

Trust Board Paper R

To:	Trust Board
From:	Jeremy Tozer, Interim Director of Operations
Date:	January 2013
CQC regulation:	As applicable

Title:	Emergency Department Performance Report										
Author:	Jeremy Tozer, Interim Director of Operations										
Purpose of the Report:	To provide an overview and update on the Emergency Care Delivery for UHL.										
The Report is provided to the Board for:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Decision</td> <td style="width: 10%;"></td> <td style="width: 25%;">Discussion</td> <td style="width: 40%; text-align: center;">√</td> </tr> <tr> <td>Assurance</td> <td style="text-align: center;">√</td> <td>Endorsement</td> <td></td> </tr> </table>			Decision		Discussion	√	Assurance	√	Endorsement	
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Assurance	√	Endorsement									

Summary / Key Points:

- December has been a challenging month where performance deteriorated to **89.4%** for ED type 1 and 2 attendances
- For the second month in a row only 1 out of the 5 quality indicators was achieved.
- Despite robust planning for the Christmas and New Year period there were high numbers of breaches and poor flow across the emergency process .CCGs have asked for a detailed account of the issues.
- The 2 priority workstreams focussing on ED processes and assessment units are well underway. Some early changes should take effect as early as January and February 2013.
- The CCG collaborative continue to support the internal steps taken by UHL to improve performance through the programme of work to be facilitated by Right Place Consulting.
- Bids have been submitted and the proposals supported by the ECN for the application of winter pressures funding.
- CCGs have provided the Trust with an incentive for achieving the 95% target through an incentive payment of £150K for each week that the Trust achieves or exceeds the target

Recommendations:

The Trust Board is invited to receive and note this report.

Previously considered at another UHL corporate Committee N/A

Strategic Risk Register	Performance KPIs year to date
Yes	Please see report

Resource Implications (eg Financial, HR)

Monthly incentive payment for delivery of the 95% target.
Non recurrent funding to support winter pressures

Assurance Implications

The 95% (4hr) target and ED quality indicators.

Patient and Public Involvement (PPI) Implications

Impact on patient experience where long waiting times are experienced

Equality Impact

N/A

Information exempt from Disclosure

N/A

Requirement for further review ?

Monthly

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REPORT TO: TRUST BOARD
REPORT FROM: JEREMY TOZER, INTERIM DIRECTOR OF OPERATIONS
REPORT SUBJECT: ED PERFORMANCE REPORT
REPORT DATE: 31 JANUARY 2013

1.0 INTRODUCTION

Sustained performance improvement across UHL's emergency processes and the ability to achieve the emergency 95% target on a continuous basis still remain a top priority for both UHL and the local health economy. Of equal priority is the need to deliver high quality, safe care to all patients presenting for emergency care and treatment. Renewed efforts to deliver some of the key changes required in order to deliver the necessary performance improvements continue with the external support from Right Place Consulting.

Throughout December and in particular over the Christmas New Year period the Trust was particularly compromised in the ability to manage the emergency flow which resulted in poor achievement of the ED target over several days. In month the Trust saw a continued deterioration in achievement of the 4 hour target. Performance for UHL Type 1 and Type 2 activity to week ending 8th January 2013 was 84.4% against an achievement of 89.4% in November, and the UHL + UCC performance was 88.1% compared with 91.6% in the previous month. The Trust only achieved 1 of the 5 ED quality performance indicators which continues to reflect the process issues within the hospital.

This report provides details for the current level of performance, an overview of the issues faced by the Trust over the holiday period and the progress against plans that are now being developed at pace to remedy performance and improve emergency flow.

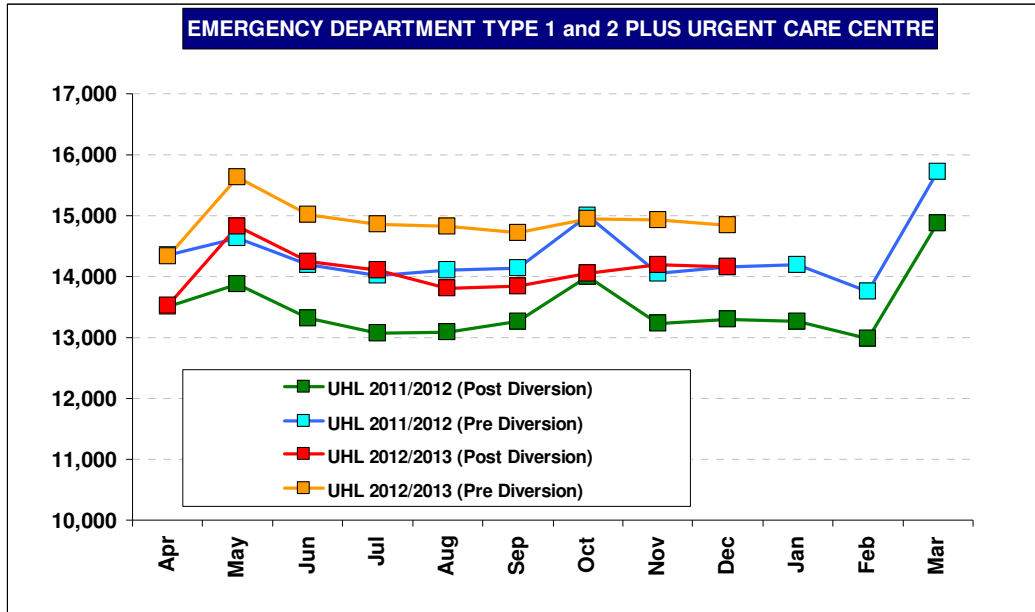
2.0 CURRENT ACTIVITY AND PERFORMANCE

2.1 Attendance rates

In line with reports from previous month's ED attendance rates remain consistently above attendance rates seen in 2011/12 even when pre diversion rates are taken into consideration as shown in figure 1 below. Attendances remained higher than average when compared to a monthly average of 13,949 attendances. This equates to a 4.8% increase in activity when compared with the same period last year and a reduction of 51 attendances against the previous month.

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Figure 1: ED Attendances April – December 2012



Further analysis of the trend over the Christmas and New Year period is provided later in the report.

2.2 UCC conversion rates

The downward trend in numbers of patients being diverted to the UCC has continued between October and December.

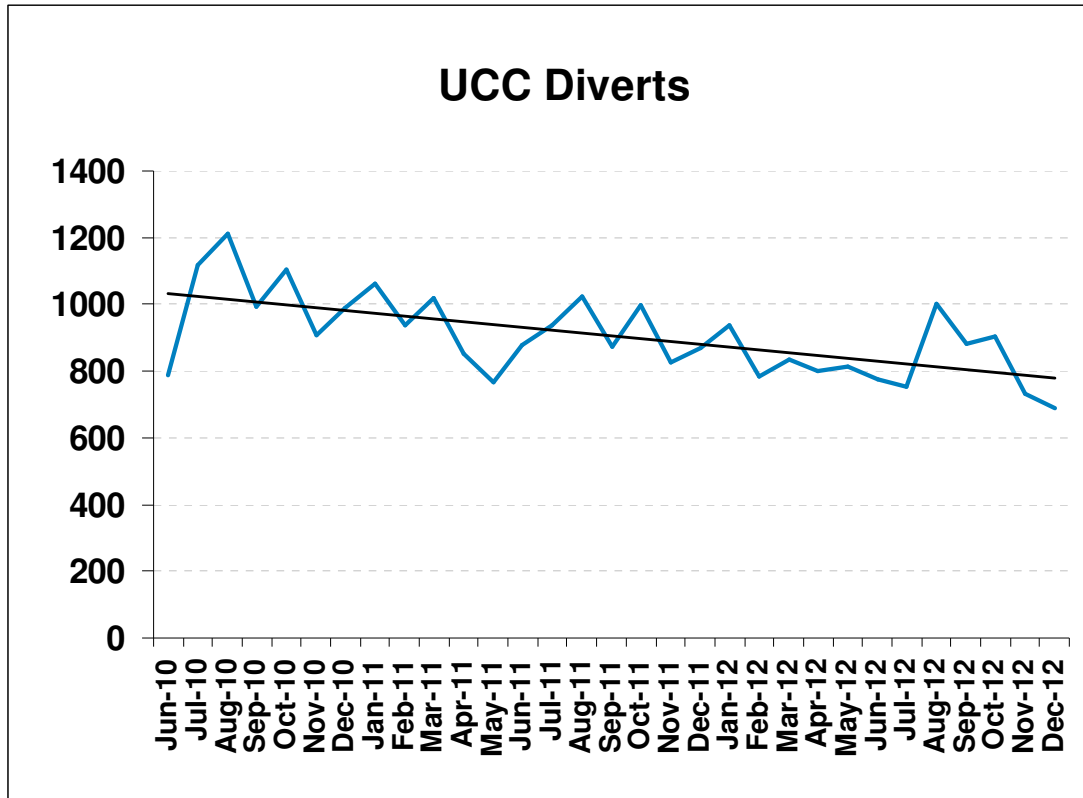
Table 1: ED Pre and Post Diversion Attendances April – December 2012

EMERGENCY DEPARTMENT TYPE 1 and 2 PLUS URGENT CARE CENTRE							
	UHL 2010/2011 (Post Diversion)	UHL 2010/2011 (Pre Diversion)	UHL 2011/2012 (Post Diversion)	UHL 2011/2012 (Pre Diversion)	UHL 2012/2013 (Post Diversion)	UHL 2012/2013 (Pre Diversion)	Overall % Change 12/13 vs 11/12
Apr	14,117	14,117	13,507	14,358	13,532	14,332	-0.2%
May	14,574	14,574	13,871	14,636	14,819	15,633	6.8%
Jun	13,509	14,298	13,318	14,197	14,248	15,022	5.8%
Jul	12,983	14,100	13,075	14,014	14,107	14,860	6.0%
Aug	12,544	13,757	13,086	14,109	13,815	14,817	5.0%
Sep	12,726	13,720	13,270	14,142	13,839	14,719	4.1%
Oct	12,918	14,022	14,002	15,000	14,051	14,955	-0.3%
Nov	13,057	13,963	13,226	14,051	14,201	14,933	6.3%
Dec	13,500	14,488	13,291	14,162	14,150	14,839	4.8%
Jan	12,830	13,893	13,260	14,196			
Feb	12,263	13,202	12,978	13,762			
Mar	14,100	15,119	14,884	15,719			
Sum:	159,121	169,253	161,768	172,346	126,762	134,110	

As reported in previous months post diversion activity continues to be above pre diversion activity levels for the same period in 2011/12. In December 2010/11 6.8% of attendances were deflected. This shifted to 6.1% in 2011/12 and this year the figure stands at 4.6%. There is a similar trend with overall activity and the position year to date as summarised:

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Figure 2: UCC Diverts June 2010 to December 2012



Active dialogue continues with our external partners to review the concept of a 'single front door' aimed to change existing pathways to maximize deflection.

2.3 ED 4 Hour Performance target

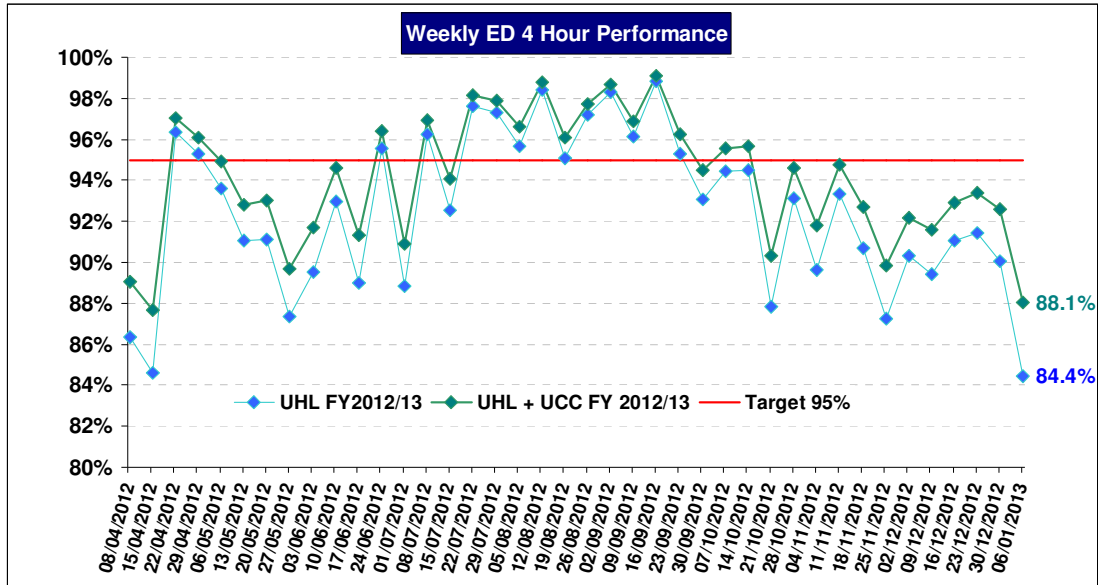
The following graph shows the performance of the Trust 4 hour target to week ending 8th January 2013. In December there were issues with flow across the emergency system which resulted in a further deterioration in performance from 89.4% in the previous month for ED type 1 and 2 attendances to 84.4% to week ending 8th January 2013 and from 91.6% to 88.1% when UCC activity is taken into account during the same period, to as shown below:

Table 2 Overall ED Performance December 2012

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	14,150	1,447	89.77%
Urgent Care Centre	Type 3	4,090	4	99.90%
UHL + UCC Total	All	18,240	1,451	92.04%

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Figure 3: Overall Weekly ED Performance to Week Ending Sunday 6th January 2013



Against the revised trajectory submitted to CCGs in November weekly performance has fallen short of the requirement as demonstrated below:

Date w/c	Actual	Trajectory	Attendances	Breaches
09/12/2012	91.6%	91.6%	4,129	347
16/12/2012	92.9%	92.2%	4,204	299
23/12/2012	93.4%	94.6%	4,110	272
30/12/2012	92.6%	94.3%	4,068	301
06/01/2013	88.1%	94.6%	4,169	498

The trajectory shows 95% performance from 18th February and beyond as agreed with the CCG's and SHA. The 18th February was put into the trajectory based on various strands of the Right Place Consulting work being completed and showing benefit. These strands of work are on track, however hitting 95% will provide a real challenge to the Trust internally To demonstrate continued support CCGs have recently offered a weekly incentive payment for each week that the 95% target is achieved.

Based on performance year to date and the trajectory going forward the Trust would only achieve 94.5% against the 95% target for the year.

2.4 Christmas performance

Over the Christmas and New Year period the Trust experience heightened pressures on the emergency process. Analysis of performance over the past 2 years shows that there were 128 more attendances over the Christmas and New Year period for 2012/13 with 376 more breaches.

Acute admissions and discharges between the 20th December 2012 and 3rd January 2013 were overall similar between years but different on a day to day basis. This was due to the profiling of bank holiday days. Using the weekend and bank

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holidays compared from one year to another there is virtually no difference in numbers admitted. There was however a noticeable difference in the over 90yr old range where admissions in this range were up 36%.

Occupancy in the wards in the week commencing 26th December 2012 to 2nd January 2013 changed from 89% to 95% in Medicine, 89% to 100.3% in Respiratory, and from 88.1% to 94.4% across the Acute Division as a whole

2.5 Breach analysis

The most significant breach numbers continue to appear within the Majors area of the department, totalling 815 in the month of December 2012. Consistent with previous months 63% of the total number of breaches occurred within the Majors area of the department between October 2012 and 8th January 2013

Table 3: Breach analysis by allocation Oct 12 – 8th Jan 2013:

Allocation	Oct-12	Nov-12	Dec-12	1st to 8th Jan-13	Total	Cumulative %
CHILDREN	52	72	66	6	196	5%
MAJORS	620	873	815	316	2624	63%
MINORS	79	118	127	52	376	9%
RESUS	233	306	313	104	956	23%
Sum:	984	1369	1321	478	4152	100%

Whilst the Childrens and the Minors areas of the emergency department are performing better, action is being taken to ensure that these areas strive for a zero tolerance of breaches.

The top 3 reasons for breaches are summarised as:

- Bed breaches 32 %
- ED process 27 %
- Clinical reasons 16%

Table 4: Type 1 Delay Reasons in Quarter 3 to 8th January 2013

Delay Reason	Oct-12	Nov-12	Dec-12	1st to 8th Jan-13	Total	Cumulative %
Bed Breach	312	434	397	184	1327	32%
ED Process	259	382	340	148	1129	27%
ED Capacity (Cubicle Space)	28	8	17	10	63	2%
ED Capacity (Inflow)	36	94	128	30	288	7%
ED Capacity (Workforce)			4		4	0%
Clinical Reasons	161	186	245	56	648	16%
Specialist Assessment	36	33	36	11	116	3%
Specialist Decision	9	8	7	1	25	1%
Investigation (Imaging and Pathology)	62	80	56	8	206	5%
Transport	68	105	73	29	275	7%
Treatment	13	39	18	1	71	2%
Sum:	984	1369	1321	478	4152	100%

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This picture is consistent with previous monthly reports although the number of delays due to capacity and inflow has increased again in December. There has been a slight improvement in the numbers of breaches that are transport related. Work is on-going within the department to improve accuracy of recording of breaches supported by daily review.

Bed breaches:

The continuous availability of beds on assessment units and access to speciality beds is a key element to allow the timely flow of patients out of the Emergency Department. Both the availability of beds at the time of request and the ability of the emergency department to transfer a patient from the department without delay once a bed is available result in lengthy waits for patients.

2.6 ED Quality Performance Indicators

Only one of the clinical quality indicators was met again in December as shown in figure 5 below. Time spent within the department has increased once again and continues to remain at the highest level since April 2012. The reasons for this are multi faceted and include higher levels of attendance, poor ED processes, lack of outflow associated with lack of bed availability and staffing levels as reported in previous months.

Figure 5: ED Quality indicators January 2012– December 2012

CLINICAL QUALITY INDICATORS									
<u>PATIENT IMPACT</u>									
	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	TARGET
Left without being seen %	3.0%	2.7%	2.4%	2.1%	2.2%	2.7%	2.5%	2.5%	<=5%
Unplanned Re-attendance %	5.9%	5.9%	6.4%	5.6%	5.3%	5.0%	5.2%	5.2%	< 5%
<u>TIMELINESS</u>									
	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	TARGET
Time in Dept (95th centile)	317	322	240	238	240	298	326	344	< 240 Minutes
Time to initial assessment (95th)	31	25	20	15	16	23	24	24	<= 15 Minutes
Time to treatment (Median)	49	59	57	53	58	64	69	68	<= 60 Minutes

2.7 Staffing Impact on performance

Vacancy levels continue to remain high for the Emergency Department despite rigorous recruitment and retention activities supported by the Deputy Director of Human Resources. As previously reported significant numbers of bank and agency staff continue to be used in order to achieve optimum staffing levels. The singular contract for nurse agency staff continues to be used in order that some continuity can be achieved in terms of staff working within the department. Fortnightly recruitment strategy meetings continue with Senior HR input, to look at recruitment alternatives and creative recruitment solutions. Permanent and locum consultant positions continue to be advertised. Promotion of nursing opportunities within ED will feature as part of the planned recruitment drive planned for 26th January 2013.

2.8 Right Place Consulting:

The work continues on track with the new model of care due to be implemented on 18th February 2013. Attached are 4 documents relating to the work:

1. ED and Assessment agreed model (appendix 1)
2. ECP highlight report (appendix 2)
3. Milestone Plan (appendix 3)
4. Suggested KPIs (appendix 4)

There is still considerable risk associated with the 18th February date for compliance of the 95% target. This centres around having enough capacity in the system to allow the model to embed.

Weekly reports are taken to Executive Directors looking at all options to temporarily increase capacity.

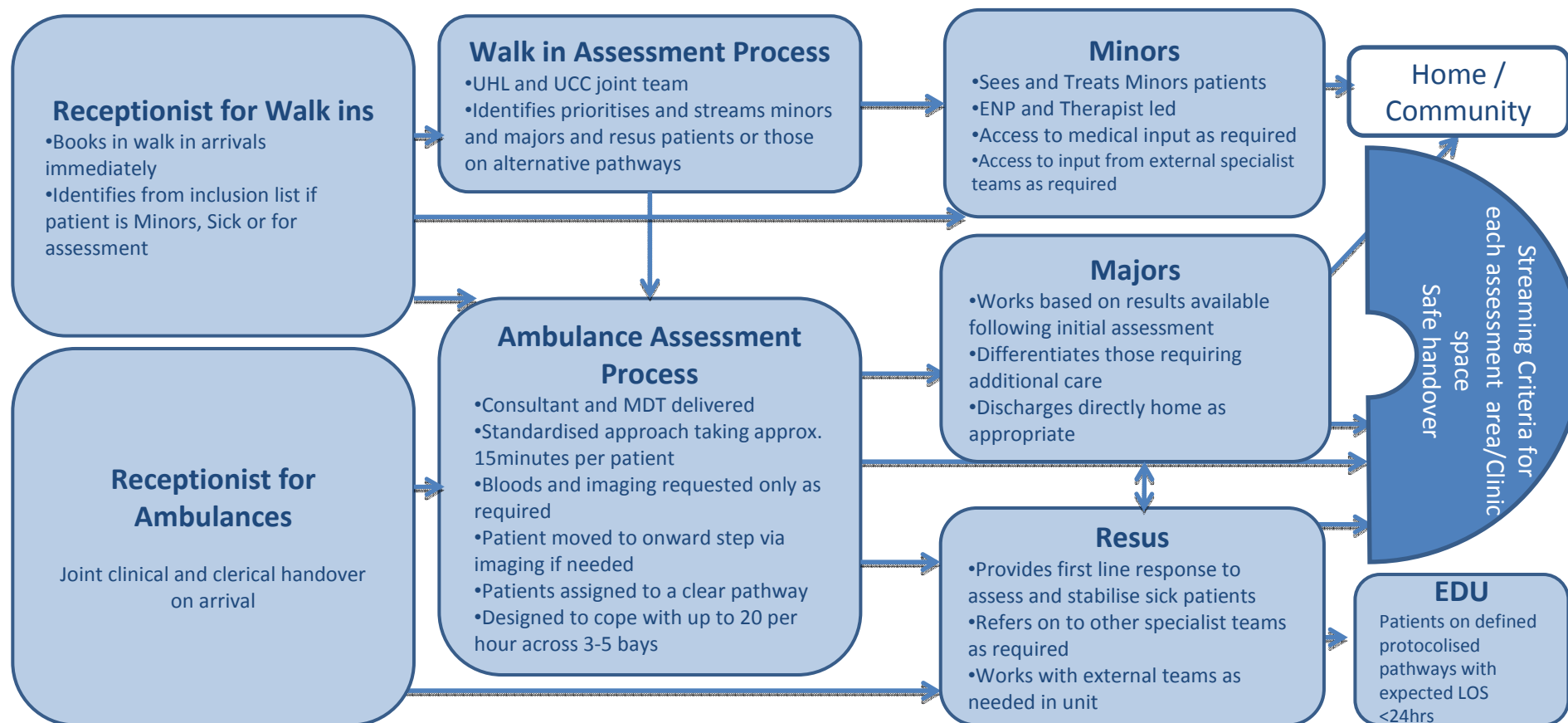
5 RECOMMENDATIONS

Board members are asked to:

- Note the content of this report;
- Continue to support the revised programme of improvement recognising the opportunity created through the right place consulting work, and
- Note CCG support and the associated incentives for weekly achievement of performance.

UHL Emergency Department Pathway

Appendix 1



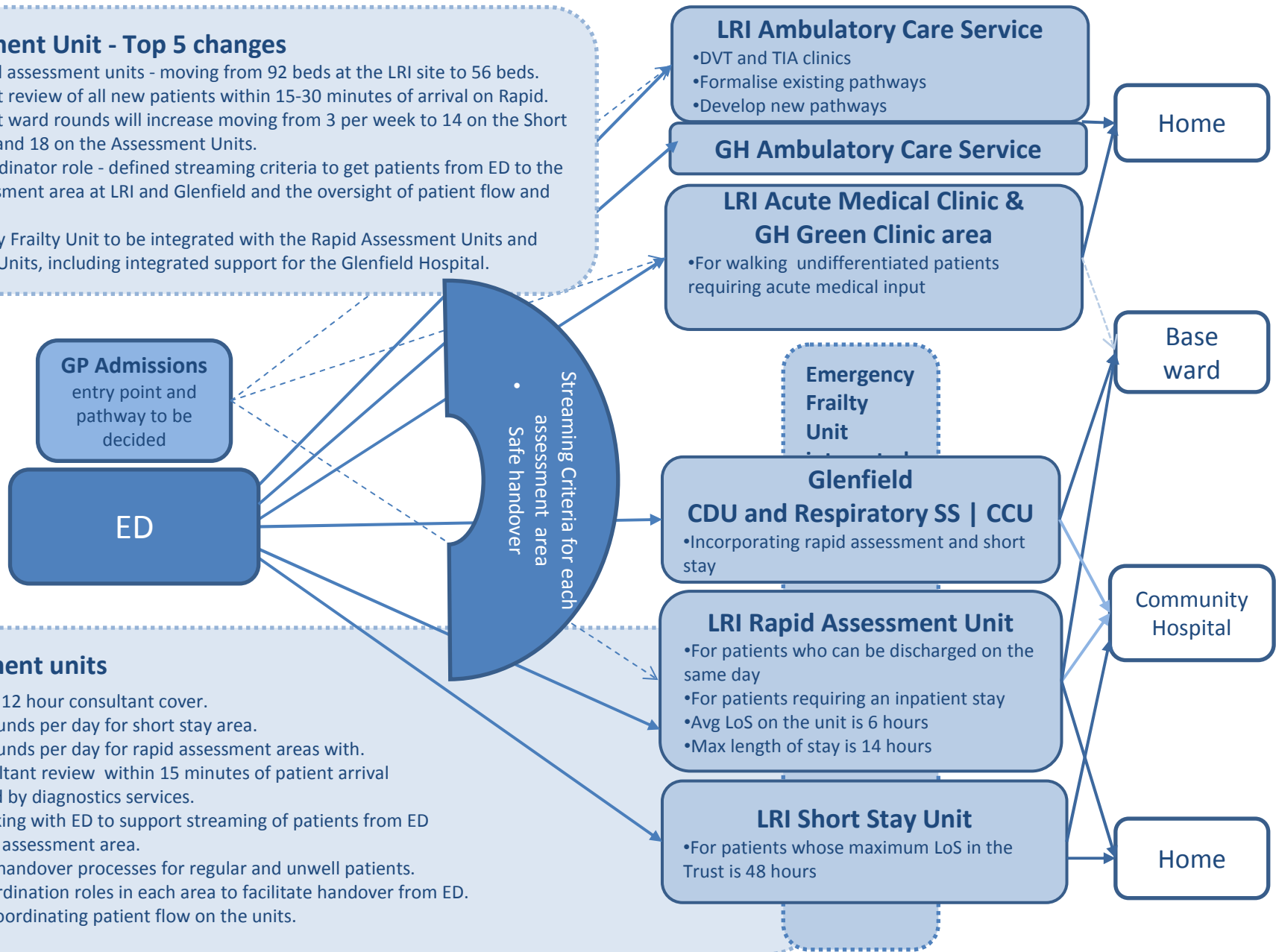
Emergency Department - Top 7 Key Changes

- Consultant led Standard Assessment process for all Ambulance Arrivals during peak periods within 15 minutes of patient arrival (ST4 or above after 11pm) supported by multi disciplinary team approach to assessment bay process enabling removal of queues and waits.
- Minors - by-pass standard triage for clear cut Minors patients where the wait to be seen is <30minutes with the aim of diverting all UCC patients appropriately and identifying higher risk majors patient. See and Treat service with productive ENP and MDT team.
- Majors is used to undertake additional work up to differentiate the patients pathway or where patient is in need of first line treatment only prior to discharge.
- Resus supported by responsive external teams in line with the case mix and appropriately staffed and equipped.
- EDU continuing to take patients on a range of protocolised pathways up to a maximum LOS of 24hours (except head injuries).
- The department is staffed to cope with 90 percentile demand.
- The department has a geared approach to cope with a range of common scenarios supported by clear escalation plans information dashboards and role cards.

UHL Assessment Units Pathway

Assessment Unit - Top 5 changes

- Right sized assessment units - moving from 92 beds at the LRI site to 56 beds.
- Consultant review of all new patients within 15-30 minutes of arrival on Rapid.
- Consultant ward rounds will increase moving from 3 per week to 14 on the Short Stay Units and 18 on the Assessment Units.
- Floor coordinator role - defined streaming criteria to get patients from ED to the right assessment area at LRI and Glenfield and the oversight of patient flow and handover.
- Emergency Frailty Unit to be integrated with the Rapid Assessment Units and Short Stay Units, including integrated support for the Glenfield Hospital.





Assessment units

- Minimum 12 hour consultant cover.
- 2 ward rounds per day for short stay area.
- 3 ward rounds per day for rapid assessment areas with consultant review within 15 minutes of patient arrival
- Supported by diagnostics services.
- Joint working with ED to support streaming of patients from ED to the right assessment area.
- Standard handover processes for regular and unwell patients.
- Floor Coordination roles in each area to facilitate handover from ED and coordinating patient flow on the units.

Project Highlight Report

Project Name: *Emergency Care Pathway Implementation Programme (ECP)*

Period:	18 th January 2013	Summary position	
Author(s): Tessa Walton	Last period:		This period: 

1 - Status Update

Week 6:

Programme Status

- Workstream 1 and 2 implementation plans on track with identification of gaps from current to future state finalised by respective sub – groups and signed off by Programme Board on 15th January.
- Quality Impact Assessment template finalised by Suzanne Hinchliffe and Kevin Harris.
- Meeting held with Mark Wightman and Jade Atkin to agree the communication and engagement process and develop a clear plan of activities with CCGs/ GPs during design of future state. Initial GP Newsletter article submitted.
- Work on programme interdependencies across Workstreams 1 and 2 commenced.
- Agreement across Workstreams 1 & 2 to hold a trial run day on 8th February and full implementation of core model on the 18th February. Consideration and planning for the half term period preceding the 18th his critical.

Workstream 1:

- Commenced planning for minors process changes
- Assessment bay virtual planning group underway with planned visit to Nottingham w/c 21st January
- Initial scoping for departmental coordination complete
- Frail friendly ED requirements passed to WS2 for incorporation in to overarching plan for geriatrics

Workstream 2:

- Planning commenced for the Ambulatory Care pathways move to Fracture Clinic due to take place by 31st January
- Commenced Standard Operating Procedure for Assessment Unit working and detailed design of functions and roles and responsibilities
- Commenced the Service Level Agreement between Diagnostics and the Assessment Units to meet future state standard requirements of rapid access to prioritised tests.

Workstream 3

- Workstream 3 Bed Configuration inaugural meeting occurred with high level delivery milestones finalised and PID ratified at Programme Board.
- Commenced planning for 18th February changes to bed configuration – full implementation plan to be in place with associated medical model confirmed by 28th January 2013.

Stakeholder Engagement

- 2 hour Glenfield 'Drop In' Session with Workstream clinical leads delivered.
- Attendance at meetings with Registrars and Matrons at Glenfield. Attendance at Junior Doctors meeting scheduled.
- Forums and meetings being accessed to ensure staff are fully briefed and to ensure engagement exists with key stakeholders is critical to inform the implementation of the outputs of the group.



Communications







- Third edition of 'A3 Bulletin' disseminated to LRI, Glenfield sites and to Executive Team and Trust Board.
- Article placed in the next edition of the 'Team Talk' circular.
- Planning undertaken to develop a hub and wall visual representation of the future model being worked up with live weekly updates on most recent developments. These will be placed within an area in ED, Assessment Units at LRI, CDU at the Glenfield and in the RPC office on the Executive floor.

Week 7 focus:

- Drafting of the Quality Impact Assessment for each workstream
- FAQ's and staff intranet 'promo Box' booked to communicate ECP to staff further.
- Quick win implementation planning and delivery
- Standard Operating Processes to be worked up across Workstreams One and Two.
- Vocera or IBM equivalent specification to be worked up with IT director.
- Pilot exercise planning work to be finalised for 8th February including staff rotas.

Milestone	Target date	Status (R/A/G)*	Estimated date of completion
Milestone map and Quick wins implemented	21-01-13		21-01-13
Quality Impact Assessments completed and signed off	31-01-13		31-01-13
Communication Plan evaluation	08-02-13		08-02-13
Implementation completed	28-02-13		28-02-13



Description	Risk Rating (RAG)	Mitigating action	Owner	Review date
Significant resistance from key stakeholders.		Early engagement of stakeholders and strong Programme board leadership. Robust use of Escalation Process.	Jeremy Tozer, Pete Rabey	29/01/13
Programme momentum will degenerate once programme structure is removed.		Workstream meetings to embed accountability and sustainability from outset, informed by relevant performance metrics.	Workstream leads: Ben Teasdale and Catherine Free.	20/02/13
There is a risk that the A&E target poor performance will require immediate actions which are out of synch with the implementation scope and timeframes of the Programme.		Regular communication and escalation where plans do not fit with the Programme scope of work.	Jeremy Tozer, Pete Rabey	29/01/13
Lack of clinical engagement and inability to obtain consensus on the medical model may impact on design and implementation of the Emergency Care Programme		Engagement through Workstreams and existing forums, e.g. physicians and nursing meetings to ensure wide communication of designs	Pete Rabey	29/01/13
Additional scrutiny of the Trust by external agencies e.g. CCG / SHA and impact on decision making		Key messages internally and externally as to the benefits of the future design model and timeframes are being disseminated via a tailored Communications Board	Jeremy Tozer, Pete Rabey	29/01/13
Half Term falls the week prior to implementation date		Potential for poor cover of Assessment Unit and Ward areas combined with Workstream member annual	Jez Tozer, Pete Rabey and Phil Walmsley	29/01/13



		leave which is a risk to delivery		
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There are significant issues that require immediate remedial action.



Issues have been identified that will require remedial action if project is to remain within tolerance.



Project is progressing to plan.



Measure	Output	KPI Target
time for ambulance crew handover	minutes from arrival to completion of clinical and clerical handover	15minutes max
variance of inflow to outflow	the volumes attending and discharged from the ED by hour by day of the week	matched
Time to a decision by stream	time from arrival to decision	TBC by stream
discharge rates by stream	the discharge home rate	TBC by stream maintain or improve on 23% overall admission rate
Reattendance rates	reattendances	maintain or reduce across all units in ED
time in the ED	Time from arrival to discharge or transfer	4hr target achieved
Time from request to scan and request to report by imaging type	Imaging TATs	TBC by imaging type max 1hour turnaround?
Time to contact radiology/ED for imaging queries by query type	Local audit	N/A
Consultant input to ED clinical care	% of patients with consultant input in majors/resus	100% in hours ? OOH
Reg input to consultant care	% of patients not having consultant input that received registrar level input majors/resus	100%
Mortality/Morbidity	Mortality and morbidity rates by patient group and day of week	improved mortality in Dr Foster HSMR data
Input from Critical Care/ED team to resus	local analysis of input split by patient type in resus	N/A
admissions and utilisation of EDU	Volumes of admissions/transfers and discharges to/from EDU by patient stream and Average and Max LOS	TBC discharge home rate TBC Average LOS TBC max LOS
Admission avoidance	percentage of patients discharged direct from EDU without inpatient admission by pathway	TBC Discharge home rate
Patients deflected to UCC or other external providers	% of attendances assessed and referred to alternative provider from minors	TBC
Patient experience	% of patients rating their experience as good or better	Positive trend
Case mix/load	% of minors staff rating their caseload as manageable and appropriate	positive trend
Capacity of staff matched to demand	time to treatment and time in department variation across the day/charted against demand	no/minimal variance across the day
Use of initial escalation steps	% of days when the highest level of escalation are triggered	a reduction in the % of days when the director on call is required to input to flow
Clarity of roles and responsibilities	local qualitative process for assessing staff confidence in what is expected and required of them in their role	a positive trend post implementation

The number and percentage of patients with a length of stay on the unit of <48 hours	To understand base line and measure improvement against LoS targets for the area.	
The number and percentage of patients discharged home from the unit	To measure the appropriate use of beds on the unit	
WORKSTREAM 2		
Bed Bureau Area		
ED referrals	The number (and percentage) of patients who are streamed from ED to Bed bureau	Positive trend expected
GP referrals	The number (and percentage) of GP referrals via the bed bureau per hour and day	Positive trend expected
Length of stay	The number (and percentage) of patients admitted to hospital with a length of stay of zero	Positive trend expected
utilisation	The number of slots booked	Positive trend expected
AMU/Rapid Assessment Area		
Length of stay	The percentage (total volume) of patients who have a length of stay of <6 and 14 hours	Average length of stay of 6 hours, maximum length of stay of 14 hours.
Discharge rate	The number and percentage of patients discharged home as opposed to transfer	>60% discharge home rate from rapid assessment area
Out of hours utilisation	The number of sleep overs in the area	Positive trend expected
Unit Capacity	The number of empty beds throughout the day	Positive trend expected
Time to consultant assessment	The time from patient arrival to consultant assessment	A reduction in time expected
Short Stay Area		
Length of stay	The number and percentage of patients with a length of stay on the unit of <48 hours	Maximum length of stay of 48 hours.
Discharge rate	The number and percentage of patients discharged home from the unit	Positive trend expected
Patient flow	The number and percentage of patients moved from the unit to a base ward.	NA
Time to consultant assessment	The time from patient arrival to consultant assessment	Average length of time from patient arrival on the unit to consultant assessment
Unit capacity	The number of empty beds throughout the day	Proportion of empty beds to accept daily demand.
Diagnostics		
AMU/Rapid Assessment Area turn around times	AMU length of time between request made to report verified	Less than 1 hour turn around