Royal United Hospitals Bath
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | **Public Board of Directors** | **Agenda item:** | **12** |
| **Date of Meeting:** | **31 May 2017** | | |

| | |
|---|---|
| **Title of Report:** | **4 Hour Improvement Plan – 2017/18** |
| **Status:** | **For approval** |
| **Board Sponsor:** | **Francesca Thompson, Chief Operating Officer** |
| **Author:** | **Suzanne Wills, Divisional Manager Medicine** |
| **Appendices** | **Appendix 1: 4 Hour Performance Report Month 1 (April 17)** |

| **1.** | **Executive Summary of the Report** |
|---|---|

The recent publication of the "Next Steps on the NHS Five Year Forward View" (March 2017) outlined the ongoing challenges which are faced by NHS and social care providers. The aging population, cancer survivorship and improving medical treatments are leading to ever increasing demand for our services, placing unprecedented pressure on acute providers.

The document also recognises the complexity of the modern health care economy, the inter-dependencies and need for system wide service improvement to manage these pressures. It describes the need to "*upgrade the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services*".

This paper outlines the key areas of focus for the system and specifically for the RUH over the coming year. It describes the underpinning issues which have shaped the 4 hour improvement plan (Appendix 1) and seeks to provide assurance in relation to governance and monitoring of the delivery of this plan.

Sustainability and Transformation Funding is aligned to the delivery of the system wide 4 hour trajectory and the financial position of the Trust is therefore also intrinsically linked to 4 hour performance.

| **2.** | **Recommendations (Note, Approve, Discuss)** |
|---|---|

Board of Directors is asked to approve the 4-hour improvement plan presented (Appendix 1).

| **3.** | **Legal / Regulatory Implications** |
|---|---|

Care Quality Commission (CQC) Registration 2017/18.

| **4.** | **Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)** |
|---|---|

The 4 hour performance is currently on the risk register ID: 634.

| **5.** | **Resources Implications (Financial / staffing)** |
|---|---|

Any requests for investment linked to this programme will continue to be reviewed monthly by the Urgent Care Collaborative Board and as directed by the Board, business cases will be taken through the usual Trust process in line with Standing Financial Instructions.

| |
|---|
| Further bids may be approved by commissioners in line with MRET reinvestment or ORCP allocations and the priority areas are highlighted within this paper. |

| 6. | Equality and Diversity |
|---|---|
| All services are delivered in line with the Trust's Equality and Diversity Policy. | |

| 7. | References to previous reports |
|---|---|
| Monthly 4 hour performance reports and ECIP recommendations. | |

| 8. | Freedom of Information |
|---|---|
| Public. | |

## 1) Executive Summary

This paper sets out to summarise the key aspects of 4 hour delivery during the course of 2016/17 and introduce the rationale and components of 2017/18 urgent care and emergency planning.

The 2017/18 RUH 4 hour improvement plan has been revised to reflect the priorities set within the National and local agenda and can be seen in Appendix 1. The leadership and governance structures have been slightly modified in order to further strengthen the monitoring arrangements (Appendix 1).

The recent publication of the "Next Steps on the NHS Five Year Forward View" (March 2017) outlined the ongoing challenges which are faced by NHS and social care providers. The aging population, cancer survivorship and improving medical treatments are leading to ever increasing demand for our services, placing unprecedented pressure on acute providers.

The document also recognises the complexity of the modern health care economy, the inter-dependencies and need for system wide service improvement to manage these pressures. It describes the need to "*upgrade the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services*".

While the hard work and excellence of front line staff is acknowledged, a new approach is being indicated nationally to address the following key areas for improvement:

- The fragmented nature of out-of-hospital services unable to offer patients adequate alternatives to ED
- The need to consistently adopt good practice in acute hospitals
- The need to improve discharge rates to home or step down care

A system wide 4 hour improvement plan is being developed in conjunction with commissioners and other health and social care partners, in order to drive the necessary work plans and to monitor progress through the A&E Delivery Board. This system improvement plan is based upon the urgent care delivery plan (section 2) and led by the A&E Delivery Board. Whole system key performance indicators remain outstanding at the time of writing this report.

Sustainability and Transformation Funding (STF) is aligned to the delivery of the system wide 4 hour trajectory and the financial position of the Trust is therefore also intrinsically linked to 4 hour performance.

## 2) Summary outline of 4 hour improvement plan 2016/17

In September 2016 it became clear that the original STF trajectory set on 14th June 2016 would not be met. Non-elective pressures remained high during the summer months and delayed transfers of care significantly impacted on flow. Initiatives expected to be delivered by system partners did not achieve the forecast performance improvement which meant that the RUH took the lead in revising the 2016/17 4-hour trajectory.

A refresh of the trajectory was agreed with NHS Improvement (NHSI) in October 2016 along with a number of informal actions for the Trust to focus on while seeking to improve performance.

In response to the internal actions indicated, a weekly performance monitoring group was established to drive the actions against the existing scorecard. The programme is detailed in a monthly 4-hour exception report with identified leads, actions and timescales. These monthly reports are overseen by Urgent Care Collaborative Board, Management Board and the Board of Directors. A dedicated ED risk register was also created for lead executive oversight.

On review of the oversight of plan delivery it was concluded that there would be increased Non-Executive Director scrutiny at the Fit for the Future Board, a delegated Board Committee attended by both the Trust Chairman and a Non-Executive Director. As a result, Ambulatory Care, Silver patient (aligned to SAFER Bundle), evening consultant cover and ART (Home First) were agreed as priority areas for the Trust.

Throughout 2016/17, the RUH engaged with Emergency Care Improvement Team (ECIP) and other NHS acute trusts to share learning from their experiences which included site visits. Information events were held in both surgical and medical divisions to remind clinical teams and support managers of the importance of the 4 hour performance as a barometer of the wider health system. This was supported by a trust wide communication campaign focused on “Flow”. It was recognised that patients admitted through an overcrowded ED have a higher mortality rate further into their admission. Delivery of the 4 hour performance target is therefore a quality and safety measure for the entire system.

The learning from these events aligned to the agreed priorities for the Trust and was supported by ECIP during their visit in October 2016 and March 2017. In addition, quality improvement methodology has been gained on the FLOW coaching programme run by Sheffield University Hospitals, supported by the Academic Health Science Network and The Health Foundation. The aim of the Patient Flow Coaching Programme is to learn how to apply team coaching skills and improvement science at care pathway level in order to improve patient flow through a healthcare system. A number of key ‘Big Rooms’ are now established. Each group focuses upon a clinical pathway, working to a weekly drumbeat and is attended by a wide representation from the multi-disciplinary team. The RUH has 6 fully trained flow co-coaches and from January 2017 has been delivering training for a local cohort of 24 people, which includes 10 RUH staff each of whom are planning to undertake a programme of improvement across a clinical pathway.

The Frailty Big Room was the first to be established as part of the FLOW coaching programme. Success has been achieved, particularly in the introduction of frailty scoring and comprehensive geriatric assessment and the successful pilot of the Frailty Flying Squad. The evidence is being presented to the commissioners in line with the bids to seek reinvestment of the marginal rate emergency tariff (MRET).

A Big Room was established as a sub group to the front door group in order to review ambulatory care. In a relatively short space of time the improvement trajectory was set and performance significantly improved.

Key success in 2016/17:

- Introduction of Frailty Scoring
- Introduction of comprehensive geriatric assessment
- 100% delivery of the National Frailty CQUIN 2016/17
- Frailty Flying Squad pilot January and February 2017
- Pyjama paralysis awareness 1st March 2017 – part of the wider March on Frailty throughout the month of March where the team held training and education events and information stands in public areas of the Hospital.
- Sustained reduction in length of stay by 1 day on the Short Stay Frailty Unit (ACE) and sustaining performance
- 90% of patients discharged from ACE Ward to their usual place of residence
- Sustained 30% of the medical take through ambulatory care

Overall, it is disappointing that the improvement trajectory reset in September 2016 was not fully met despite the completion of all NHSI informal actions and a comprehensive 4 hour improvement plan.

In February 2017 a system wide RUH discharge summit, led by NHSI and NHS England took place as a means of accelerating the scale and pace behind discharge to assess ( one of the 7 National priorities set), together with the high levels of delays. As an outcome, the RUH initiated the lead in the implementation of Home First, as there is recognition that our local health and social care system is in a period of transition.

The Urgent Care Collaborative board held a planning and strategy event on the 31st March 2017, bringing together all key stakeholders across the RUH working in Emergency and Urgent Care. This informed next steps for the 2017/18 programme across the key focus areas.

## 3) Urgent and Emergency Care (UEC) – The National Picture

Further to the NHS 5 year Forward View (March 17), NHS England released the Urgent and Emergency Care Delivery Plan in April 2017. The document describes 7 priorities to deliver transformation with the requirement that these will be worked into detailed delivery plans by the NHS England regions and Sustainability & Transformation Programmes (STP) during Q1 2017/18. There is an expectation that regions and STPs will thereby focus on local needs, scaling up standardised initiatives which will deliver the greatest gain. STPs will coordinate activity with regional PMOs linking to UEC Networks.

The areas highlighted in yellow have been incorporated into the RUH 2017/18 improvement plan (Appendix 1) which includes a continuation of ECIP support in the areas of front door design and Home First implementation.

### 3.1 Front Door

The 7 priorities are as follows:

- Innovative new models of service that enable patients to enter their symptoms online and receive advice online or a call back.
- Improve effectiveness of NHS 111 so that by the end of 2017/18 the percentage of calls receiving clinical advice will exceed 50%.
- By March 2019 patients and the public will have access to evening and weekend appointments with general practice.
- Standardise access to 'Urgent Treatment Centres' though booked appointments with the aspiration to offer services open 12 hours a day, staffed by clinicians with access to simple diagnostics.
- The ambulance service will offer a more equitable and clinically focussed response that meets patient needs in an appropriate time frame with the fastest response for the sickest patients.
- Emergency Departments will develop new approaches to prioritising the needs of the sickest patients. Frail and elderly patients will get specialist assessments at the start of their care and those better treated elsewhere will be streamed away from Emergency Departments.
- The assessment process will be quicker to ensure patients are sent home as soon as possible or they will be transferred promptly to the most appropriate care setting for their needs.

While much of the focus for this work is on reducing demand for acute providers, there are opportunities to enhance our integration with patient pathways and primary care streaming, to ensure patients are treated in appropriate settings. This will be an important consideration should the RUH be successful in its bid to run the Urgent Care Centre.

### 3.2 Hospitals

By the end of Q2 2017/18, all hospitals are expected to have in place core best practice to deliver patient flow. These are:

- Ambulance / Hospital interface – clear escalation processes to address handover delays >30mins.
- Comprehensive front-door streaming tailored to local case mix.
- Ambulatory Care – 7 days a week tailored to local case mix.
- Frailty Pathway – MDT assessment which agrees expected date of discharge.
- Ward rounds which consistently meet the SAFER bundle on all assessment and medical wards.
- Discharge- trusted assessor, discharge to assess and seven day discharge capabilities.
- Psychiatric liaison service to be in place by end Q4 2017/18.

It is expected that the focus on patient flow will be supported by processes and systems that support front line staff and builds resilience into the system. This includes:

- An understanding of case-mix and patient flows into hospital that allow resources to be matched to activities appropriately e.g. ED workforce aligned to arrivals by time of day.
- An electronic patient tracking and bed management system that identifies blockages in the pathway.
- Modelling of the appropriate bed base and workforce mix to facilitate patient flow, including the use of non-bedded ambulatory care and alternative treatment areas outside of hospital e.g. step down beds.
- Hospitals to begin planning for winter with system partners in Q1 2017/18 to include:
    - Planning for a significant reduction in occupancy pre-Christmas including the impact on elective care.
    - Developing clear escalation protocols should occupancy exceed 92%.
    - Planning for a perfect week or alternative focussed 'break the cycle' event for December 2017 and/or January 2018.

### 3.3 Discharge - Hospitals to Home

A comprehensive plan has been developed by the centre (Hospital to Home: Activities and Responsibilities) which sets out the system wide work-streams to address the current pressures.

Areas of focus include:

- Working towards a 7 day Service: Enhancing support and resilience in community services.
- Trusted assessors.
- Focus on choice: Supporting patients' choices to avoid long hospital stays.
- Enhancing health in care homes.
- NHS continuing healthcare.

The activities and responsibilities which underpin this programme include:

- Cross Sector Partnerships
- Data and Metrics
- Bespoke National Support
- Integrated working
- Technology

This is an ambitious national programme which seeks to increase the number of patients discharged home or to interim care and then to their normal place of residence, reducing the likelihood of deterioration. Increased partnership working and collaborative learning is expected to improve efficiency, patient outcomes and reduce length of stay in acute / step down providers.

## 4) 4-Hour Improvement Plan 2017-18 (Appendix 1)

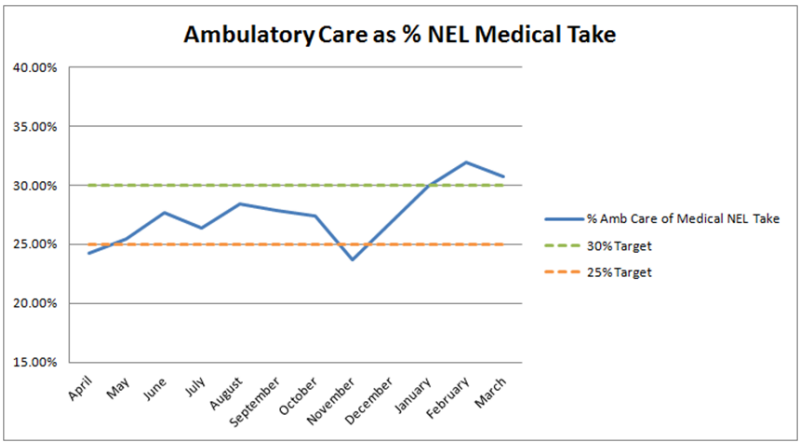
In revising the 4 hour improvement plan it became apparent that aspects of performance required much greater granularity and day to day management, for example the implementation of SAFER versus a transformational approach commanding more time and attention to change management.

The following sections identify the key areas of focus with some further detail, in particular the opportunity to align our priorities with Marginal Rate Emergency Tariff bids (MRET) to the A&E Delivery Board in June 2017:

### 4.1 Front Door: Improvement and MRET investment

The main areas of front door focus in early 2017/18 are in ambulatory care and frailty.

The RUH has made significant progress in relation to the % of the medical take managed through Ambulatory care against the target of 30%.




The existing unit was refurbished in November 2016 (2 week closure) with a subsequent increase in capacity.

The clinical teams are working closely with ED and the Acute Medicine physicians to actively pull appropriate patients from the emergency department and to streamline care onwards to the Medical Assessment Unit when required. An additional senior nurse has been appointed to support the extended services.

A further extension of opening hours will be delivered if the MRET (Marginal Rate investment) bid for additional consultants is supported by commissioners in June 17. This will allow an acute medical consultant to be on site until 9pm each day to support ED, promoting admission avoidance and early discharge.

Consultant connect and “urgent connect” have been rolled out to all acute specialties to provide direct senior clinical advice to GPs and other relevant health professionals. These systems include an audit trail of attendance or admission avoidance to track effectiveness and impact on non-elective activity.

ECIP visited the Trust in March 2017 and commended the Ambulatory Care team for the progress made. Further expansion of hot clinics and focus on the pull from ED was recommended as well as other priorities to include:

- Communications on Ambulatory Emergency Care (AEC) with primary care, including Wiltshire at relevant GP education events.

- Communications of AEC with new ED junior doctors, given the 4 monthly rotation and their input in relation to patient admission.
- Use of Glasgow predictive score for AEC.

Work is ongoing to promote the service both internally and externally so that appropriate patients can be referred and the service also offers an opportunity for discharged patients to be seen should they require an urgent review.

ECIP also noted the successful pilot of the Frailty Flying Squad to support early assessment of frail elderly patients in ED with the aim to avoid admission for those able to be managed in community settings or their own homes, and early discharge for those who need some intervention.

A bid to support the ongoing delivery of this service is also to be presented to commissioners as part of the proposal to reinvest the MRET. Additional consultants, Medical nurse practitioner and therapist support will be required to fully embed this service and maximise the impact across 7 days.

Further benefits have been identified in relation to the management of "major trauma" within the frail elderly cohort as an opportunity to reduce length of stay, improve clinical outcomes and reduce mortality rates and MRET investment will be sought.

It should be noted that a Falls Rapid Response pilot has commenced which involves the RUH therapy team working with the ambulance service to attend falls. This will allow assessment of the patient and their situation in their usual place of residence and it is forecast that attendances and admissions will be avoided by providing appropriate advice at the scene of the accident. The 10 month pilot will be evaluated and a business case developed if the success measures are delivered.

### 4.2 Implementation of SAFER and 'Silver' Patients

National evidence demonstrates that focus on the "SAFER" bundle improves patient flow, clinical outcomes and reduces length of stay.

| | | |
|---|---|---|
| **S** | **Senior Review** | All patients have a senior review before midday |
| **A** | **All patients EDD** | All patients have an expected discharge date |
| **F** | **Flow** | Flow of patients will commence at the earliest opportunity (by 10am) from assessment units to inpatient wards |
| **E** | **Early Discharge** | 33% of patients will be discharged from base inpatient wards before midday |
| **R** | **Review** | A weekly, systematic review of patients with extended lengths of stay |

ECIP assessed the emergency pathways and our progress in implementing SAFER consistently across all acute clinical services during the March 2017 visit. This review identified that there is variation in the way the bundle is observed and work to address this is continuing with the Heads of Division.

The gap in evening acute medical cover was also highlighted and this will be addressed if the bid for MRET reinvestment is approved and candidates can be found to fill the existing and new vacancies.

A significant factor for the RUH is the congestion arising in ED from the availability of beds and ability to move patients from front door areas to inpatient beds. The Trust has launched a "Silver patient" initiative which seeks to identify at least one patient per ward who will be discharged by 10am. The successful identification of patients able to leave early is heavily dependent upon medical staff, allied health professionals and pharmacy supporting the discharge process. The fact that a patient can leave the next morning has increased the number of evening discharges as it has helped to challenge the need for an additional night in hospital.
Delays in discharge inevitably impact on the ability to move patients from assessment areas to inpatient wards.

ECIP recommended a relaunch of the "Silver" initiative to ensure plans are in place for beds to be available by 10am, not just patients being discharged by this time. They emphasised the value of routine second, afternoon board rounds to review next day discharges so that all necessary preparations are in place.

There was also a suggestion that a discharge lounge could be reconsidered which has been discussed at the Urgent Care Collaborative Board and not identified as a priority for 2017/18.

However, embedding the principles of SAFER has been a priority to support earlier discharge and improve flow through the hospital. The Specialty Big room was launched in March 2017, replacing the Specialty Group, to align the focus of the group to clinical pathways and opportunities to embed SAFER through practical application to key patient journeys using the FLOW methodology. The aim of the group is to identify areas within SAFER to improve, complete small tests of change for a specific ward and clinical pathway, learn from these changes and then support spread of good practice across all ward areas.

The initial pathway under review to test these cycles relates to gastroenterology patients and the Haygarth ward team. Learning is already being shared with Cardiology to ensure consistent messages are taken forward as part of the coaching framework. A roll out programme will be devised and report through to the Fit for the Future Board as part of the transformation work to be undertaken.

### 4.3 Discharge

The Discharge Board is chaired by the Director of Nursing & Midwifery and oversees a wide work plan of initiatives to support the discharge planning process at ward level.

ECIP noted that the therapy establishment appears low and the medical division is reviewing this resource across the Trust. A detailed therapy review will be presented to Management Board in June 2017.

Non-emergency patient transport delays were identified as a major obstacle to flow at the discharge summit in February 2017 and an action was allocated to BaNES CCG to seek improvement.

Significant success has been achieved by the 'Active Recovery Team' (ART) which has now morphed into the 'Home First' initiative led by the RUH A&E Delivery Board. The RUH continues to be instrumental in the successful delivery of this programme which seeks to bridge the gap between secondary care and packages of care within the home setting for Pathway 1 patients. Since the pilot went live in November 2016, approximate 666 bed days have been saved by allowing 41 patients to return to their own homes sooner than could have been achieved through social care alone.

| Metric | Target | Trend | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 |
|---|---|---|---|---|---|---|---|
| Number of patients suitable for supported discharge with ART per month (8 discharges per week) | 44 | | 8 | 24 | 45 | 56 | 62 |
| Actual | 44 | | 3 | 19 | 36 | 42 | 41 |
| Total bed days saved (3.4 day LoS reduction per patient) | 149.6 | | 10.2 | 153 | 282 | 602 | 666 |

NHSI acknowledged the challenges faced by the Trust in embedding this essential service, particularly during the transition of Sirona to Virgin care. NHSI have pledged their support in holding other organisations to account to achieve the successful delivery of this service model.

A dedicated operational lead has been appointed to support pathway 2 and 3 patients who require intermediate care settings e.g. when unable to weight bear for a defined period of time pending return to their usual residence. At the time of reporting this is also being considered as an area of transformation in partnership with BaNES.

### 4.4 Delays in transfers of care (DTOC)

During 2017/18 it was identified that the RUH had under reported delayed transfers of care due to the weekly data snapshot, rather than a daily account of those medically fit for discharge (MFFD). The reporting change has been accepted by NHSI and the central team made aware of the step change in the numbers recorded.

Aligning our reporting to other health and social care systems has demonstrated that we are consistently higher than the mandated DTOC 3.5% rate.

The 4-hour Improvement Plan (Appendix 1) now sets out the MFFD by CCG and is one of the key metrics for the implementation of Home First.

### 4.5 Reduce Length of Stay (Gastro and Cardiology)

In recognition of these high volume specialities, the consultants in Gastroenterology have reviewed and revised their job plans to ensure that daily outlier ward rounds take place. This has reduced the time to senior review for all patients under the gastroenterology team.

A deep dive review of Cardiology services is underway, led by the Deputy Head of Division. This will review productivity and patient pathways, particularly for inpatients

awaiting diagnostic or intervention as it is this element of the length of stay which is currently having the greatest impact on overall performance. The first phase of the review will be concluded by the end of Q1.

### 4.6 ED Dashboard

A dashboard has been developed and will be shared with Management Board in May 2017. Work is ongoing to include the quality indicators in the monthly reports (Appendix I) which are devised to provide assurance on the quality and safety of care delivery within the Emergency Department.

### 4.7 Fit for the Future Board

Significant, transformational projects are planned to be overseen by the Fit for the Future Board and Chaired by the Chief Executive. The current areas of the work programme include:

- Social Care Investment
- Home First (Pathway 1)
- IT Clinical Informatics Board and First Net Project Board
- Front Door redesign and urgent care tender

All work streams are linked back to the overriding principles outlined in the NHS England Urgent and Emergency Care Guidance documents described in sections 1 and 2.

## 5) Governance and Performance Monitoring

The governance structure has been refreshed to demonstrate the oversight of the various elements of delivery and accountability (Appendix 1).

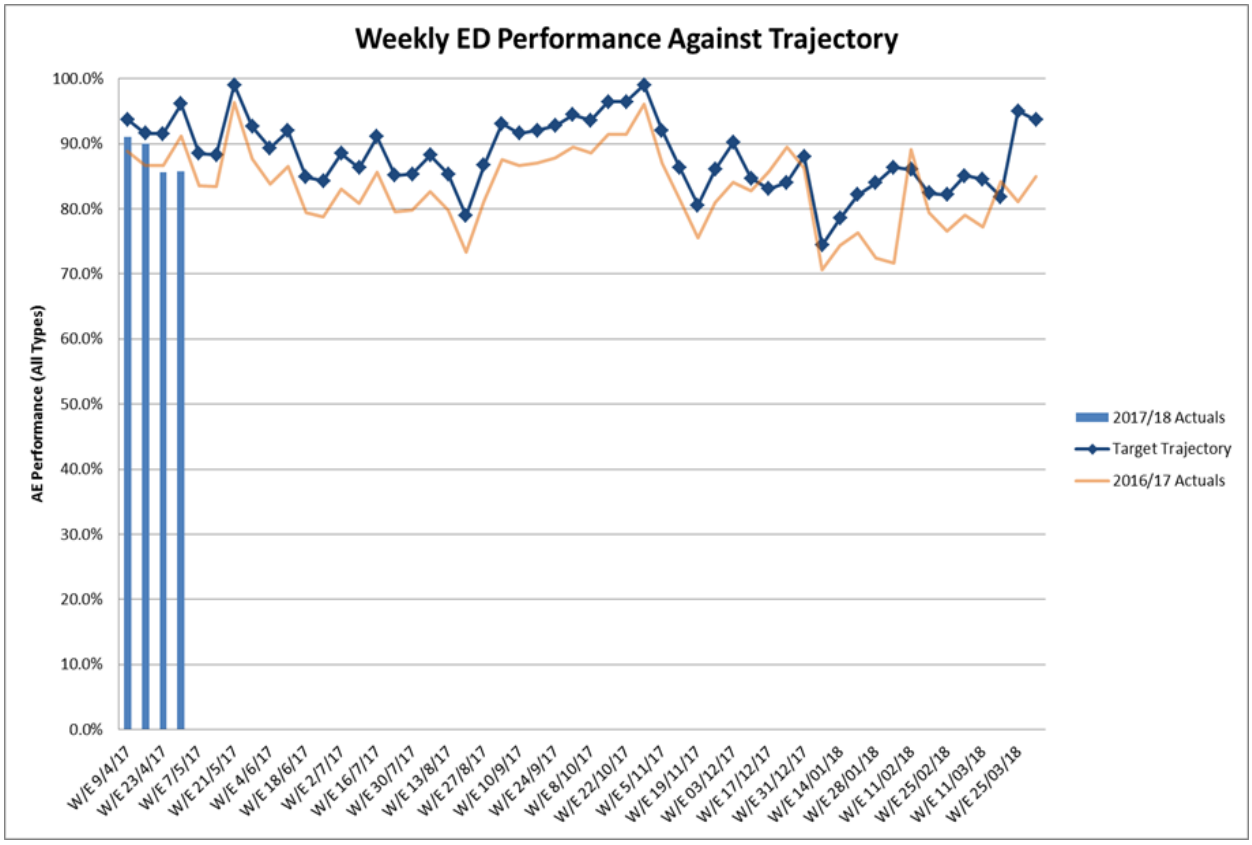
- The performance element of operational delivery will continue to be overseen and challenged by the Urgent Care Collaborative Board, Management Board and Board of Directors.
- The longer term, transformational programmes will be overseen by the Fit for the Future Board.
- The RUH reports to the A&E Delivery Board, attended by NHSI and NHSE along with system partners and commissioners to provide assurance to the regulatory and monitoring bodies.

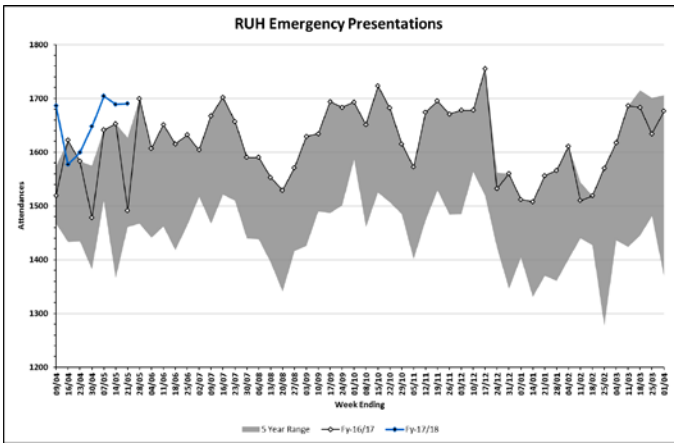
Daily and weekly operational performance is monitored by the Urgent Care Weekly Action review group. This forum monitors the progress of the weekly “Big Room” groups and receives updates from the monthly Discharge Board and work-streams. The aim is to maintain momentum for service improvement, unblock issues as required and to commission additional actions from the Front door, Specialty or Discharge groups.

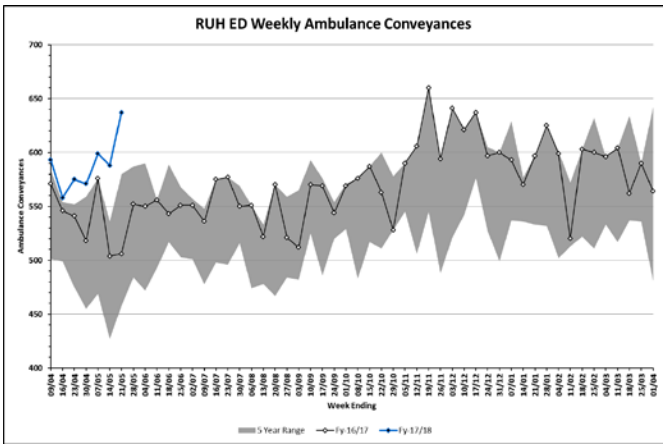
A range of performance indicators are now being captured to reflect not just the 4 hour performance alone, but quality indicators which provide richer data in relation to the services provided. Qualitative data, including Friends and Family Test, vacancies, sickness, turnover and senior decision maker cover, will be included in the report.

## 6) Trajectory and Planning Assumptions

The trajectory below shows the 2016/17 actuals and the improvement assumptions, underpinned by current schemes to deliver enhanced performance in 2017/18. Delivery against this trajectory continues to be challenging with ongoing high non-elective demand and infection control issues regarding Norovirus and Flu.




It is of note that the pressure on acute services at the RUH continues to significantly exceed the previous 5 years as shown above.

## 7) Summary and Recommendations

In summary, the delivery of improved 4-hour performance requires a system wide programme which can demonstrate focus and concerted efforts on the key priorities set. At the time of writing this paper the system improvement plan or key

performance indicators has not been finalised  It has been agreed that the main priority is the implementation of Home First which is currently being led by the RUH during a period of transition across our health and social care providers .

BaNES CCG is the lead organisation responsible for the monitoring and holding to account of the system wide improvement plan The RUH is a major contributor to the system wide improvement plan and has ensured that the internal plan is aligned to the national and local priorities as set.
The Board of Directors is asked to discuss the 2017/18 4 hour RUH improvement plan and approve the outlined approach and content.

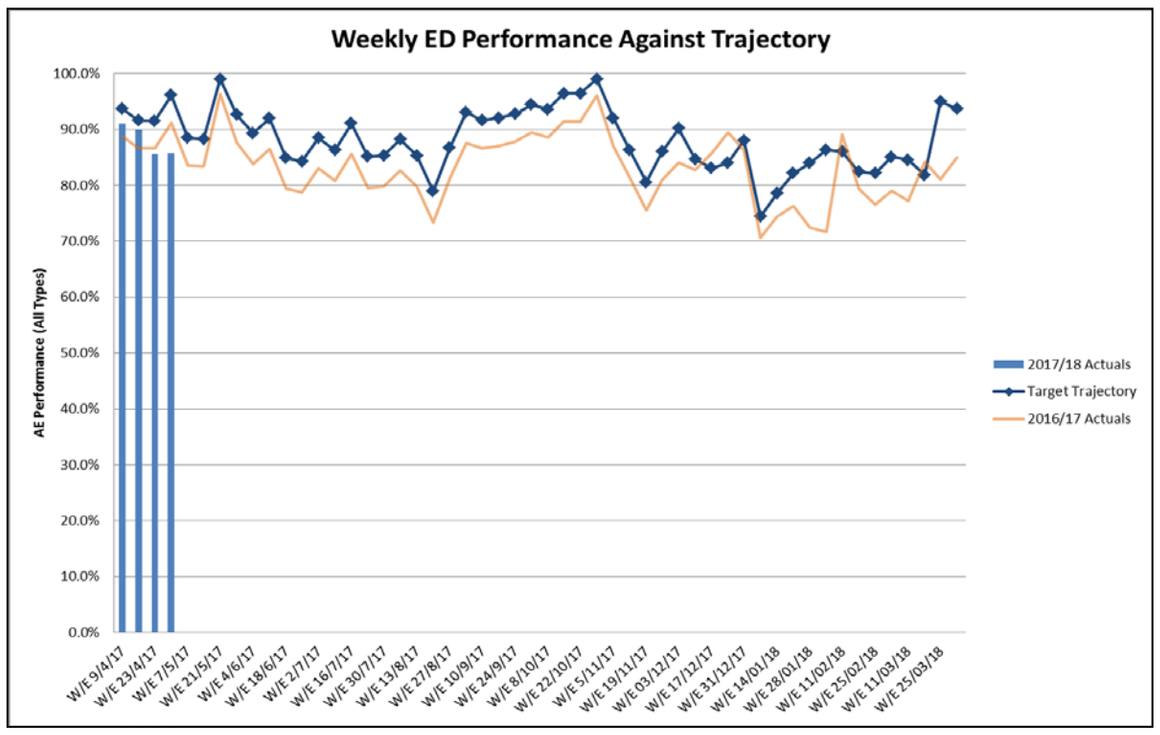
Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

# 1. RUH 4 Hour Performance: April 2017 Month 1

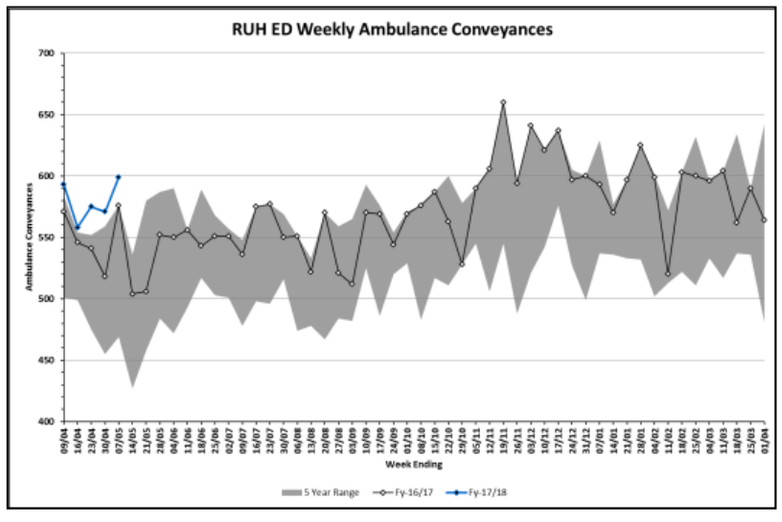
## Improvement Trajectory - Segment 2

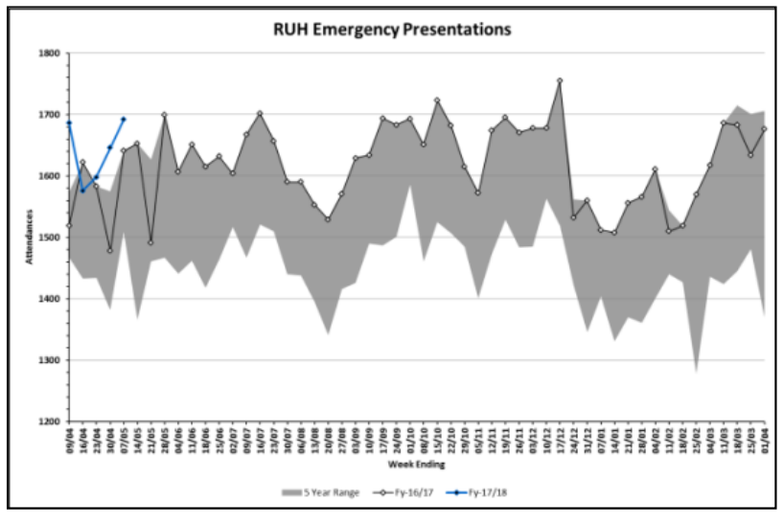
- April 2017 four hour performance not achieved: 88.4% (All types).
- Performance did not achieve the performance trajectory of 91.8%.

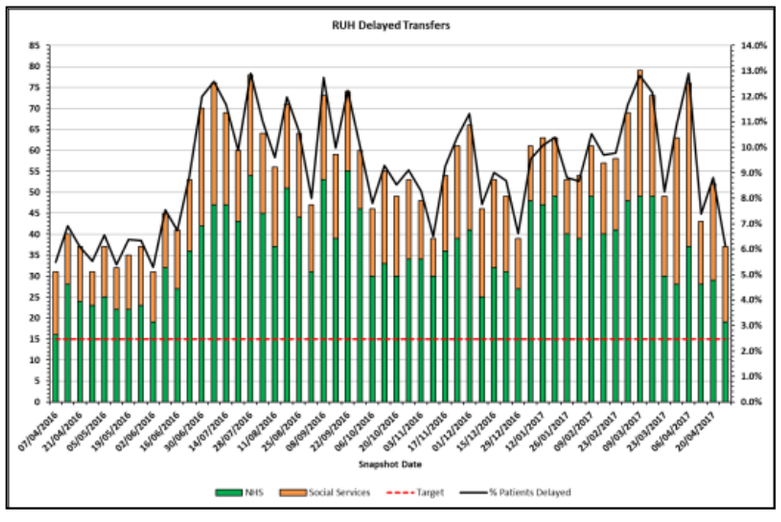



## Key Diagnostics

- Ambulance conveyance activity +5.2% variance compared to 2016/17 for week ending 07/05/2017.
- Emergency presentations +4.5 % year to date variance in emergency presentations compared to the last financial year.
- Emergency Department attendances +4.7% year to date variance in ED attendances compared to last financial year.
- Negative impact on bed capacity due to high Delayed Transfers of Care (DTOC). 37 patients reported at the April month end snapshot and 1256 delayed days (7.2%) reported.
- Early flow (discharges before midday)  not sufficient to support flow.



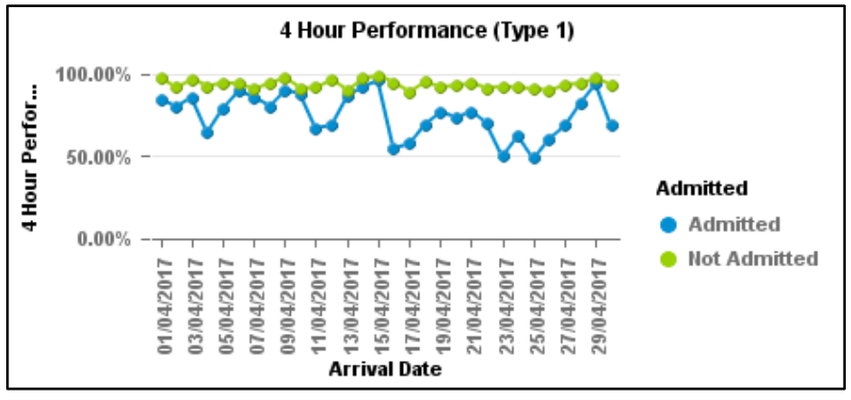



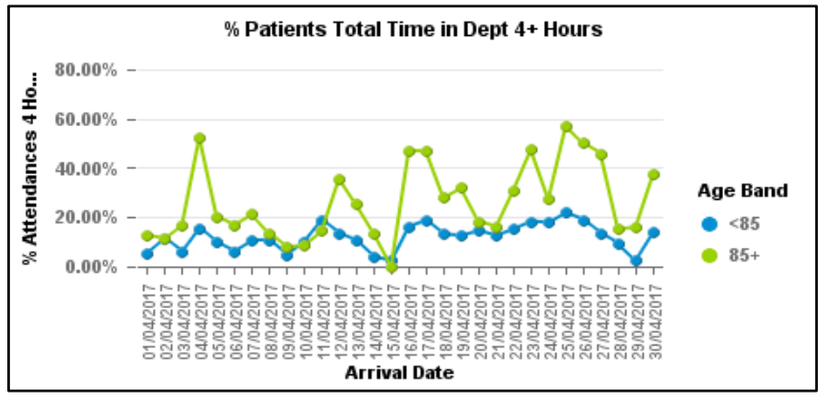



# 2. Emergency Department National Quality Indicators

| | | | | |
|---|---|---|---|---|
| **Majors** | **Actual Performance** 74.5% | **Average Time to Initial Assessment (mins)** 5 | **Average Time to Treatment (mins)** 73 | **Actions**<br>1. Increase Senior Decision Makers at the Front Door, Frailty Flying Squad and Acute Medicine (A&E Delivery Board Business Case).<br>2. Internal professional standards escalation.<br>3. Ambulatory Care access including Trauma & Orthopaedics |
| **Minors** | **Actual Performance** 94.7% | **Average Time to Initial Assessment (mins)** 7 | **Average Time to Treatment (mins)** 73 | **Actions**<br>1. To protect minors treatment times and overall performance, minors staff not to be moved to manage the Corridor. Utilise staff to support the Emergency Department from specialty wards during period of poor flow.<br>2. Internal professional standards escalation as increased in patients being admitted through minors, minor injury's requiring specialty input.<br>3. Daily and weekly review of non-admitted breaches through Front Door Group and Urgent Care Weekly group. |
| **Self Presenters** | **Actual Performance** 94.7% | **Average Time to Initial Assessment (mins)** 9 | **Average Time to Treatment (mins)** 60 | |
| **Streaming** | **Actual Performance** 97.2% | **Average Time to Initial Assessment (mins)** 4 | **Average Time to Treatment (mins)** 25 | **Actions**<br>1. Urgent Care Centre (UCC) Tender application<br>2. Continue to work with UCC team to improve services and access |

| Royal United Hospitals Bath NHS Foundation Trust | April 2017 | | 2016/17 |
|---|---|---|---|
| Reason For Breach | Breaches | % | |
| Bed Management | 407 | 49.6% | **74.1%** |
| Waiting For Diagnostics | 8 | 1.0% | **0.7%** |
| Waiting For Specialist Opinion - Acute | 73 | 8.9% | **4.2%** |
| Waiting For Specialist Opinion - MH | 33 | 4.0% | **2.1%** |
| Wait For First Clinician (Not Triage) | 0 | 0.0% | **0.0%** |
| A&E Assessment | 159 | 19.4% | **10.2%** |
| Clinical | 104 | 12.7% | **5.5%** |
| Treatment Decision | 0 | 0.0% | **0.0%** |
| Primary Care Assessment / Streaming | 27 | 3.3% | **2.6%** |
| Transport | 10 | 1.2% | **0.6%** |
| Unknown | 0 | 0.0% | **0.0%** |
| **Total:** | **821** | **100.0%** | **100.0%** |
| **OOH (7pm-8am) Arrival Breach Total:** | **372** | **45.3%** | **46.3%** |
| **Evening (8pm-Midnight) Arrival Breaches Total:** | **147** | **17.9%** | **20.1%** |




## Performance Summary

1. Patients are managed through the Emergency Department via 4 points of access; Majors, Minors, Self presenters and Streaming.
2. Consistently the Emergency Department achieve time to assessment across all points of access.
3. The average time to treatment has been achieved for 2 points of access, in year reduced flow out of the Emergency Department and the use of Minors staff to manage patients in the corridor is impacting on the average time to treatment in Minors resulting in reduced performance.
4. Overall 4 hour performance not achieved for Majors, minors and self presenter performance impacted by flow out and staffing. Streaming performance is dependent upon the Urgent Care Centre being fully staffed and streaming in line with national guidance.
5. Increased number of patients breaching the 4 hour standard who were not admitted .
6. Increased time in the Emergency Department for patients > 85 years old who are subsequently admitted, extended length of time for this cohort for a decision to admit to be agreed.

Royal United Hospitals Bath
NHS Foundation Trust

# 3. Urgent Care Collaborative Board: Performance Priorities & Integrated Balanced Scorecard

| Key Area | Metric | Target | Mar-17 | Apr-17 | | | | Current Trend |
|---|---|---|---|---|---|---|---|---|
| | | | 26/03/2017 | 02/04/2017 | 09/04/2017 | 16/04/2017 | 23/04/2017 | 30/04/2017 | |
| 1. Quality & Safety: To Provide Rapid Intensive Support to those Patients at Highest Risk | ED 4 Hour Breaches | | 304 | 245 | 149 | 164 | 236 | 233 | |
| | ED 4 Hour Performance | 95.0% | 81.1% | 85.0% | 91.1% | 90.0% | 85.6% | 85.7% | |
| | ED Ambulance Handovers within 15 minutes | 100.0% | 100.0% | 99.8% | 100.0% | 100.0% | 100.0% | 100.0% | |
| | ED Specialty 4 Hour Breaches | 4 | 11 | 17 | 23 | 14 | 17 | 16 | |
| | ED Conversion Rate | 26.6% | 33.0% | 34.2% | 34.7% | 36.0% | 33.9% | 36.2% | |
| | Average Daily Medical outliers | 15 | 29 | 28 | 30 | 33 | 32 | 17 | |
| 2.Performance: To implement Best Practice in Timely Senior Review and Discharge | GP Direct Admissions to SAU | 40 | 24 | 27 | 39 | 33 | 36 | 39 | |
| | GP Direct Admissions to MAU | 20 | 15 | 16 | 28 | 15 | 18 | 6 | |
| | ED and GP Direct Admissions to ACE | 5 | 5 | 4 | 2 | 8 | 3 | 2 | |
| | Ambulatory Care Activity | 30% | 34.1% | 32.7% | 24.5% | 25.0% | 26.9% | 30.4% | |
| | ESAC Activity | 30 | 43 | 43 | 35 | 37 | 30 | 43 | |
| | Ambulatory Cardiac Hot Clinic Attendances | 7 | 5 | 5 | 2 | 9 | 7 | 7 | |
| | MAU Transfers by 10am | 20 | 5 | 15 | 7 | 3 | 8 | 8 | |
| | SAU Transfers by 10am | 5 | 5 | 10 | 3 | 7 | 4 | 8 | |
| | Cardiology NEL LOS | 9.5 | 8.8 | 11.9 | 8.8 | 12.3 | 19.2 | 12.4 | |
| | Gastroenterology NEL LOS | 9.5 | 7.8 | 8 | 6.3 | 12.6 | 8.6 | 11.2 | |
| | MSS LOS | 3.0 | 3.5 | 2.4 | 2.7 | 3.6 | 2.9 | 2.8 | |
| | % Discharges Before Midday | 33.0% | 16.2% | 13.7% | 16.1% | 18.5% | 16.0% | 19.6% | |
| | % Weekend Discharges | 25.0% | 15.3% | 14.1% | 17.5% | 16.0% | 19.3% | 16.2% | |
| | Silver Patients identified on discharge tracker | 75 | 45 | 52 | 56 | 56 | 41 | 53 | |
| | DTOCS | 15 | 50 | 63 | 76 | 43 | 52 | 37 | |

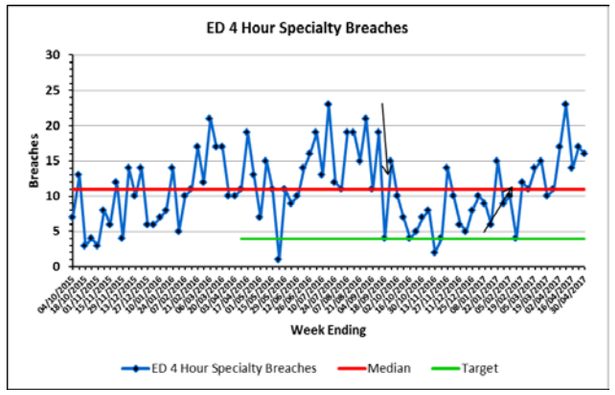
## Performance Priorities In Development

1. **Quality & Safety**
   NEWS and Sepsis
2. **Performance**
   TTA's, Inpatient Diagnostic waits
3. **Workforce**
   Rostering compliance, vacancies, sickness, turnover, senior decision maker cover
4. **Finance**
   STF, Social care investment, agency spend

Royal United Hospitals Bath
NHS Foundation Trust

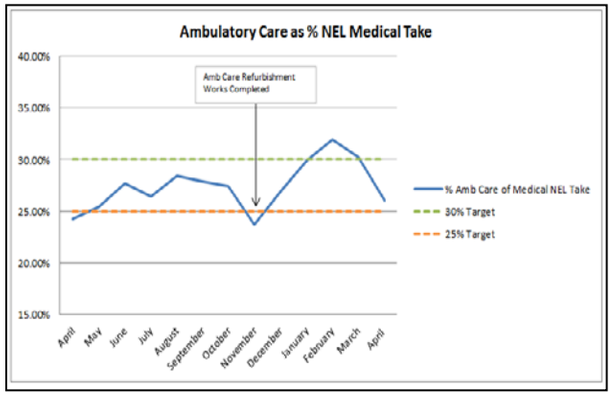
# 4. Key Areas of Focus: Managing ED Demand & Freeing Hospital Capacity

## 1. Internal Delays and Access to Specialty Opinion



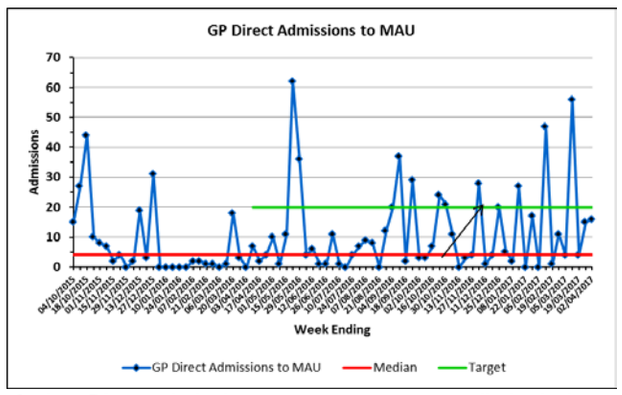

***Action: Front Door Group to ensure internal professional standards and senior escalation processes adhered to.***

## 2. Alternative Pathways to Admission - Medical Ambulatory Care



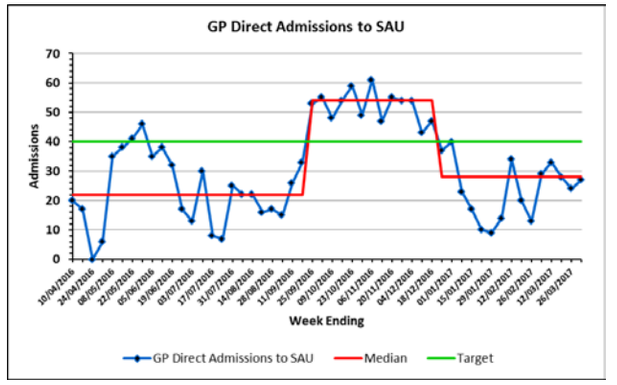

***Action: Nurse model fully in place from 15th May, enabling Medical Nurse Practitioners to proactively pull more patients from the Emergency Department..***

## 3. Direct Access to Medical Assessment Unit

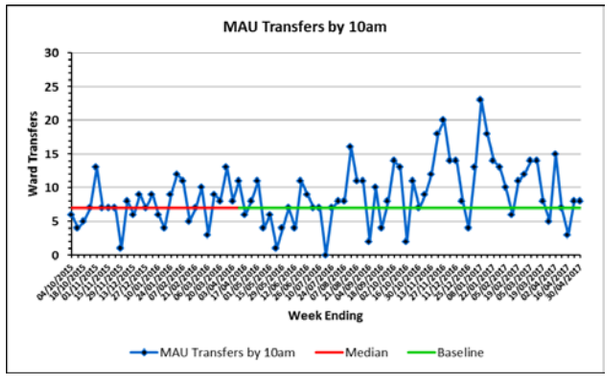



***Action: Direct admissions to assessment areas limited when flow out of assessment areas does not occur before 10am Front Door Group to review all actions across MAU, MSS and Ambulatory Care to increase discharges.***

## 4. Direct Access to Surgical Assessment Unit

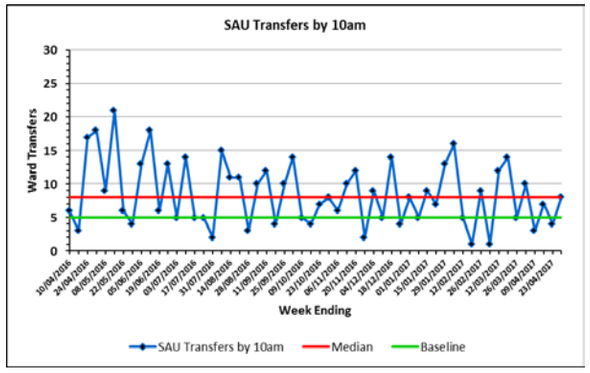



## 5. Early Flow out of Assessment Area - MAU

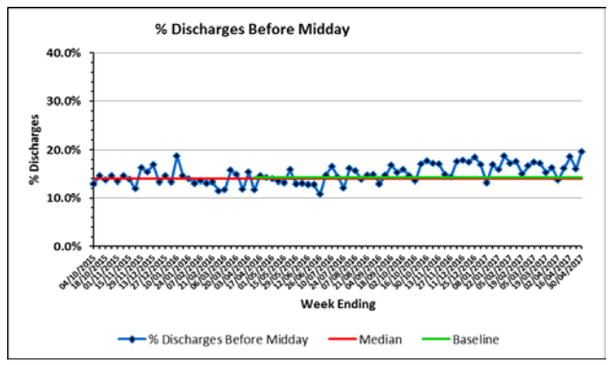



***Action: Front Door Group to review all actions across MAU, MSS and Ambulatory Care to increase discharges as current trust wide discharges before midday do not deliver the required improvement to support early flow.***

## 6. Early Flow out of Assessment Area - SAU

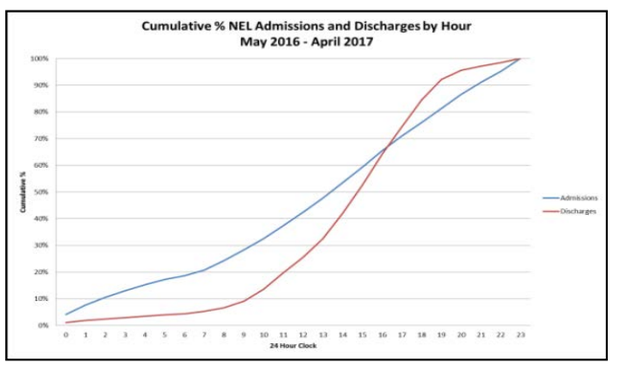



## 7. Early Flow Trust Wide

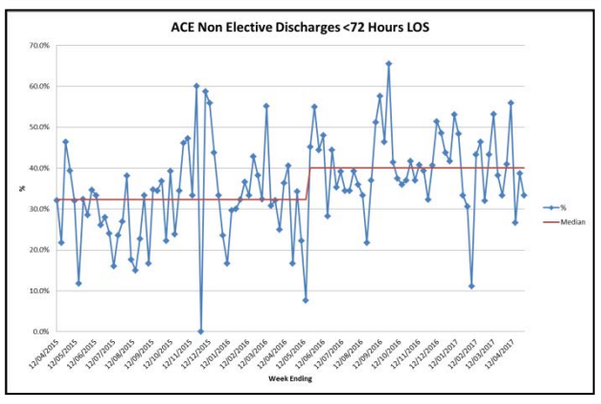



***Action: Specialty Big Room delivery of SAFER.***

## 8. Admissions Verses Discharges

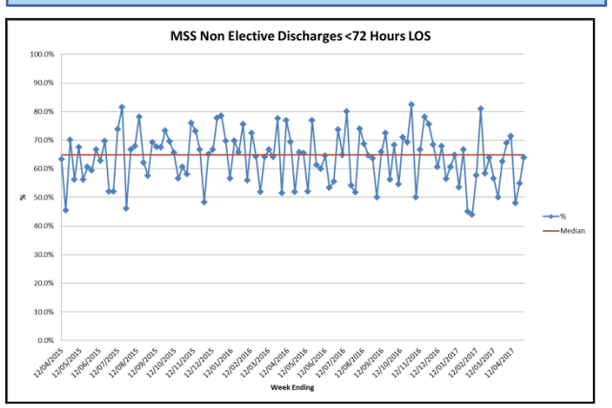



## 9. Short Stay Frailty Length of Stay < 72 Hours



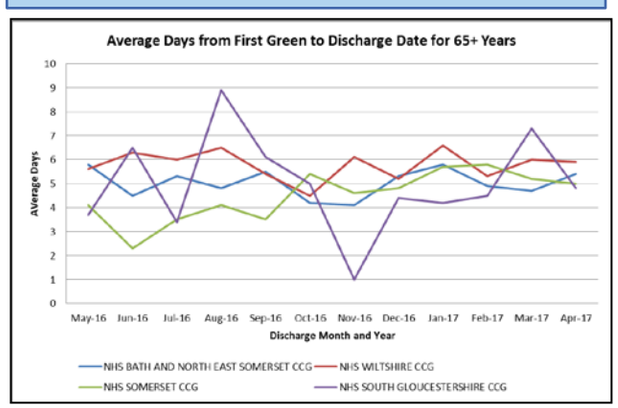

***Action: Frailty Flying Squad permanent 7 day service, business case to be presented to A&E Delivery Board.***

## 10. Short Stay Medical Length of Stay <72 Hours



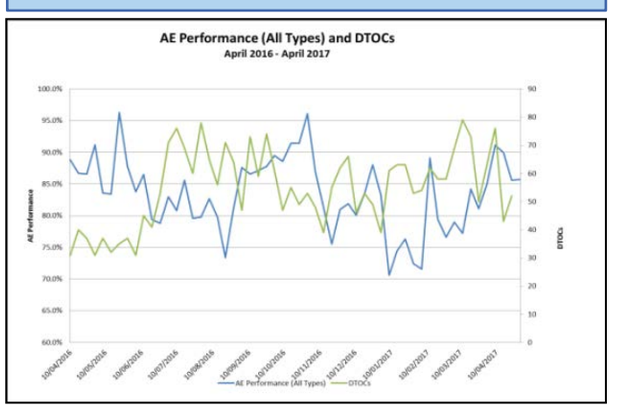

***Action: Extended Acute Medicine 7 days a week business case to be presented to A&E Delivery Board.***

## 11. Medically Fit for Discharge by CCG




***Action: DTOC improvements A&E Delivery Board action.***

## 12. 4 Hour Performance Verses DTOC




***Action: DTOC improvements A&E Delivery Board action.***

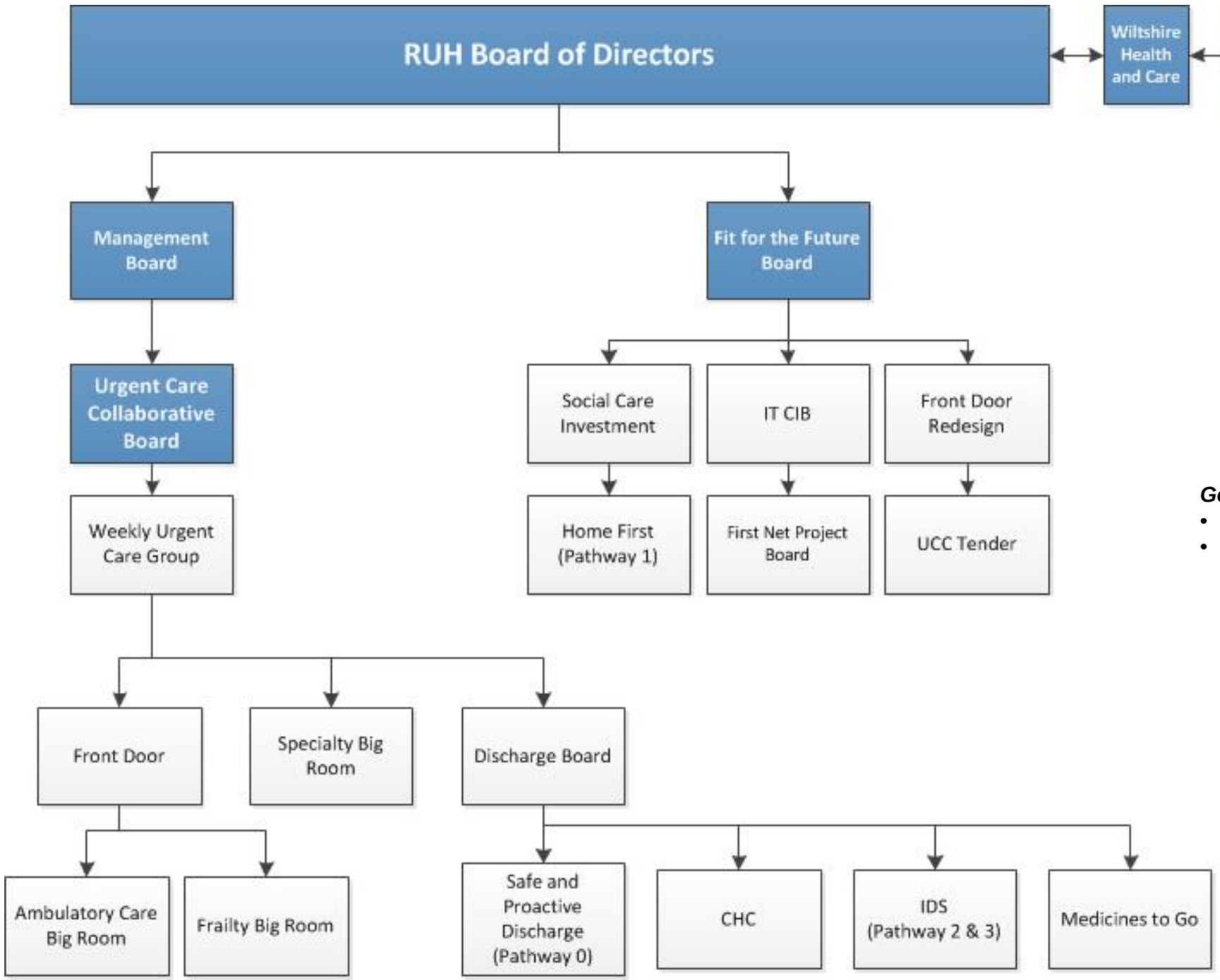
Royal United Hospitals Bath
NHS Foundation Trust

# 5. RUH Urgent Care Transformation Programme 2017/18

***Mission Statement: Learn from the past, analyse the present, motivate the team to plan for a better future***

| | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 17-Apr | 17-May | 17-Jun | 17-Jul | 17-Aug | 17-Sep | 17-Oct | 17-Nov | 17-Dec | 18-Jan | 18-Feb | 18-Mar |
| **National Initiative to Increase Front Door Primary Streaming models by September 2017** | Support the Urgent Care Centre in developing a sustainable model to increase streaming via the Joint Governance Meeting. Submit tender application to manage the Urgent Care Centre | | | PDSA increased weekday streaming aim to develop to 7 days from September 2017. Urgent Care Centre tender awarded. | | Launch of 7 day model | Ongoing KPI monitoring and refinement of streaming pathway | | | | | |
| **Ambulatory Care Models Extended** | Nursing model to be implemented fully in medical ambulatory care.. Develop proposal for trauma and orthopaedic ambulatory care model | | A&E Delivery Board bid to support additional Acute Medicine Consultants to support extended hours working | Develop models for 7 day working with consistent nurse establishment | | PDSA extended working models. KPI review via the Ambulatory Care Big Room | | | | Fully implement extended hours model | | |
| **Front Door Re-design (ECIP Supported)** | Develop models to improve urgent care and 4 hour performance to include Ambulatory care, direct admissions, increase short stay capacity, ED observation and Clinical Decision Unit options. | | | Management Board proposal | | PDSA extended working models. KPI review via the weekly Urgent Care Group | | | | Fully implement model | | |
| **Frailty Assessment Pathway Expansion** | Analysis of Frailty Flying Squad outcomes | Develop Business Case to continue Frailty Flying Squad | A&E Delivery Board bid to develop Frailty Flying Squad substantively | Depending upon A&E Delivery Board outcomes prepare for implementation in September 2017 | | Implement Frailty Flying Squad. Ongoing KPI monitoring via Frailty Big Room | | | | | | |
| **Home First Implementation (ECIP Supported)** | System Wide Patient Pathway agreement | KPI development and monitoring arrangements | KPI review via the weekly IDS and Urgent Care Groups | | | | | | | | | |
| **Digital Strategy Opportunities** | First Net Benefits realisation assessment | | Presentation of outcomes to the RUH Fit for the Future Board | Scope the options for digital solutions to support urgent care and flow i.e. interactive white board, hardware access | | Actions depending upon scoping exercise outcomes | | | | | | |
| **Communication Strategy** | Executive lead on key organisations messages to under pin urgent care and efficient patient flow | | Trust wide communication plan delivery | Review of communication plan delivery at the UCCB | | Further actions depending upon communication plan outcomes and UCCB recommendations | | | | | | |
| **Medical Take Model** | Develop models to improve the medical take in line with ECIP recommendations | | | | | PDSA extended working models. KPI review via the weekly Urgent Care Group | | | | Fully implement model | | |
| **SAFER - Focus on Clinical Gastroenterology Pathway** | Series of planned PDSA's in line with QI assessment of SAFER implementation. Key areas of focus include discharge and proactive pull. Specialty Big Room aim to spread successful PDSAs within the Gastroenterology clinical pathway to other specialties. This links to the groups aim to roll out best practice to support flow. | | | | | Specialty Big Room 6 month review | Next actions dependent upon 6 month review and recommendations from both the UCCB and weekly urgent care group | | | | | |

# 6. Governance Structure




***Governance Links to be Confirmed***

- *BaNES & Somerset Social Care Investment Governance*
- *Wiltshire Health and Well Being Board*