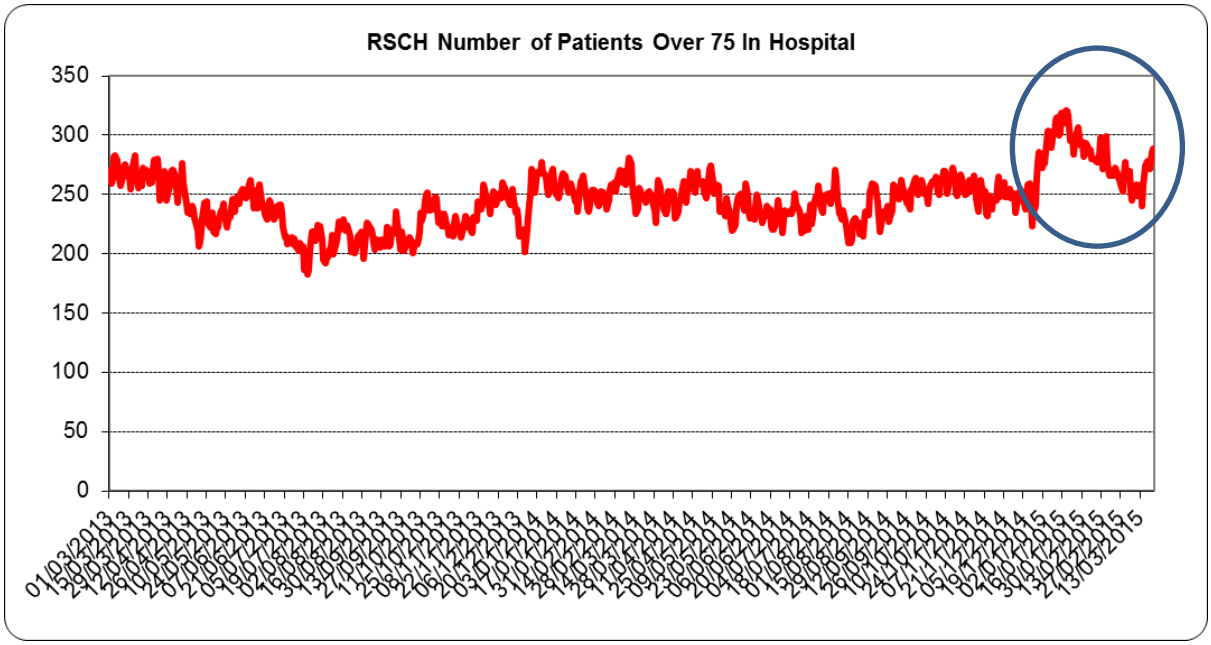
Performance against the four hour standard remains below the required level of 95% however the Trust has seen some improvement over recent weeks.

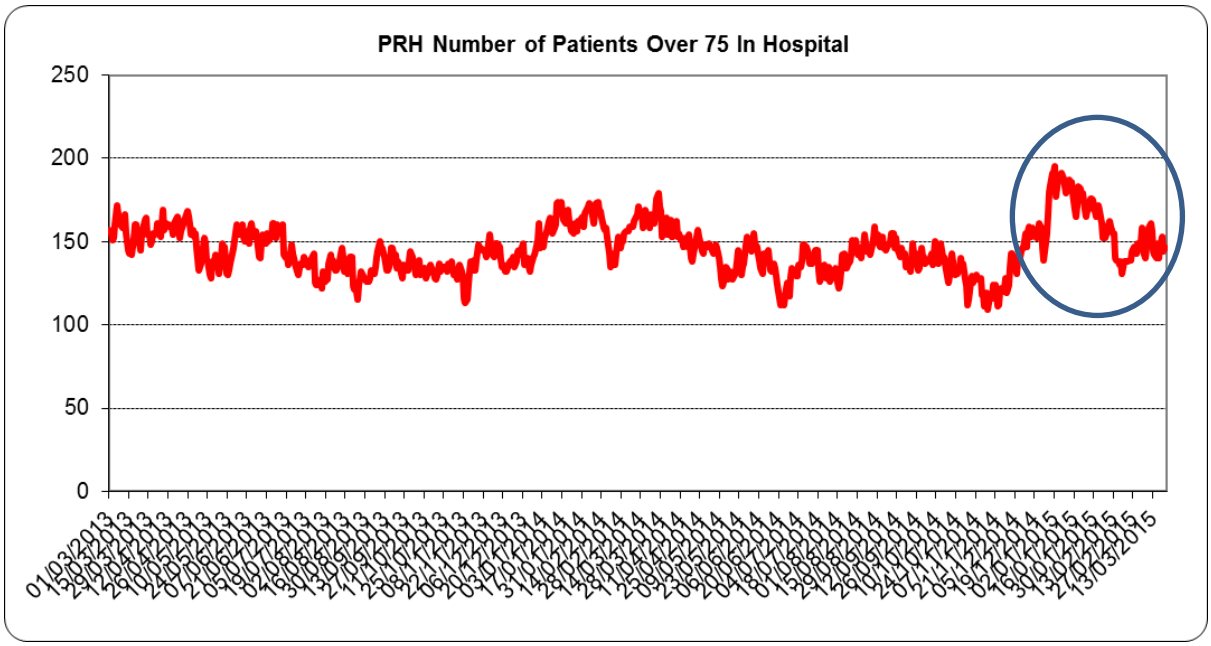


Significant factors in this appear to be a downturn in the age profile and acuity of the admitted patients and an improvement in the medically ready for discharge position (MRD). We do remain vulnerable however and continue to work near the limits of our bedded capacity. This can mean that relatively small changes in acuity or volumes can result in a noticeable downturn in performance as has been evidenced in the week ending 22nd March.

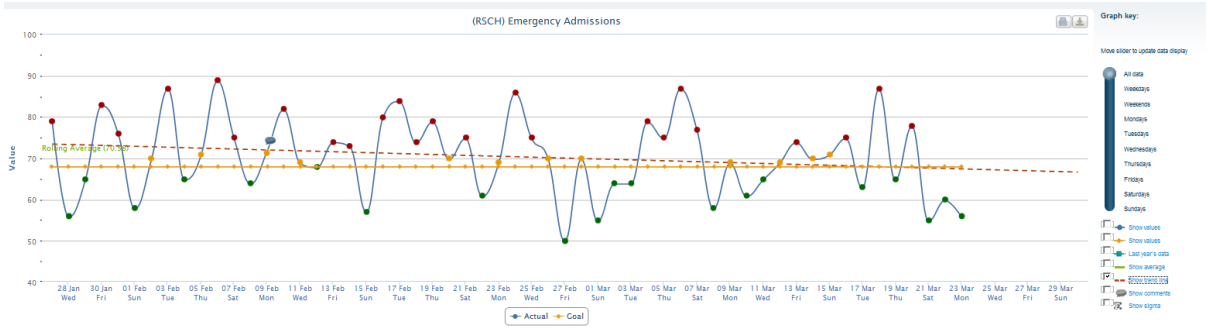
The demographic complexities of ill health and ED attendance profiles are not an exact science however there are some indicators that seem to map to our qualitative experience and resulting performance.

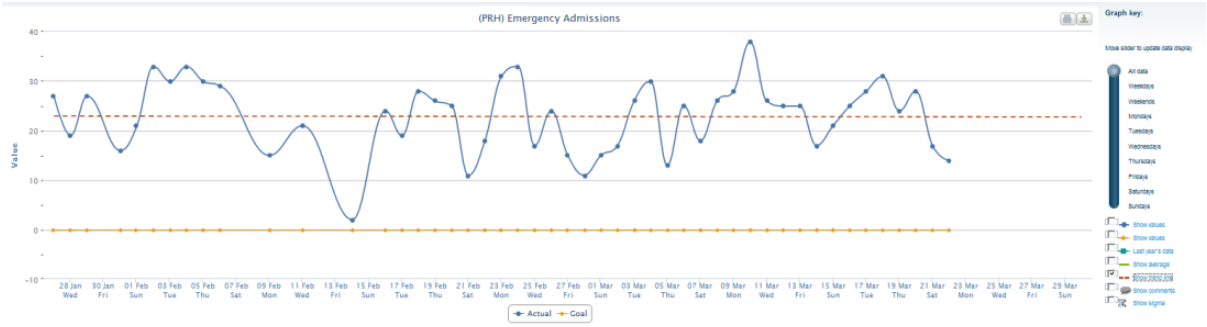
The board should note the recent fall in elderly admissions. Often these are more complex, have higher acuity and higher post-acute needs resulting in longer lengths of stay. The downturn in >75 year old admissions at RSCH and PRH matches our improved performance. In addition, the recent slight upturn matches our own performance downturn.



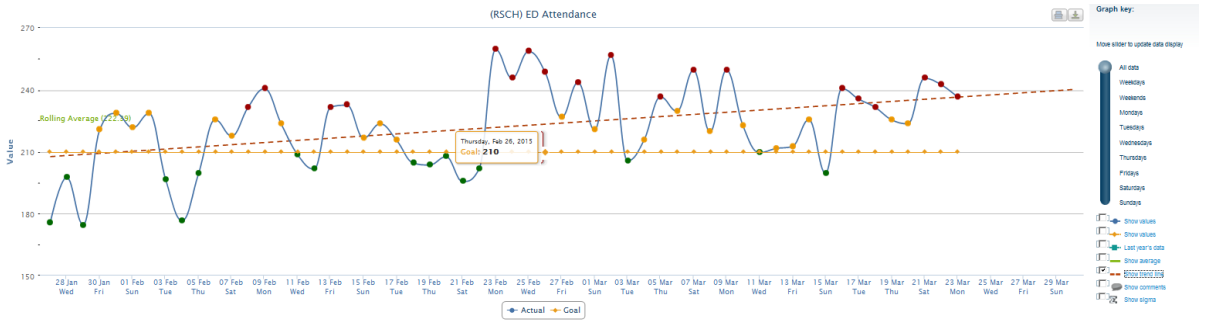


Other factors of note in the overall general improvement in performance are the fall in admissions on both sites, although PRH's is very small.

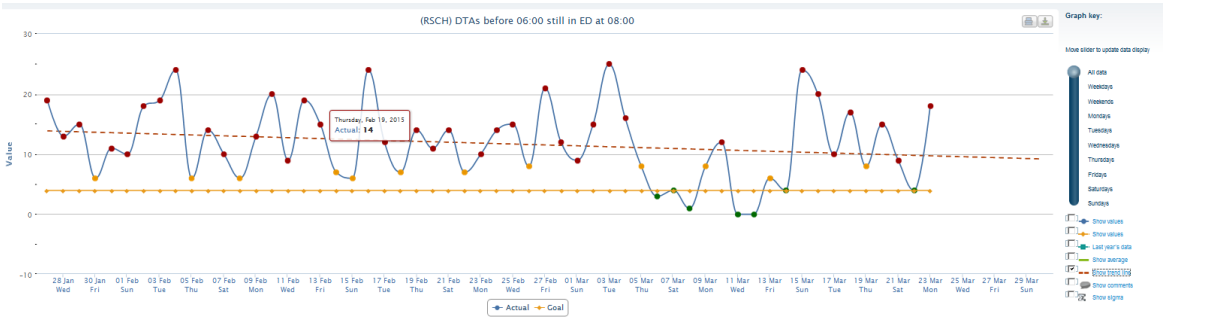


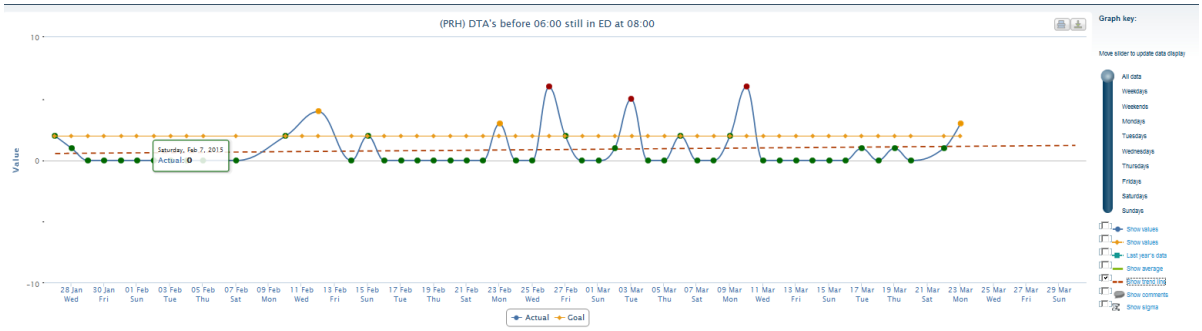


This comes in spite of rising attendances on both sites, suggesting a fall in acuity and more less-acute presentations.



There is further evidence of improvement in flow with fewer patients waiting overnight in ED for a bed, particularly at the RSCH site where the trend is markedly downward over the last 8 weeks. PRH again has relatively minor movement but it should be noted that there is a small upward trend. The tolerances and variation at PRH is much smaller.





It was noted at the previous Board Meeting that colleagues were keen to see a deeper dive around the breaches of the four hour standard to get more of an understanding of their causes and the factors to be considered with regard to improving performance by reducing their occurrence.

The data from PRH is currently incomplete and perhaps reflects some of the work being undertaken in understanding the “back end” functionality of the new IT system. There is however detailed current data available for RSCH and it is likely that the patterns are similar.

It is important to be clear that the analysis of the numbers and breach reasons offers a very 2 dimensional view of operations within the ED. The methodology for the coding for the breach reasons is embedded within the Symphony IT system and goes back a number of years. There are anomalies in as much as patients may have multiple causations in a single episode of care that contribute to their breach and yet the system can only record one. Choosing which one can be subjective. Nevertheless, breach analysis can give some guidance as to areas of concern and when matched with other data and qualitative experience, offer an operational insight into the progress of process and infrastructure improvements.

The most recent six week period prior to the compilation of this report was chosen for analysis (Monday 2nd February to Sunday 15th March inclusive).

Of the 2 901 breaches in that period, 140 were legitimate clinical breaches where the care of the patient dictated a stay in the emergency department of over four hours. This equates to 1.5% of attendances. This is extremely low. The government standard of four hours is set at 95% to allow 5% clinical breaches. This may indicate that patients that are clinical breaches are being recorded as other types of breaches. Importantly however it indicates that patients are not being breached and then coded as “clinical breaches” in an attempt to clinically justify the breach unreasonably. If anything this illustrates that the emergency department are likely to be being overly critical of their own performance.

In summary then, if clinical breaches were the only breaches at RSCH the Trust would be delivering 98.50% against the four hour standard of 95%.

The next category of breaches are those attributed to delays in the emergency department. These account for 746 breaches (26% of all breaches). When combined with the clinical breaches then the total number of breaches occurring within ED that may be seen as ED

breaches, equates to 886 breaches which, if they were the sole breaches at RSCH would give a performance of 90.52% against the four hour standard.

Given that the performance for the six weeks analysed was 68.97% it indicates how very important the contribution of the rest of the hospital becomes to achieving the 95% standard when just over 20% of the performance comes from there whilst only 5% is not achieved due to factors within ED itself. This is likely to be even more prescient when the ED breaches are looked at in more depth.

Of the 746 ED breaches (clinical breaches have been discounted), 313 occurred with patients who were subsequently referred and admitted. The attribution of some of these breaches may well be due to the vagaries of the reporting system where only the first action that causes a delay is recorded as the breach reason. Given what we know about delays in waiting for a bed, this seems highly likely.

When looking at the 313 patients who were attributed as ED breaches but admitted as in-patients (therefore being under the care of specialty teams) 205 (65%) had delays waiting for a bed that took their total ED stay over 8 hours.

104 ED breaches occurred in the Urgent Care Centre in patients that were sent home. This equates to 1% of all attendances. Whilst ideally this should be zero, given the walk-in primary care pressures on the ED this is a remarkably low number and indicates that although work should continue to achieve the “zero breaches” position, there is not a significant issue in that area.

Over the six weeks of the study period 1 267 of the breaches (44%) occurred whilst the patient was in the care of specialty teams. Were this the sole reason for breaching performance would be 86.44% against the standard of 95%.

This cohort of breaches can be broken into two categories – waiting for specialty review and waiting for a bed. The former equates to 523 breaches (18% of all breaches) and the latter 744 breaches (26% of all breaches).

The key specialties appear to be general medicine and general surgery although given the predominance of those specialties within presenting complaints this does not seem unsurprising. However there is definitely room for improvement in their performance. There is an expectation that a specialty review will be secured within 30 minutes of a referral and that a specialty bed will be secured within 1 hour of a request for a specialty bed.

Over the six week period in question the average wait for a general surgical review was 3 hours 48 minutes and the wait for a medical review was 3 hours 39 minutes. The wait for a bed across all specialties from the time of decision to admit (DTA) to leaving the ED was 7 hours and 17 minutes.

It is important to understand these delays beyond the simplicity of the percentage set against the standard. Each ED cubicle must turnover twice within an 8 hour period. If a patient stays in that cubicle waiting for a bed then clearly the next patient arriving by ambulance cannot go into the cubicle and thus delays in offloading ambulances begin to occur. Furthermore, with nowhere to physically see the patient the ED delays begin to also accrue.

577 breaches (20%) have been recorded as being due to no capacity in the ED and their being an inability to begin care. Set against the four hour standard these breaches along (6% of attendances) would be enough to take the Trust below the 95% threshold. The subsequent delays in ambulance handovers are also noted along with the impact on 999 services whose ambulances are held at ED waiting to offload rather than responding to calls.

Exit block therefore is not only a significant factor in our own breaches but also in the ability of other services to meet their standards.

There were a range of other delays leading to breaches including portering (6 breaches), delays in diagnostic tests or results (45 breaches) and delays in transport (3 breaches) these are very small totalling just 2% of total breaches (0.5% of performance set against all attends) but nonetheless may be important in terms of setting our own tolerances and expectations around performance.

A significant part of this report has focussed on numbers and percentages. It is absolutely vital that we record formally and recognise that all of these represent individual patients. As such delays in care are a significant aspect in poor patient experience and poor clinical outcomes. A recent study indicated that delays over 6 hours in the ED increased mortality in admitted patients by the 10th day of an in-patient stay. The Trust must therefore continue to carefully understand the data it is collecting and use it operationally to improve the patient experience.

Whilst there continues to be work to be done within ED to improve flow and responsiveness it is evident that the success of the Trust in achieving the four hour standard involves a major investment by the rest of the hospital in the daily workings of that department. Indeed, this extends beyond the walls of the hospital. We have clearly identified the impact of not being able to place patients safely and swiftly into beds in the Trust when their ED care is complete. The fact that the Trust continues to support 30 plus patients whose acute care is complete but whose community or social care is not ready to start (Medically Ready for Discharge – MRD) adds to the impedance of the required flow needed to secure a consistent performance against the four hour standard.

The ED has long been a barometer of the success or otherwise of schemes outside of the hospital aimed at preventing admissions and increasing discharges. Despite significant work from partners including “hear and treat” and “see and treat” by the ambulance service to avoid conveyances and preventative work within primary care such as GPs in the ambulance control room, out of hours GP cover and the Roving GP scheme, the site has still seen a 7% increase in attendances overall, including a 3% increase in ambulance attendances.

At the height of the winter pressures the Trust opened 30 additional beds on the RSCH site. However, these were not always in optimal locations and could only be very short term to offset any immediate risks. Overall the restoration of flow will depend on fundamentally changing both our internal pathways and more challengingly, influencing our external partners to fundamentally change theirs.

The introduction of RACOP and SAU are examples of admission avoidance. SAU, which started late last year, has seen a downturn in surgical admissions of around 60% thanks to its use. The increase in scope and size of the HRDT coupled with the new RACOP

positioned at ED has also seen an increase in patients turned around and safely discharged home rather than admitted.

Expanding the bed base on the RSCH site is challenging due to the well documented space constraints and age of the estate. We are therefore working closely with SCT to secure beds at Newhaven Downs which could take up to 40 patients out of acute beds. Staffing for this area is challenging but nevertheless there may be the start of a phased opening from May.

More work to influence the practices and provision of services for social and community care will be required in the interim to ensure that the MRD list is brought down and maintained at a manageable level.

Rick Strang
Director of Emergency Care
March 2015