Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**1st June 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; and issues concerning patients who are Medically Ready for Discharge (MRD).

The report also describes the agreed trajectory to achieve sustained improvement in performance; service improvements within the emergency and unscheduled care pathway; and the positive outcome of the recent emergency planning exercise.

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

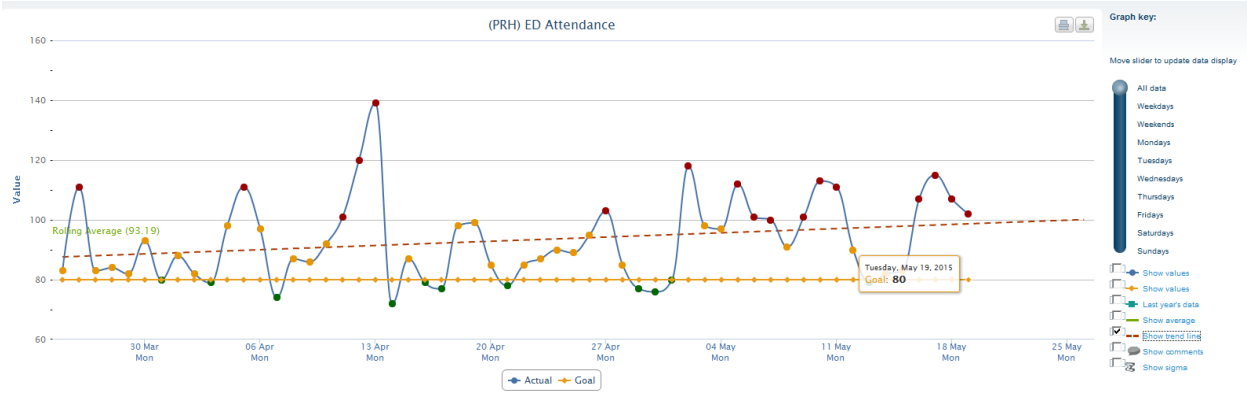
The Board is asked to note the contents of the report and support the direction of this programme of work.

Report to the Board of Directors, 1st June 2015
Emergency and Unscheduled Care

1. Performance

BSUH has continued to be challenged with regard to achieving the four hour standard. There has been some improvement this month at PRH which is to be welcomed, but RSCH continues to face a significant daily challenge to achieve the required discharges needed to ensure both elective and emergency work can be admitted in a timely way. Early work from Ernst and Young looking at capacity seems to suggest an increasing acuity profile leading to increased lengths of stay set against an already challenged bed base. With a consistent 97% bed occupancy rate only very small variances in attendance rates both in terms of total volumes and surge patterns can have a marked effect on any given day. In particular the fine variances mean that the Medically Ready for Discharge (MRD) patients play a far more prominent role in defining the shape of each day than the relatively low numbers would seem to suggest. The Trust is currently running at about 50 MRD patients. The numbers at PRH (currently 17) are exacerbated by the closure of Plumpton Winter Ward (due to the end of winter monies) which was routinely taking 12 of these patients thus reducing the pressure on acute beds to around 4 or 5.

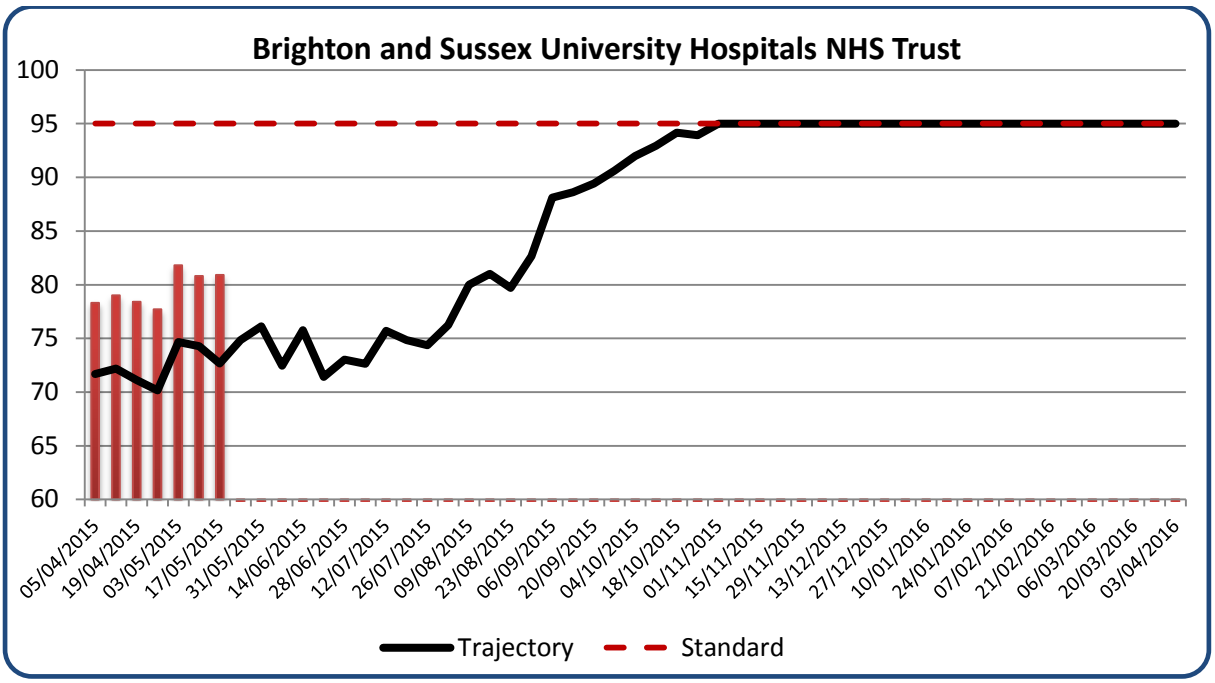
Overall footfall through the emergency departments in May has been the highest since the start of the calendar year. This has been driven in part by a consistent increase in self-presenting attends at PRH.



Ambulance attendances have remained relatively static although delays in handover have persisted at RSCH driven primarily by exit block in the ED reducing the available cubicle spaces.

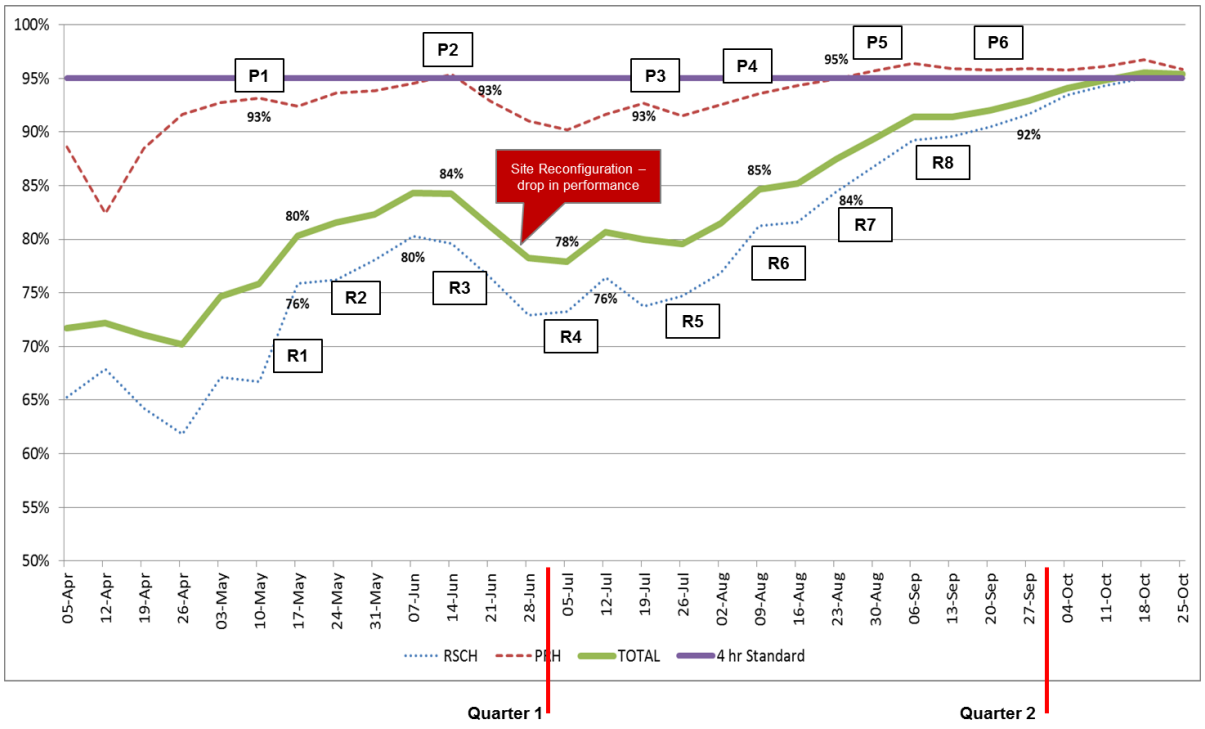
The emergence over recent weeks of 12 hour trolley breaches is a worrying development indicative of the current pressures faced at RSCH in particular with regard to patient flow. A heightened awareness around monitoring flows and reviewing situational updates is looking to reduce the instances. The key solutions will however come through the recovery of flow and a better understanding of current capacity. Early work from Ernst and Young (who have been commissioned by the CCG to deliver a system wide capacity review) indicates a significant capacity shortfall across the system which will need to be addressed in partnership with the CCG and SCT.

The current position regarding the four hour standard is outlined below:



2. Performance trajectory

A new trajectory for improvement is being discussed with the CCGs and TDA reflecting the development plans incorporated in the 10 Programmes for Change document. This forms the basis for business and performance planning into this year.



RSCH Schemes		PRH Schemes	
R1	Improved triage processes in the Urgent Care Centre and re-directing people more quickly	**P1**	Improved internal processes and Site Management – PRH Co-ordinator roles, improved use of ACU, Reinforced role of ED shift lead
R2	Clinical model for acute ambulatory assessment pathways – for GP-referred pathways from ED/UCC	**P2**	Additional consultant input from 2pm-10pm; SpR on site 8am-2pm
R3	Focus on Discharge Process – ECIST, SAFER flow bundle, Ready to GO, Criteria Led Discharge, Full Capacity Protocol	**P3**	Consolidation of ECIST work and recommendations and GP input 9am-5pm (Mon-Fri)
R4	Clinical model for ambulatory assessment pathways – for non-GP referred pathways from ED/UCC	**P4**	Site Reconfiguration pathway embedded and focus on recovery in performance
R5	New therapy model – ECIST recommendations	**P5**	7-day services: Hospital @ Night, enhanced medical cover
R6	Consolidation of assessment pathways – Acute Medical Assessment Unit and Surgical Assessment Unit	**P6**	Consolidation of Discharge Process
R7	Consolidation of Discharge Process; Focus on sub-acute patients		
R8	Newhaven Phase 1 – 20 beds; 7-day services (therapy, HRDT). Better Care Fund – reduction in SECAmb conveyances		

The detailed work on each of these schemes has yet to be finalised but is being programme managed through the Change Hub. Project initiation documents (PIDs) will be secured through June.

Work is also underway to agree a joint trajectory for improving ambulance turnaround times with SECAmb and eliminating ambulance delays. A CEO to CEO level meeting with Directors of Ops from both BSUH and SECAmb is planned for the end of the month.

The board are advised that 10 breaches of the 12 hour trolley wait standard were identified in the latter part of April in our performance dashboard and duly declared to the CCG, TDA and NHS England. However, as a part of that process, and in discussion with the CCG, it was felt that a review of how we reported and investigated 12 hour breaches was appropriate. More emphasis was to be placed on the clinical review and clinical impact of any delays. In light of this a thorough interrogation of the Symphony system was also carried out.

This validation work revealed further breaches across April. In addition we had two instances of clusters of breaches on specific days in May due to capacity and flow issues. The findings from the investigations into these breaches confirmed what we already knew; the causes of the breaches were related to our already understood challenges around flow and capacity. The investigations confirmed that the current work streams directed at improving patient flow, increasing discharges from the hospital and increasing capacity within the Community for patients who are medically ready for discharge are the correct areas to work on.

For the months of April and May the clinical teams within the Acute Floor examined a significant number potential breaches of which 30 were clinically validated. This included the 10 already declared and therefore the Trust is in the position of needing to declare a further 20 breaches.

The clinical resource and time away from the shop floor to deliver audits of this kind are considerable and work is now under way to streamline the process to deliver a real-time solution that maintains clinical integrity but allows for a more compressed delivery. In addition we are working to engage the whole organisation in understanding the causes and prevention of 12 hour breaches as although they show within the ED their causation is firmly rooted across the whole of the emergency care pathway.

3. Service improvements

As a part of this work the Acute Floor Directorate have implemented the first part of a larger piece of work aimed at rationalising and improving the emergency care footprint to improve flow, reduce admissions and create opportunities to bypass ED, thus avoiding the current bottleneck there. The Ambulatory Care Unit (ACU) and Rapid Access Clinic for Older People (RACOP) have been combined and expanded to include a GP receiving area for GP expected patients who do not arrive by ambulance. This combined unit benefits from economies of scale and the efficiencies of combined working across disciplines. It is centred in what was previously the Clinical Investigations and Research Unit (CIRU) on Level 5 and has been named the Medical Assessment and Treatment Unit (MATU). It aims to prevent admissions for around 50 medical and elderly patients per day and offers a referral point for GPs outside of ED thus reducing the workload in that unit.

Further discussion regarding emergency care is under consideration for part 2 of the board meeting.

4. Emergency planning

As an addendum to this particular report the Board are asked to note that the Trust recently took part in Exercise EmerGo which is a mandatory testing exercise for all Category 1 providers under the Civil Contingencies Act 2004.

The Trust performed extremely well, receiving maximum points in 3 out of the 5 categories and earning some pleasing plaudits from the Public Health England evaluators. Some brief commentaries from the full report are included below.

> ***The Hospital Control (HC) team*** *performed extremely well achieving the maximum 40 out of 40 performance indicator points.*
> *Roles were quickly established and action cards issued to the right staff it became clear a clinical adviser was not present, a member of staff then attended from the surgery department.*
> *The team quickly made decisions after Startex, with good team work and communications within HC and with the other departments.*
> *There was also good awareness of available external transfers, proactively sharing this information with the ED department.*
> *The decision loggist followed the appropriate guidance, ruling off after each action.*
>
> ***ED*** *achieved the maximum 32 out of 32 performance indicator points.*
> *It was identified by the evaluator that the team was well organised with roles allocated and regular briefings by the ED lead.*

Regular updates were provided to Hospital Control, action cards were issued and a decision log was used.
The department worked very well as a team.

***The ICU team** achieved 28 out of 36 performance indicator points.*
The team worked well together with good leadership.
They were pro-active in gathering information due to a lack of communication from Hospital Control.
Although a decision log was not used and the Major Incident plan was not referred to during the exercise, the team did quickly assess patients and retriaged after Startex.

***The Theatres team** achieved the maximum 44 out of 44 performance indicator points.*
The team took a pro-active approach, allocating roles including a casualty co-ordinator who maintained an accurate log.
The Major Incident Plan action cards were referred to and good communications were maintained with other departments throughout the exercise.

***Staff representing the Rest of Hospital (RoH)** worked well together despite some roles being unfamiliar to those attending the exercise. The team scored 34 out of 36 performance indicator points. Information was shared amongst the team and with other departments; the Major Incident Plan and action cards were referred to.*

The full report is attached.

Rick Strang
Director of Emergency Care
May 2015