Report to: Leicester City Health and Wellbeing Scrutiny Commission
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Author: Lisa Gowan, Head of Operations

Emergency Department at University Hospitals of Leicester

What is the current state of play since the changes have been introduced?

The move into the new Emergency Department, (ED) on 26 April 2017 went as planned. Council colleagues will recall that a principle reason for the development of the new ED was that the previous facility was built to accommodate circa 100,000 attendances a year but the exponential growth in attendances had pushed that figure to closer to 200,000 attendances. As a consequence the 'old' ED at times of high demand was cramped, overcrowded and offered a poor patient experience.

Immediately following the opening there was deterioration in both the four-hour performance and speed of ambulance handovers. There key reasons for this were:-

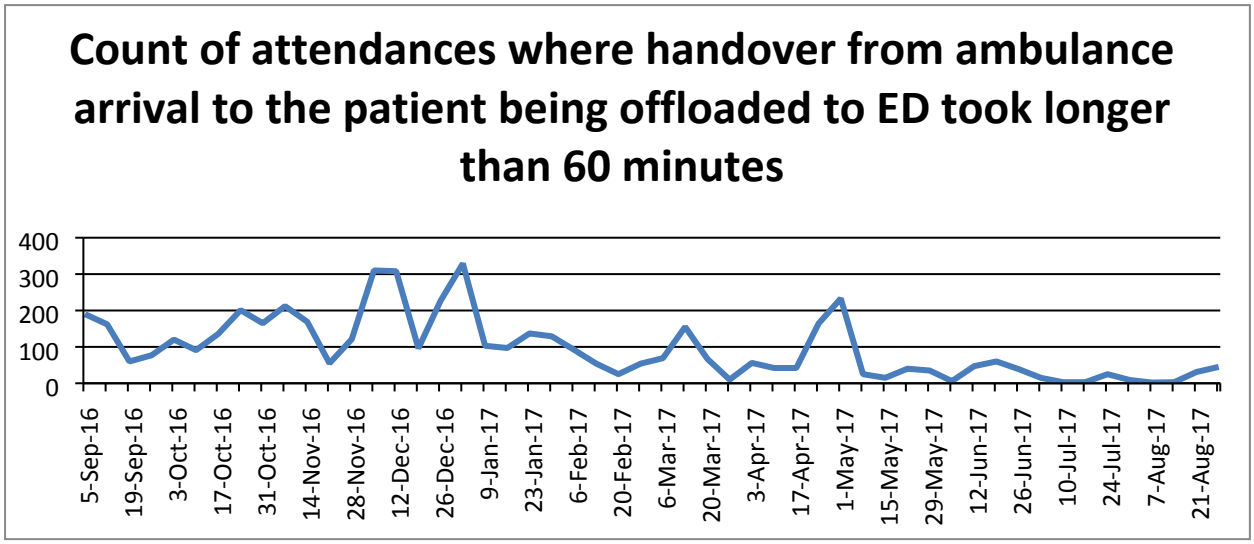
- Embedding the new Standard Operating Procedures (SOPs) and ways of working for the 450+ staff across the new department
- Staff adjusting to their new environment meaning slower processing than normal
- Staffing in the primary care component of ED
- Sustaining meaningful flow out of the Emergency Department to the wards… largely as a consequence of bed availability.

Since April, there have been improvements to our four-hour performance, despite continued high demand on our emergency care pathway, but this has not been sustained at a level we are in any way happy with and as such though patients are seen and treated in an environment that is far superior to that which was previously available, the fact remains that still too many patients wait too long.

Despite marked improvements during the day, i.e. between 8am and 6pm, performance has been poorer overnight. This is largely due to the limited availability of senior clinical decision makers later in the evening, nurse staffing issues across the department, and having sustainable and meaningful outflow from the emergency department. In essence the new department works well when we have the right staff in the right place at the right time, (and access to beds) which combined allow us to deal with peaks in demand, but the ED still 'silts up' if either staffing or beds are in short supply.

On the subject of bed availability there continues to be insufficient capacity for the number of patients we are admitting (baseline shows we are 105 short).

All that said a key measure that caused the Trust, our partners in EMAS and local government colleagues serious concern, i.e. ambulance handover times, have improved dramatically. The department has moved from being the worst performer in the region to one of the best and this improvement is now sustained. (See chart below)



The long-standing problem of ED performance deteriorating overnight, largely because medical and nursing resources do not match our demand, and the continued struggle to ensure flow along the whole emergency care pathway, have led to the Trust-wide 'September Surge' which began on September 1st.

What is 'September surge'? How will it help and what will change? Has it made a difference?

The 'September Surge' began on 1 September, and ran for 14 days, with the aim of increasing focus on getting the basics right and also testing a range of new ideas to improve the care provided for all emergency patients. The underlying principle of the surge was to try out new approaches to managing demand ahead of the inevitable winter pressures.

A number of actions were put in place in ED and across the whole Trust, in recognition that emergency care performance is not just an ED issue.

The actions included:

- More senior doctors in the Emergency Department overnight
- Increasing the number of patients discharged before noon each day
- Doctors from specialties across the hospital coming into ED to see patients, thereby ensuring patients have quicker treatment plans in place. (Known as 'in reach')

The aim of the Surge was to ascertain which specific targeted actions could make a marked difference to ED performance

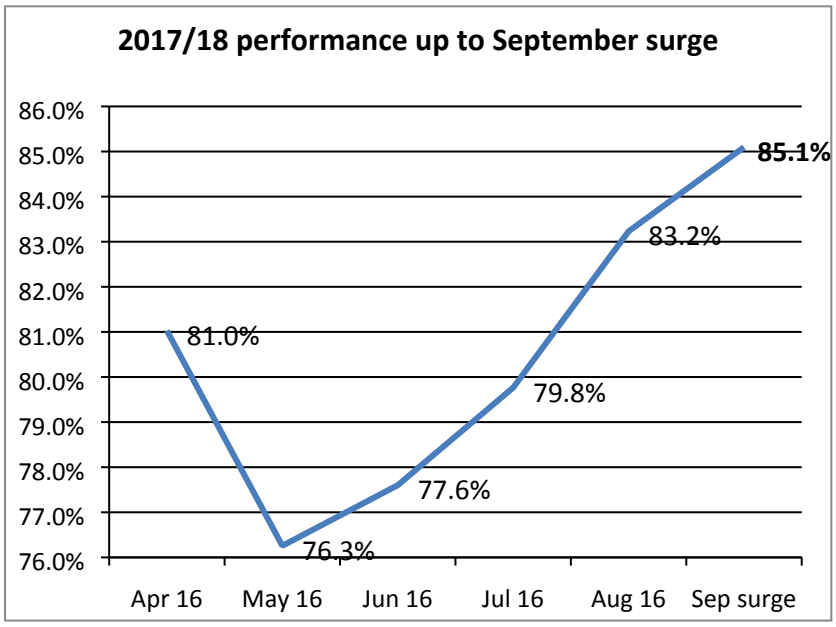
During the two-week period, performance improved, with really excellent performance on several days. This was essentially the result of good bed availability and good performance by ED itself. The additional senior doctor presence in ED made a difference between 6pm and 6am, maintaining our processing power and rapid clinical decision making as well as supporting the overnight team beyond 1am. The 'bad days' were generally being driven by a lack of bed capacity with a particular problem around

the lack of discharges at the weekend and the 'Monday spike' in attendance. (The table below shows this by day)

Daily Performance during Surge

	Arrival Date	Attendance Count	4 Hour Breaches	Performance
Fri	01/09/2017	571	100	**82.5%**
Sat	02/09/2017	597	44	**92.6%**
Sun	03/09/2017	628	28	**95.5%**
Mon	04/09/2017	719	115	**84.0%**
Tue	05/09/2017	643	151	**76.5%**
Wed	06/09/2017	569	109	**80.8%**
Thu	07/09/2017	640	134	**79.1%**
Fri	08/09/2017	628	105	**83.3%**
Sat	09/09/2017	540	76	**85.9%**
Sun	10/09/2017	621	97	**84.4%**
Mon	11/09/2017	701	132	**81.2%**
Tue	12/09/2017	623	111	**82.2%**
Wed	13/09/2017	577	46	**92.0%**
Thu	14/09/2017	605	43	**92.9%**
	Surge Period	**8662**	**1291**	**85.1%**

Overall, the surge improved ED 4 hour performance from 83.2%% in August prior to 85.1% during the surge. (The graph below shows the month on month improvement). The next steps are therefore to take those interventions that made the greatest difference to performance and seek to make them sustainable during the coming winter months and beyond.



These key actions are listed below:

PRE-ED

- Ensure GP extended access roll-out plan matches target
- Ensure minimum 36% 111 calls handled by a clinician
- Actions to address Monday attendance spike

ED

- Continue additional Registrar/Consultant shifts x 3 evening/overnight
- Develop medium-term plan for sufficient medical resources evening/overnight
- Maintain focus on 4 hour segments
- Embed new front door frailty model

ACUTE MEDICINE/AMU

- Continue additional Acute Med ED in-reach shifts
- Review working of AMU/ specialty ownership (L&D)
- GP referrals to by-pass ED (L&D)
- Maximise ambulatory care (L&D)
- Speed up mechanics of flow from ED to assessment units

SPECIALTIES

Continue daily inter-specialty huddles
Continue surgical in-reach into ED (Gen Surg/ENT) or convert to hot clinics
Improve speciality ownership of patients in ED (L&D)

WARD FLOW

- Further embed SAFER/R2G on LRI medical wards (St Helier approach)
- Ensure job plans match SAFER/R2G requirements
- Ensure reliable dedicated discharge role on every medical ward
- Physician of the week (not daily changes)

DISCHARGE

- All CHC assessments to be outside an acute setting
- Fully implement trusted assessment
- Discharge to assess (no assessment for long term care in acute setting)

COMMUNICATIONS

- Continue weekly organisational update
- Staff flu vaccination campaign

INFRASTRUCTURE/COMMAND/PROGRAMME MANAGEMENT

- Accelerate implementation of real-time e-bed management
- Implement daily “scrum” meetings to drive key actions
- Recalibrate Whole Hospital Response policy to reflect speciality ownership of ED situation

What is involved in phase 2 following the move?
As councillor colleagues may recall the new ED design and build was always in two phases. Phase 1 being the ED itself and phase 2 the ‘co-location’ of our assessment units next to the new ED (Previously the assessment units were floors apart accessed by lifts, causing inevitable delays)
The next and final phase of the Emergency Floor is therefore the relocation of the medical assessment and frailty assessment units next door to the new ED. Hence, the space of the old Accident and Emergency Department is currently a busy building site, and will become home to the assessment units from May 2018.

The assessment units are currently located on levels 3 and 5 of the Balmoral and Windsor buildings, meaning it takes time and more resources to move the patients from ED. This co-location will create a ‘hot-floor’ meaning that patients will flow quickly from ED to the assessment units for further investigation and treatment.

The new purpose built space will, like the new ED, be frailty-friendly; it will improve privacy and dignity for all patients, and provides a state-of-the-art environment for staff to provide care for some of the most vulnerable patients who visit UHL.

As part of this plan, the ambulatory service will also move into a dedicated space on the 'hot floor'. Meaning that more patients who are referred from their GP to the hospital will now be able to bypass ED by going directly to the ambulatory service.

What unexpected barriers have you come across? How have they been resolved?
Change is not easy; and moving into a new environment has not been simple. This has required lots of work by the teams to adopt new ways of working appropriate to a modern emergency department. There has been on the ground training, familiarisation sessions in each area, and coaching with teams to support the move. The staff have worked tirelessly to support each other to embed those changes.

Across the Trust, there has been a focus on the whole hospital response to our current poor performance; ensuring that everyone plays their part in improving the experience patients receive in hospital. This has been particularly positive for patients who need geriatrician and/or medical physician care. Specialty doctors have been working within the ED footprint, seeing patients as they come through the 'front door', often reducing the need for patients to be admitted to a bed, and starting a treatment plan almost immediately.

Ensuring there are enough staff remains a challenge; Staff are being asked to do more, and continue to rise to the challenge in often very difficult circumstances. Intensive recruitment continues across all areas of the hospital, as well as workforce reviews to look at varied roles and creating a flexible workforce to meet the current demands.

What would you have done differently?
Of the actions and ideas that were tested over the two week Surge, taken from national best practice and learning from other Trusts, some had more impact than others. The increase in senior doctors overnight is a good example of where marked improvements were seen in performance as a direct result of this action. Further work over the next four weeks will focus on tailoring other actions to the Trust, to ensure they have an impact on processes and flow of patients.

What is the relationship with GP's and other health professionals making referrals to A&E?
The Trust continues to work with local GPs and Clinical Commissioning Groups to reduce the number of people coming to the ED.

The GPs who work at the ED 'front door' provide a valuable primary care service to those patients who need it.

We are working closely with our GP colleagues to look at inappropriate referrals, making best use of hub availability across both the City and the County. We are also trialling in October having some primary care coordinator support at ED reception to help 'deflect' patients to alternative providers of care.

We also recognise that we see a regular spike in attendances on Mondays and this reflects a national picture. The increase is most pronounced in 'walk in' ambulatory patients so we are working with CCG and GP colleagues to look at how this can be

mitigated by extending hub access over the weekend to ensure patients are not waiting until a Monday morning to seek treatment.

Feedback from users

In summer 2017 the Trust welcomed colleagues from Healthwatch who spent time in the new ED talking to patients about their experience of our service. As ever the HW findings were incisive and contributed to our understanding of the services we provide. Since then we have acted upon a number of the recommendations from the report, including increased signage both in and outside of the ED, and putting a hot drinks machine into the main waiting area.

As regards direct patient feedback, the recent Friends and Family Test scores show UHL as the top rated acute hospital within the region with 95% of patients recommending the care that they received. This is a huge achievement and one that the team ED is rightly very proud of. Nonetheless, all Trust colleagues who daily work in, or with, our emergency department recognise that our current performance as measured by the 4 hour target is unacceptable and are therefore committed to resolving this issue for the benefit of our patients.
