| Report to: | Public Board of Directors | Agenda item: | 13 |
|---|---|---|---|
| Date of Meeting: | 27 September 2017 | | |

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

## 1. Executive Summary of the Report

To update the Management Board on the 2017/18 RUH Urgent Care Collaborative Board programme performance. The report reflects information up to and including the 31st August 2017.

## 2. Recommendations (Note, Approve, Discuss)

The Management Board are asked to note the following:

- 4 Hour performance exceeded the internal improvement trajectory and failed the National Standard.
- Factors affecting performance include:
  - Ambulance conveyance activity +3.7% variance compared to 2016/17 for week ending 27/08/17
  - Emergency presentations +2.9% year to date variance compared to last financial year
  - Emergency Department attendances +0.5 % year to date variance compared to last financial year
  - High Delayed Transfers of Care (DTOC). 40 patients reported at the August month end snapshot and 1047 delayed days (5.9%) reported

Areas for improvement in September 2017:

- Urgent Care Strategy Follow Up Event with NHS Improvement support planned for the 17th October – theme of SAFER and “Right Patient Right Team”
- Embedding of Home First principles and pathways ongoing.
- Recruitment to the MRET funded posts to increase senior decision makers at the Front Door (Acute Medicine and Frailty Flying Squad)
- Specialty Big Room – Engagement with Clinical Leads to support the implementation and delivery of the Senior Review and Review elements of SAFER
- Direct Admission to the Medical Assessment Unit – Launch 13th September 2017. Communication and implementation plans to be coordinated through the Front Door Group with a daily Quality Improvement meeting in place to work towards a sustainable service.
- Discharges before midday improvement actions and trajectory are required –

| Discharge Board and Specialty Big Room action. |
|---|

| 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. | |

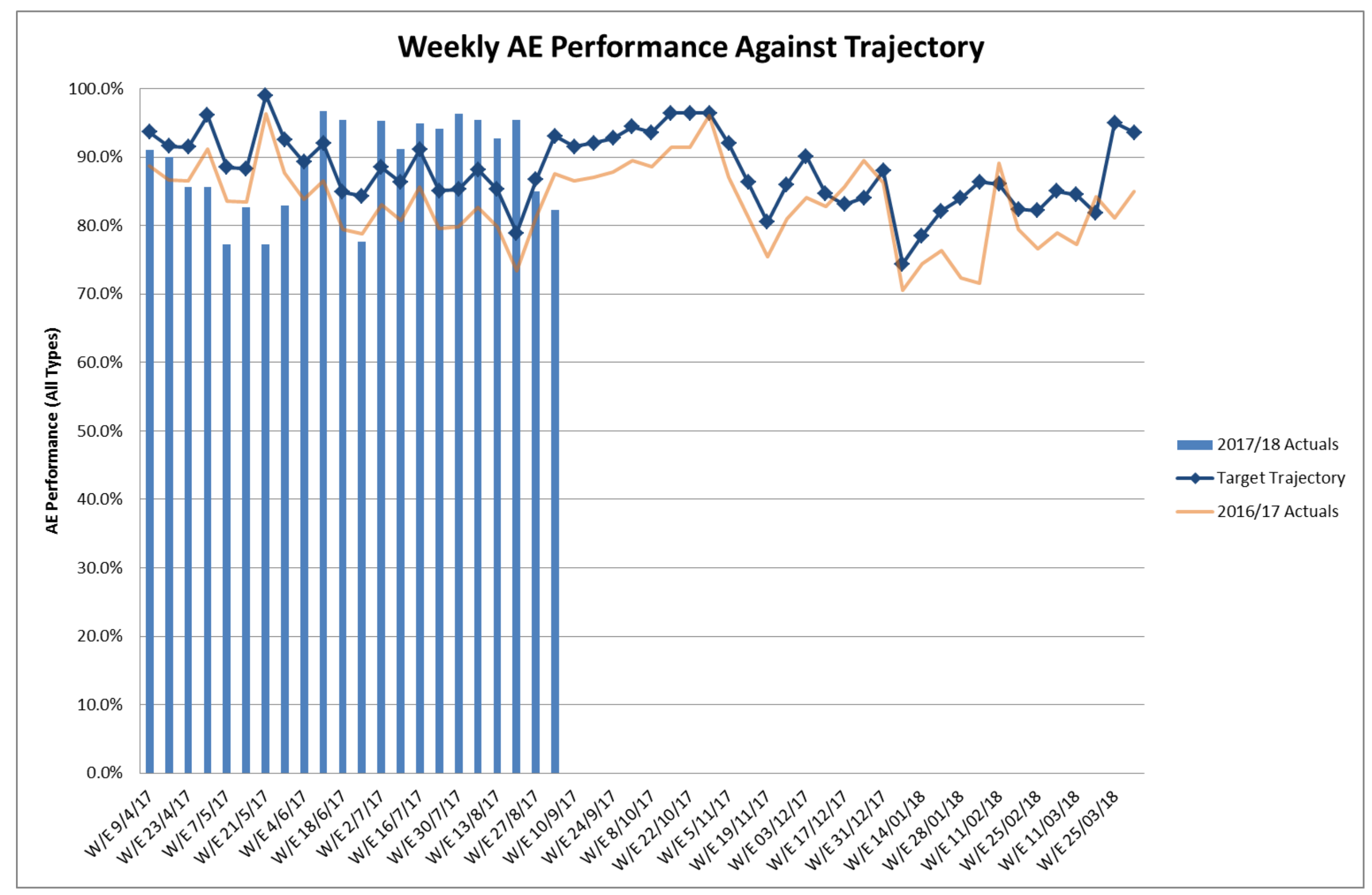
| 7. | References to previous reports |
|---|---|
| Monthly 4 hour performance reports and ECIST Recommendations. | |

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

# 1. RUH 4 Hour Performance: August 2017 Month 5

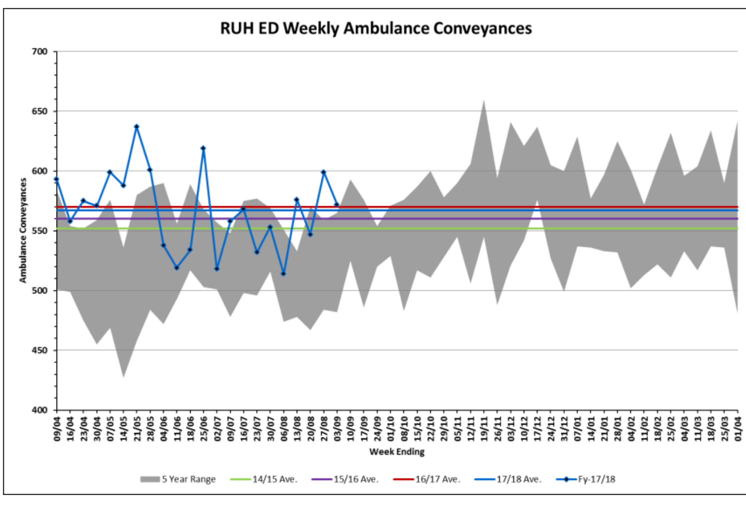
## Improvement Trajectory - Segment 2

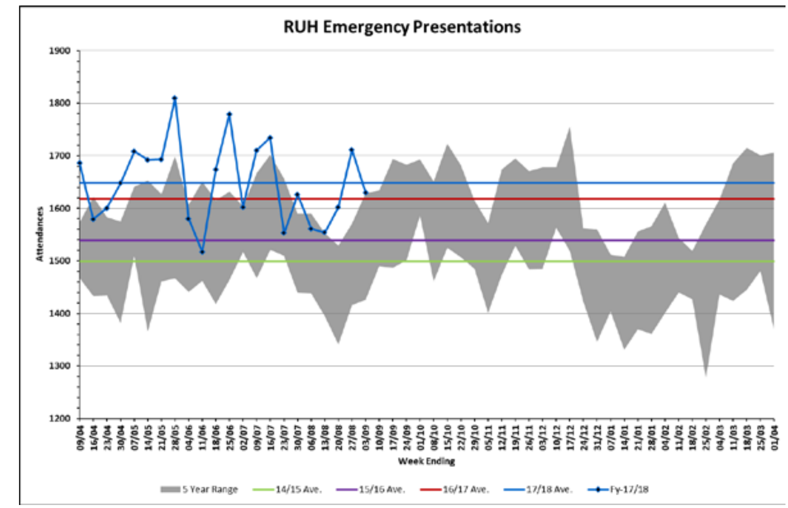
•August 2017 four hour performance not achieved: 90.4% (All types)
•Performance exceeded the performance trajectory of 85.1%

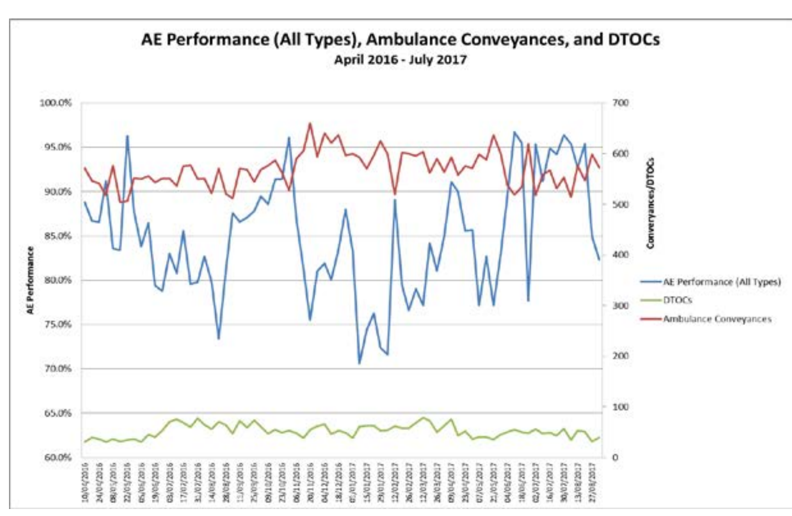



## Key Diagnostics

- Ambulance conveyance activity +3.7% variance compared to 2016/17 for week ending 27/08/17
- Emergency presentations +2.9% year to date variance compared to last financial year
- Emergency Department attendances +0.5 % year to date variance compared to last financial year
- Negative impact on bed capacity due to high Delayed Transfers of Care (DTOC). 40 patients reported at the August month end snapshot and 1047 delayed days (5.9%) reported



# 2. Emergency Department National Quality Indicators

| | | | |
|---|---|---|---|
| **Majors** | Actual Performance 78.6% | Average Time to Initial Assessment (mins) 5 | Average Time to Treatment (mins) 67 |
| **Minors** | Actual Performance 96.5% | Average Time to Initial Assessment (mins) 6 | Average Time to Treatment (mins) 61 |
| **Self Presenters** | Actual Performance 94.8% | Average Time to Initial Assessment (mins) 9 | Average Time to Treatment (mins) 59 |
| **Streaming** | Actual Performance 95.5% | Average Time to Initial Assessment (mins) 4 | Average Time to Treatment (mins) 30 |

**Actions**

1. Increase Senior Decision Makers at the Front Door, Frailty Flying Squad and Acute Medicine. MRET approved, recruitment underway
2. Internal professional standards escalation
3. Ambulatory Care access including Trauma & Orthopaedics
4. Daily review of factors affecting majors performance attributable to ED delays – Clinical Lead to action.
5. Direct Admission capacity – relaunch with QI underpinning changes from the 13th September 2017

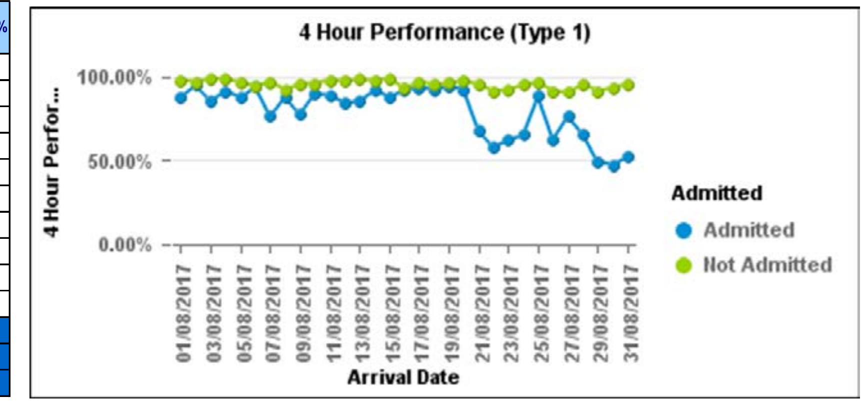
**Actions**

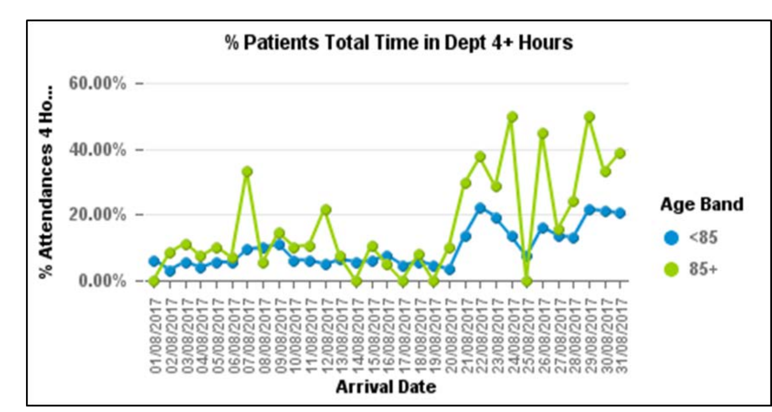
1. To protect minors treatment times and overall performance, minors staff not to be moved to manage the Corridor. Utilise staff to support the Emergency Department from specialty wards during period of poor flow.
2. In September 2017 focus on Minors – moving the majors from minors
3. Internal professional standards escalation as increase in patients being admitted through minors, minor injury's requiring specialty input
4. Daily and weekly review of non-admitted breaches through Front Door Group and Urgent Care Weekly group

**Actions**

1. Urgent Care Centre (UCC) Tender application successful, transition of services May 2018, mobilisation group has been established and regular meeting scheduled
2. Continue to work with UCC team to improve services and access to increase GP streaming
3. A&E Delivery Board requested agenda item to discuss streaming and impact on RUH Minors Service

| Royal United Hospitals Bath NHS Foundation Trust | 2017/2018 | | | | | Aug-17 | 2016/17 % |
|---|---|---|---|---|---|---|---|
| Reason For Breach | April | May | June | July | August | | |
| Bed Management | 407 | 841 | 336 | 58 | 318 | 48% | 74.1% |
| Waiting For Diagnostics | 8 | 12 | 4 | 3 | 6 | 1% | 0.7% |
| Waiting For Specialist Opinion - Acute | 73 | 91 | 34 | 55 | 72 | 11% | 4.2% |
| Waiting For Specialist Opinion - MH | 33 | 50 | 32 | 21 | 28 | 4% | 2.1% |
| Wait For First Clinician (Not Triage) | 0 | 0 | 0 | 0 | 0 | 0% | 0.0% |
| A&E Assessment | 159 | 293 | 188 | 163 | 142 | 22% | 10.2% |
| Clinical | 104 | 96 | 46 | 83 | 59 | 9% | 5.5% |
| Treatment Decision | 0 | 0 | 0 | 0 | 0 | 0% | 0.0% |
| Primary Care Assessment / Streaming | 27 | 47 | 22 | 31 | 32 | 5% | 2.6% |
| Transport | 10 | 8 | 2 | 1 | 1 | 0% | 0.6% |
| Total: | 821 | 1440 | 664 | 415 | 658 | 100.0% | 100.0% |
| OOH (7pm-8am) Arrival Breach Total: | 372 | 647 | 306 | 179 | 321 | 48.8% | 46.3% |
| Evening (8pm-Midnight) Arrival Breaches Total: | 147 | 302 | 120 | 91 | 138 | 21.0% | 20.1% |




## Performance Summary

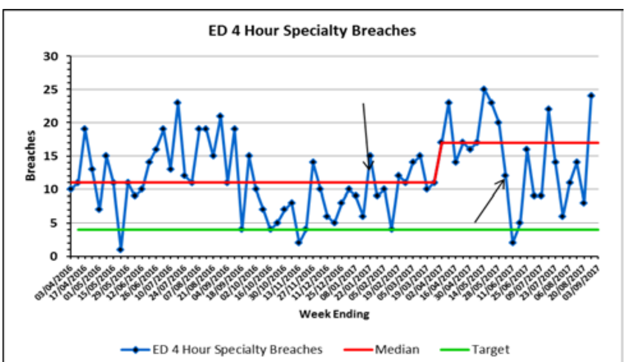
1. Patients are managed through the Emergency Department via 4 points of access; Majors, Minors, Self presenters and Streaming
2. Consistently the Emergency Department achieve time to assessment across all points of access
3. The average time to treatment has been achieved for 2 point of access, a review 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 and review of Minors
4. Overall 4 hour performance not achieved for Majors
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 which will be further supported by the Frailty Flying Squad

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

| Key Area | Metric | Target | Jul-17 | Aug-17 | | | | | Current Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | | 23/07/2017 | 30/07/2017 | 06/08/2017 | 13/08/2017 | 20/08/2017 | 27/08/2017 | |
| 1. Quality & Safety: To Provide Rapid Intensive Support to those Patients at Highest Risk | ED 4 Hour Breaches | | 91 | 55 | 66 | 110 | 69 | 243 | |
| | ED 4 Hour Performance | 95.0% | 94.2% | 96.4% | 95.4% | 92.7% | 95.4% | 85.0% | |
| | ED Ambulance Handovers within 30 minutes | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | |
| | ED Specialty 4 Hour Breaches | 4 | 14 | 6 | 11 | 14 | 8 | 24 | |
| | ED Conversion Rate | 32.0% | 36.3% | 32.2% | 34.1% | 35.3% | 36.8% | 35.9% | |
| | Average Daily Medical outliers | 15 | 23 | 12 | 9 | 16 | 24 | 22 | |
| 2.Performance: To Implement Best Practice in Timely Senior Review and Discharge | GP Direct Admissions to SAU | 40 | 39 | 62 | 47 | 53 | 32 | 46 | |
| | GP Direct Admissions to MAU | 20 | 14 | 78 | 41 | 29 | 17 | 13 | |
| | ED and GP Direct Admissions to ACE | 5 | 0 | 2 | 8 | 3 | 5 | 3 | |
| | Ambulatory Care Activity | 30% | 25.8% | 30.7% | 28.2% | 27.2% | 26.6% | 29.9% | |
| | ESAC Activity | 30 | 35 | 45 | 30 | 29 | 35 | 32 | |
| | Ambulatory Cardiac Hot Clinic Attendances | 7 | 3 | 14 | 6 | 10 | 7 | 6 | |
| | MAU Transfers by 10am | 20 | 10 | 12 | 15 | 7 | 6 | 14 | |
| | SAU Transfers by 10am | 5 | 2 | 6 | 2 | 3 | 8 | 1 | |
| | Cardiology NEL LOS | 9.5 | 9.5 | 10.0 | 15.9 | 15.8 | 8.9 | 13.8 | |
| | Gastroenterology NEL LOS | 9.5 | 9.5 | 10.0 | 11.3 | 11.8 | 14.4 | 21.4 | |
| | MSS LOS | 3.0 | 2.3 | 2.8 | 3.0 | 2.5 | 2.6 | 2.3 | |
| | Green Patients 28+ LOS | | 61 | 43 | 34 | 38 | 43 | 37 | |
| | Green Patients 56+ LOS | | 12 | 10 | 11 | 16 | 17 | 10 | |
| | % Elective Discharges Before Midday | 33.0% | 15.6% | 18.9% | 14.0% | 16.0% | 23.6% | 23.2% | |
| | % Non Elective Discharges Before Midday | 33.0% | 16.3% | 17.9% | 17.9% | 19.4% | 17.4% | 14.5% | |
| | % Weekend Discharges | 25.0% | 15.4% | 19.3% | 16.4% | 18.3% | 16.1% | 18.4% | |
| | Silver Patients identified on discharge tracker | 75 | 33 | 50 | 41 | 43 | 46 | 41 | |
| | DTOCS | 15 | 43 | 57 | 35 | 53 | 51 | 32 | |

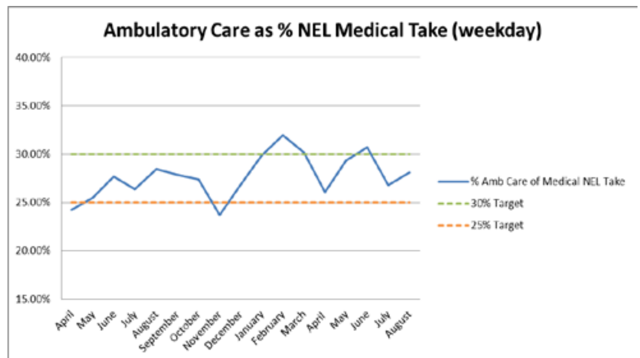
# 4. Key Areas of Focus: Managing ED Demand & Freeing Hospital Capacity

## 1. Internal Delays and Access to Specialty Opinion



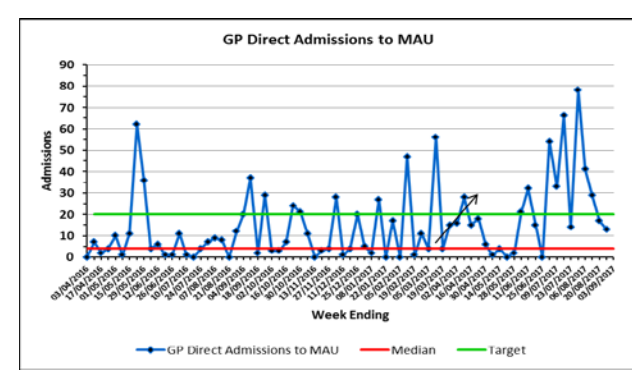

*Action: Front Door Group to ensure internal professional standards and senior escalation processes adhered to*

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



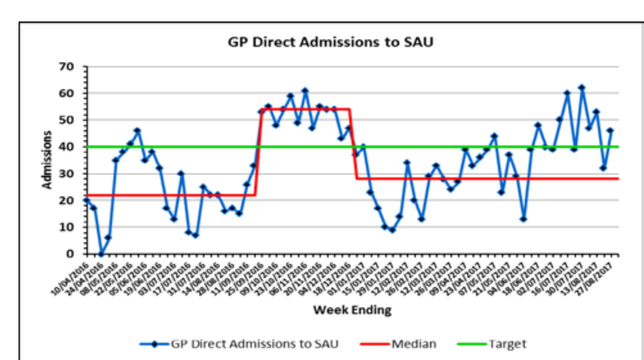

*Action: Nurse model fully in place from 15th May, enabling Medical Nurse Practitioners to proactively pull more patients from the Emergency Department*

## 3. Direct Access to Medical Assessment Unit

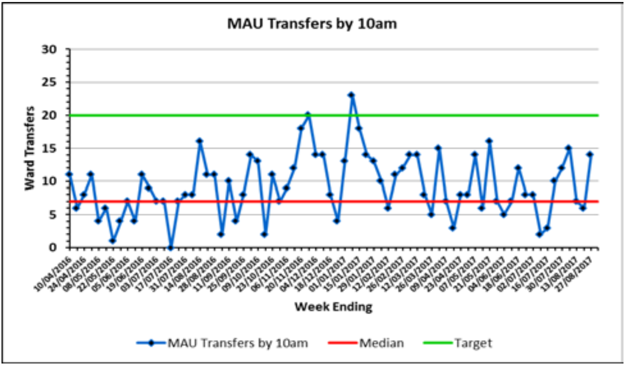



*Action: Direct admissions to assessment areas limited when flow out of assessment areas does not occur before 10am Front Door Group to review all actions across MAU, MSS and Ambulatory Care to increase discharges*

## 4. Direct Access to Surgical Assessment Unit

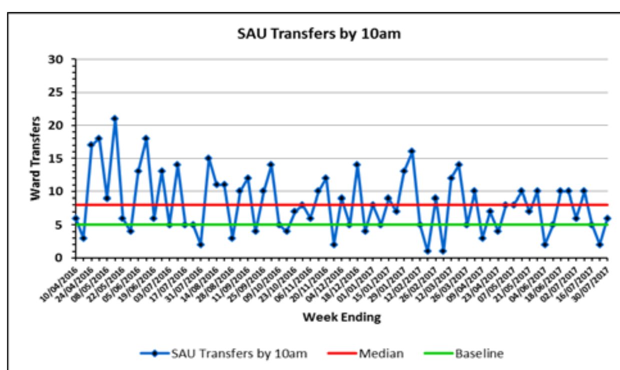



## 5. Early Flow out of Assessment Area - MAU

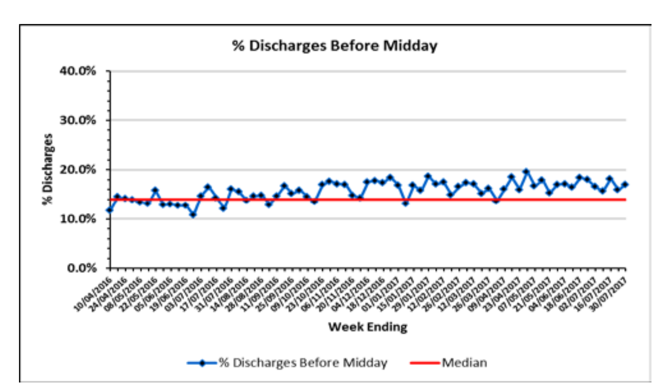



*Action: Front Door Group to review all actions across MAU, MSS and Ambulatory Care to increase discharges as current trust wide discharges before midday do not deliver the required improvement to support early flow*

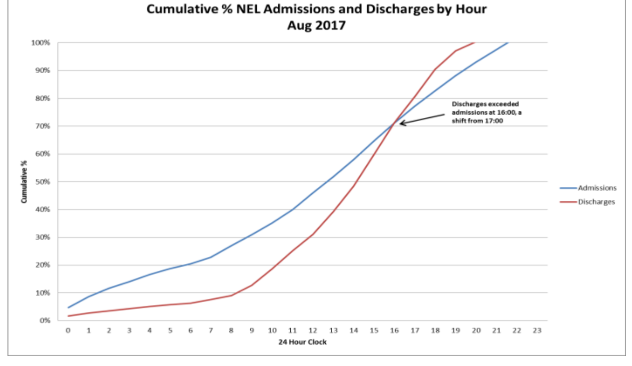
## 6. Early Flow out of Assessment Area - SAU



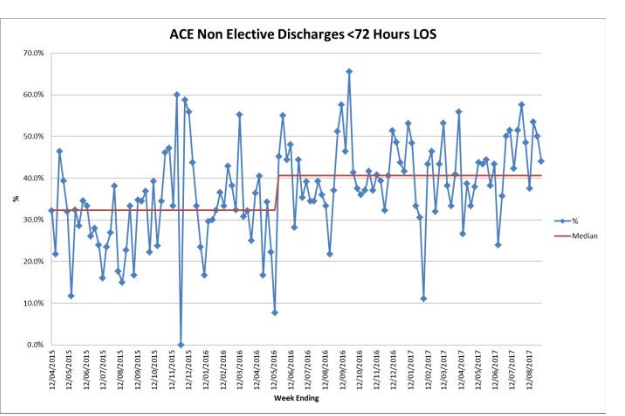

## 7. Early Flow Trust Wide




## 8. Admissions Verses Discharges

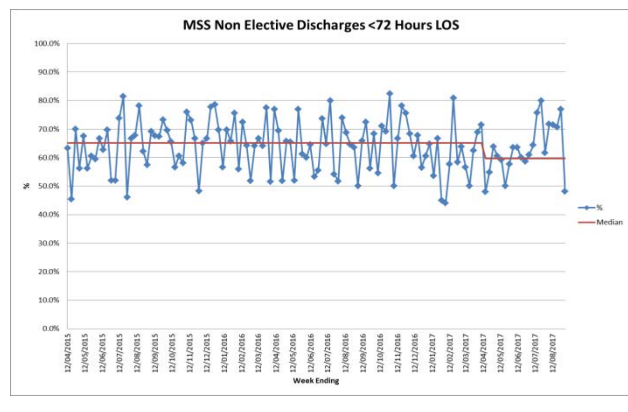



## 9. Short Stay Frailty Length of Stay < 72 Hours



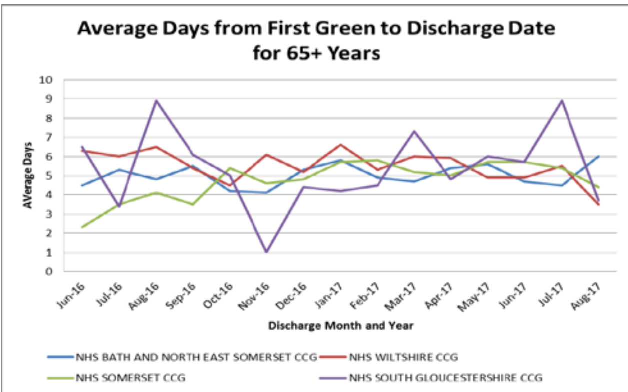

*Action: Frailty Flying Squad permanent 7 day service, business case to be presented to A&E Delivery Board*

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



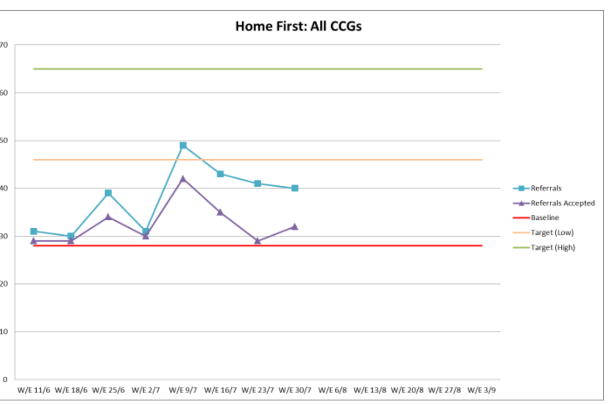

*Action: Extended Acute Medicine 7 days a week business case to be presented to A&E Delivery Board*

## 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.

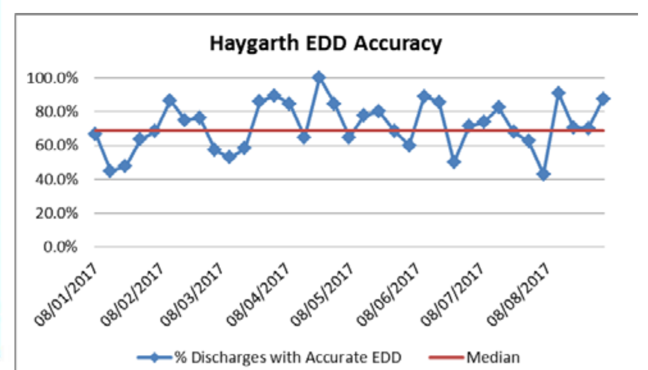
Applying the FLOW principles focusing on a clinical pathway to complete a full diagnostic against each of the elements of SAFER and to apply small tests of change to improve performance and sustain.

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

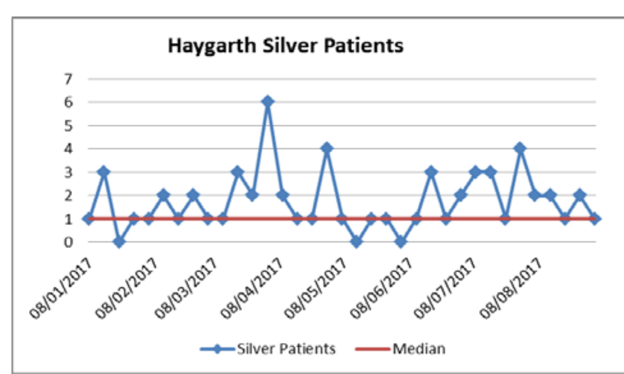
**Actions in September**

- Specialty Big Room "triangle" to be tested – occupancy, Los and daily discharges to be used as a prompt for ward level support
- Focus on Haygarth by the IDS Team to support > 6 day length of stay discharges
- Supporting MAU with early pull, applying the learning from the PDSA to roll out to other specialties
- Presentation to Medicine Clinical Leads re SAFER – support required for S and R
- Clinical Reference Group 12th September 2017 SAFER principle implementation for discussion

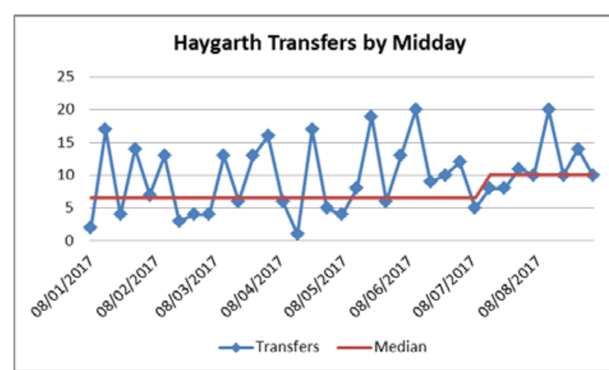
**A** Accurate Estimated date of Discharge



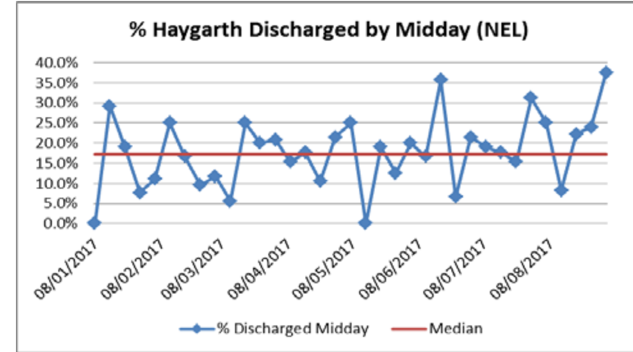

**E** Identification of Silver patients who will discharge before 10am



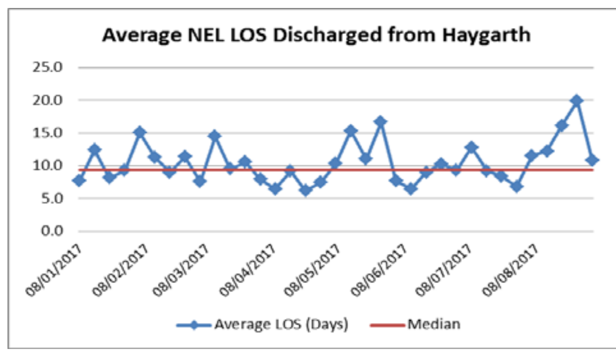

**E** Early transfer from Haygarth Ward



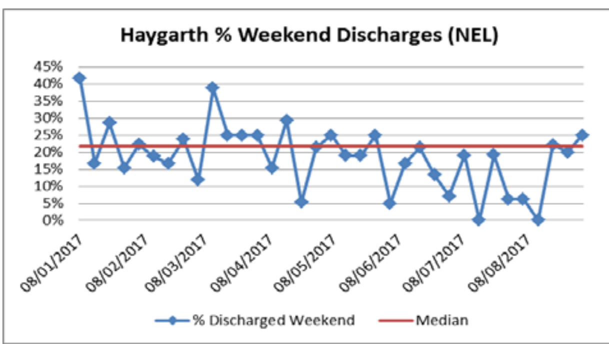

**E** 33% of discharged before midday Haygarth



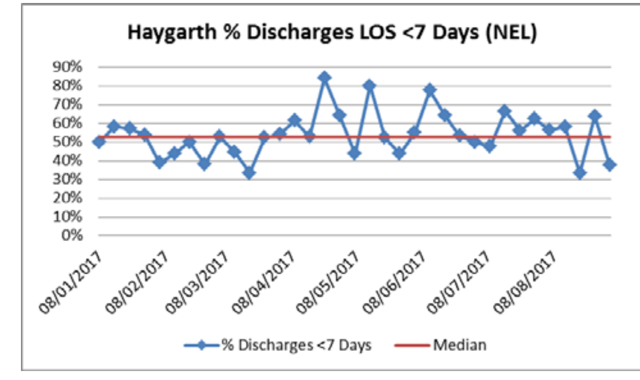

**E** Non-elective Length of Stay Haygarth



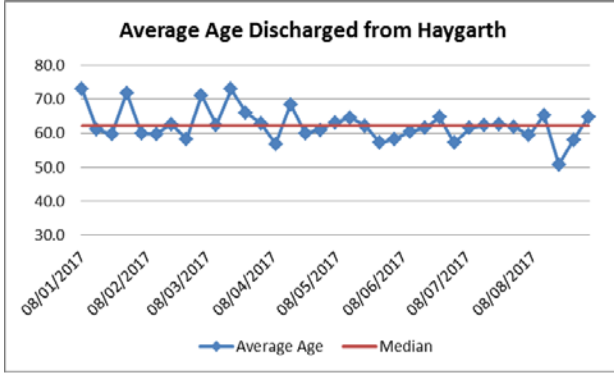

**F** Early flow at the weekend




**R** % Haygarth discharges with a < 7 day Length of stay




**R** Age profile of all Haygarth discharges




*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***

<table>
<tr><th></th><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th><th colspan="3">Q4</th></tr>
<tr><th></th><th>Apr-17</th><th>May-17</th><th>Jun-17</th><th>Jul-17</th><th>Aug-17</th><th>Sep-17</th><th>Oct-17</th><th>Nov-17</th><th>Dec-17</th><th>Jan-18</th><th>Feb-18</th><th>Mar-18</th></tr>
<tr><td>National Initiative to Increase Front Door Primary Streaming models by September 2017</td><td colspan="3">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</td><td colspan="2">PDSA increased weekday streaming aim to develop to 7 days from September 2017. Urgent Care Centre tender awarded.</td><td>Launch of 7 day model</td><td colspan="6">Ongoing KPI monitoring and refinement of streaming pathway</td></tr>
<tr><td>Ambulatory Care Models Extended</td><td colspan="2">Nursing model to be implemented fully in medical ambulatory care.. Develop proposal for trauma and orthopaedic ambulatory care model</td><td>A&E Delivery Board bid to support additional Acute Medicine Consultants to support extended hours working</td><td>Develop models for 7 day working with consistent nurse establishment (weekend working PDSA planned for July 2017)</td><td colspan="5">PDSA extended working models. KPI review via the Ambulatory Care Big Room</td><td colspan="3">Fully implement extended hours model</td></tr>
<tr><td>Front Door Re-design (ECIP Supported)</td><td colspan="3">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.</td><td>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</td><td colspan="5">PDSA extended working models. KPI review via the weekly Urgent Care Group</td><td colspan="3">Fully implement model</td></tr>
<tr><td>Frailty Assessment Pathway Expansion</td><td>Analysis of Frailty Flying Squad outcomes</td><td>Develop Business Case to continue Frailty Flying Squad</td><td>A&E Delivery Board bid to develop Frailty Flying Squad substantively</td><td colspan="2">Depending upon A&E Delivery Board outcomes prepare for implementation in September 2017</td><td colspan="7">Implement Frailty Flying Squad. Ongoing KPI monitoring via Frailty Big Room</td></tr>
<tr><td>Home First Implementation (ECIP Supported)</td><td>System Wide Patient Pathway agreement</td><td>KPI development and monitoring arrangements</td><td colspan="10">KPI review via the weekly IDS and Urgent Care Groups*</td></tr>
<tr><td>Digital Strategy Opportunities</td><td colspan="2">First Net Benefits realisation assessment</td><td colspan="2">Scope the options for digital solutions to support urgent care and flow i.e. interactive white board, hardware access</td><td colspan="4">Actions depending upon scoping exercise outcomes</td><td>Presentation of outcomes to the RUH Fit for the Future Board</td><td colspan="3">Actions depending upon scoping exercise outcomes</td></tr>
<tr><td>Communication Strategy</td><td colspan="2">Executive lead on key organisations messages to under pin urgent care and efficient patient flow</td><td>Trust wide communication plan delivery</td><td>Review of communication plan delivery at the UCCB</td><td colspan="8">Further actions depending upon communication plan outcomes and UCCB recommendations</td></tr>
<tr><td>Medical Take Model</td><td colspan="4">Develop models to improve the medical take in line with ECIP recommendations</td><td colspan="5">PDSA extended working models. KPI review via the weekly Urgent Care Group</td><td colspan="3">Fully implement model</td></tr>
<tr><td>SAFER - Focus on Clinical Gastroenterology Pathway</td><td colspan="4">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.</td><td>Specialty Big Room 6 month review</td><td colspan="7">Next actions dependent upon 6 month review and recommendations from both the UCCB and weekly urgent care group</td></tr>
</table>

****Home First actions***

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

# 7. Governance Structure

- RUH Board of Directors ↔ Wiltshire Health and Care ↔ A&E Delivery Board
- RUH Board of Directors
  - Management Board
    - Urgent Care Collaborative Board
      - Weekly Urgent Care Group
        - Front Door
          - Ambulatory Care Big Room
          - Frailty Big Room
        - Specialty Big Room
        - Discharge Board
          - Safe and Proactive Discharge (Pathway 0)
          - CHC
          - IDS (Pathway 2 & 3)
          - Medicines to Go
  - Fit for the Future Board
    - Social Care Investment
      - Home First (Pathway 1)
    - IT CIB
      - First Net Project Board
    - Front Door Redesign
      - UCC Tender
- A&E Delivery Board
  - Home first
  - Clinical Sub Group
  - Data Group

***Governance Links to be Confirmed***

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