Report to:	TRUST BOARD – 25 APRIL 2013

Enclosure 5

Title	Patient Flow Sustainable Action Plan
Sponsoring Executive Director	Debbie Kadum – Chief Operating Officer
Author(s)	Ian Donnelly – Asst Chief Operating Officer Unscheduled Care
Purpose	To inform the Board of the internal plans to improve performance against the 4 hour target.
Previously considered by	

Executive Summary
The Trust has failed to deliver the 4 hour target since July 2011. This cannot continue and whilst we are working with the Local Health Economy on new models of care there are improvements that can be made internally to improve patient flow and improve performance against the 4 hour target. This remedial action plan outlines the short, medium and longer term actions that need to be taken. Further work is needed to identify the percentage improvement in performance that these will deliver.

Related SATH Objectives	SATH Sub-Objectives
Providing the best clinical outcomes, patient safety and patient experience. Delivering consistently high performance in health care standards.	QS7, QS9, HS1, HS2, HS3

Risk and Assurance Issues (including resilience risks)	Non compliance impacts on FT application.
Equality and Diversity Issues	No
Legal and Regulatory Issues	No

Action required by the Trust Board
The Board are asked to note the contents of the action plan and raise any concerns for discussion at the Board meeting.

INDICATOR INFORMATION AND ACCOUNTABILITY			
Key Performance Indicator	**Total time in A&E (95th percentile)**		
Lead Officer	**Ian Donnelly**	Executive Director	**Dr Kevin Eardley**

PERFORMANCE DATA				
IN-MONTH PERFORMANCE	IN-MONTH TRAJECTORY/TARGET	**YTD PERFORMANCE**	**YTD TRAJECTORY/TARGET**	***END OF YEAR FORECAST RISK RATING*** *(Low/Med/High)*
SaTH wide	**90%**	**SaTH wide**	**95%**	
RSH	**88%**	**RSH**	**96%**	***96%***
PRH	**92%**	**PRH**	**97%**	***97%***

WHY IS CURRENT/PROJECTED PERFORMANCE NOT ON TARGET?

During 2012/13 SaTH made progress in attempting to reduce the number of breaches of the 4 hour access standard, but failed to meet or exceed it during the whole year. This is a trust patient safety target that focuses on patients' care when patients' are normally at their most vulnerable point.

The performance of the trust has dropped month on month and we failed to achieve the final quarter access standard was missed with a year-end position of 85.87% This is an extremely disappointing position for both Site Teams' and key specialties, the key causes of which are listed below.

- Activity increase of 698 attendances 2.68% above same period last year.

- On occasions the ED departments have been holding upwards of 12 DTAs in the department and can be over capacity until very early morning even into the afternoon.

- Modelling shows 4 hour performance to have a direct relationship of patient volume and exit route block. I.e. 100+ patients breach due to no downward capacity this is an excessive number of breaches, even if there are beds in the system.

- Increase in long waits and breaches of the 12 hr safety target.

- During times of surge/high demand response from specialties, particularly out of hours is variable with regard to pulling patients directly to assessment units or coming down to the department to see patients. This has improved but still adds to the breaches.

- RSH does still not have the correct number of medical beds to support medical demand, the use of flex wards has supported the site, these wards are now permanently funded wards. SaTH does not have any available surge capacity.

- Patients bedded in Non Ward based area such as day case add to LOS problems as Medical teams are completing safari ward rounds.

This action plan aims are:

-To update the CEO/COO on actions and provide future updates
-Identify further work streams to improve performance
-Reassure the CEO/COO that all aspects of performance are being addressed along the whole pathway
-To give a commitment to sustained delivery of the 4 hour standard.

REMEDIAL ACTIONS

	Action	Executive Lead/ *Operational Lead*	Target Completion Date of Action	How & why this action will make a positive difference? What risks are associated with this action?	Anticipated improvement in numbers/percentage as a direct result of this action (e.g. 50 more patients treated)	Status (including actual completion date of action)
SHORT TERM - within 90 days – *priority actions designed to address performance immediately*						
1	Install an electronic system fit for purpose within all assessment areas.	Ian Donnelly Kerry Malpass/ Rachael Redgrave	July 2013	Currently within ED and Assessment areas, patients arrive and are admitted onto a dummy tracking system. This system has no visible performance information or data on where the patient is in the journey. A new IT system will provide true real time electronic information, for site/strategic performance and clinical management of patients.	This will allow a full overview of all assessment areas, it will provide electronic visual performance management and clinical system, it will also provide additional benefits including an electronic live coding system.	Waiting Outline Business case.
2	Implement electronic referrals between ED and AMU to eliminate the need to call and verbally handover patients between the two areas, this will be part of the new ED electronic system.	Kerry Malpass/ Rachael Redgrave	July 2013	It can take 0-30 minutes to handover patients from ED to AMU due to the AMU co-ordinator not being available or in handover. This delays ED clinicians in getting on with the next task. If handover is not done properly there may be on a potential risk to patient care.	Will release approximately 10 minutes per patient referred. Department refers c 30 medical patients over 24 hrs which equates to c5 hrs of clinician time taken up in referring a patient which can now be used in direct patient care.	Need to agree trial in July ahead of the new doctor change over in August.
3	Revision of escalation process to ensure specialty input is available to the ED during time of surge in hours and out of hours. Embedded previously agreed protocol of referred patients being seen in assessment units unless critically unwell.	Kerry Malpass/ Rachael Redgrave	April 2013	A recurring performance issue is the unpredictable surge (high numbers of patients registering each hour in ED); this is compounded by GP arrivals into ED. The proposal is to have inpatient teams respond to this surge by either pulling patients out of ED before being seen in the assessment units or specialty teams seeing patients directly in the department to reduce arrival to clinician time and therefore decision to admit or discharge. No GP referrals will be accepted in ED. Instead of coming to ED. AMU/SAU will take all GPs and not redirect to ED. This practice is to cease on AMU/SAU with the reconfiguration change.	If patients are pulled out by specialties to be seen in their own areas (previous experience) that will save c1.5hrs per patient of ED clinician time plus frees the cubicle for another patient. If patients are seen in ED by the specialty team, then it enables the ED teams to move to the next patient, therefore keeping up the momentum in time to clinician, time from arrival, during a period of surge. Rigorous approach to patients being referred and seen in assessment units should also reduce specialty breaches.	Discussion with specialities to take place, AMU and SAU to agree non redirect of GPs.

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4	Review the role of the ED co-ordinator/ band 7 and relationship with the clinical site manager (CSM).	ED/AMU Matron and Site Lead Nurse for Capacity	May 2013	The presence and support from CSM into the department can cause confusion over responsibilities for departmental process between ED senior sister and the site team. ED need to take ownership of the 4 hr breach target and seek support via agreed escalation.	This should reduce the number of breaches between through more established and defined co-ordination / role definition / escalation and support.	ED band 7 and CSMs to agree way of working within escalation framework.
5	Carry out full restructure of Unscheduled/Scheduled Care across ED and AMU aligning management and clinical support in all areas.	Debbie Kadum Ian Donnelly Sara Biffen	April/May 2013	This will ensure true escalation and ownership by management and clinical teams. It will define responsibility for each part of the pathway specifically with regard to patient flow.	Each site will see improvements in a number of areas which will support flow. The increase in targeted approach to discharge and accountability at every level will ensure patient safety is at the forefront and that flow is maintained across the site(s).	Currently confirming full HR process and agreement.
6	Ensure all patients have a Consultant derived EDD/PDD within 24 hrs of admission which includes criteria/plan for discharge.	Kevin Eardley / Margaret Barnaby	April 2013	Once patients are admitted into specialty / gen med wards the application of a Consultant led EDD/PDD with criteria for discharge is patchy. Weekend discharge numbers are still poor in relation to weekday and potential discharges are low.	Uniform introduction of a consultant led EDD/PDD for each patient with clearly defined parameters for discharge will improve discharge numbers particularly over the weekend periods. This supports flow on the individual days and will prevent the site from going to extremis on Sunday / Monday.	This will be supported by the roll out of JONAH.
7	Introduction of internal CQIs for acute medicine which are reported and monitored by site.	Kerry Malpass/ CD for ED/Acute Med	May 2013	CQIs for acute medicine, which document certain professional standards on time from arrival to decision maker and from arrival to consultant, review. Meeting these standards as a minimum will inevitably bring within it an enhanced level of productivity as decision making will be occurring more quickly with senior input earlier in the patients' journey.	Patients are seen within 2 hours of arrival and reviewed by a consultant within 4 hours (Daylight hours). Meeting / exceeding these standards will support a reduction in the current average cycle time. Linked to Action 10 and 11.	This will be linked to AMU/SAU swap and AMU working as a functional assessment unit with defined short stay separate.
8	AMU/SAU Swap RSH	Kerry Malpass/ Rachael Redgrave/ Pete Gordon	29 April 2013	Agreed swap AMU to SAU, this would allow AMU to function as a true assessment area and would then create a CDU of 9 beds managed by ED. The 20 assessment beds split 8 Male 10 female and 2	As part of the Medicine bed reconfiguration across the RSH site this would improve flow and define pathways, linked to Action 9 and 11.	Agreed between Unscheduled Care and Scheduled care with a complete

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				side rooms would allow targeted approach to admission avoidance, reducing unnecessary admissions' and improving patient flow from ED. In line with this swap all GP arrivals would be facilitated in AMU and SAU with no diversion to ED accepted.	The criteria for CDU will be defined with key pathways in place to support.	action and communications plan to be implemented.
9	Ward Swaps	Hazel Davies/ Pete Gordon	29 April 2013	Ward 22E to Ward 28, Ward 28 to Ward 22E this will give a net gain of 13 beds. This will become the Acute Medical Short Stay 20 beds and 18 Gen Med. Renal and Acute Medical physicians will provide the medical cover. Therapy will provide a REACT service that is rapid response and able to deliver 7 day working to ensure patients' stay does not exceed 5 days on average. Support will be required from the LA and DLN teams to ensure parallel discharge planning.	This development in the Acute Medicine plan will support that of the AMU assessment area, providing direct flow to the short stay beds. Only patients' identified by Acute Med consultants' will be admitted into the 20 beds. A discharge target for these 20 beds will be set at 4 per day, with an additional 3 for the other 18 beds providing a high turnover ward.	Agreed between Unscheduled Care and Scheduled care with a complete action and communications plan to be implemented.
10	Additional Ward Swaps	Hazel Davies/ Pete Gordon	29 April 2013	Ward 25 18 beds becomes Gastro and remainder Colorectal and ward 27 becomes completely respiratory - Net gain 22 beds. This will support the problem of respiratory outliers and ensure focused targeted support for all Respiratory patients.	The team will be able to remain on the ward and will ensure no time is lost doing ward rounds in many areas. All specialists, medical, nursing and therapy teams will be able to target early support and improve recovery.	Agreed between Unscheduled Care and Scheduled care with a complete action and communications plan to be implemented.
11	JONAH	Mags Barnaby	April/May/June 2013	Implementation of JONAH theory of constraints across all wards will allow for the ability to identify internal queues for diagnostics/referrals/therapy and to increase discharge rates with the ability to manage flow across the site better by early identification and escalation of external queues. The check, chase challenge will ensure that ward managers know what is preventing patients from being discharged. Escalation at site level to an Executive Director will ensure ownership to at	Improvement in discharge planning and consistency demonstrated by the knowledge that no patients' remain who could be discharged. Knowledge that all patients' discharge process are managed in a parallel working pattern.	Currently an implementation plan being agreed and a roll out will take place during the latter part of April. Success is linked to the development of leadership roles focusing on patient flow.

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				Executive level.		
12	Back to Basics	Deputy Chief Nurse/ COO/ MD	April/ May 2013	Roles and Responsibilities of nurse leadership roles including Matrons, Ward Managers, and coordinators within assessment areas, focusing on what they should do to support flow and discharge. They will also provide a daily update at the first site safety meeting ensuring the following is covered: • Staffing • Safety • Flow Doctors will also be targeted and this links to action 6. They will also ensure that full discharge action planning has taken place as per action 11, this will allow the development of action 13.	This will ensure that as part of the metrics for ward management and assessment area function planning and flow are at the top of ward priorities.	To be agreed at Senior level meeting between Ops, Nursing and Medical leads.
13	Nurse facilitated / Event led discharge	Deputy Chief Nurse Head Nurses, Care Groups, Medical Directors and Associate Medical Directors	April 2013	A model of nurse facilitated /event led discharge to be implemented across both sites. This will allow consistent discharge planning and maintain flow. It will support the development of 7 day discharging across all areas. It is, and will be completely reliant on consultant engagement and leadership.	This will ensure more robust discharge process and support 7 day planning. This will provide true ward team cohesion and agreement of patients' discharge plans.	To be agreed.
14	Creation of a CDU	Kerry Malpass/ Rachael Redgrave, Medical Lead for EDs	29 April 2013	Linked to action 10, a CDU will allow development of true CDU pathways (observational medicine) and ensure admission avoidance schemes are implemented. THE set up of CDU will need a targeted REACT therapies service and an elderly care front door service which will be part of the frail and elderly pathway that will support admission avoidance and will link community teams as part of in reach.	A development of CDU will ensure patients' are given the ability to be assessed and observed away from ED and support breach prevention.	Delivery expected 29 April.
15	Provide short term capacity	Debbie Kadum / Margaret Barnaby	29th April 2013	The Trust does not have sufficient in-patient beds to meet demand (confirmed by ATOS) which compounds its ability to deal with any surge in	Additional 20 beds per week	Plan agreed with Shropshire CCG, LA, Community Trust.

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				activity. Short term capacity needs to be put in to address this whilst medium and longer term strategies are being agreed to achieve this.		
16	Ambulatory Care	Kevin Eardley / Hazel Davies / Kerry Malpass / CD for Assessment	May 2013	Ambulatory care is delivered across many areas it is a splintered approach with seemingly no overriding plan has been agreed. The team will work with commissioners' and deliver a true ambulatory care model.	As part of the development on each site, increase in attendance into ambulatory care and admission avoidance will improve flow and allow interface working relationships between primary and secondary care.	A current model is already in place. This will be supported and enhanced with an improved model of care, starting in May 2013.
17	Redefine AMU and SAU pathways with GPs direct to AMU and SAU and not diverted to ED	Kevin Eardley / Hazel Davies / Kerry Malpass / CD for Assessment	April 2013	This action supports the previous ward and AMU/SAU reconfiguration and allows ED to deliver true emergency care at the point of need and not have to deliver support to medical and surgical referred patients'.	This will support flow across the sites and prevent EDs being blocked up with Acute Medical and Surgical patients.	Developed as part of the ward and AMU reconfiguration.
18	PRH Ward 12	Kerry Malpass / Rachael Redgrave / CD for Assessment	May 2013	Remain as a medical ward but transferred to a short stay AMU 2 function, supported by acute med physicians in line with action point 11.	Increased discharges on a short stay ward through targeted support will enable and improve flow.	TBC
19	Match Nurse Rotas to Demand	Kerry Malpass / Andy Aldridge	June 2013	At the recent ATOS event, the work completed by the ATOS team clearly showed that the rotas within the ED do not match the demand. The rotas are to be reviewed and must include the ENPs and HCA teams to show the full capacity against demand.	This will ensure that the demand is met with a consistent workforce and ensure that staff are able to work in a safe sustainable manner.	
MEDIUM TERM – 3 months plus						
1	Review medical workforce within acute med so it becomes compliant with College guidance on consultant input seven days per week to ensure patients are reviewed by a consultant within 14 hours of admission to an assessment unit.	Kevin Eardley / CD for Assessment	July/ August 2013	Will allow review, assessment and improved discharge over a 7 day period. Increased senior decision making within the AMU at weekends will ensure rapid progression of patients undergoing onward medical care resulting in correct diagnosis and treatment. This will also optimise Length of Spell. This development will require integration with hospital @ weekend which will ensure review in the event of a deterioration in condition and timely discharge.	Reduction in variation between weekday and weekend admission / discharge numbers to make the weekends akin to weekday with regard to senior clinical input.	On-going. Baseline assessment already undertaken by previous management structure, to be picked up by new team.

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2	Medical Day Unit	Kevin Eardley / Hazel Davies	August 2013	A medical day unit on the RSH site will allow improvement in discharge planning allowing patients to come back to respective clinics' with particular focus on the frail elderly/patients with dementia and linking in the RAID service.	This will support early discharge practices as patient will have the ability to continue any health care in a secondary care environment as an outpatient.	To be discussed with Commissioners
3	Reconfigure Stroke	Suzy Thompson / Hazel Davies	June 2013	The current stroke service is across two sites, as part of the stroke review it was agreed that centralisation of specialised services was needed to ensure that optimum care was provided for patients. This is in line with the regional stroke review. The current medical workforce is struggling to appoint to vacant medical posts to support Stroke on 2 sites, shortly we will have to.	One site needs to be the focused support for acute care provision for stroke services, this will increase turnover and speed up the acute phase of recovery.	Medical teams briefed, decision needs to be taken as part of the Clinical Services Strategy
LONG TERM – 6 months plus						
1	Review ED clinician rotas to respect the known seasonal variation in attending with higher activity during the summer months of May, June and July	Kerry Malpass / CD for Assessment Kerry Malpass / CD for Assessment	August 2013	As part of the ATOS work, it was identified that the current rotas do not match the demand across the hour of day and day of the week. This is both medical and nursing. A review with new rotas to match demand to be agreed and implemented to ensure workforce meets patient demand.	This should allow improvements in response time within ED and ensure that flow is maintained especially at heightened demand.	Data confirmed
2	Development of an Advanced Care Practitioner programme	Kerry Malpass / CD for Assessment	September 2013	Development of a robust ACP model will provide a more coordinated level of support for the junior doctor rota. When fully trained, this will improve consistency of the junior doctor tier, improved nursing recruitment and retention. Development of the ED staff and has been shown to underpin clinical safety as a direct result of this model.	This is a tried and trusted model of staff development used in acute trusts across the country and should be implemented without fail.	TBC
3	Agree the strategy for Cardiology	Hazel Davies	September 2013	The current PCI pathway has patients being transferred to centres such as Stoke for PCIs. As part of the process, patients can wait up to 5 days to be transferred.	Reduce cardiology waits reducing length of stay.	TBC

PREDICTED PERFORMANCE TRAJECTORY

Based upon the above detailed actions, complete the trajectory below to show the level and timescale of expected improvement between now and the end of the year.

April - forecast	May - forecast	June – forecast	July - forecast	August - forecast	September - forecast
85%	93%	95%	96%	97%	95%
October - forecast	**November - forecast**	**December - forecast**	**January - forecast**	**February - forecast**	**March – forecast**
96%	96%	94%	93%	94%	95%

WHAT ARE THE RISKS AND OPPORTUNITIES?

What issues/factors may adversely impact on performance and stop the target from being achieved? What is being done to manage these risks?

- On-going surge in activity without the seasonal downturn post March which has been seen in previous years.
- Regional '111' project increasing demand to EDs TBC
- On-going difficulty with other site, with diverts to PRH
- Specialty / site savings programmes!
- Instability from current structure/ re-structure with key personnel changes at a time of "challenge" particularly in relation to key changes amongst the site teams.
- Engagement of health and social economy to manage the speed of change required to move patients' into the community

SIGN OFF

Lead Officer	Ian Donnelly	**Signature**		**Date**	19th April 2013
Executive Director	Debbie Kadum	**Signature**		**Date**	19th April 2013