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To:	**Trust Board**
From:	Michelle Rhodes, Director of Nursing, Neill Hepburn, Medical Director and Mark Brassington, Chief Operating Officer
Date:	26th February 2019
Healthcare standard	Patient Safety Standards

Title:	**Delivering Safe and Sustainable Urgent Care – Full Capacity Protocol**

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Responsible Director – Michelle Rhodes, Director of Nursing, Neill Hepburn, Medical Director and Mark Brassington, Chief Operating Officer

Purpose of the report:

This report will provide the Board with a progress update thus far in regard to 'next steps' and seek approval to move forward with the implementation of an agreed revised Full Capacity Protocol

Decision	X	Discussion	X
Assurance	X	Information	

The report is provided to the Board for:

Summary/key points:

- Trust Board to discuss, agree and endorse the direction of travel
- Agree a trial of EXIT phase 1 starting from Monday 18th March
- Agree a trial of the 10@10 model (exact number to be determined following the risk assessment) from Monday 18th March

Recommendations:

- Discuss the contents of the paper, progress being made and agree sign off to proceed.

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?

1.0 Introduction

The purpose of this paper is to provide an update to the Trust Board on the progress made with regard to reducing the risk of overcrowding in ED. The paper focuses on 1 of the 5 principles agreed by the Trust Board in January 2019, these are listed below.

Whilst work is progressing on all the principles below and this paper focuses on principles 1,2 4 &5.

Principles

1. Defining when each ED is unable to meet patients' needs due to exit block
2. Prevention of exit block
3. Better utilisation of community capacity – community pull
4. Automatic Patient Transfers at agreed time
5. Early Internal De-escalation when an ED reaches 'black' Escalation

The paper will also outline the Clinical Engagement framework, events to date and events planned.

2.0 Early Internal De Escalation.

ULHT patients, at times of high demand, are experiencing unacceptably long waits in ED. In the main these waits are caused by exit block, meaning our patients are unable to access a bed in our wards because they are full. Currently patients waiting for an inpatient bed are held within ED. This means that the ED department becomes overcrowded as it takes on an additional function of ward based care. ED is also subject to periods of increased demand, which are not related to bed waits that can potentially affect its function, flow and safety.

The priority for us as a health system with regard to ED is twofold. Firstly to do whatever we can to enable patients to be safely cared for out of hospital, this will of course reduce demand in the department, secondly we have a responsibility to ensure that patients who come to ED are able to access good, safe and timely care whether they are discharged home or admitted to our wards at the end of their ED journey.

This paper describes 3 process changes that will reduce exit block and overcrowding in ED.

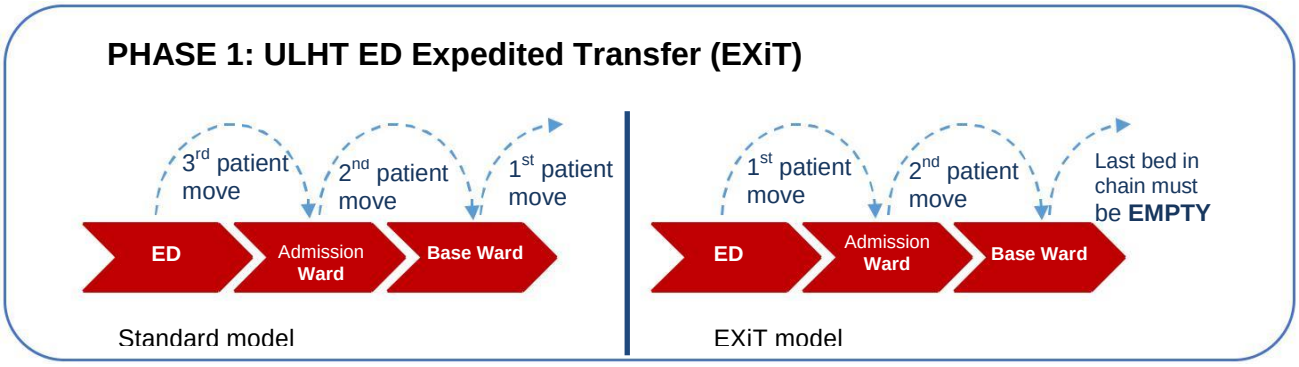
2.1 ED Expedited Transfer Procedure (EXiT) (Phase 1)

The EXiT procedure uses of knowledge of patient flow to help alleviate ED pressure whilst not creating unmitigated risk elsewhere in the hospital. Importantly this procedure does not change the patients intended destination; it just expedites it.

Where a bed chain exists (a sequence of linked patient transfers), patients will no longer be held in ED until the bed is empty on the admission ward. Porters/transfer teams will move patients on beds from ED to their admission ward and then immediately move the next patient in the chain to their destination, which may be a base ward or the discharge lounge.

This is the reverse of what currently happens, with porters starting by moving patients to the discharge lounge first and then admission areas and ED last. In phase 1 we will simply reverse the 'bed chain' allowing the rapid transfer of patients from

ED. This is known as the ULHT ED Expedited Transfer (EXiT) Protocol and can be applied to all adult inpatient areas (excluding maternity). The process cannot be used when patients in the chain have a NEWS of 4 or above or have an Infection control concern.



This process has been discussed and supported in principle by 30 plus of the ward leads across the Trust.

To enact this process consideration will need to be given to the number of available porters/transfer team and the capacity of the discharge lounge to take more patients.

In addition to the actions outlined above, patients on base wards who are waiting to be discharged will ‘sit out’ on designated wards to create immediate capacity for patients waiting for ward beds from ED or admission areas. These patients are at the far end of a bed chain.

This means that wards that are already full will be expected to hold an additional patient in the nominated day room/sitting area for a short period of time whilst the discharge is enacted. At the current time additional patients are placed on wards where there is a definite discharge and through this trial we will look to extend this to include wards where there is a high likelihood of discharge as this should enable the Trust to further reduce pressure in the ED.

ULHT has a Full Capacity Protocol that was updated in 2018, this protocol describes the steps to take when the hospitals are under extreme pressure. It defines the triggers of activation, the management of the protocol and the actions to be taken to de- escalate. The protocol is intended to provide support to the ED to ensure safe care to patients across the whole of our hospitals. The protocol names the wards on each site where an additional patient can safely sit out.

This list is currently under review following on from the reconfiguration at the Pilgrim site. This review will include a formal risk assessment for each ward area and may increase/decrease the number of wards available for ‘fit to sit’ patients.

The protocol is currently not applied consistently across the Trust and work is underway with the ward nursing leads to ensure that the ward teams are able to own this process and are actively involved in ensuring that the right patients are on their wards.

3.0 Sustaining patient flow away from the department

Many hospitals across the country have implemented a variation of a model known as 10@10. This models builds upon the work that the Trust is currently undertaking to identify patients who are fit for discharge early in the day to free up available beds for poorly patients who require admission.

The process follows on from EXiT where by 10 am every morning a number of patients (in the 10x10 example it's 10 patients) will leave the admission wards to go to their base/speciality ward which means that the receiving ward must have made available bed space to receive that patient, the same process is applied at 2pm. This guarantees empty beds on the admission areas at times of known pressure in ED, leaving them free to receive patients from the Emergency Department. This process should become embedded in the hospital systems to improve patient flow.

Again as for EXiT, portering numbers and appropriate discharge lounge capacity are required to enable this to be successful.

This process is currently in draft form whilst we wait for formal risk assessments and QIA to be completed on each ward area and agreed by the Executive triumvirate (COO, DoN & MD). This will be completed by Friday 1st March and the Board will be updated verbally on the 5th.

4.0 Clinical Ownership

A number of engagement events are in place and supported by Dr Boden, Emergency Medicine Consultant, Dr Richard Andrews, Deputy Medical Director and Michelle Harris, Deputy Director of Operations, Urgent Care and Michelle Rhodes Director of Nursing.

The Full Capacity Protocol has currently been presented to Clinical Management Board (7th February) where the feedback was positive and supported by the medical staff present.

More recently (25th February), a presentation was given to the ward sisters/charge nurses and matrons, led by the Director of Nursing and Dr Boden. Over 30 ward sisters attended a 2 hour session where a full and frank discussion took place with regard to the risks of overcrowding in ED. EXiT process, Boarding/Fit to Sit and 10@10 were all discussed and the nursing teams agreed that overcrowding in ED was not acceptable for patients, they did however raise a number of concerns with regard to 'overcrowding' on their ward areas.

The group raised a number of issues that if sorted would have a positive impact on overcrowding across the Trust. These included;

- Outlying patients being reviewed earlier in the day
- Capacity in the discharge lounges at Pilgrim and Lincoln (physical and staffing)
- The full sign up of Criteria Led Discharge by all clinicians in all areas
- Current position with diverting clinic/GP patients back to ED

- Pharmacy support for TTO's earlier in the day
- AHP support
- Imaging capacity
- CNS pulling patients
- Staffing on wards
- The better use of community beds/risk adverse discharge practices
- Earlier ward rounds
- Waiting for patients to be clerked in ED (Pilgrim)
- Engagement from the medical workforce

At the end of the meeting the ward sisters agreed to go back to the areas and identify a safe place where an additional patient could be placed (sitting out not in a bed), they were asked to risk assess this (Michelle Harris to support) and feed back to the DoN by the 1st of March. This work will inform where we can appropriately place additional patients as described in section 2.1.

The sisters also agreed that consistent roll out of Criteria Led Discharge would enable the wards to discharge patients earlier in the day, all sisters agreed to discuss this with the consultant ward leads and feedback if they needed support/training to take this forward. The Deputy Chief Nurse (Patient Safety) will lead an urgent piece of work on this.

All of the other issues and concerns raised have been discussed between the COO and DoN many are within the ED transformation plan and those quick wins will be acted upon immediately with other suggestions addresses through the UC Improvement Plan shared at the last Board.

Specific medical engagement forums are planned over the next 3 weeks and include a weekly 'drop in' session via video conferencing to allow maximum exposure and opportunity for discussion as well as a further discussion at Clinical Management Board on the 7 March. These sessions will led by Dr Boden and Dr Andrews, supported by Michelle Harris.

This work will also be presented at the Medical Advisory Committees (MAC) by Dr Andrews.

5.0 Recommendations

The Board is asked to accept the update provided in this paper and support a trial of the 3 initiatives described in the paper starting on Monday 18th 2019 at Lincoln and at Pilgrim Hospitals with the trial will lasting for 6 months. Continuous monitoring will take place throughout the trial and an evaluation will be presented to the Trust Board in September.