

Report to:	Public Board of Directors	Agenda item:	10
Date of Meeting:	26 July 2017		

Title of Report:	Four Hour Improvement Plan 2017/18
Status:	For Discussion
Board Sponsor:	Francesca Thompson, Chief Operating Officer
Author:	Suzanne Wills, Divisional Manager Medicine Sarah Hudson, Deputy Divisional Manager Medicine
Appendices	None

1. Executive Summary of the Report
To update the Board of Directors on the 2017/18 RUH Urgent Care Collaborative Board programme performance. The report reflects information up to and including the 30 th June 2017.

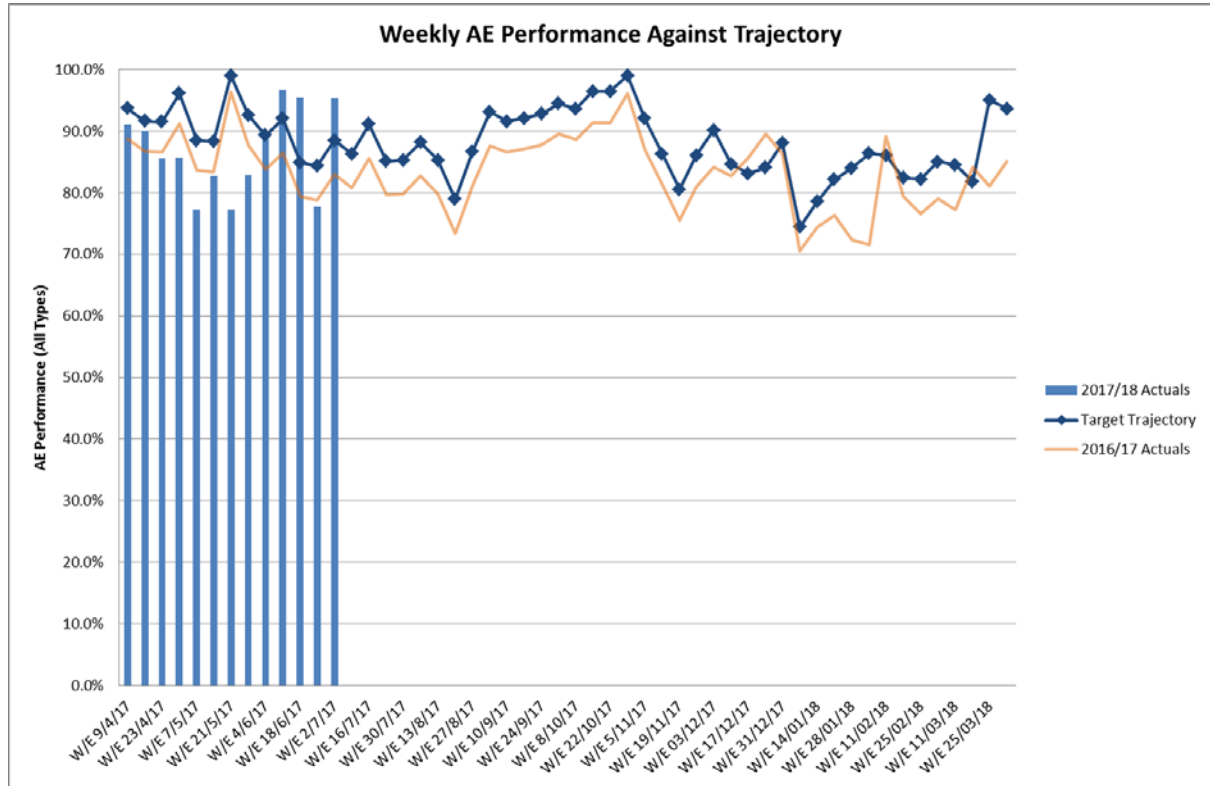
2. Recommendations (Note, Approve, Discuss)
<p>The Board of Directors are asked to note the following:</p> <ul style="list-style-type: none"> • 4 Hour performance met the internal improvement trajectory. • Factors affecting performance include <ul style="list-style-type: none"> • Ambulance conveyance activity +6.4% variance compared to 2016/17 for week ending 25/06/17 • Emergency presentations +4.0% year to date variance compared to last financial year. • Emergency Department attendances +3.9 % year to date variance compared to last financial year • Negative impact on bed capacity due to high Delayed Transfers of Care (DTOC). 48 patients reported at the June month end snapshot and 1165 delayed days (6.8%) reported. • Impact on available bed capacity due to infection, 428 bed days closed due to infection, total bed days lost in June 87 (peak 55 on the 19th June 2017) <p>Areas for improvement in July 2017:</p> <ul style="list-style-type: none"> • Development and embedding of Home First principles and pathways • Agree next step for business cases submitted for MRET funding if not successful • SAFER Principles – metric assessment for Haygarth as the Specialty Big Room primary testing ward • Direct Admission to Assessment Units – Planning for launch 13th September 2017 • Discharges before midday improvement actions and trajectory is required • Medical Ambulatory Care PDSA weekend working • Improve short stay length of stay and improve pull of suitable patients

3.	Legal / Regulatory Implications
	Care Quality Commission (CQC) Registration 2016/17
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 taken through the usual Trust process.
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 ECIST Recommendations.
8.	Freedom of Information
	Public

1. RUH 4 Hour Performance: June 2017 Month 3

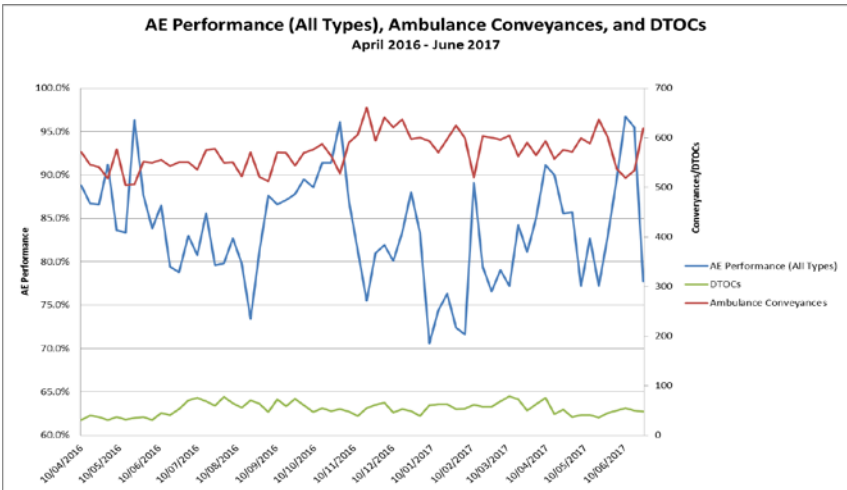
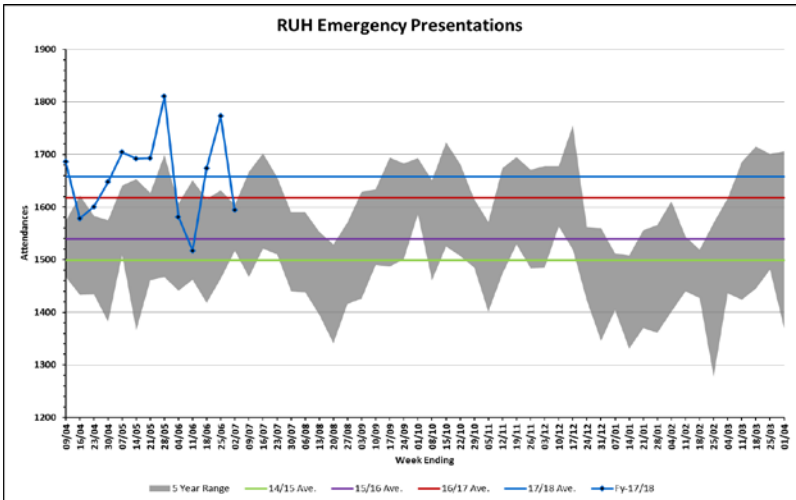
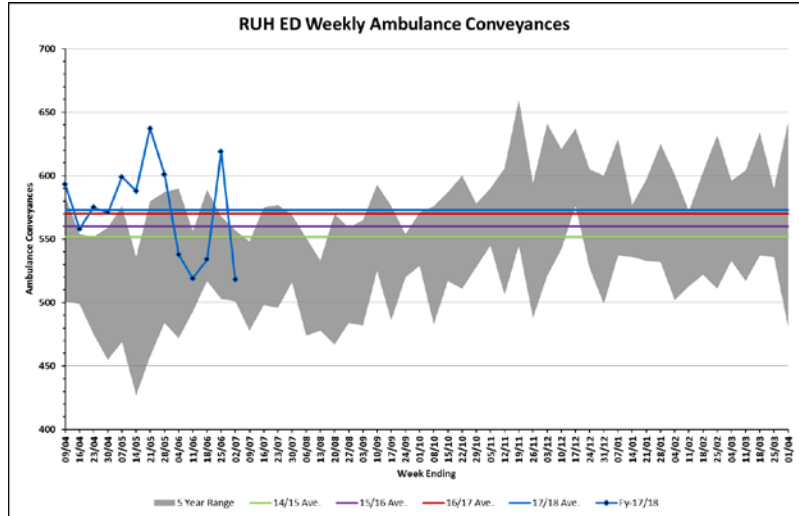
Improvement Trajectory - Segment 2

- June 2017 four hour performance not achieved: 90.3% (All types)
- Performance exceeded the performance trajectory of 86.9%



Key Diagnostics

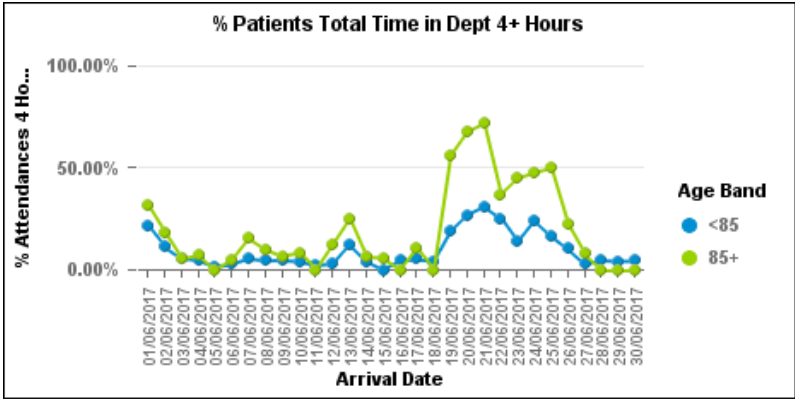
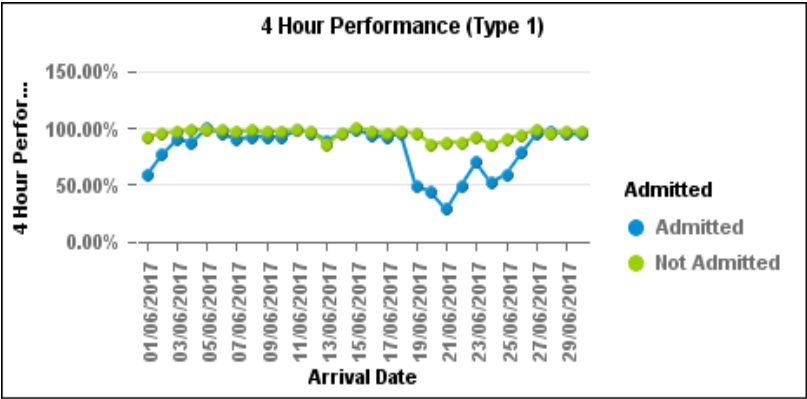
- Ambulance conveyance activity +6.4% variance compared to 2016/17 for week ending 25/06/17
- Emergency presentations +4.0% year to date variance compared to last financial year.
- Emergency Department attendances +3.9 % year to date variance compared to last financial year
- Negative impact on bed capacity due to high Delayed Transfers of Care (DTOC). 48 patients reported at the June month end snapshot and 1165 delayed days (6.8%) reported.
- Impact on available bed capacity due to infection, 428 bed days closed due to infection, total bed days lost in June 87 (peak 55 on the 19th June 2017)



2. Emergency Department National Quality Indicators

Majors	Actual Performance 78.6%	Average Time to Initial Assessment (mins) 5	Average Time to Treatment (mins) 68	Actions 1. Increase Senior Decision Makers at the Front Door, Frailty Flying Squad and Acute Medicine (A&E Delivery Board Business Case) 2. Internal professional standards escalation 3. Ambulatory Care access including Trauma & Orthopaedics 4. Review of factors affecting majors performance attributable to ED delays – Clinical Lead to action
Minors	Actual Performance 94.6%	Average Time to Initial Assessment (mins) 6	Average Time to Treatment (mins) 67	Actions 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. 2. Internal professional standards escalation as increase in patients being admitted through minors, minor injury's requiring specialty input 3. Daily and weekly review of non-admitted breaches through Front Door Group and Urgent Care Weekly group
Self Presenters	Actual Performance 95.4%	Average Time to Initial Assessment (mins) 9	Average Time to Treatment (mins) 56	
Streaming	Actual Performance 98.2%	Average Time to Initial Assessment (mins) 3	Average Time to Treatment (mins) 14	Actions 1. Urgent Care Centre (UCC) Tender application (outcome expected August 2017) 2. Continue to work with UCC team to improve services and access to increase GP streaming



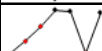
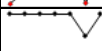
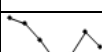
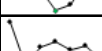
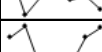
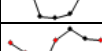
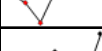
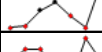

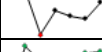
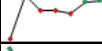
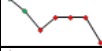




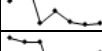
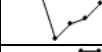

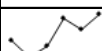

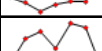
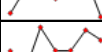
Royal United Hospitals Bath NHS Foundation Trust	2017/2018			June 17%	2016/17 %
	April	May	June		
Reason For Breach					
Bed Management	407	841	336	50.6%	74.1%
Waiting For Diagnostics	8	12	4	0.6%	0.7%
Waiting For Specialist Opinion - Acute	73	91	34	5.1%	4.2%
Waiting For Specialist Opinion - MH	33	50	32	4.8%	2.1%
Wait For First Clinician (Not Triage)	0	0	0	0.0%	0.0%
A&E Assessment	159	293	188	28.3%	10.2%
Clinical	104	96	46	6.9%	5.5%
Treatment Decision	0	0	0	0.0%	0.0%
Primary Care Assessment / Streaming	27	47	22	3.3%	2.6%
Transport	10	8	2	0.3%	0.6%
Unknown	0	0		0.0%	0.0%
Total:	821	1440	664	100.0%	100.0%
OOH (7pm-8am) Arrival Breach Total:	372	647	306	46.1%	46.3%
Evening (8pm-Midnight) Arrival Breaches Total:	147	302	120	18.1%	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 point of access, a review is being undertaken by the clinical lead for Emergency Medicine to determine all the factors impacting the average time to treatment in Majors, including staffing.
4. Overall 4 hour performance not achieved for Majors and Minors.
5. Improvement in the number of patients breaching the 4 hour standard who were not admitted
6. Improvement in the time in the Emergency Department for patients > 85 years old who are subsequently admitted.

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

Key Area	Metric	Target	May-17		Jun-17			Jul-17		Current Trend
			21/05/2017	28/05/2017	04/06/2017	11/06/2017	18/06/2017	25/06/2017	02/07/2017	
1. Quality & Safety: To Provide Rapid Intensive Support to those Patients at Highest Risk	ED 4 Hour Breaches		375	294	170	48	74	402	71	
	ED 4 Hour Performance	95.0%	77.3%	82.9%	89.4%	96.7%	95.5%	77.7%	95.3%	
	ED Ambulance Handovers within 30 minutes	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	100.0%	
	ED Specialty 4 Hour Breaches	4	23	20	12	2	5	16	9	
	ED Conversion Rate	32.0%	38.9%	31.1%	34.4%	35.3%	33.9%	34.7%	32.1%	
	Average Daily Medical outliers	15	29	34	16	15	17	29	33	
2. Performance: To Implement Best Practice in Timely Senior Review and Discharge	GP Direct Admissions to SAU	40	37	29	13	39	48	40	39	
	GP Direct Admissions to MAU	20	0	2	21	32	15	0	54	
	ED and GP Direct Admissions to ACE	5	2	3	3	1	0	4	2	
	Ambulatory Care Activity	30%	33.3%	34.2%	27.6%	31.2%	30.3%	30.0%	32.4%	
	ESAC Activity	30	9	37	27	27	25	32	33	
	Ambulatory Cardiac Hot Clinic Attendances	7	9	7	4	6	6	6	2	
	MAU Transfers by 10am	20	16	7	5	7	12	8	8	
	SAU Transfers by 10am	5	7	10	2	5	10	10	6	
	Cardiology NEL LOS	9.5	9.3	10.4	13.6	15.9	12.7	7.0	10.9	
	Gastroenterology NEL LOS	9.5	14.9	19.8	11.1	13.2	11.4	10.9	11.1	
	MSS LOS	3.0	3.9	3.8	3.8	2.9	3.2	3.3	3.6	
	Green Patients 28+ LOS		31	30	28	43	51	50	55	
	Green Patients 56+ LOS		11	8	10	15	13	16	15	
	% Elective Discharges Before Midday	33.0%	22.9%	21.2%	18.3%	20.5%	21.6%	21.4%	31.7%	
	% Non Elective Discharges Before Midday	33.0%	14.3%	16.5%	17.1%	15.6%	17.8%	17.4%	14.0%	
	% Weekend Discharges	25.0%	16.4%	14.6%	18.5%	16.4%	16.4%	18.2%	17.3%	
	Silver Patients identified on discharge tracker	75	45	51	33	64	51	41	43	
	DTOCS	15	36	45	50	55	50	48	56	

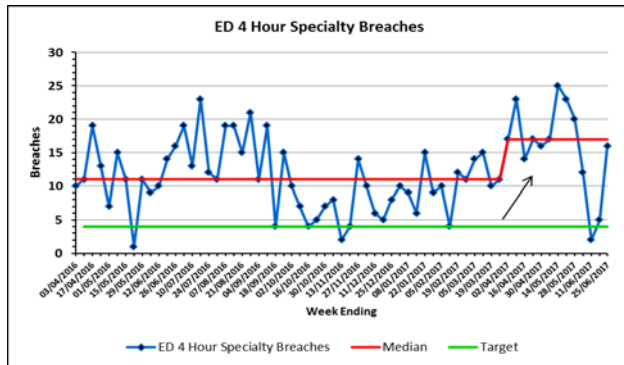
Performance Priorities In Development

- 1.0 Workforce
 - Rostering compliance
 - Vacancies
 - sickness
 - Turnover
 - senior decision maker cover
- 2.0 Finance
 - STF
 - Social care investment
 - Agency spend

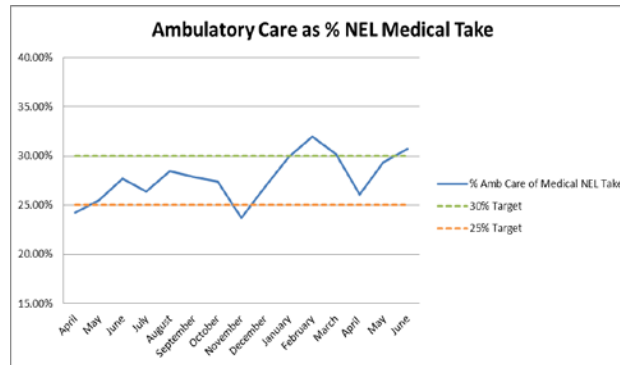
Key Area	Metric	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
3. Quality & Saftey	ED Observation Unit NEWS Score Accuracy	90%	96%	86%	97%				
	Sepsis - Antibiotics within 60 Minutes in ED	100%	80%	80%					
4. Performance	One Hour Turaround for TTAs (Trust Wide)	51% <i>baseline</i>	47.50%	48.50%	54.00%				

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

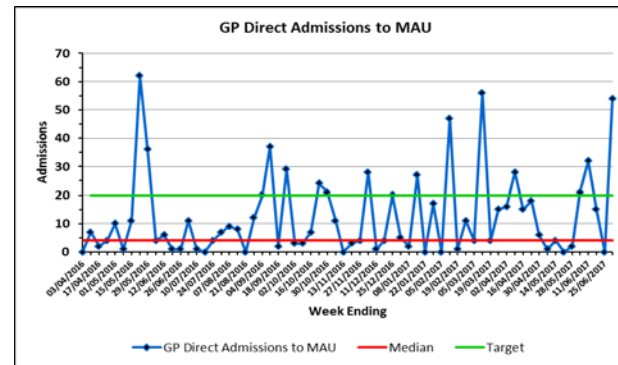
1. Internal Delays and Access to Specialty Opinion



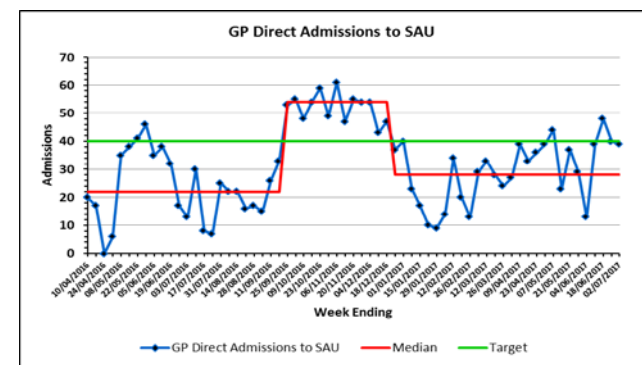
2. Alternative Pathways to Admission - Medical Ambulatory Care



3. Direct Access to Medical Assessment Unit



4. Direct Access to Surgical Assessment Unit

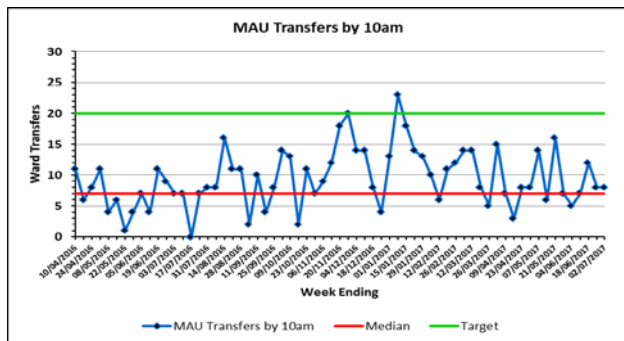


Action: Front Door Group to ensure internal professional standards and senior escalation processes adhered to

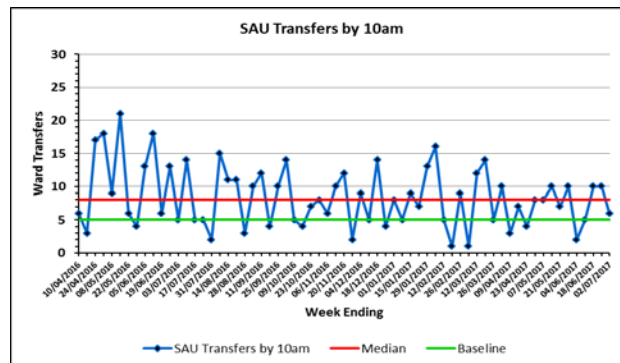
Action: Nurse model fully in place from 15th May, enabling Medical Nurse Practitioners to proactively pull more patients from the Emergency Department

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

5. Early Flow out of Assessment Area - MAU

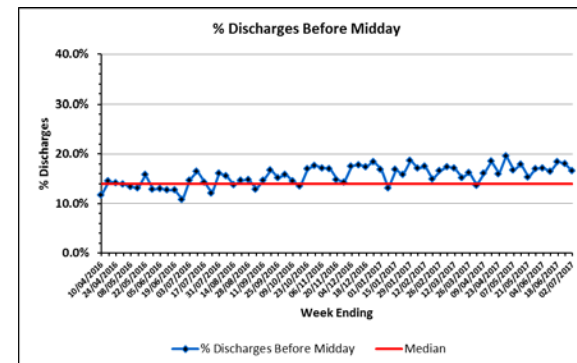


6. Early Flow out of Assessment Area - SAU



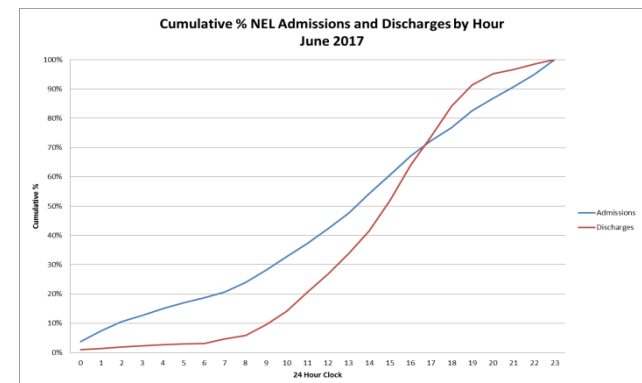
Action: Front Door Group to review all actions across MAU, MSS and Ambulatory Care to increase discharges as current trust wide discharges before midday do not deliver the required improvement to support early flow

7. Early Flow Trust Wide

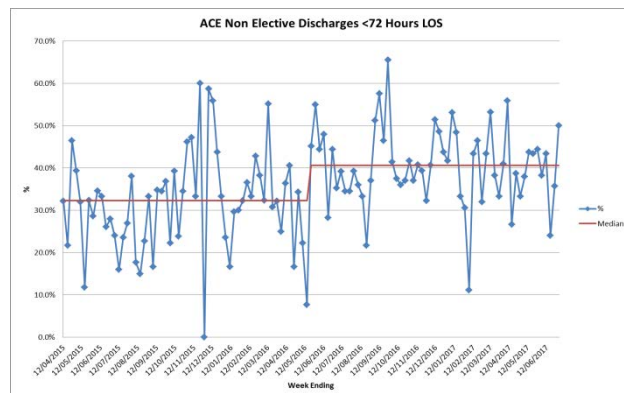


Action: Specialty Big Room delivery of SAFER

8. Admissions Verses Discharges

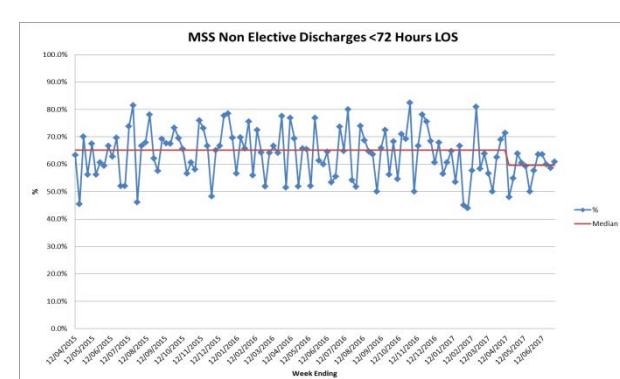


9. Short Stay Frailty Length of Stay < 72 Hours



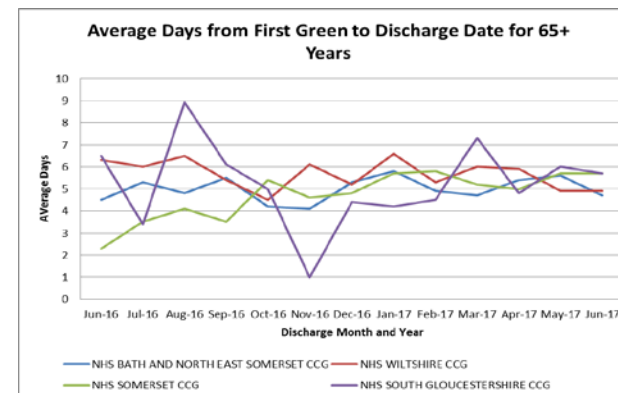
Action: Frailty Flying Squad permanent 7 day service, business case to be presented to A&E Delivery Board

10. Short Stay Medical Length of Stay <72 Hours



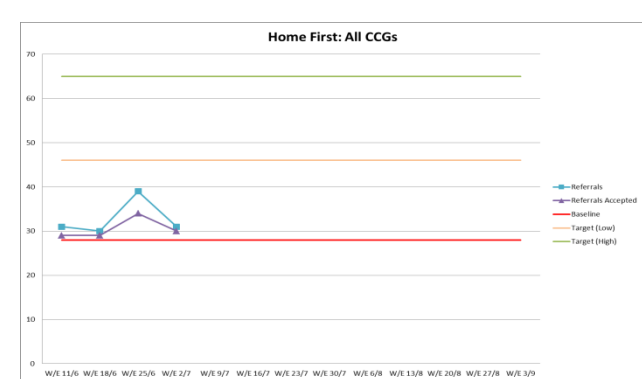
Action: Extended Acute Medicine 7 days a week business case to be presented to A&E Delivery Board

11. Medically Fit for Discharge by CCG



Action: DTOC improvements A&E Delivery Board action

12. Home First – All CCGs



Action: DTOC improvements A&E Delivery Board action

4. Implementing the SAFER Bundle – Clinical Gastroenterology

The SAFER Patient Flow Bundle

S – **Senior Review.** All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All patients** will have an **Expected Discharge Date and Clinical Criteria for Discharge.** This is set assuming ideal recovery and assuming no unnecessary waiting.

F – **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge.** 33% of patients will be discharged from base inpatient wards before midday.

R – **Review.** A systematic MDT review of patients with extended lengths of stay (> 7 days – ‘stranded patients’) with a clear ‘home first’ mind set.

SAFER Implementation Plan

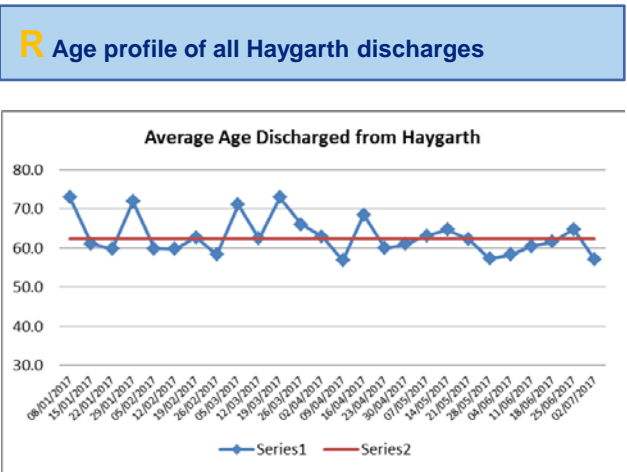
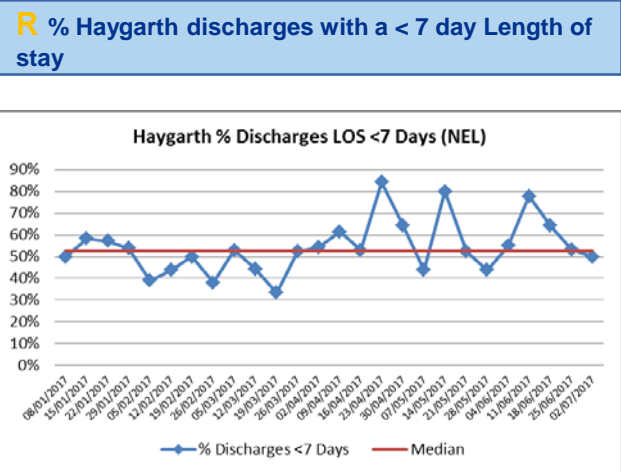
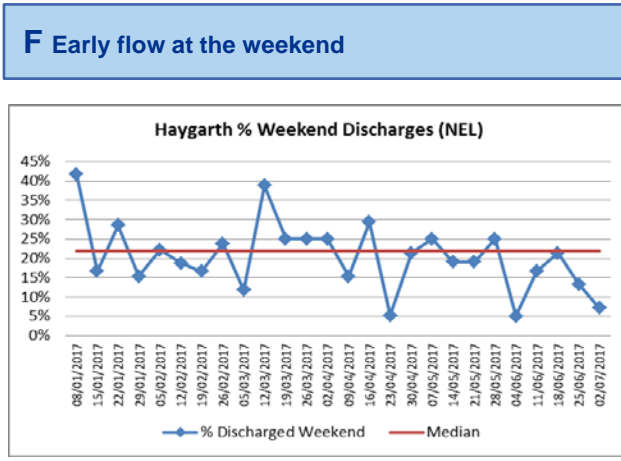
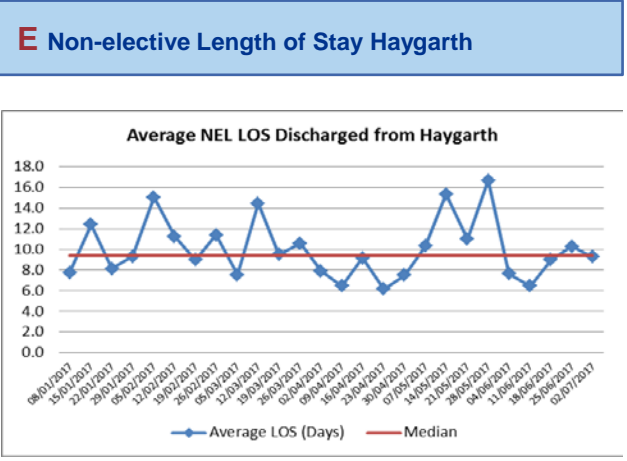
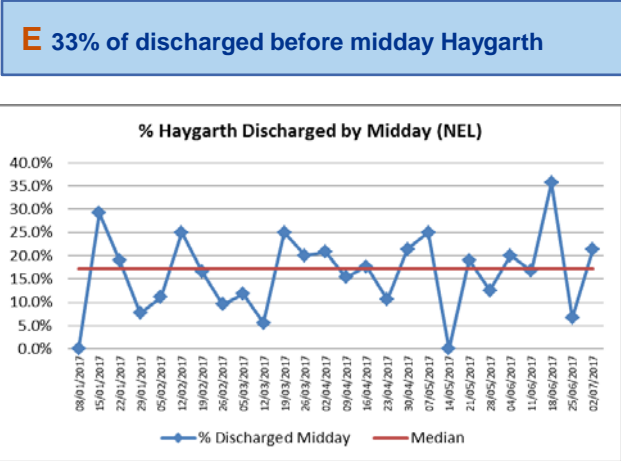
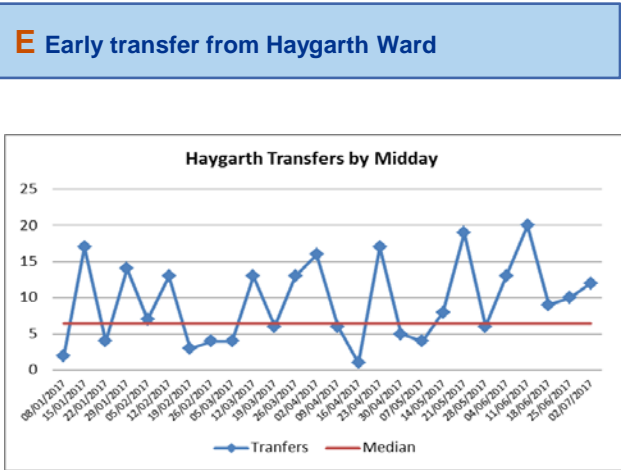
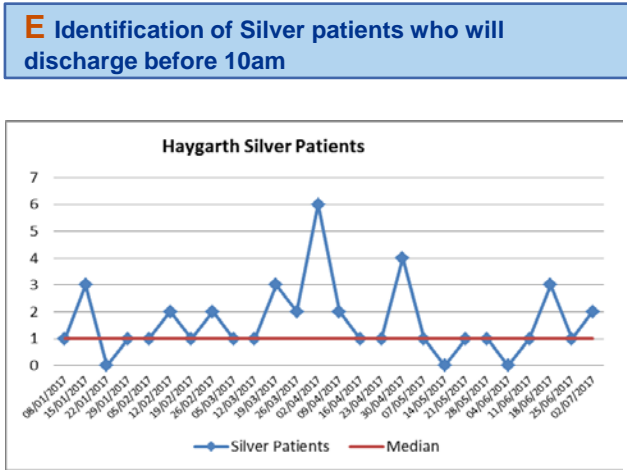
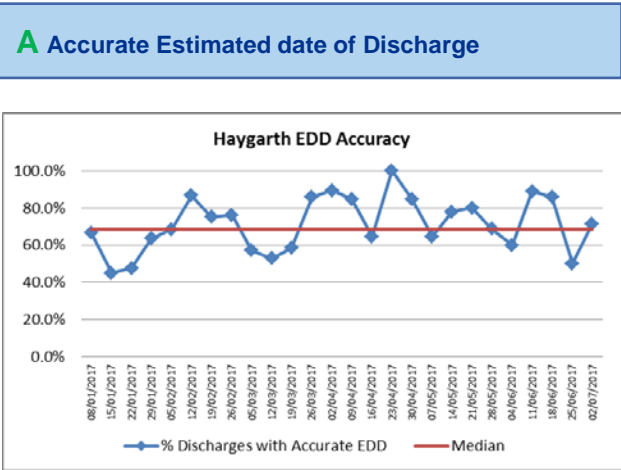
The Specialty Big Room is leading on the implementation and embedding of the National SAFER Bundle.

Applying the FLOW principles focusing on a clinical pathway to complete a full diagnostic against each of the elements of SAFER and to apply small tests of change to improve performance and sustain.

Clinical Gastroenterology is the first clinical pathway to be reviewed and is the focus of testing.

Actions in July

- Senior review PDSA continuing across Haygarth and expanded to Pulteney and Cardiology
- Focus on Haygarth Medically fit patients and length of stays over 7 days – IDS to attend board rounds, review of therapy input and communication of escalation processes to all staff.
- Value added days PDSA on Cardiology ward
- Agree SAFER Learning roll out plan across all ward areas at the Urgent Care Collaborative Board



Note: Changing the profile of the ward to ensure that gastroenterology patients are being proactively pulled

6. 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		
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
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 (<i>weekend working PDSA planned for July 2017</i>)		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 to focus on 1) increasing ambulatory care capacity 2) MAU functioning as an assessment unit (September 2017) and 3) Increasing senior decision maker capacity		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		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				Presentation of outcomes to the RUH Fit for the Future Board	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						

***Home First actions**

1) BaNES from the 1st week in July are now accepting telephone referrals to make the processes more time efficient 2) Wiltshire capacity acknowledged as limited and plans are in place to increase capacity 3) South Gloucestershire will commence telephone referrals in July 2017 4) Somerset have completed a first PDSA, which was successful, now require full implementation plan and timescales

7. Governance Structure

