To:	**Trust Board**
From:	Mark Brassington, Chief Operating Officer
Date:	
Healthcare Standard	Urgent Care Constitutional Standards

Title:	**Delivering Safe and Sustainable Urgent Care**
Author/Responsible Director: Authors – Clare Culpin, Managing Director & Sarah Hall, Transformation Lead **Responsible Director –** Mark Brassington, Chief Operating Officer	
Purpose of the report: This report will provide the Board with a progress update on the structure and delivery of the urgent and emergency care improvement programme based on the paper submitted and discussed at Board in February 2019.	

The report is provided to the Board for:

Decision	X	Discussion	X
Assurance	X	Information	

Summary/key points:
- The Trust has been addressing risks associated with poor urgent care performance for a number of years and responding to the CQC inadequate rating of Pilgrim Hospital 30th November 2018.
- Since the introduction of a shadow divisional structure, a refreshed improvement programme has been devised supported by a governance structure and engagement of key stakeholders. There are plans to invest in an extensive improvement team.
- Key Personnel have been identified as Senior Responsible Officers to ensure delivery and ongoing compliance with new processes and behaviours.
- This report delivers an update on all key areas identified for improvement
- The PMO has been established and Associate Transformation Leads are now in post to support delivery and secure sustainability of impact.

Recommendations:
- Note the contents of the paper and progress being made.

Strategic risk register	**Performance KPIs year to date**

Resource implications (eg Financial, HR)
Assurance implications
Patient and Public Involvement (PPI) implications
Equality impact
Information exempt from disclosure
Requirement for further review?

**Urgent and Emergency Care Improvement Programme
Progress Report February 2019**

This report will confirm the overarching approach to the delivery of the improvement programme which will enable a stable platform to ensure safe and sustainable urgent care provision.

1.0 Overview
The Trust has been addressing urgent care performance for some time and responding to the CQC inadequate rating of Pilgrim Hospital emergency department. Since the introduction of a shadow divisional structure, a comprehensive improvement programme has been set up supported by a governance structure and engagement of key stakeholders. Key Personnel have been identified as Senior Responsible Officers to ensure delivery and ongoing compliance with new processes and behaviours.

2.0 Urgent and Emergency Care Continuous Improvement Programme
Improving practice, patient care and performance needs to be wider than just the emergency department itself and this improvement programme includes practice and patient flow in the assessment function, the wards and discharge.

Each of the work streams has a senior responsible officer (SRO) who leads and oversees the delivery of the plan. Recognising the work and time commitment to achieve this there has been a recent decision made to have a triumvirate team leading each of the work streams and therefore a manager, clinical and professional lead are being appointed to each work stream to ensure there is additional support for the SRO and delivery of the plan. This model of working is also reflective and aligned to the proposed Trust Operational Management (TOM) structure. A key benefit of a triumvirate model also ensures the delivery of continuous improvement which is clinically led rather than management imposed.
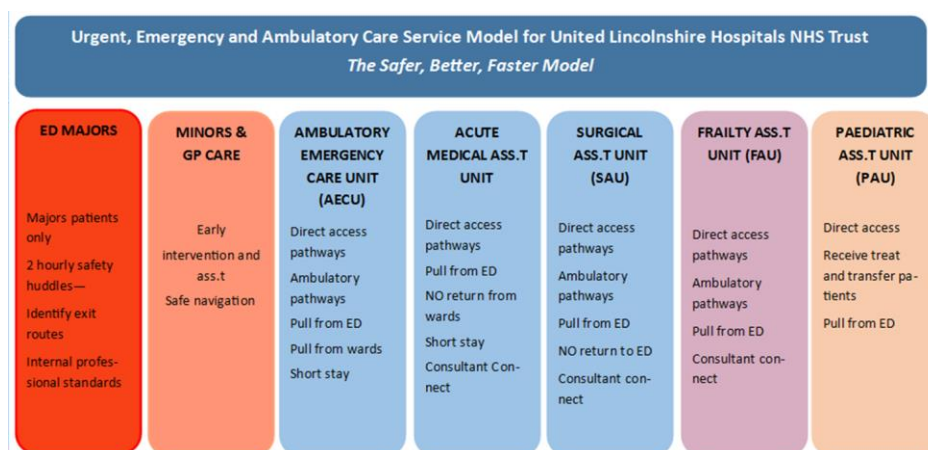
Task and finish groups are associated with each of the work streams to develop, agree and deliver the plan. Membership is wide ranging, multi-disciplinary and includes system partners. Engagement and ownership of the change is important as well as celebrating success, and therefore a communication and engagement plan is being created.

The continuous improvement programme commenced with a period of intensive support in order to address some urgent patient safety issues and implement some immediate change. The approach to this has been command and control, and has required leaders to support patient care on a shift by shift basis. Whilst there remains a need to continue to address underperformance the improvement programme team are committed to ensuring that delivery is underpinned by robust and evidence based improvement methodology, and as such knowledge and expertise regarding improvement methodology is being developed with the support of the Trust PMO.

The improvement approach is using the national Quality Improvement and Service Resign (QiSR) framework aligned with the Trust organisational development programme. Measuring for improvement is a vital component of any programme to demonstrate delivery, credibility and maintaining engagement and pace. For this programme there has been a significant delay in being able to measure change due to the lack of capacity within the business intelligence team to develop the

performance and improvement dashboards. Despite funding for a vacant post the Trust has been unable to appoint, and this element of the programme has only just been introduced in the last two weeks following the appointment of an interim.

The agreed overarching model of transformation for the urgent and emergency care improvement programme is based on the NHSI model for 'Safer, Better, Faster' (NHSI, August 2015). The diagram below outlines the model underpinned by the improvement programme.

| Urgent, Emergency and Ambulatory Care Service Model for United Lincolnshire Hospitals NHS Trust | | | | | | |
| *The Safer, Better, Faster Model* | | | | | | |
ED MAJORS	MINORS & GP CARE	AMBULATORY EMERGENCY CARE UNIT (AECU)	ACUTE MEDICAL ASS.T UNIT	SURGICAL ASS.T UNIT (SAU)	FRAILTY ASS.T UNIT (FAU)	PAEDIATRIC ASS.T UNIT (PAU)
Majors patients only 2 hourly safety huddles— Identify exit routes Internal professional standards	Early intervention and ass.t Safe navigation	Direct access pathways Ambulatory pathways Pull from ED Pull from wards Short stay	Direct access pathways Pull from ED NO return from wards Short stay Consultant Connect	Direct access pathways Ambulatory pathways Pull from ED NO return to ED Consultant connect	Direct access pathways Ambulatory pathways Pull from ED Consultant connect	Direct access Receive treat and transfer patients Pull from ED

To reflect this the programme has five work streams each with a plan as follows:

2.1 Improving practice and patient care in the emergency department (incorporates the 3 section 31 notices for pilgrim hospital)
Whilst there are underpinning standards across all of the emergency departments to ensure patients receive evidence based best practice whichever emergency department is used across the Trust, there are separate sub sections of this work stream to address the specific areas of improvement in each of the individual emergency departments. This approach also reflects that they all have slightly different issues and avoids slowing the pace of improvement.

2.2 Improving practice and patient care in the assessment functions
This involves further development of the existing assessment functions such as ambulatory care as well as introducing new services for example frailty.

2.3 Site management
Ensuring we have effective capacity management practice and escalation in the delivery of patient flow. Developing sound decision making based on robust information is the focus of this work stream

2.4 Ward practice and patient pathways
This work stream focuses on the practice of the multidisciplinary team, aiming to develop productive and clinically effective patient pathways, and routine management of patient flow through the SAFER model. The wider hospital needs to work more integrated with the emergency departments and ensure that there is speedy assessment and transfer of patients from the ED and assessment functions. A significant piece of work is underway to review the way we manage and respond to exit block in the ED.

2.5 Discharge and system collaboration

With much of the success of urgent and emergency care performance reliant upon flow and discharge, this work stream is heavily focused around stranded patients (LoS >7 days) and super stranded patients (LoS >21 days), red to green and system wide transfer of care. Working in collaboration with system partners this work stream will develop pathways with East Midlands Ambulance Service (EMAS) for early intervention vehicles, hospital avoidance response teams, access to transitional and palliative care beds.

3.0 Programme Management and Leadership

Recognising the significance of this improvement programme, and the capacity and capability (related to improvement methodology skills and expertise) a programme management team has started to be introduced. The interim Managing Director for the Division of Medicine has set up, and has been overseeing the programme, but this has been challenging due to the focus and time commitment required to lead the improvement programme alongside establishing the division and addressing wider practice and patient care performance. Interim improvement leads based at Lincoln County Hospital and Boston Pilgrim Hospital have been in post since October and are now being replaced until July 2019. A programme manager to assist with the management of the whole programme, providing robust milestone and documentation leadership was introduced in January. To continue delivery at pace a programme management office (PMO) has been established and the model for delivering sustainability is now under discussion.

4.0 Governance and Monitoring

A governance structure has been introduced as outlined below. The programme steering group meets every two weeks to monitor and ensure pace of delivery. The work stream plans and improvement trajectories have been shared at this meeting and agreed. Progress update templates have been developed and introduced by the programme manager. Performance and improvement dashboards have been the missing element, but as previously described, this work is now underway with the addition of a business analyst to the PMO. Having system partners and NHSI as part of the steering group further increases the robust monitoring and governance of the programme but also provides an opportunity to share the performance risk.

**Improvement Programme Governance Structure**
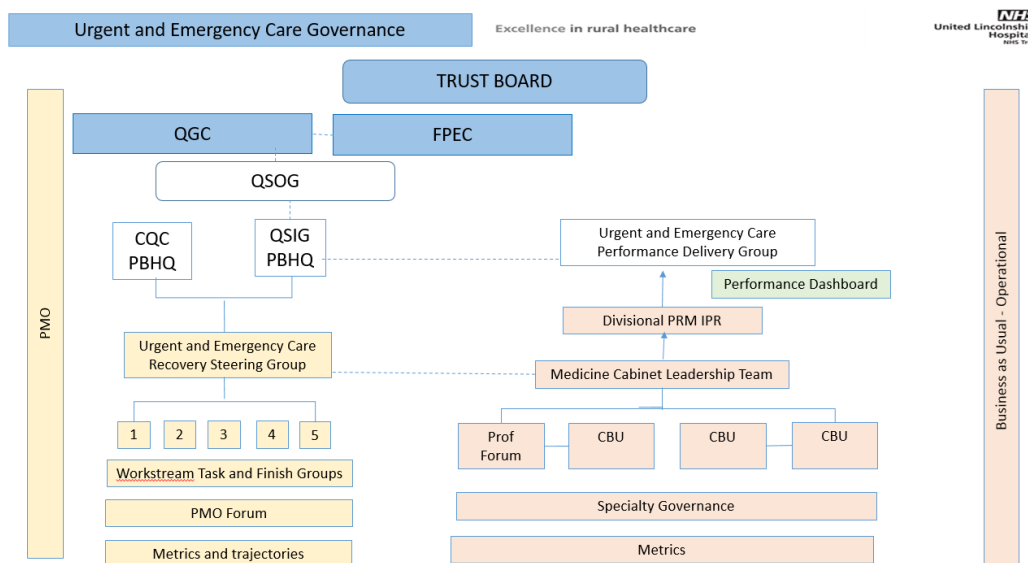
5.0 Progress update

The changes and improvements made within each of the work streams are detailed below. A progress report template is being created in order to provide the board and committees with a standardised report and with the introduction of a business analyst, this will be supported by evidence and data.

5.1 Work stream 1

Improving Practice and Patient Care in the Emergency Department, Pilgrim Hospital Boston (PHB)

- Team working structure - there is now a multidisciplinary team allocated to care for patients in the non-admitted pathway, the fit to sit area and the minor areas.   Admitted area, receiving patients arriving by ambulance from handover to rapid assessment and majors area care, and finally the resuscitation area team. This way of working ensures that there is a team focused on the care delivered to the patients in these streams, managing and monitoring their performance.
- Improved handover procedure - ensuring this is focused on patient care, proactive senior decision making and effective flow through the ED.
- Safety huddles - between the doctor in charge of the shift (EPIC) and the nurse in charge of the shift reviewing the safety of patients within the department, performance i.e triage, the flow through the department. The huddles take into account the risk level of the department and escalate any issues.
- Review of the pre-hospital practitioner (PHP) and ambulance handover procedures - New standard operating procedures (SOP) have been developed and agreed. The PHP job description has been redrafted and this post is now being appointed to substantively.
- Rapid assessment procedure – has been reviewed and a new SOP introduced.
- Clocks - are being installed above the rapid assessment cubicles to monitor the time spent undertaking the assessment to support productive working and not driving speed over quality of assessment.
- Workforce – reviewed the workforce establishment and increased the template levels within ED.
- Vital sign monitoring - introduced a HCA to monitor the patients waiting in the waiting room.
- Second triage nurse - introduced for walk-in patient stream in ED to reduce delays in patients being assessed.

% Triage Achieved under 15 mins

% Triage Data Not Recorded
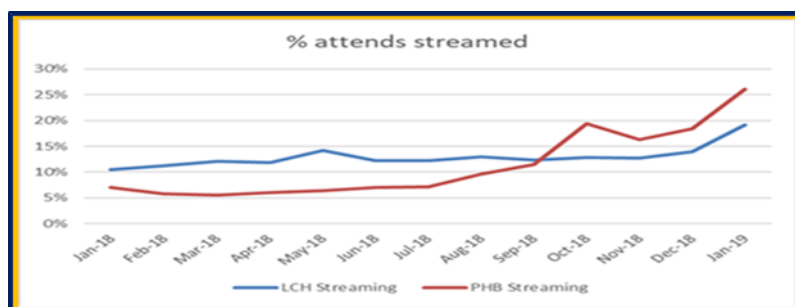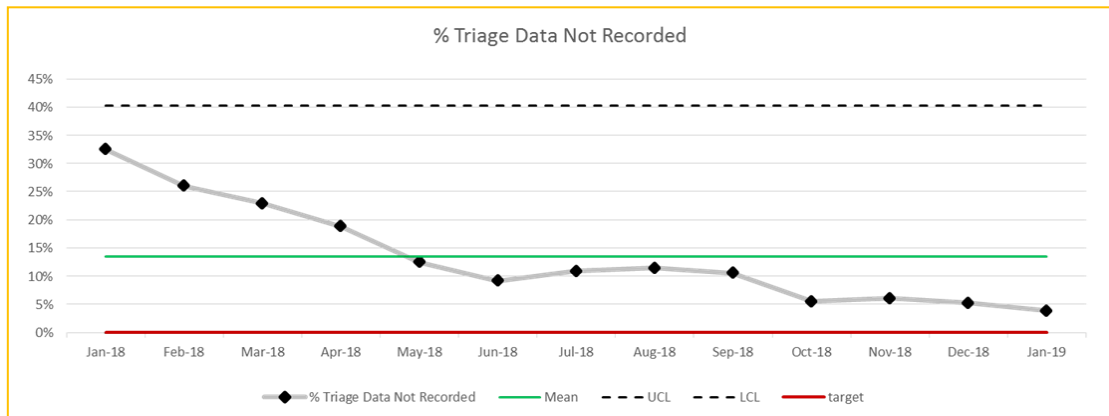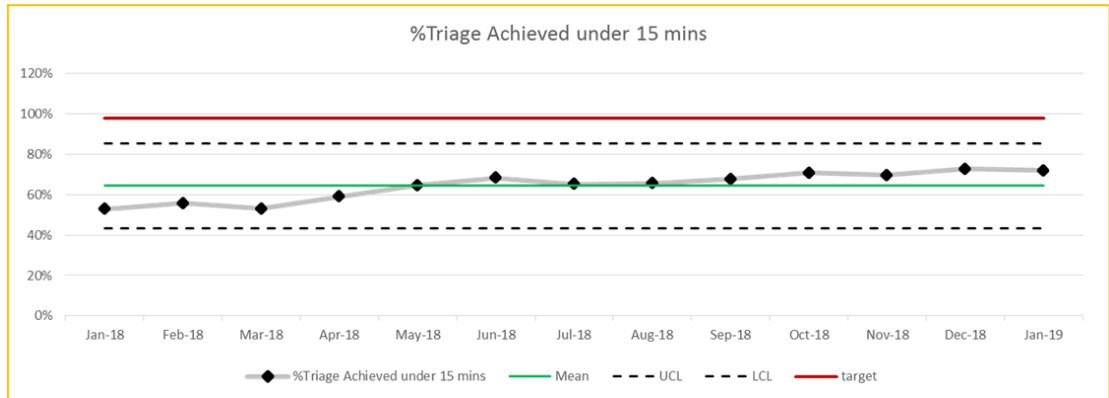
- Triage training programme - established with all triage trained nurses completing their yearly refresh training by April 2019 and all new nurses are being trained in triage, also aiming to be completed by April 2019.
- Dedicated cubicle for children – a dedicated child friendly cubicle for children has been introduced as has a child friendly waiting area.
- Successful collaboration with LCHS colleagues to review shared care for minors patients which has led to increased numbers of patients accessing streaming pathways. January 2019 demonstrated the largest increase at 26.1% against a target of 25%.

Improving Practice and Patient Care at Lincoln County Hospital
- The team at Lincoln County have been focusing on the patient pathway from ambulance handover to rapid assessment in order to improve the flow, and as result we have introduced a senior nurse to lead and care for patients in this area of the ED. There is a new SOP to support this revised practice.
- LCHS streaming at LCH is not as yet as responsive (day to day) to that of PHB but work is in place to replicate the model entirely. January performance was recorded at 19.6% against a target of 25%.
- There is a level 4 children's care competency nurse on duty 24 hours a day in a more visible way
- There is an increased number of nurses who are trained in 'spotting the sick child' competencies

- The introduction of a new daily assurance process has been valuable in identifying improvement priorities and as a result the SSKIN, SBAR and Sepsis screening compliance have all improved and were all at 100% in February
- A triage audit process is undertaken on a regular basis on an unannounced basis which showed clinical assessment was good, but found that there was a tendency to over prioritise patients and therefore further individual education and training is being carried out.

5.2 Work stream 2

### Improving Practice and Patient Care in the Assessment Functions

- The Integrated Assessment Centre (IAC) was introduced in Boston Pilgrim Hospital, this has led to improved multispecialty working. However, there is currently work underway to further improve the ambulatory pathway with support from ECIST colleagues. Additional capacity has been created for ambulatory care and changes to the pathway has commenced through a clinically led group.
- There is a review of the ambulatory patient pathway at Lincoln County hospital with support from ECIST colleagues, and an expectation that changes will commence in April 2019.
- A proof of concept was undertaken at both Lincoln and Pilgrim hospitals for a frailty service. Although slightly different models, both had a positive impact on admission rates. An integrated service at Pilgrim continues and funding to support this model and associated system level support has been agreed for 2019/20. There has been challenges in gaining a locum consultant to cover for the Lincoln lead however all sites are included in the integrated frailty service model development. This work is being supported by ECIST colleagues and their frailty clinical lead.
- The acute medicine short stay unit at Pilgrim hospital has been fully opened as part of the reconfiguration work.
- The scope and function of the medical and surgical emergency admission units and ambulatory care units at Lincoln County hospital is currently being process mapped as part of a PDSA cycle. The team have identified delays in the patient pathway and environmental constraints as immediate actions. Both sites are learning from each other about service models and best practice.

5.3 Work streams 3, 4 and 5
Flow of patients through the hospital and discharge
- Delayed transfers of care (DTOC) patients are cohorted into a dedicated area to promote a focused and timely pathway to discharge.
- Medical outliers are cohorted onto a dedicated area to ensure daily senior review and expedited discharges.
- Each ward is being held to account for their daily discharge levels and actions taken to deliver these
- A detailed review of 0 – 1 day LOS on IAC and MEAU
- Long Stay patients weekly reviews on all sites now being undertaken

- A more robust and collaborative relationship exists with external partners
- Current DTOC performance is 2.4% against the 3.5% standard
- Introduction of long stay patient reviews with support from ECIST both in terms of resource and methodology

Super Stranded Patients > 21 days - Trust Level
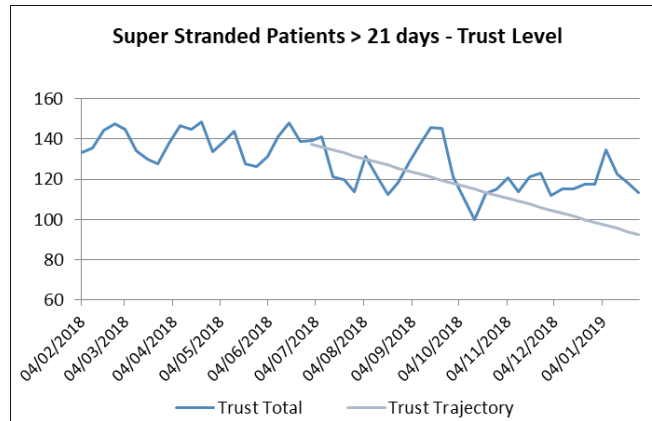
- An integrated discharge team and hub is being introduced to further increase system wide working. This is a fundamental shift towards integrated working.
- Video conferenced site meetings are being piloted to be able to provide oversight of all the sites to inform decision making.
- Collaborative work with EMAS to support the implementation of primary care pathways, hospital avoidance, response teams, access to transitional and palliative care beds.

6.0 Key Milestones in next 4 weeks

Over the next 4 weeks improvement activity will be focused around the following areas :

- Ambulatory pathway at pilgrim
- Ambulatory pathway at Lincoln
- Frailty service development at Lincoln, transferring the learning from Pilgrim
- Refresh of Red to Green and SAFER model using PDSA cycling
- Integration of new integrated discharge hub
- Completion of triage training for all nurses at Pilgrim

7.0 Future reports

The next iteration of this programme update will include for each identified project critical milestones and the expected impact with a monthly trajectory.

8.0 Recommendation

The Trust Board I asked to note the content of this paper