Agenda Item: 10.2

To:	Trust Board
From:	Chief Operating Officer
Date:	March 2017
Healthcare standard	

Title:	**Urgent Care – Short Term Actions to Improve Performance**

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Purpose of the report:
As an adjunct to the IPR - Urgent Care Performance Exception Report, this paper is intended to inform the board of a plan designed to tackle some high impact immediate actions with the aim to improve ED 4 hour performance to 82% for Q1.

The report is provided to the Board for:

Decision		Discussion	x
Assurance	x	Information	

Summary/key points:

This paper presents 7 key outcomes required to improve our performance in the trusts ED's. The actions are outlined and mechanism for holding the clinical directorates to account on delivery are described.

Recommendations:
That the board note this report.

Strategic risk register	**Performance KPIs year to date** Performance against the 4 hour target. Trust YTD 79.18%
Resource implications (eg Financial, HR)	
Assurance implications	
Patient and Public Involvement (PPI) implications	
Equality impact	
Information exempt from disclosure	
Requirement for further review?	

Urgent Care – Short Term Actions to Improve Performance

Introduction

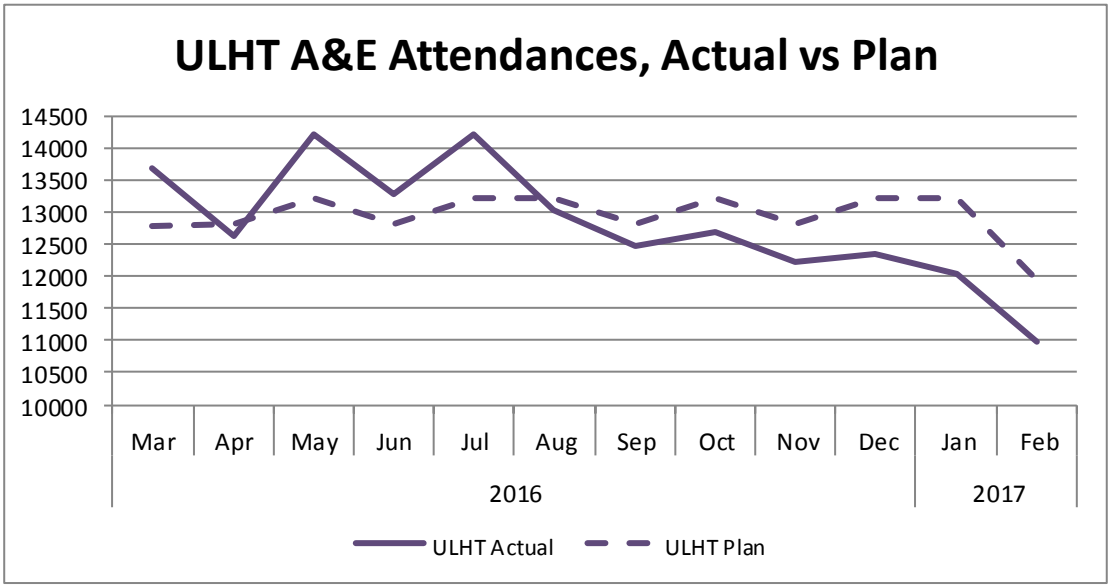
In line with many Trusts this winter ULHT has seen a deterioration in its ability to deliver safe, effective and timely care to patients who attend our emergency departments (ED).

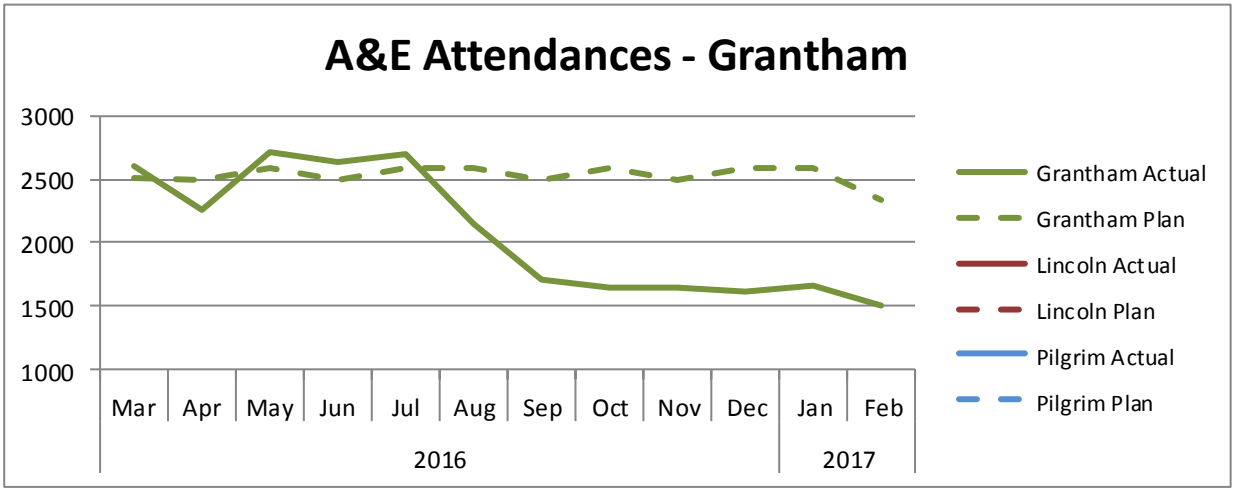
Our patients have seen long waits from the time they are conveyed by ambulance and through the system to arrive on a ward.

Unlike many other Trusts we have not seen the signs of recovery we would expect given the action plans in place to recover performance.

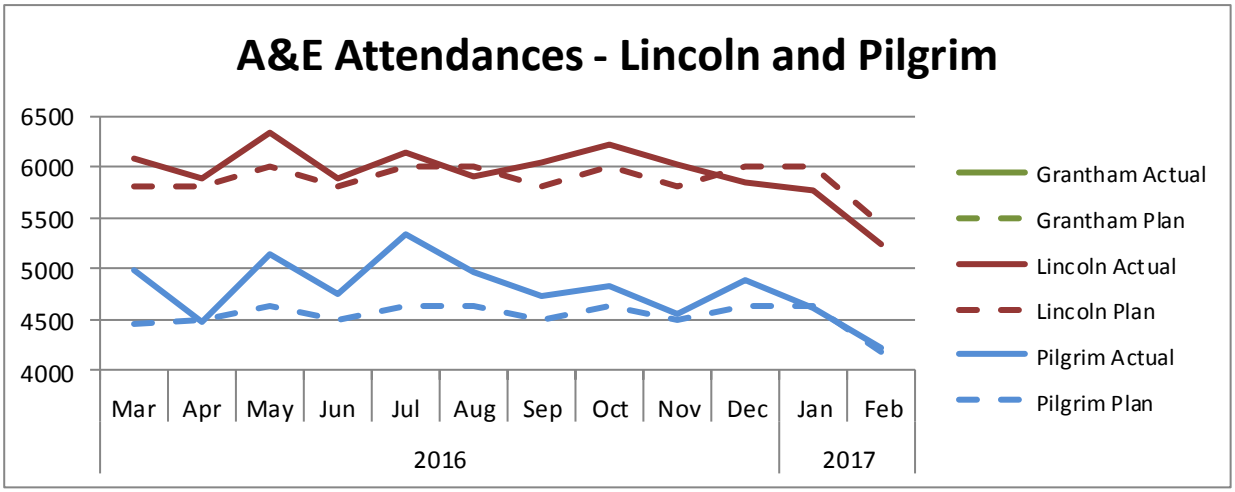
ULHT is recognised to have internal constraints such as workforce / recruitment issues; outdated facilities; poor hospital flow and a high bed occupancy.

Attendances across the trust have fallen in real terms and against plan largely due to the reduction in hours at Grantham.

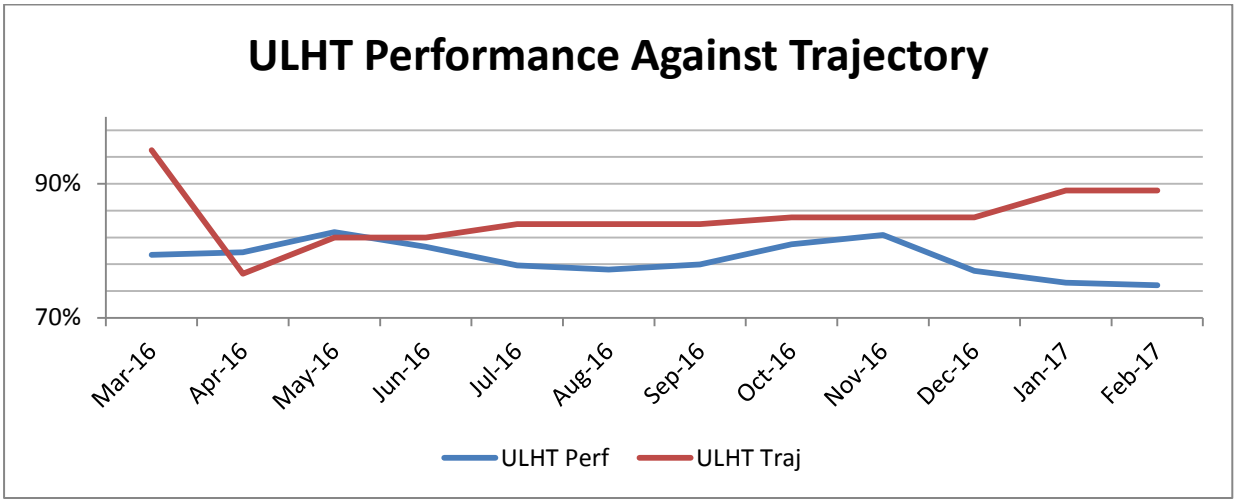




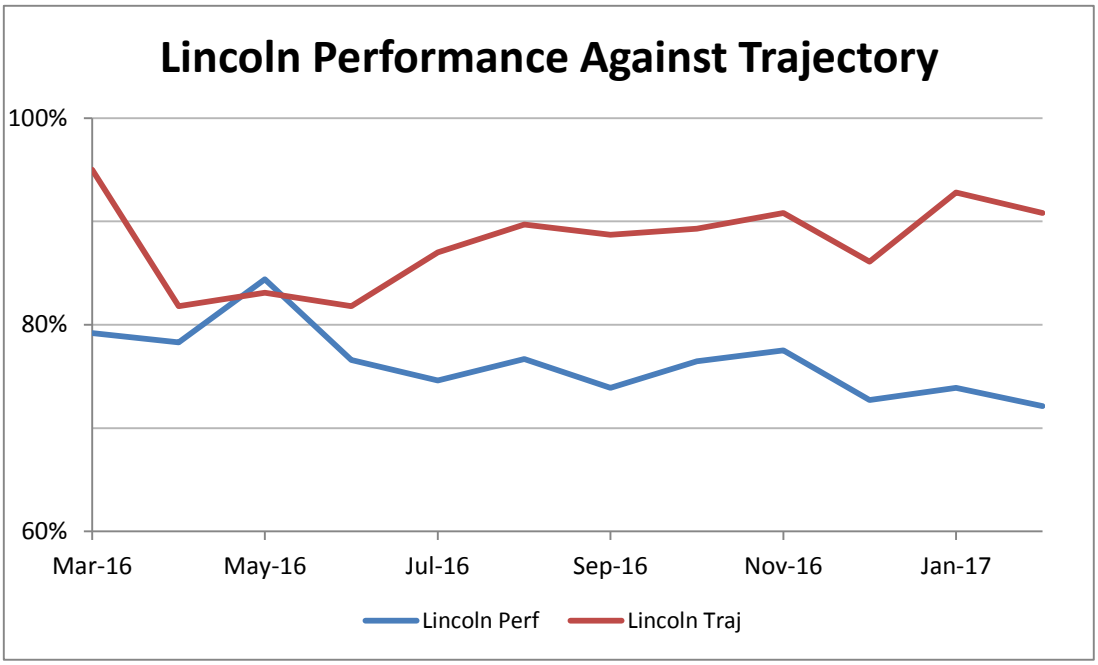
Lincoln and Pilgrim have seen attendances above plan through most of the year:

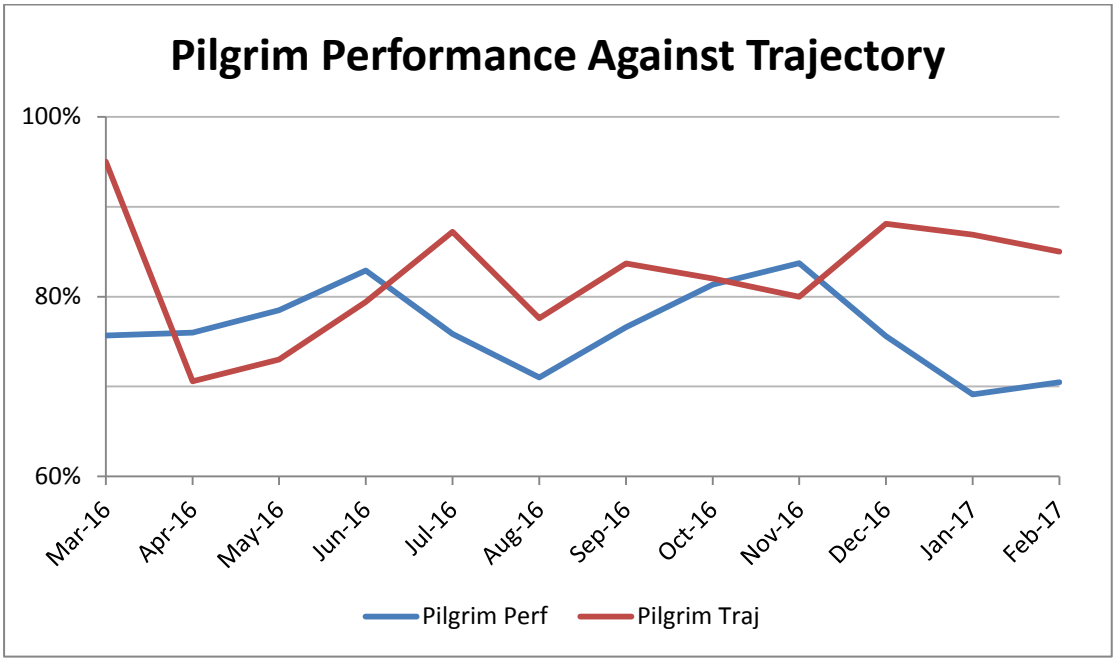


At the end of 15/16 performance trajectories for the 4 hour standard were agreed with NHSI & the commissioners. ULHT is significantly off track to deliver these trajectories.



The two sites driving this underperformance are Lincoln and Pilgrim.





Actions to Improve Our Performance

Each clinical directorate has its own detailed plan to improve performance. These have been in place for some time and can be seen embedded below

Urgent Care Improvement plan V1

However, given that we have not demonstrated improvement in performance a number of focussed actions based on outcome deliverables have been prioritised from these plans to be delivered by the End May 2017.

Immediate focussed actions

Front door and ED efficiency

Incorporates:

– Suitable cubicle capacity in the ED

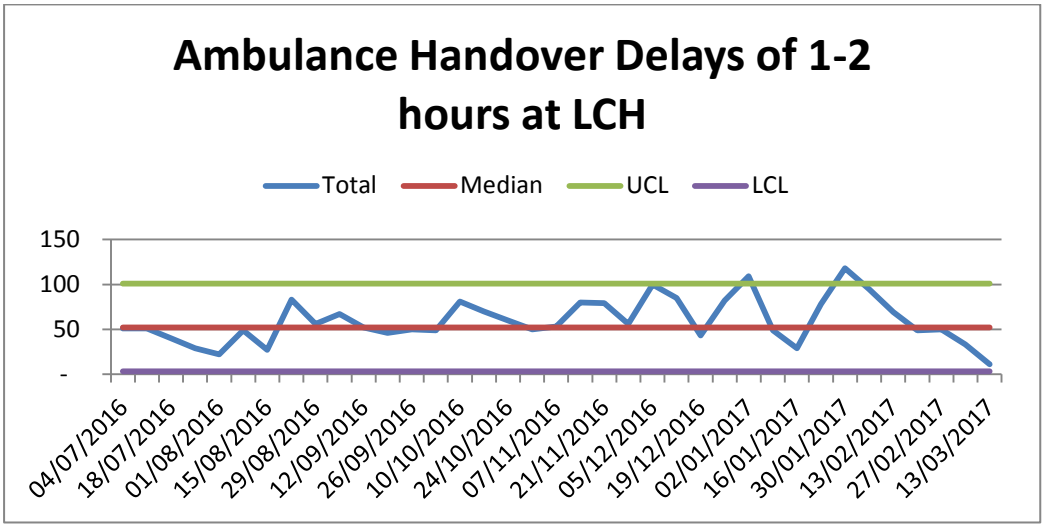
– Appropriate staffing in ED and possible enhanced recruitment or changes in model to work around shortages

1. *Reduction in minors breaches to zero tolerance*
   A&E performance can be split by minors (mainly minor injuries and minor medical conditions that will not be admitted) and majors (mainly attending by ambulance with serious traumatic or medical conditions requiring urgent intervention and often admission).

Actions to improve performance will be individual to each site but will centre around improving current space, ensuring dedicated staffing and developing a single trust policy / SOP to drive the culture of zero tolerance.

2. *Reduction in Ambulance handover waits to zero tolerance of over 1 hour*

Historically this has been a predominant problem at Lincoln, however the recent move of the Ambulatory Care Unit and business case has enabled the clinical directorate to develop an ambulance assessment area / RAT area. This needs to be staffed and embedded.



3. *Ensure Wait to be Seen is <2 hours @ 85th Centile*

Once a patient has been seen and streamed to majors or minors there can be a delay to be seen by the doctor. This often occurs at busy times of the day, or when acuity is high leading to a high number of staff diverted to the resus area.

This pressure is seen at both Lincoln and Boston. Each site has analysed capacity and demand with the existing workforce and developed business cases that enhance staff and protect majors and minors streams to ensure that wait times within the department are controlled for the majority of the time.

A further component is the introduction and use of professional standards and escalation processes to keep the departments functioning at times of pressure.

4. *Increased % proportion of patients through Ambulatory Emergency Care*

The evidence from the national Ambulatory Emergency Care Team suggests that the number of patients seen within Ambulatory Emergency Care Units should equate to 25% of a hospitals total Emergency Admissions.

Each site has models at various stages of progress to improve throughput, however geography, staffing and operational policies are still being developed.
Lincoln's new AEC unit is now seeing up to 17 patients per day which is nearly three times more than the old model.
Pilgrim conducted a pilot changing the pathways into the AEC unit last year. This was successful and needs to be developed.
Grantham's AEC unit has been limited by a lack of trained staff and an unclear operational model. .

Hospital flow

Incorporates:

– Red2Green / SAFER bundle

– An effective plan to reduce DTOC including enhanced discharge to assess.

5. Increase number of discharges before midday

A standard part of the SAFER patient flow bundle, increasing the number of patients that are discharged in the morning will help flow on site when demand increases in the afternoon.

ECIP have offered more support to the trust to help embed and sustain the SAFER bundle, commencing with work at Lincoln from 21st March. The Lincoln Medical Directorate has also had help from a dedicated interim management resource who has helped to increase early flow from the wards.

The Red to Green process is now being embedded on the Lincoln site and has shown significant improvements in flow.

At Pilgrim, plans are in place to integrate the Red 2 Green process with the Pride and Joy system.

Grantham will also adopt the Red to Green process

All site have also recommenced the "stranded patients" meetings which focus specifically on patients wo have a length of stay longer than 7 days.

6. Increased usage of discharge lounge

Each discharge lounge will be reviewed around the criteria for use. Culture and suitability often prevent the full usage of discharge lounges.

Each site will consider the criteria for use and the workforce needed to increase this. At Lincoln, a review of potential other areas will take place to expand the footprint.

We will monitor the directorate with the number going through currently as a baseline. An expectation has been set for an increase of 30%. All discharges will be suitable for the lounges unless proven otherwise.

7. Reduced DTOC

Our DToC rate is an outlier and must be reduced. Some of this action will depend on work done by the community and adult social care but by implementing and embedding Red to Green and Stranded Patient Reviewed on each site we can identify these patients and ensure their discharge is being planned earlier.

At Pilgrim a new model of community and adult social care ownership of the discharge hub will be piloted from 20th March to see if new ways of working can improve discharges.

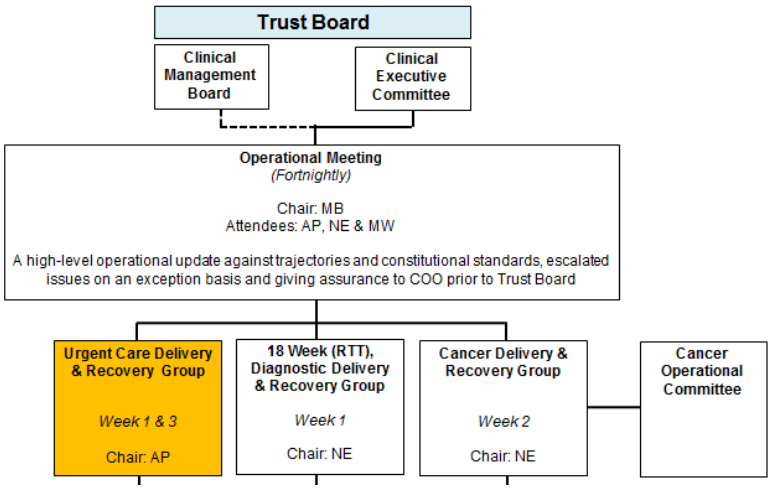
Governance

The Clinical directorates will be expected to plan, implement, deliver and review changes to process, models and estate, in order to deliver the outcome deliverables.

Information services will provide daily information on some metrics direct to the clinical directorates and a weekly dashboard (appendix 1), which will be monitored through the Urgent Care delivery & Recovery Group, overseen by the Operational meeting Chaired by the COO (see diagram 1 below)

Clinical Directorates will continue to be held to account at their Business Review Meetings. The dashboard from the Urgent Care Short Term Plan will be incorporated into the Trust Board Reports in line with the prioritisation of Urgent Care within next year's STF.

Diagram 1

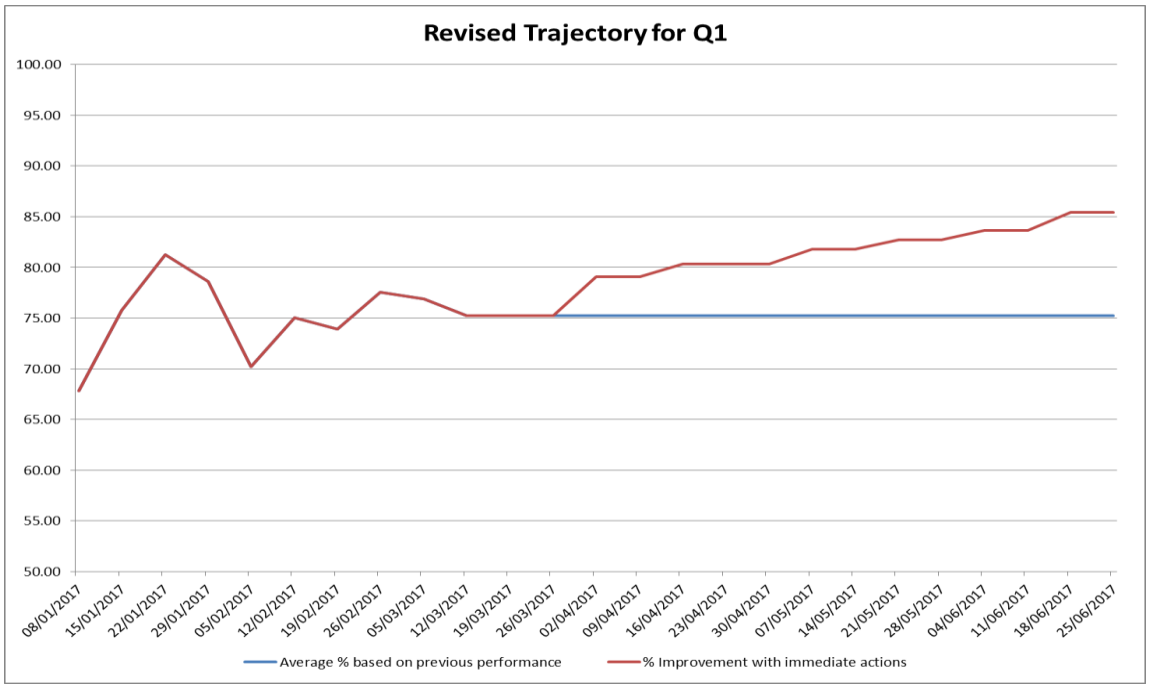


Impact

The expected improvements by the end of Q1 from the 7 immediate focussed actions include:

- Reduction in breaches from 680 per week to 400
- Reduction in stranded patients from 50% to 30%
- Reduction in midnight bed occupancy from 94% to 92%

The actions from Q1 will lead to an improvement in ED performance to 82% for Q1



Appendix 1

7	Immediate actions	Site	Target (per week)	Baseline	02/01/2017	09/01/2017	16/01/2017	23/01/2017	30/01/2017	06/02/2017	13/02/2017	20/02/2017	27/02/2017	06/03/2017
1	Outcome - Zero tolerance of Minors breaches	Lincoln	0	33	47	18	13	30	19	53	30	33	33	52
		Pilgrim	0	24	41	23	18	11	42	22	19	20	17	25
		Grantham	0	2	0	3	5	2	6	1	1	4	2	0
		ULHT	0	59	88	44	36	43	67	76	50	57	52	77
2	Outcome - Zero ambulance handover waits over 59 mins	Lincoln	< 10	94	153	62	42	92	167	131	127	65	61	42
		Pilgrim	< 5	35	64	43	18	26	57	48	11	19	27	34
		ULHT	<15	130	219	105	61	118	229	179	138	84	88	76
3	Outcome - ensure wait to be seen is < 2hrs @ 85th Centile	Lincoln	120	169	178.85	159.8	149	156	179	178	173	149	177.3	190
		Pilgrim	120	160	200	176.6	136	132	164.2	145	159.8	155	157	171
		ULHT	120	160	180	158	140.55	143	168.9	159	165	145	165	173
4	Outcome - Increased utilisation of AEC (25% of all E Adm)	Lincoln												
		Pilgrim												
		Grantham												
		ULHT												
5	Outcome - 30% of Discharges before noon	Lincoln	30%	18.56%	20.33%	20.27%	19.19%	17.16%	16.54%	13.82%	20.51%	17.71%	18.79%	21.25%
		Pilgrim	30%	17.35%	16.44%	15.36%	14.49%	18.45%	19.54%	14.95%	15.67%	22.73%	18.60%	17.30%
		Grantham	30%	24.53%	23.38%	15.38%	33.33%	33.33%	25.53%	24.44%	17.86%	19.15%	25.30%	27.55%
		ULHT	30%	18.74%	19.26%	18.15%	19.07%	19.30%	18.47%	15.24%	18.57%	19.53%	19.32%	20.51%
6	Outcome - 30% increase in discharge lounge usage	Lincoln	94	72.5	64	70	80	61	75	72	60	75	73	95
		Pilgrim	24	18.5	15	24	15	17	23	16	13	21	19	22
		Grantham	17	13.3	11	5	11	22	14	18	7	17	19	9
		ULHT	136	104.3	90	99	106	100	112	106	80	113	111	126
7	Outcome - reduced DTOC to 3.5%	Lincoln	3.50%	4.01%	4.82%	2.29%	3.24%	5.36%	3.85%	3.89%	5.65%	5.65%	2.62%	2.71%
		Pilgrim	3.50%	4.31%	6.12%	2.84%	5.16%	4.73%	4.57%	4.52%	3.58%	3.27%	3.94%	4.39%
		Grantham	3.50%	9.88%	15.46%	12.09%	5.26%	6.67%	0.99%	0.00%	12.22%	18.39%	19.75%	8.00%
		ULHT	3.50%	4.66%	6.40%	3.46%	4.15%	5.27%	3.80%	3.70%	5.48%	5.97%	4.59%	3.74%
Additional measures														
a	Stranded patients	Lincoln	156	208										
		Pilgrim	102	170										
		Grantham	30	50										
		ULHT	288	428										
b	Bed occupancy @ 0800	Lincoln	92%	93.99%	91.38%	92.66%	94.10%	93.33%	95.76%	99.45%	93.61%	92.36%	92.72%	94.51%
		Pilgrim	92%	97.70%	98.56%	97.78%	97.21%	94.68%	98.31%	98.06%	99.73%	97.39%	99.44%	95.80%
		Grantham	92%	92.83%	96.04%	91.00%	98.96%	98.13%	98.06%	97.27%	95.74%	90.63%	84.38%	78.13%
		ULHT	92%	94.22%	93.24%	93.33%	94.66%	93.31%	95.96%	97.56%	95.09%	93.03%	93.51%	92.48%
c	Arrival to triage (15mins)	Lincoln		43.56%	45.55%	50.95%	56.95%	41.26%	35.76%	44.36%	37.80%	42.35%	46.76%	33.90%
		Pilgrim		58.80%	51.17%	59.74%	69.42%	60.20%	52.84%	60.24%	56.68%	60.00%	57.39%	60.31%
		Grantham		79.32%	71.43%	84.66%	81.66%	79.89%	72.06%	83.92%	80.31%	77.75%	74.13%	87.38%
		ULHT		57.28%	53.10%	60.83%	67.62%	57.14%	50.37%	59.56%	53.18%	57.43%	56.63%	56.90%
d	Ambulance handover > 30 mins	Lincoln	110.4	220.80	247	177	140	243	303	304	249	159	229	157
		Pilgrim	57.5	115.00	191	92	51	98	159	132	67	106	128	126
		ULHT	171.75	343.50	443	274	195	353	486	447	321	269	359	288
e	ED performance	Lincoln	95	73.09%	68.00%	75.64%	78.10%	75.59%	67.77%	68.28%	68.70%	79.64%	76.40%	72.75%
		Pilgrim	95	69.61%	56.17%	68.20%	78.96%	75.10%	63.86%	74.59%	72.98%	66.89%	69.91%	69.41%
		Grantham	95	96.93%	97.36%	98.18%	96.94%	97.31%	93.24%	98.11%	96.68%	96.95%	97.14%	97.41%
		ULHT	95	75.05%	67.55%	75.64%	81.09%	78.38%	69.98%	74.88%	73.85%	77.29%	76.74%	75.14%