Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD

30th May 2013

TITLE	**Emergency Care**
EXECUTIVE SUMMARY	The purpose of this paper is to set out the issues within the Emergency Care department highlighted by the current failure to achieve the four hour waiting time target. There are a number of actions the Trust may wish to implement, in addition to those already planned for 2013/14, to ensure sustainable delivery of a safe and effective emergency care pathway.
BOARD ASSURANCE (Risk) / IMPLICATIONS	Compliance is reflected in the Board Assurance Framework. BAF Risk 1.8 (poor capacity and flow in the emergency department).
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient expectations in terms of access are reflected in NHS performance targets.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	The failure to meet the four hour standard for waiting times in A&E creates a potential regulatory issue for the Trust.
The Trust Board is asked to:	The Trust is asked to consider this paper and to discuss the issues within the emergency department and the options presented.
Submitted by:	Valerie Bartlett, Deputy Chief Executive
Date:	23rd May 2013
Decision:	For Discussion.

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Emergency Care

1 INTRODUCTION

The purpose of this paper is to set out the issues within the Emergency Care department highlighted by the current failure to achieve the four hour waiting time target. There are a number of actions the Trust may wish to implement, in addition to those already planned for 2013/14, to ensure sustainable delivery of a safe and effective emergency care pathway.

2 CONTEXT

This paper comes at a time when there has been great national debate about four hour performance following the worst performance nationally against this target for many years.

At a national level:

- 88 acute trusts did not meet the 4 hour target during quarter 3 of 2012/13 (this was double the number recorded in the same period the year before; and a fourfold increase compared with quarter 2).
- In the first three weeks of 2013/14 the target was missed by 125 out of 143 trusts, with a national average of 90.4% of patients seen within four hours
- The 4 hour target was met by just over half of hospital trusts with major accident and emergency departments in the four weeks to 12th May 2013.

In terms of the analysis that has taken place nationally about the root causes of the problem, it is fair to say that there are many views. However, the following have been described as key drivers of the significant deterioration in performance:

- The difficulty in recruiting to key posts in A and E departments, and the national shortage of A&E consultants.
- The impact of the 2004 renegotiation of the GP contract and the removal of the requirement for GPs to provide their own out of hours cover.
- The launch of the new national 111 service, where risk-averse algorithms and poor project management have added a significant burden to already over stretched A&E departments.
- Inexorable rises in year on year attendances, with increasing intensity and an older population with more complex needs.

3 THE TRUST'S ACTIONS TO DATE

To date the Trust has undertaken a very significant work programme to address problems across its unplanned care pathway. The Trust's work programme has been supported by the Emergency Care Intensive Support Team (ECIST), and ECIST have signed off the Trust's work. This work programme has been comprehensive and has covered all aspects of the pathway. Further details of the work programme and the actions undertaken in 2012/13 are set out in the Appendix to this report.

4 IMPACT OF THE TRUST'S ACTIONS & WINTER 2012/13

As a result of this action plan the Trust saw a 4.5% improvement in performance in Q3 and a 0.4% improvement in performance in Q4 against the previous financial year. It delivered the performance standard for Q1, 2 and 3 last year but missed Q4. It did however deliver the standard for the year as a whole.

During the winter of 2012/13 it became clear that the changes undertaken were not yet sufficient to meet the changes being seen in the hospital and across the wider system. During

the winter we saw a further 5% increase in A&E attendances compared with our plan and a further 7.6% increase in emergency admissions. In addition, we saw a striking increase in the case mix and acuity of patients presenting to our A&E department – meaning that sicker patients were arriving, as demonstrated in Figure 1. This too has been reported nationally as one of the reasons for the deterioration in national performance.

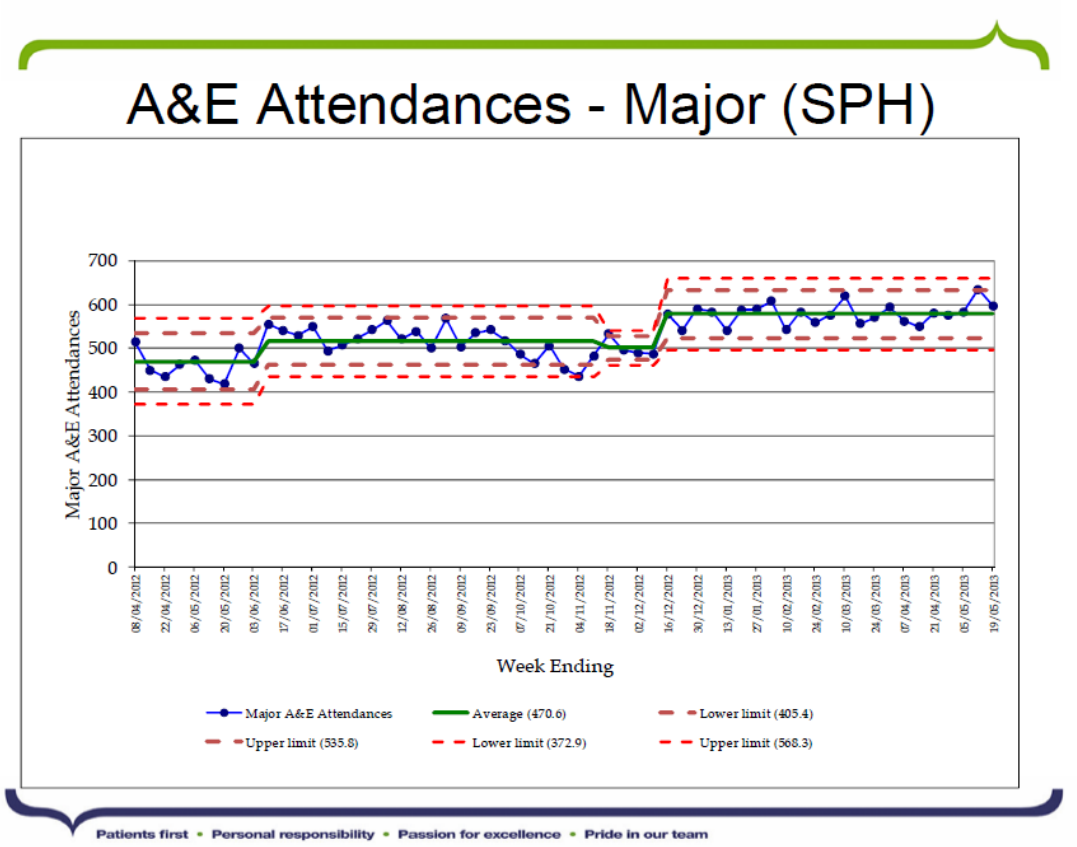


Figure 1

The rise in acuity may be attributable to the growing numbers of frail elderly people presenting to A&E departments. We know that whilst the proportion of elderly people living in North-West Surrey is one of the lowest in Surrey, it has the highest absolute number of patients aged over 65 that fall into the category either of being unable to manage one domestic task on their own, predicted as having dementia or predicted as having severe depression. North-West Surrey also has the highest number of people aged over 75 in Surrey that live alone.

5 FURTHER PLANS FOR 2013/14

In anticipation of further increases in demand for winter 2013/14 the Trust has already begun work on a number of additional improvements, which are set out in our business plan for the year. These include:

- Development of a frail elderly pathway (to include frailty assessment, comprehensive geriatric assessment and a frailty assessment unit) as recommended by ECIST and the British Society of Geriatricians.
- Implementation of a new Surgical Emergency pathway, including significant improvements to the Surgical Assessment Unit.
- Recruitment of additional A&E consultants, including the Trust's first dedicated paediatric A&E consultant.
- Development of our partnership with Virgincare through Swift at Home, facilitating the care of older people closer to home.
- Collaboration with NW Surrey CCG to reinvest reablement funding into more community services.
- A further reallocation of our inpatient beds to better match demand and capacity.

In the light of the national debate, the key concern is whether these changes will be sufficient to meet rapidly rising demand.

6 OTHER STRATEGIC OPTIONS AVAILABLE TO THE TRUST

In the light of rising demand the Trust could decide to make more radical decisions. This could include:

- Significantly increasing capacity within the acute sector (e.g. increasing in patient medical beds).
- Rapidly increasing the size of the A and E department (built for some 80,000 attendances a year and now dealing with over 90,000 attendances a year).

Some other local Trusts have taken this route, but their experience has been that additional capacity has stimulated demand and therefore only alleviated the problems on a temporary basis.

Most likely route to success

In reviewing all of the evidence and commentary about four hour performance the following have been highlighted as the strategies and tactics most likely to result in success:

- Running acute hospitals with senior decision makers at the front door (our MAU model, and delivered by our increase in A&E consultants).
- Targeting GP practices with high utilisation rates of secondary care, and reducing the batching of patients attending A&E by changing the current home visiting service by GPs.
- Changing the way that care homes and nursing homes are incorporated into the system and worked with (delivered partly by our current nursing home project, but with significant potential for improvement and expansion).
- Developing different relationships between providers (for example through schemes like our Swift at home scheme with Virgincare).
- Improved leadership across local systems (through effective Unplanned Care Boards for example).
- Improved services for people with chronic diseases.

Some of these are within the direct control of ASPH, others will benefit from our contribution and influencing.

The human impact

In considering all of these options the Board also needs to consider the human impact on its staff. It is largely the same group of staff who are both dealing with the day to day impact of the very heavy workload on the front door of A&E, and also developing and delivering the complex pathway changes that will improve our service to patients in the medium term. The day to day burden of managing an increasingly busy front door is a heavy one for staff at all levels.

7 ACTION REQUIRED

The Trust is asked to consider this paper and to discuss the issues within the emergency department and the options presented.

FIXING THE EMERGENCY CARE PATHWAY

A review of the 2012/13 plan

May 2013

2012/13 OUTLINE PLAN

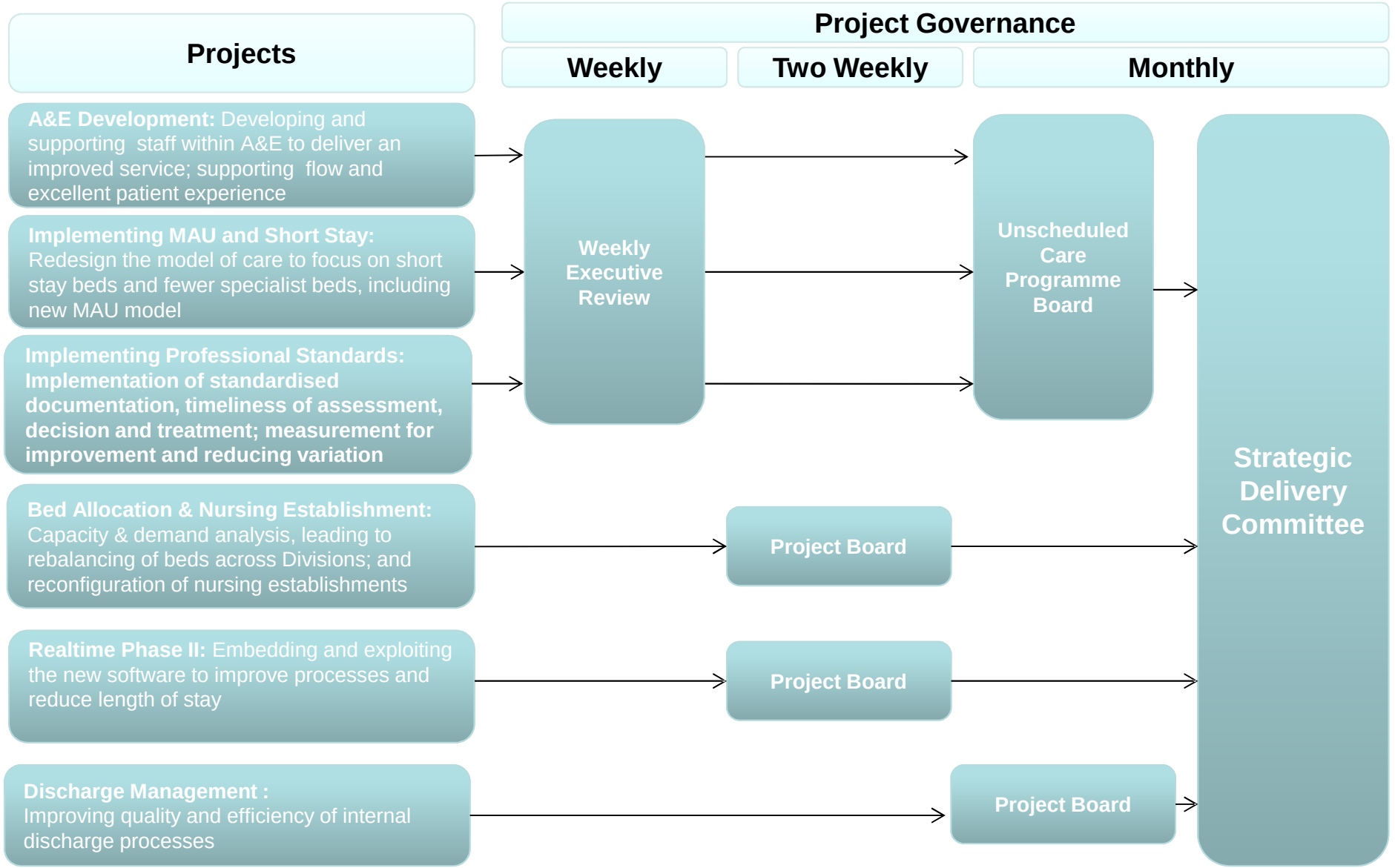
Quarter 1 and 2

- Minor changes and improvements in organisational response to A&E performance, capacity and flow
- Redesign across the whole medical pathway with ECIST support
- Review specialty bed allocation and deliver phase 1 changes
- Continued focus on improved LoS and RealTime project completion
- Implement the Ready-to-Go Discharge project

Quarter 3 and 4

- Comprehensive stakeholder engagement
- Implement new pathway for emergency medical care
- Implement the recommended Internal Professional Standards
- Commence redesign of emergency surgical pathway

GOVERNANCE ARRANGEMENTS



REDESIGN ACROSS THE WHOLE PATIENT PATHWAY

Arriving at the Hospital → **Being Admitted** → **Being Treated** → **Being Discharged**

Issues:
- Lack of services in NW Surrey for patients with chronic conditions
- Increase in self-referrals and ambulance conveyances to A&E
- No increase in ambulances conveyances to walk-in centres
- Long waits for decisions in A&E and right staff not always available at the right time
- Alternatives to admission not well known or well used
- Lack of clarity of roles and increasing stress in busy A&E department

Actions:
- ECIST commissioned to work across whole system
- Review of all shift patterns, on-call systems and job plans
- Review of minors pathways
- NW Surrey Capacity group convened and meeting weekly
- Recruitment of new Consultants
- Daily breach analysis and feedback to specialties
- Workforce and OD Programme developed to support changes in the A&E team
- RealTime module in development for A&E
- “Full Capacity Protocol” developed
- 21 Ambulatory Emergency Care pathways developed and implemented
- 7 day breach analysis tool implemented

REDESIGN ACROSS THE WHOLE PATIENT PATHWAY

Arriving at the Hospital → **Being Admitted** → **Being Treated** → **Being Discharged**

Issues:

- All roads lead to A&E
- Patients waiting in beds for emergency surgery
- Unexpected and unplanned peaks and troughs in elective admissions
- Long delays from A&E to admission to beds
- Many patients being admitted that could have been treated elsewhere (nursing homes, virtual wards, etc.)

Actions:

- Redesign of emergency surgery pathway completed and business case submitted
- Redesign of medical model of care with ECIST support
- New MAU and MSSU established
- Internal Professional Standards agreed
- Established direct admission pathways
- Redesign of theatre timetable and job plans underway
- Review and relaunch of Site Capacity Management Plan
- The Nursing Home project

REDESIGN ACROSS THE WHOLE PATIENT PATHWAY

Arriving at the Hospital → **Being Admitted** → **Being Treated** → **Being Discharged**

Issues:

- Length of Stay not reducing in a sustainable way
- Bed capacity not matched to patient numbers
- Pattern of beds does not meet patient needs
- Staff skills and numbers are not configured to patient needs

Actions:

- Reconfiguration of beds to match demand (phase 1 complete, phase 2 and 3 planned for 2013/14)
- Discharge task force established
- Implementation of enhanced recovery programme for surgical patients
- Implementation and embedding of Realtime on inpatient wards
- Design of 24/7 hospital model underway.
- 7 day working implemented on MAU and MSSU
- Standards for ward rounds agreed and daily 8am board rounds embedded
- Speciality in-reach established on MAU
- Investment in additional psychiatric liaison cover

REDESIGN ACROSS THE WHOLE PATIENT PATHWAY

Arriving at the Hospital → **Being Admitted** → **Being Treated** → **Being Discharged**

Issues:

- Lack of ownership of discharge process
- Discharge planning too late in the process
- Complex and time consuming discharge processes for some patients
- Average time of discharge too late in the day
- Length of stay in elderly care above the national average

Actions:

- Focused improvement programme of discharge processes in care of the elderly wards
- Daily, system-wide conference call on delayed discharges established
- Introduction of key performance discharge indicators
- Discharge documentation and planning incorporated into Realtime
- Secured ECIST support for system-wide improvement of discharge processes
- “Ready to Go” project established
- Procurement of ring-fenced hospice beds
- Investment in an additional 3 WTE Discharge Coordinators
- Investment in additional ICT, Medihome and IV capacity