

Report to:	Public Board of Directors	Agenda item:	11
Date of Meeting:	31 January 2018		

Title of Report:	Four Hour Improvement Plan 2017/18
Status:	For Discussion
Board Sponsor:	Clare O'Farrell, Deputy Chief Operating Officer
Author:	Sarah Hudson, Acting Divisional Manager Medicine
Appendices	None

1.	Executive Summary of the Report
To update the Board on the 2017/18 RUH Urgent Care Collaborative Board programme performance. The report reflects information up to and including the 31 st December 2017.	

2.	Recommendations (Note, Approve, Discuss)
<p>The Management Board are asked to note the following:</p> <ul style="list-style-type: none"> Ambulance conveyance activity +3.4% variance compared to 2016/17 for week ending 31/12/17 Emergency presentations +1.7% year to date variance compared to last financial year Emergency Department attendances -0.2% year to date variance compared to last financial year Negative impact on bed capacity due to high Delayed Transfers of Care (DTC). 31 patients reported at the December month end snapshot and 829 delayed days (4.8%) reported Negative impact on bed capacity due to infection, 339 closed beds (81 empty) in December. Infection control restrictions also affecting bed availability and flow due to high volume of patients with suspected influenza <p>Areas for improvement in January 2018:</p> <ul style="list-style-type: none"> In collaboration and supported by the Emergency Care Improvement Programme implement recommendations from the teams site visits in November and December 2017 Delivery and KPI monitoring of the additional winter schemes <ul style="list-style-type: none"> Home Hub and on the day/unplanned patient transport Embedding of SAFER across medicine Additional Emergency Department medical staffing during periods of greatest demand Increase senior decision maker in put out of hours at the Front Door Specialty Big Room – Engagement with Clinical Leads to support the implementation and delivery of the Senior Review and Review elements of SAFER – focus on Ward & Board Rounds and reducing variation in practice underpinned by IDS support 	

- Ensuring patients are able to answer the 4 questions about their stay in hospital – *what's wrong with me, what's happening today, what do I need to happen to go home, when will I be discharged?*

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.

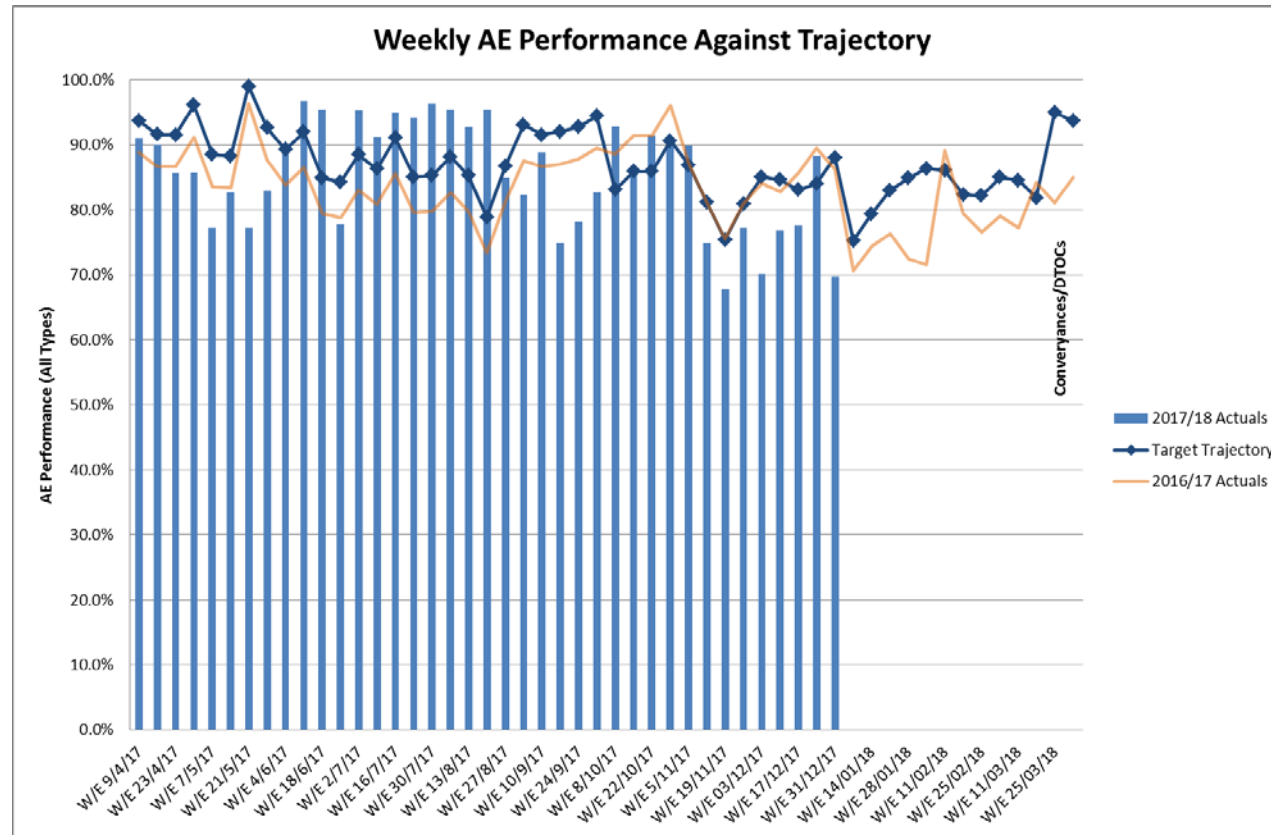
8. Freedom of Information

Public

1. RUH 4 Hour Performance: December 2017 Month 9

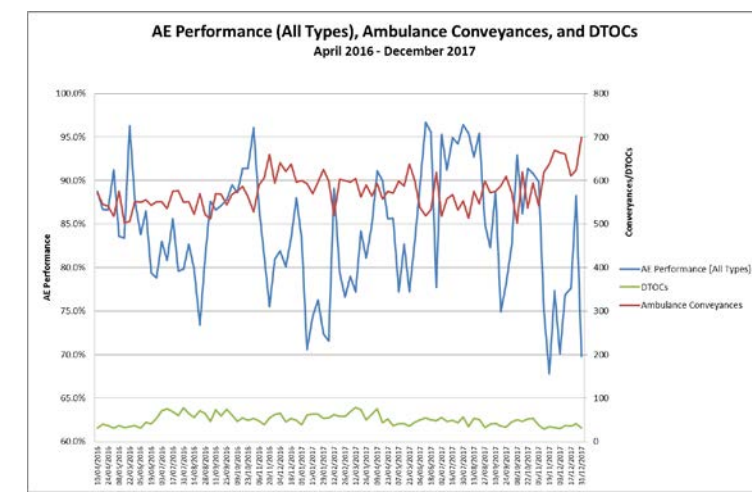
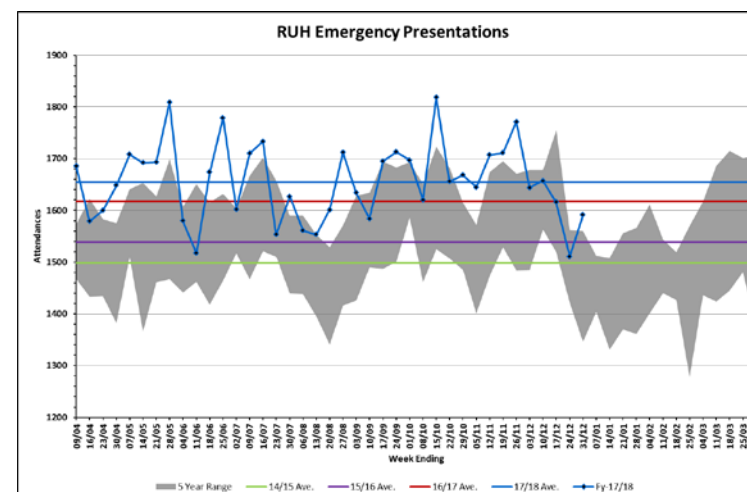
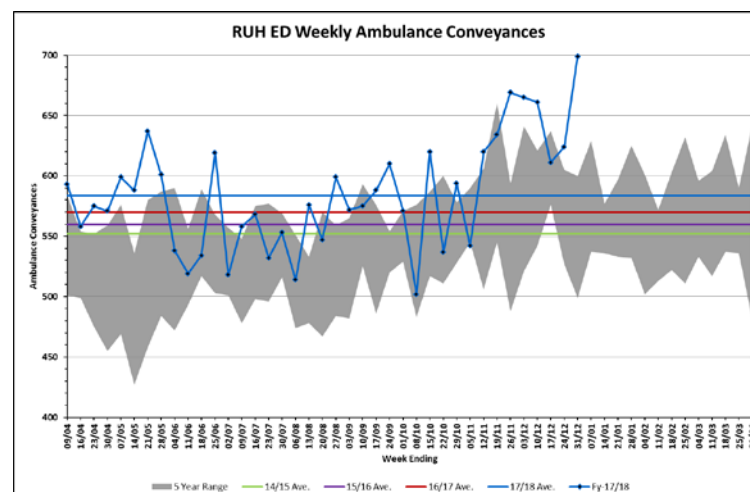
Improvement Trajectory - Segment 2

- December 2017 four hour performance not achieved 76.9% (All Types)
- Performance did not meet the performance trajectory of 86.0%



Key Diagnostics

- Ambulance conveyance activity +3.4% variance compared to 2016/17 for week ending 31/12/17
- Emergency presentations +1.7% year to date variance compared to last financial year
- Emergency Department attendances -0.2% year to date variance compared to last financial year
- Negative impact on bed capacity due to high Delayed Transfers of Care (DTOC). 31 patients reported at the December month end snapshot and 829 delayed days (4.8%) reported
- Negative impact on bed capacity due to infection, 339 closed beds (81 empty) in December.
- Infection control restrictions also affecting bed availability and flow due to high volume of patients with suspected influenza



2. Emergency Department National Quality Indicators

Majors	Actual Performance 54.3%	Due to FirstNet Go Live, Initial Assessment Reporting is Under Review	Average Time to Treatment (mins) 69	Actions <ol style="list-style-type: none"> Review of factors affecting majors performance attributable to ED delays at the weekend. ECIP identified area of focus in January 2018 Winter funding opportunities to support flow and prevent exit block in ED to be implemented <ul style="list-style-type: none"> Emergency flow pathway team Additional Registrars in ED during high volume periods and when limited decision makers Home Hub supported by patient transfer teams
Minors	Actual Performance 87.4%	Due to FirstNet Go Live, Initial Assessment Reporting is Under Review	Average Time to Treatment (mins) 74	Actions <ol style="list-style-type: none"> 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. ECIP identified area of focus in January 2018 Review of minor clinical staff model and increase advanced nurse practitioners during periods of highest demand – ECIP supported area of focus supported by capacity and demand modelling Continue focus on Minors including the proposed clinical pathway through the Urgent Care Centre Internal professional standards escalation as increase in patients being admitted through minors, minor injury's requiring specialty input. Review of process and divisional escalation in and out of hours to improve escalation response times Daily and weekly review of non-admitted breaches through Front Door Group and Urgent Care Weekly group
Self Presenters	Actual Performance 88.5%	Due to FirstNet Go Live, Initial Assessment Reporting is Under Review	Average Time to Treatment (mins) 60	
Streaming	Actual Performance 99.3%	Due to FirstNet Go Live, Initial Assessment Reporting is Under Review	Average Time to Treatment (mins) 34	Actions <ol style="list-style-type: none"> Urgent Care Centre (UCC) transition of services planned for May 2018. Mobilisation group has been established and bi-weekly meetings scheduled, clinical model and delivery of model priority area of focus supported by ECIP Continue to work with UCC team to improve services and access to increase GP streaming, additional streaming agreed for the winter period which commenced mid December 2017

Royal United Hospitals Bath NHS Foundation Trust	2017/2018									YTD
Reason For Breach	April	May	June	July	August	September	October	November	December	
Bed Management	407	841	336	58	314	789	262	906	935	4848
Waiting For Diagnostics	8	12	4	3	6	10	9	29	20	101
Waiting For Specialist Opinion - Acute	73	91	34	55	73	98	61	86	86	657
Waiting For Specialist Opinion - MH	33	50	32	21	28	30	22	28	31	275
A&E Assessment	159	293	188	163	145	273	219	359	340	2139
Clinical	104	96	46	83	59	84	106	105	105	788
Primary Care Assessment / Streaming	27	47	22	31	32	31	38	7	1	236
Transport	10	8	2	1	1	2	6	6	9	45
Other								90	50	140
Unknown								84	21	105
Total:	821	1440	664	415	658	1317	723	1700	1598	9336
OOH (7pm-8am) Arrival Breach Total:	372	647	306	179	321	594	387	758	793	4357
Evening (8pm-Midnight) Arrival Breaches Total:	147	302	120	91	138	256	150	334	337	1875

* Change in IT system resulted in a period of non capture of breach codes (classified as unknown) which has now been resolved.
There are also additional breach codes available which for the purposes of this report have been grouped as "other"

Performance Summary

- Patients are managed through the Emergency Department via 4 points of access; Majors, Minors, Self presenters and Streaming
- Emergency Department achieve time to assessment data is under review due to changes in workflow processes due to IT system changes
- The average time to treatment has not been achieved for Majors or Minors
- Overall 4 hour performance not achieved for Majors or Minors
- Further work is required which will be ECIP supported to further reduce the number of patients breaching the 4 hour standard who were not admitted
- 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 (partial service now in place, full service from May 2018)



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

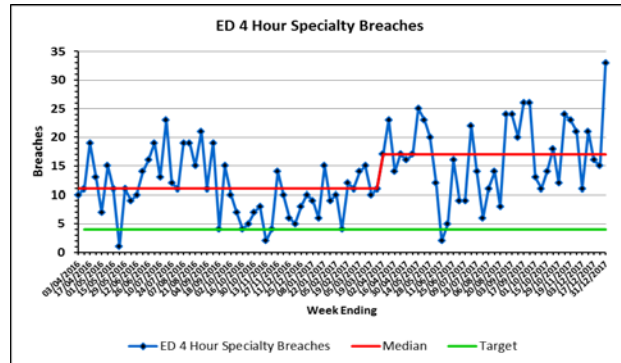
Key Area	Metric	Target	Nov-17			Dec-17				Current Trend
			19/11/2017	26/11/2017	03/12/2017	10/12/2017	17/12/2017	24/12/2017	31/12/2017	
1. Quality & Safety: To Provide Rapid Intensive Support to those Patients at Highest Risk	ED 4 Hour Breaches		523	384	484	375	349	166	495	
	ED 4 Hour Performance	95.0%	67.8%	77.0%	70.0%	76.8%	77.4%	88.3%	69.8%	
	ED Ambulance Handovers within 30 minutes	100.0%								
	ED Specialty 4 Hour Breaches	4	23	21	11	21	16	15	33	
	ED Conversion Rate (Type 1&3)	32.0%	32.2%	33.3%	32.0%	32.1%	35.7%	33.8%	34.7%	
	Adult Acute Bed Occupancy	92.0%	95.6%	95.8%	93.6%	96.1%	95.2%	85.2%	91.5%	
	Average Daily Medical outliers	15	35	35	42	56	44	28	32	
2. Performance: To Implement Best Practice in Timely Senior Review and Discharge	GP Direct Admissions to SAU	40	26	32	23	35	23	35	21	
	GP Direct Admissions to MAU	20	3	2	0	6	5	32	8	
	ED and GP Direct Admissions to ACE	5	0	3	1	8	3	3	7	
	Ambulatory Care Activity	30%	35.8%	36.0%	31.8%	34.2%	30.6%	40.2%	21.7%	
	ESAC Activity	30	28	39	37	59	38	47	23	
	% MAU Discharges <24 Hours		60.9%	55.4%	69.2%	40.5%	68.6%	69.4%	65.5%	
	% SAU Discharges <24 Hours		56.8%	52.1%	59.1%	53.9%	70.0%	70.4%	56.1%	
	% MSS Discharges <72 Hours		54.1%	50.0%	51.6%	38.5%	40.0%	74.6%	79.3%	
	Haygarth Weekday/Weekend Discharge Variation		0.9	3.4	1.8	0.2	1.9	0.5	0	
	% Discharges Before Midday	33.0%	15.1%	12.5%	12.4%	17.4%	15.4%	16.1%	14.1%	
	DTOCS	15	35	32	30	37	36	41	31	

¹ ED ambulance handovers are currently not reportable due to SWAST and RUH IT changes

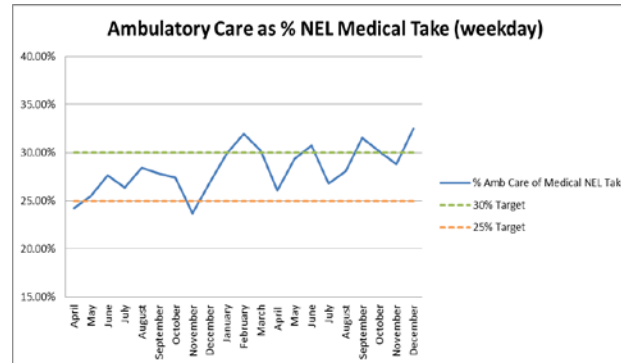
² Haygarth discharge variation, this metric compares weekday to weekend discharge variance, the aim to be zero i.e. discharging the same number of patients at the weekend as a weekday

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

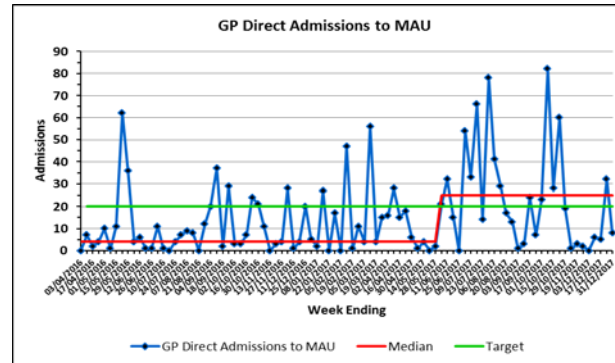
1. Internal Delays and Access to Specialty Opinion



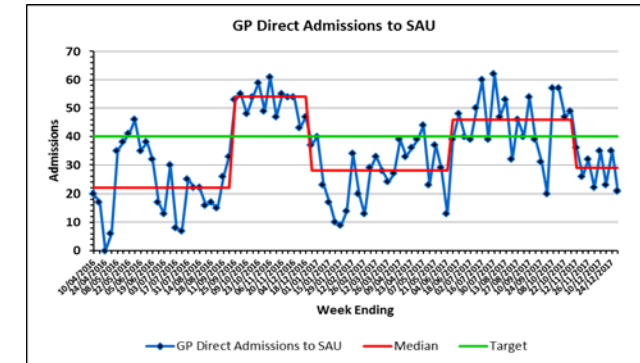
2. Alternative Pathways to Admission - Medical Ambulatory Care



3. Direct Access to Medical Assessment Unit



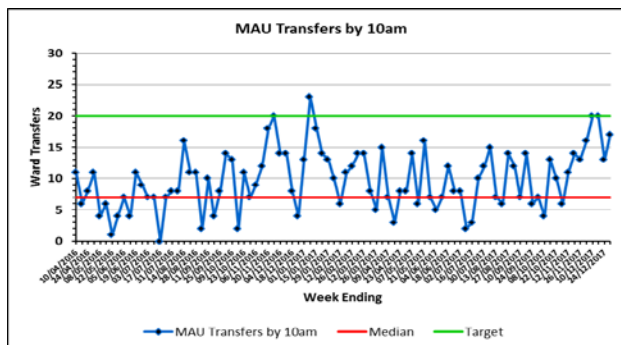
4. Direct Access to Surgical Assessment Unit



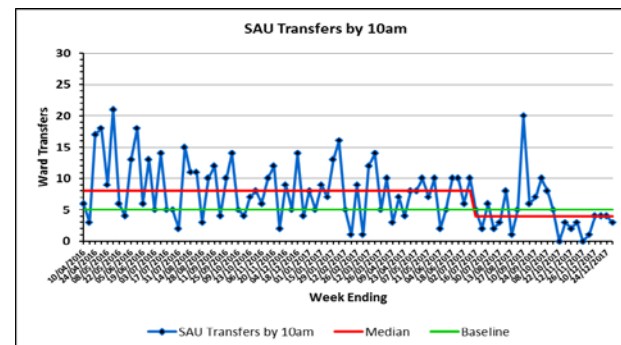
Action: Front Door Group to ensure internal professional standards and senior escalation processes adhered to

Action: 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

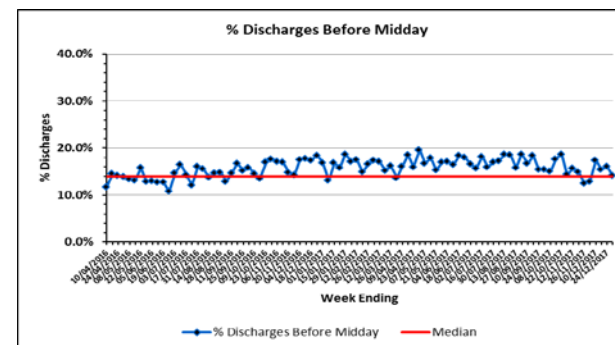
5. Early Flow out of Assessment Area - MAU



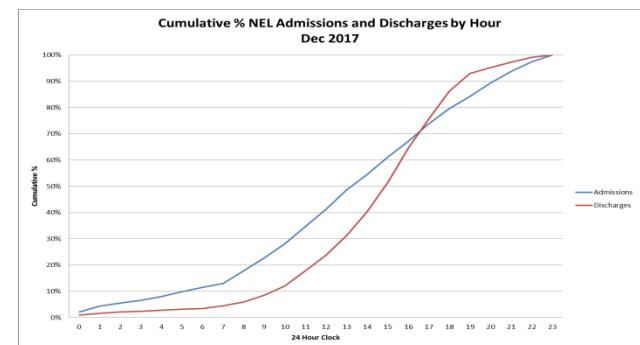
6. Early Flow out of Assessment Area - SAU



7. Early Flow Trust Wide

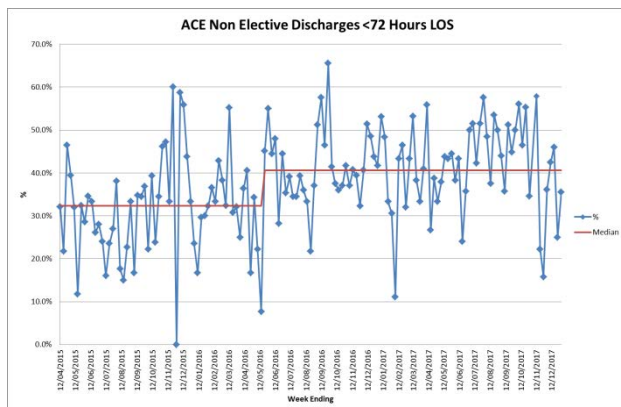


8. Admissions Verses Discharges

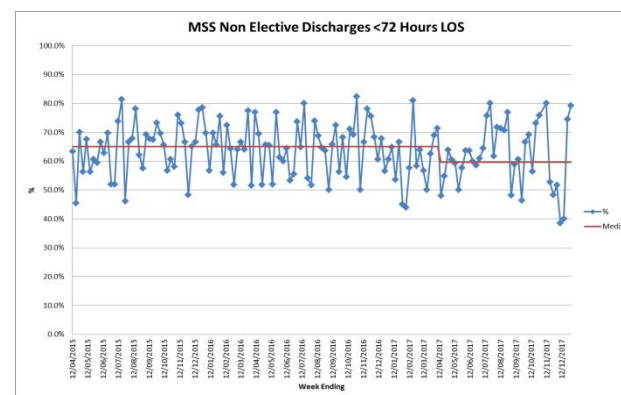


Action: Front Door Group to review all actions across MAU, MSS and Ambulatory Care to increase discharges as current trust wide discharges before midday do not deliver the required improvement to support early flow

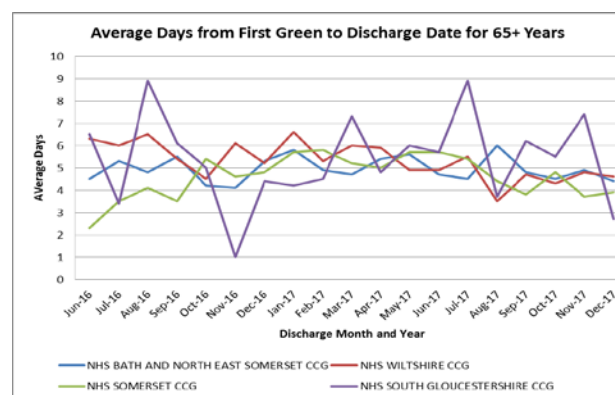
9. Short Stay Frailty Length of Stay < 72 Hours



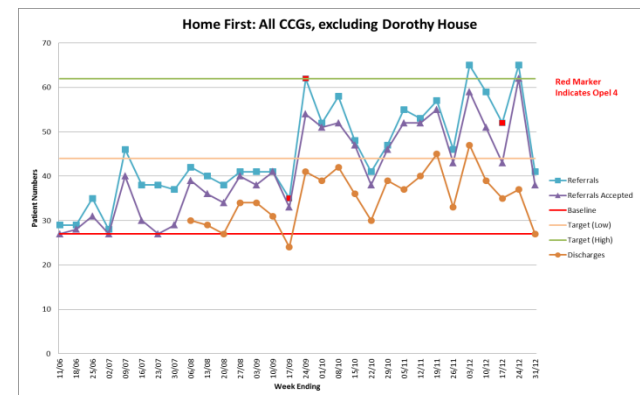
10. Short Stay Medical Length of Stay <72 Hours



11. Medically Fit for Discharge by CCG



12. Home First – All CCGs



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

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

Action: DTOC improvements A&E Delivery Board action

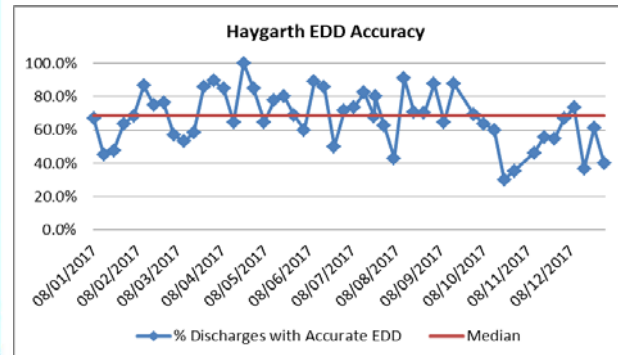
Action: DTOC improvements A&E Delivery Board action

4. Implementing the SAFER Bundle – Clinical Gastroenterology

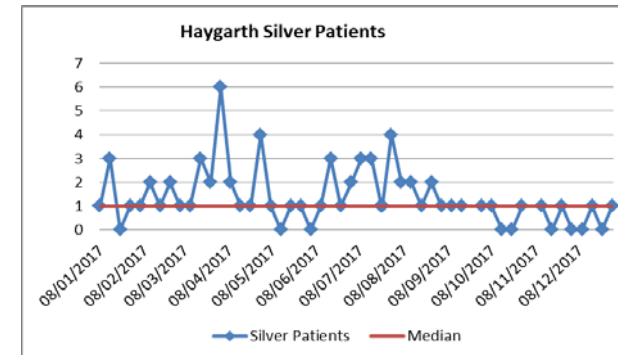
The SAFER Patient Flow Bundle

- 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.

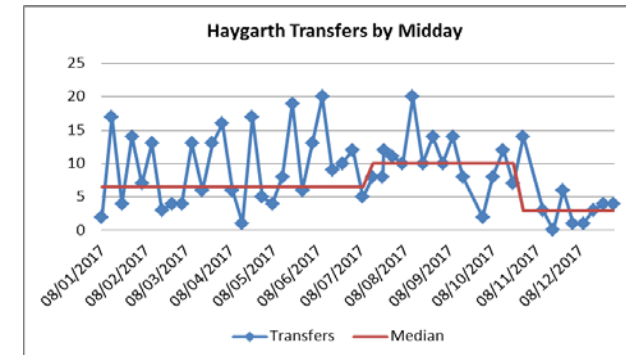
A Accurate Estimated date of Discharge



E Identification of Silver patients who will discharge before 10am



E Early transfer from Haygarth Ward



SAFER Implementation Plan

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

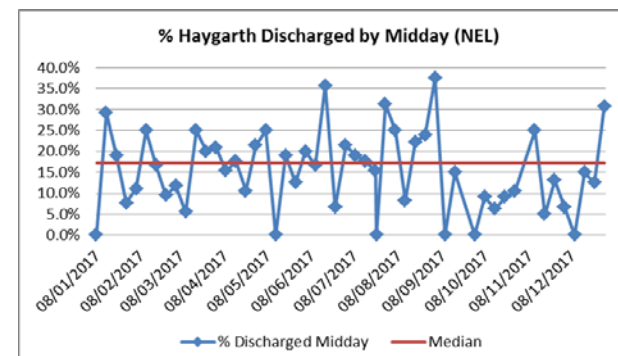
Applying the FLOW principles focusing on a clinical pathway to complete a full diagnostic against each of the elements of SAFER and to apply small tests of change to improve performance and sustain.

Clinical Gastroenterology is the first clinical pathway to be reviewed and is the focus of testing, Cardiology is also participating and undertaking PDSA's.

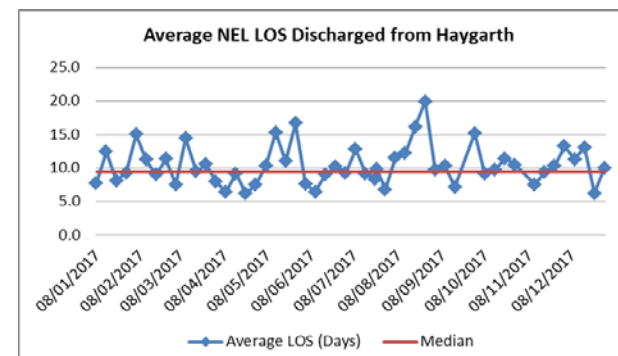
Actions in January

- Preparation for ECIP supported SAFER immersion event w/c 29th January 2018
- Embedding of the “4 questions” which patients should be able to answer about their stay in hospital and discharge planning which are also included in the ward/board round checklists. Roll out across all wards ongoing
- Focus on earlier ward discharge and supporting the Home Hub (discharge lounge) PDSA
- Staff and patient information posters to support early discharge principles agreed to be distributed across the trusts and displayed on all electronic patient screens.

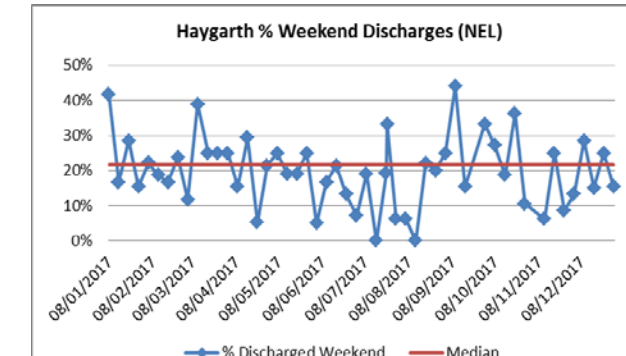
E 33% of discharged before midday Haygarth



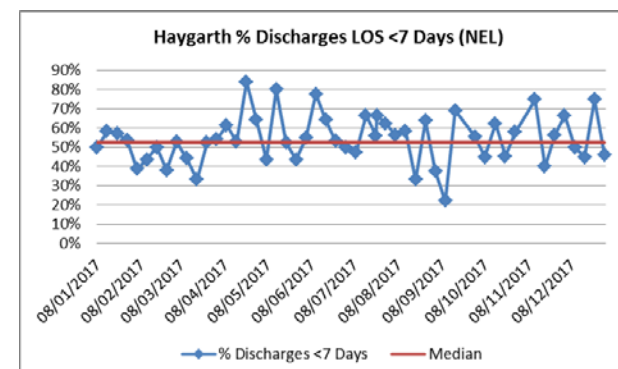
E Non-elective Length of Stay Haygarth



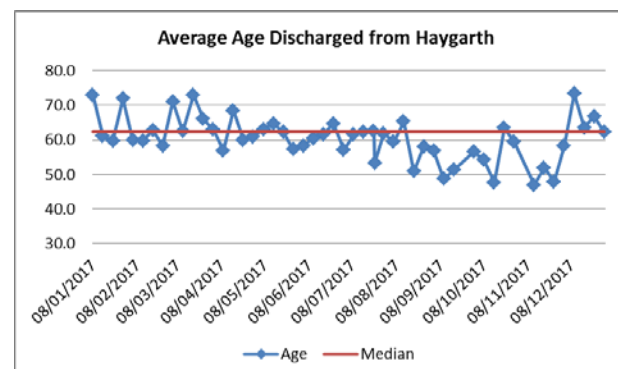
F Early flow at the weekend



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 – overall impact can be seen with a reduction in average age. This is due to correct pull, early escalation and IDS input to the ward for any complex patients.

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 ¹			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 ²									
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 ³		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 ⁴				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						

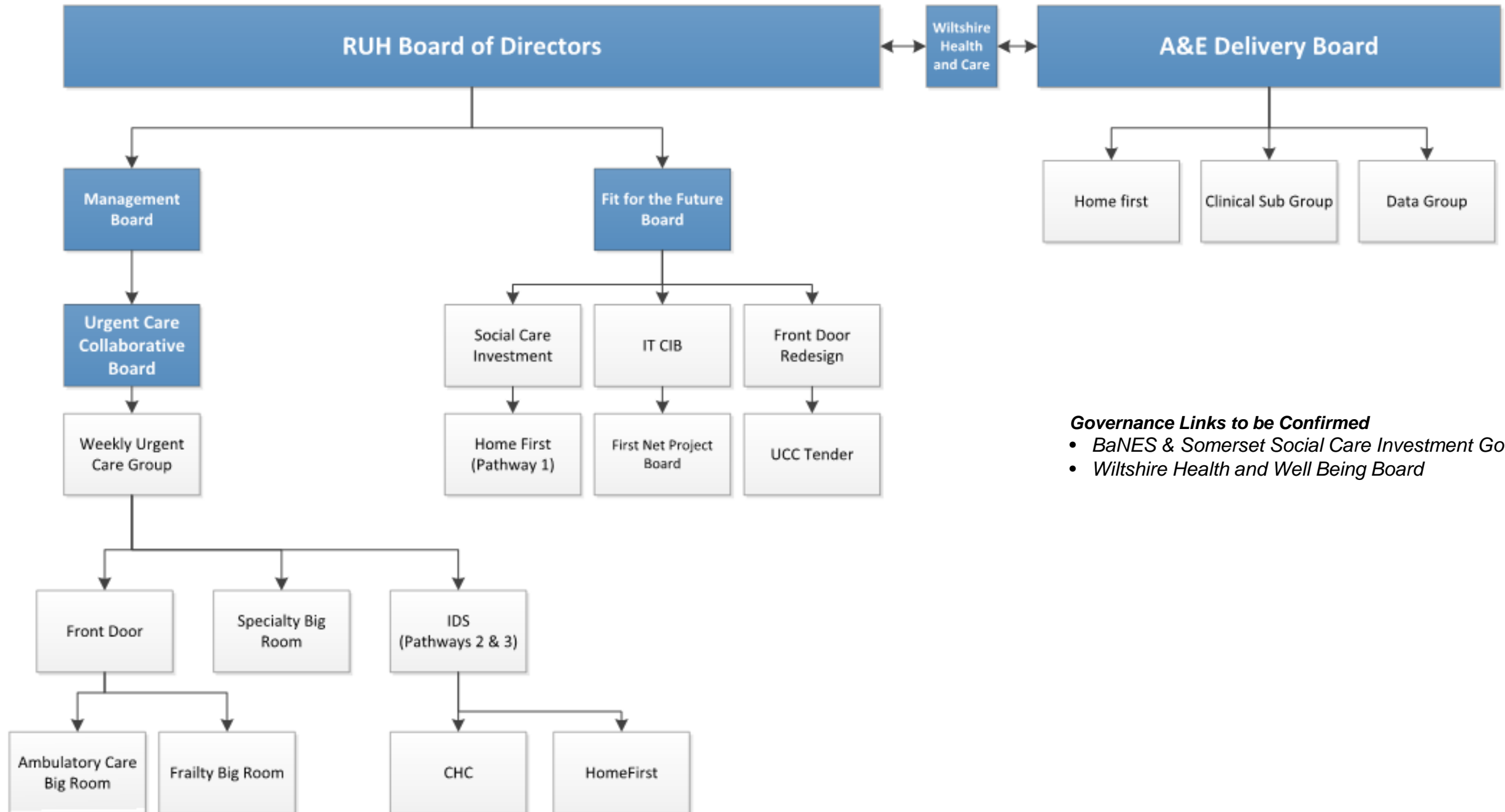
¹ **Frailty Assessment Pathway expansion.** Partial service in place from the start of October 2017 whilst recruitment to all posts is underway, MNP and therapist interviewed and all posts filled, awaiting start dates. Consultant posts are currently out to advert with interview date November 2017

² **Home First Implementation.** 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 Somerset have completed a first PDSA, which was successful, full implementation plan with timescales ongoing action.

³ **Digital Strategy Opportunities.** Tele tracking now recognised as a potential opportunity to improve patient flow, one model has been reviewed with plans to review a second, identified as a potential IT programme development area.

⁴ **Medical Take Model.** Further work is required to define the RUH Model depending upon Acute Medicine Consultant recruitment. A partial service for extended hours in acute medicine have started providing an ED presence until 9pm one day per week and ambulatory care has Consultant presence 5 days a week until 7pm.

8. Governance Structure



Governance Links to be Confirmed

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