Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**27th April 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, detailing performance against the four hour Accident and Emergency standard since the last Board meeting; challenges in admitting patients in a timely manner; the consequences of 'exit block'; and the impact on the experience of patients of cohorting within the Emergency Department.

The Trust has developed ten high impact programmes to deliver improved safety and quality and performance with a particular focus on emergency and unscheduled care. The agreed actions in this area are detailed in the report.

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

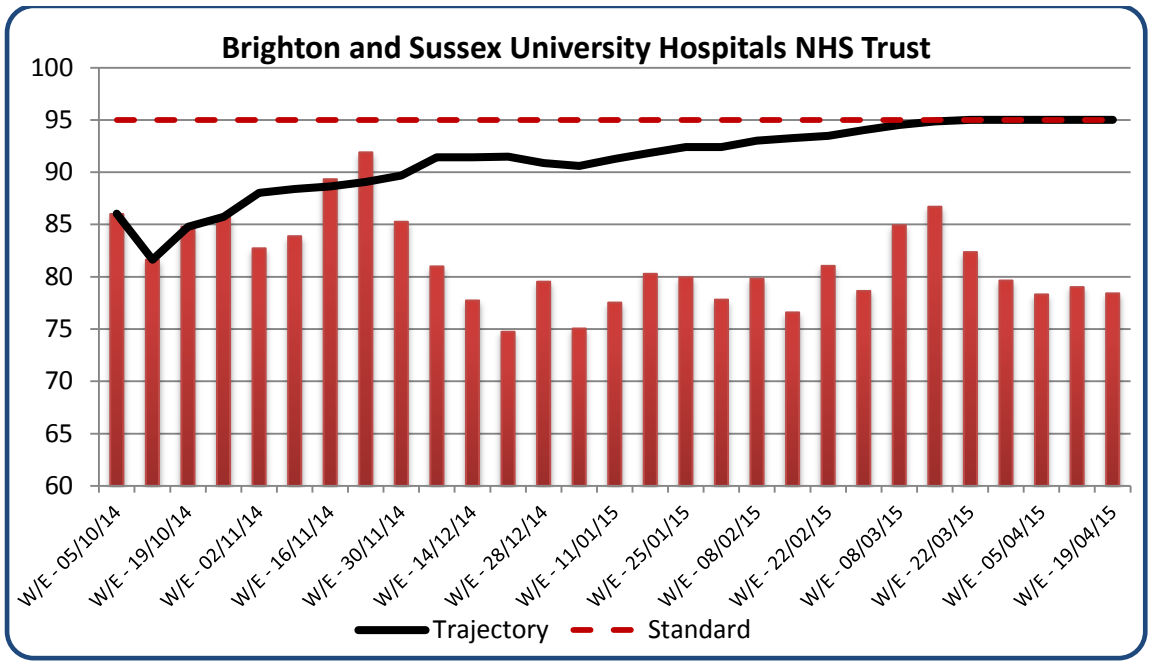
The Board is asked to note the contents of the report and support the direction of this programme of work.

Report to the Board of Directors, 27th April 2015

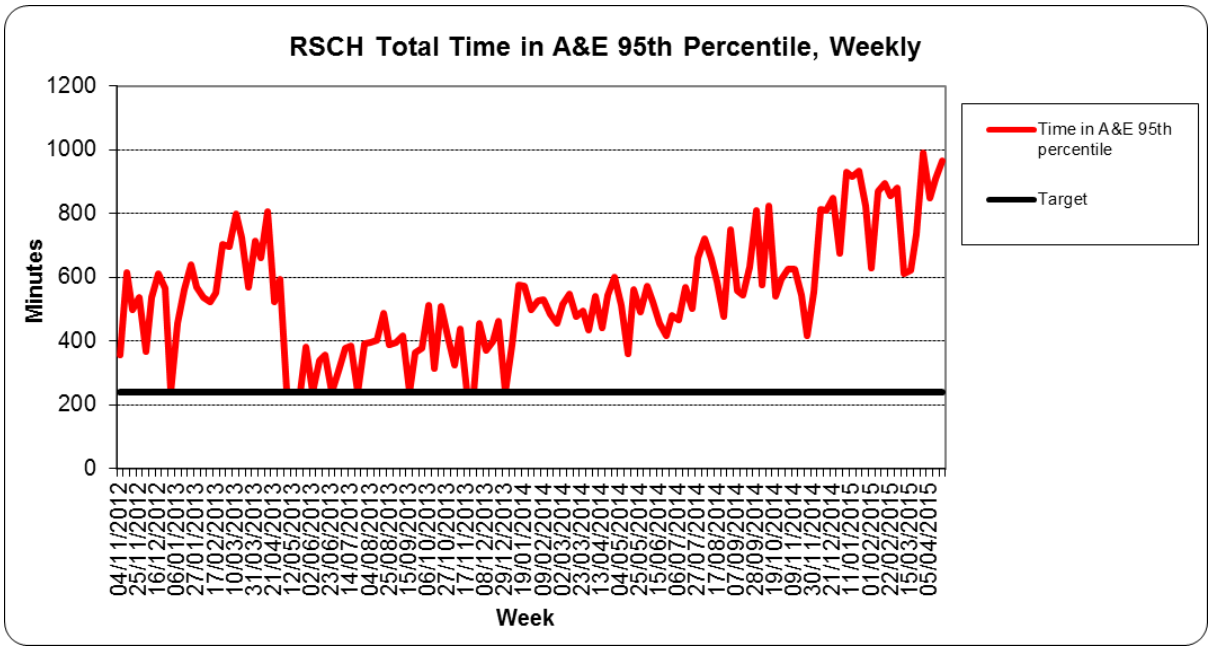
Emergency and Unscheduled Care

1. Performance

The Trust continues to face challenges that hinder the return to a consistent 95% delivery of the four hour Accident and Emergency standard. Performance since the last Board meeting is detailed in the table below.



Matched to the low performance there has been a steady increase in Emergency Department (ED) delays caused primarily by exit block and the unavailability of beds. Whilst this is an occasional cause of failure to achieve the standard at PRH it is a consistent and persistent cause of failure at RSCH.



At RSCH from 1st April to 22nd April there have been 1,028 admissions to wards from ED. Of the 1,676 breaches so far between 1st April and 22nd April, 1,241 (74%) have been directly accredited to a lack of admission space on the wards (exit block) or a lack of space in the ED as a consequence of exit block.

A further consequence of exit block has been the continuing challenge of cohorting i.e. holding patients delivered by ambulance in ED whilst awaiting an ED cubicle. Figures from SECAmb indicate that ambulance delays means 282 hours of ambulance time were lost last month.

This is a consequence of over half of all ambulance attends into the RSCH site being held for over 30 minutes against a national standard of 100% held less than 15 minutes.

To support this area, a cohort policy has been developed to maximise patient safety and mitigate poor patient experience. The physical attributes of the cohort space limit what can be achieved however staff work very hard to ensure that patients continue to receive full and appropriate care in this area despite its shortcomings.

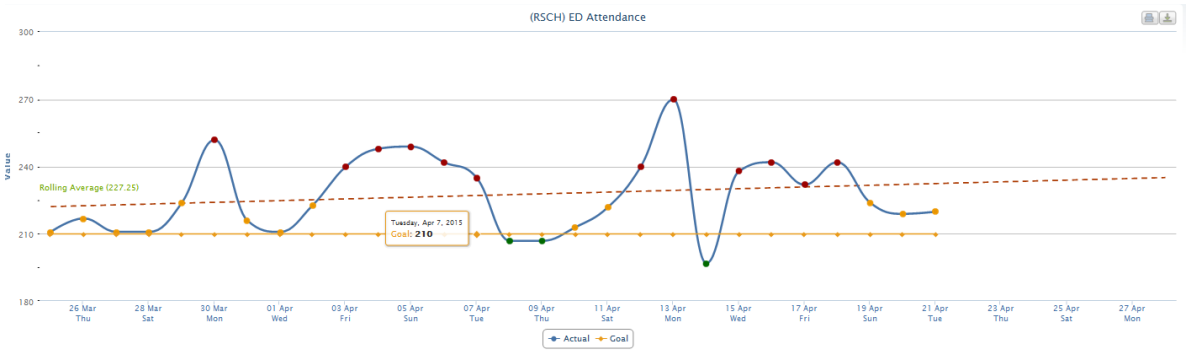
Around a third of patients who attend the ED will spend some of their time in the cohort area. Looking at just those who arrive by ambulance, this rises significantly to around 75% of ambulance attends spending at least some of their journey in the cohort area. Furthermore, half of all admitted patients will have spent some of their time in the cohort area and 64% of all four hour breaches will have been cohorted at some point.

Patient experience

Understanding the patient experience is more complex.

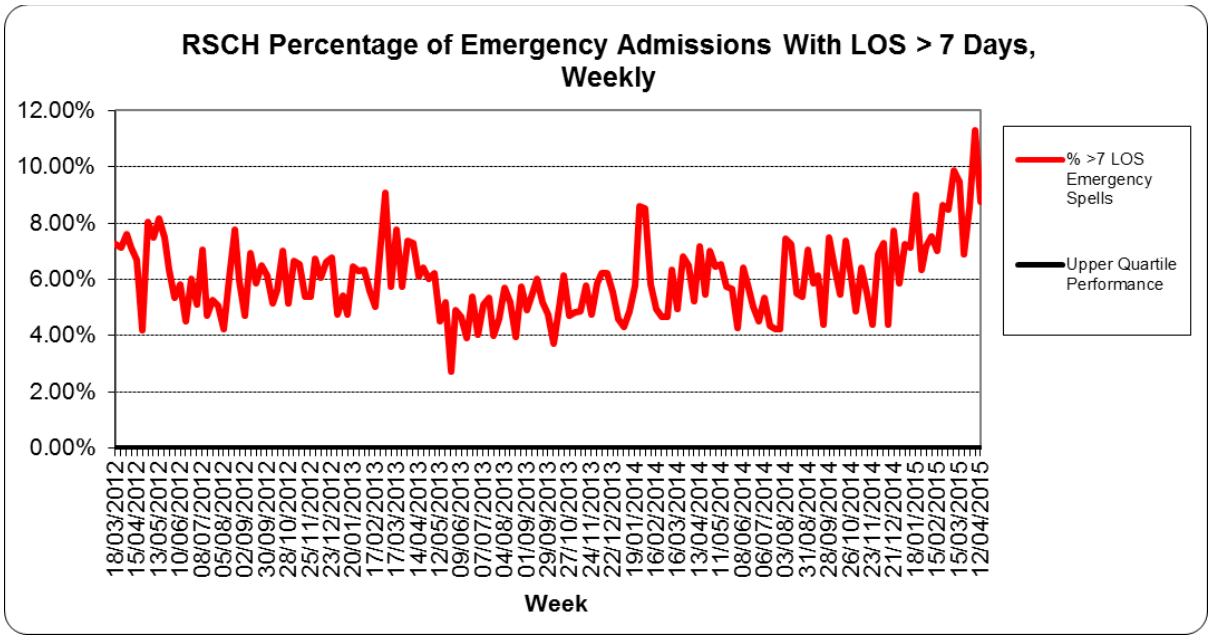
There have been no formal complaints from patients regarding the cohort area for January, February or March. In addition, there have been no clinical incidents recorded as a direct result of cohorting. It is difficult however to draw a clear conclusion from this as the area is designed as circulating space. It is a tribute to staff that patient care is managed to a high level in this area and thus complaints and incidents are avoided. Despite this we do not want to use this area and staff morale is poor on days that we are cohorting and staff who, as advocates for their patients, feel it offers a poor care space.

The causation for these challenges is varied. We've continued to see an upward drift in ED attendances over the last four weeks.



The Trust continues to face issues around what is already a tight bed stock. PRH has had some sporadic ward closures due to Norovirus. At RSCH the Acute Medical Unit (AMU) has reduced bed capacity by 9 beds to increase the patient to staffing ratio. 6 of those beds arere-opened on a flexible basis with dedicated staff outsisde of the AMU team to support surges. CDU is also closed with a loss of 14 beds due to building works required for 3Ts. Again, 5 of those are opened temporarily to provided flex capacity. 3Ts works still preclude the admission of any immuno-compromised patients into the Jubilee building. These are being admittd into side rooms within the cardiac wards.

Paralell to this, lengths of stay over 7 days are increasing sharply. This would appear to be acuity related as medicial delays are on the decline. Having said that the clinicians are conviced that there is a significant cohort of sub-acute patients filling the beds who do not require acute care and yet do not trigger as “medically ready”. Further work to define and monitor this cohort is required.



Having outlined the scale of the challenge it is important to understand the breadth of the improvement plan required to resolve these issues. The Trust is committed to achieving the 95% four hour standard by the end of Q2 and is in the process of agreeing the requisite trajectory with partners and the TDA. Tied to this is a trajectory for improvement around the ambulance handovers. Any trajectory for this area must also be linked to reducing attendances and reducing the medically ready for discharge cohort as ambulance delays are a direct symptom of exit block and poor flow.

The Trust has developed ten high impact programmes to deliver safety and quality (and thus performance) going forward. Programme One relates to unscheduled care and includes:

- Deliver the first Phase of the Level 5 plan, changes to RACOP and ACU
- Agree revised trajectory for 95% , identifying five key deliverables;
    - Newhaven and other capacity changes including Hospital at Home
    - Seven day services
    - Managing no waits in our hospital beds
    - Early ward rounds and discharges before mid-day

- Early specialty review in ED patients wait no longer than 12 hrs in ED
- Review the best model for the Front door with CCGs
- AMU Plan Five key Improvement deliverables
    - Review the functions and the capacity of current AMU
    - Improve senior leadership capacity
    - Ensure additional staffing in place at peak times
    - Work with CSM team to review practice of admissions
- Appoint new COO - Meet with recruitment consultancy

These programmes will be owned across the executive and the clinical directors linked into the trajectory for improvement agreed with the TDA and CCGs for quarters 1 and 2. Other programmes in the ten high impact portfolio will impact indirectly on unscheduled care and include:

- Maximising capacity to improve patient flow
- System Wide Capacity Review
- Delivering the significant change to services described as “Site Reconfiguration”
- Improving the effectiveness of our workforce across the week – 7 day working
- Secure Specialist Services across Sussex
- Strategic service developments including a focus on recovery of 18 weeks for key areas
- Delivering Organisational Change
- Developing service options and the refresh of the Clinical strategy
- Securing the Financial Health of our organisation
- Developing the next phase of our people change programme

This work programme will deliver the changes required in the first half of the year to move the Trust to steady state. Maintiaining that and reducing the vulnerability to surges in emergency activity and delays in discharge will require continued work with external providers and the CCG. As noted in the Unscheduled Care Programme a jointly worked re-design of “front door” services offering an integrated primary care hub alongside the ED and a suite of specialist assessment areas will look to take pressure away from the ED itself and allow the teams there to develop their own performance around core business including major trauma and those patients with siginicant major illnees and/or injury.

Rick Strang
Director of Emergency Care
April 2015