Cover page	
Meeting	Trust Board
Paper No.	18
Paper Title	Improving ED Performance
Date of meeting	7th February 2019
Date paper was written	31st January 2019
Responsible Director	Nigel Lee
Author	Nigel Lee, Chief Operating Officer Sara Biffen, Deputy Chief Operating Officer Carol McInnes, Assistant Chief Operating Officer (Unscheduled Care)
Executive Summary	

The urgent care performance for SATH has remained well below national targets and the operational plan trajectory for 2018/19. This paper describes the background of last 12 months including the workforce challenges but also the current programme of work, noting how the Trust is accessing support from national experts, and using the SATH improvement methodology to drive improvement.

The current performance and the nature of demand and delivery is outlined.

The document describe the key themes and challenges that SATH faces to be able to deliver a satisfactory level of performance, all of which play a part in the challenges, and all will need addressing to a degree to improve our performance. The themes include: Workforce; Capacity; Demand; Flow & processes; Pathways; Leadership & culture and IT enablers.

Finally the paper notes the interim objective to achieve over 80% performance on a consistent basis, as well as looking ahead to longer term sustainability.

The aim of the paper is to summarise the challenges to improving ED performance, and to support the discussion and prioritisation as part of the Trust operational plan and strategy.

Previously considered by	Trust Board, with all three Board Committees having played a key role in understanding performance, quality & safety, finance and workforce aspects of urgent care delivery pressures.

The Board is asked to:			
☐ Approve	☑ Receive	☐ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare
	☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care
	☑ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities
	☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions
	☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	Noted on the BAF and operational risk register.

Equality Impact Assessment	⦿ Stage 1 only (no negative impact identified)
	○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	⦿ This document is for full publication
	○ This document includes FOIA exempt information
	○ This whole document is exempt under the FOIA
Financial assessment	Yes, as part of operational planning.

Main Paper

Situation

The urgent care performance for SATH has remained well below national targets and the operational plan trajectory for 2018/19. There are a number of factors affecting the performance, not only in the Emergency Department (ED), but also in the wider Trust and indeed across the health and social care system. A number of measures, such as the numbers of super-stranded patients (those patients with a length of stay over 21 days), show good performance. However, performance against the 4 hour ED measure is one of the lowest in England, and the Trust is committed to improving this performance, and in parallel improving the service to patients and families.

This paper sets out the background of the recent and current work programme of improvement, briefly notes the current performance and high level analysis, and sets out the key themes and constraints which currently influence performance. The Trust is fully aware of these factors, which are both complex and interdependent, and considerable work is underway to address the issues.

Background

Throughout FY 18/19, SATH has experienced significant challenges on urgent care performance, alongside existing and changing workforce pressures in the Emergency Department (ED) medical and nursing staff. In addition, other specialties have pressures which impact on ED, with Acute Medicine becoming a greater factor in Q3. The Board is fully sighted on the challenges during 2018, with extensive whole region involvement, the Board decision in September to begin planning for reduction in hours of one ED, as well as the decision to maintain services in November. Workforce constraints were at the heart of the concerns, but the programme of work also took up a great deal of managerial and clinical capacity. Leadership time has been released to focus on broader improvements on urgent care, and additional support has been brought in.

During the year, under the system leadership of the A&E Delivery Board, SATH has worked on the 6 high impact change workstreams; these have been further translated and focused within SATH under the leadership of the Urgent Care Operational Group, which is a multi-disciplinary group meeting weekly, and specifically manages the following workstreams:

- ED Systems and Processes
- SAFER/Red 2 Green (Standard work Value Stream)
- Stranded Patients

The wider system leads on capacity & demand, integrated discharge team and frailty workstreams. The governance framework for the SATH Urgent Care Operational Group is attached at Appendix 1. The Group receives 'flash report' updates each week, notifying on progress against key objectives, and identifying performance against agreed metrics. Examples of these reports are attached at Appendix 2.

During Q3, the national Emergency Care Intensive Support Team (ECIST) has been allocated to support SATH on a variety of pathways, some to compliment the workstreams noted above, but also to advise on any further areas of concern and challenge. Two key additional projects added are: Ambulatory Emergency Care pathways and models, and weekend working. ECIST have supported the Trust with visits by clinical experts, and provided reports to highlight proposed areas of work. These additional areas of work have been reviewed and added to the programme of work, and are also managed by the Group. The 2 main reports are attached at Appendices 3 and 4. ECIST have also supported capacity and demand analysis.

The importance of the urgent care flow and performance challenges is also recognised by the inclusion of 2 key areas as Value Streams as part of the Transforming Care Institute's programme. The Standard Work value stream is the second stream that SATH undertook, and is now led and

managed by the Care Groups; the ED value stream began in Q2 18/19 and has already taken on some key issues such as Minors and Ambulance handover.   Brief summaries of the 2 value streams are also attached at Appendix 5.

As a result of internal and wider system work, SATH has a sound knowledge of the factors affecting urgent care performance, and a better understanding of the elements which the Trust will lead and those that require wider system action.

Assessment

Performance analysis

The latest 4 hour performance data, taken from the Month 9 performance report, is attached as part of the monthly performance report which is briefed at the Performance Committee and forms part of the Board papers. Whilst certain elements show some change (such as an improvement in performance on Minors by location – ie those patients treated in the minors section of ED), the performance overall has not improved during 18/19, and indeed has deteriorated during Q3. Ambulance handover delays, over 15 minutes and those waiting over an hour, also remain higher than target. And, whilst the quantity is significantly less than winter 2017/18, the Trust has also seen a small number of 12 hour breaches during January 2019. The performance indicators demonstrate a variety of challenges, and also indicate both process and flow pressures.

A 'typical' 24 hour period in the ED is shown below (both sites have a similar profile).
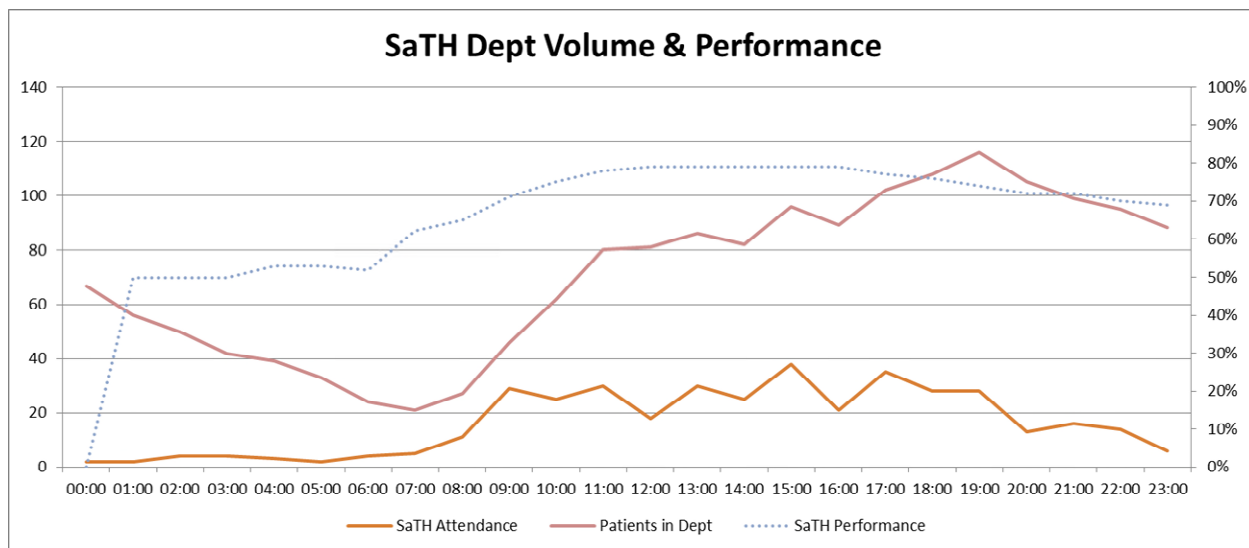
Both sites have an average of 50 patients in the department from 16.00hrs – 23.00hrs compared to an average of 38 from 09.00hrs – 17.00hrs. Arrivals (attendance) are higher after 1200, with the overall number in the department rising from 1000 and peaking in the early evening. The nature of activity varies depending on the day of the week and time of day; minors demand tends to be higher after lunchtime and into the early evening. In sum, pressure builds during the day.

The daily number of ED attendances is 350-400 across the 2 sites, which are broadly made up of 2 categories – admitted and non-admitted pathways.

Circa 20-25% of the total patients are admitted pathways (ie those needing a period of care in a clinical decision unit, acute assessment unit or specialty ward beds). The pressures on patient flow mean that admitted 4 hour performance is running at no more than 50%, with some days lower than this. This constitutes 50-60 breaches per day.

The remainder are 'non-admitted' patients, with up to 75% of the total activity. The non-admitted performance normally runs at 80-85%, but this group also constitutes 50-60 breaches per day. Non-

admitted pathway breaches occur for a variety of reasons, but include:

- patients planned for admission without bed capacity available, who remain in ED with treatment for a period of hours resulting in discharge from ED.
- Delays to be seen in ED, especially with lower overnight staffing capacity, but also at times of peak demand.

Within the overall non admitted total, circa 100 patients are Minors; this group is now running consistently at 95% performance.

There are also patterns of demand that are predictable, with times of day, and days of the week that present greater pressure. Whilst predictable, these remain difficult to manage and mitigate. Overnight staffing remains lower than the day, and surges in demand will be more difficult to manage (SATH has one middle tier doctor in ED per site); Sunday and Monday are also the busiest days for demand, coinciding with the weakest position in terms of available bed capacity. Ambulance demand also has peak times of activity; for example, the table below for 2018 (April to December) shows that 39% of arrivals at PRH take place between 1400 and 1800.

Ambulance handover example

PRH

Month	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
Apr-18		1	1					1	2	1	2					1	2	1	2	1		1	2	
May-18	1	1			2						1		3	2	2	8	9	1	1	5	3	3	5	4
Jun-18		3	1	1				1	1	2	1	2		1	2	3	11	5	3	2	5	3	1	
Jul-18	3	1			2			1			1	2	2	2	3	5	4	8	2	3	2	5	7	3
Aug-18	1						1		1					2	5	2	7		1	2	1			2
Sep-18	1								3	3	1	3	4	9	3	11	8	3	1	5		1	6	5
Oct-18	2	1		1				2	1	1		3	4	14	13	7	9	13	5	11	5	8	12	5
Nov-18		2							3	1	3		4	10	11	10	13	11	3	5	8	4	12	5
Dec-18	2	3		1			1		1	2	9	5	7	14	11	11	18	20	9	7	12	10	2	9
Total	10	12	2	3	4	0	2	5	12	10	18	15	24	54	50	58	81	62	27	41	36	35	47	33
	2%	2%	0%	0%	1%	0%	0%	1%	2%	2%	3%	2%	4%	8%	8%	9%	13%	10%	4%	6%	6%	5%	7%	5%

39%

This is the % of arrivals between 2pm - 17:59pm

Themes and Constraints

Workforce

The medical workforce concerns in ED have been well documented, and were the primary driver for the extensive work carried out during Q2 and Q3 2018. The latest update on ED workforce is attached at Appendix 6.

The substantive consultant numbers are slowly increasing, bolstered by the announcement of the £312M reconfiguration capital, but only number 7 individuals as at the start of February 2019. We also have 3 locum consultant staff. This remains lower than the RCEM recommended number and the SATH clinical view. For the middle tier, there has been an increase in the numbers, but the reliance on variable locum staff (for reliability and clinical competency) remains a concern; it should be noted that only 1 middle tier doctor is on duty overnight per site (with SHOs), and there is inherent risk to performance if demand rises, or clinical urgency takes precedence. As staff numbers rise, the department is updating the alignment of staffing to the activity pattern, but recruitment of medical staff remains a high priority. The national advice is to match the medical workforce to the arrival time for patients

The ED nursing workforce is also pressured and has vacancies; the ratio of agency versus substantive staff is closely monitored, and whilst there is greater use of long term agency booking to reduce risk, agency staff remain less reliable. Furthermore, using national benchmarking, it is recognised that the seniority of the ED coordinators, the skill mix, and the overall numbers of staff (including overnight to

manage the activity) require an updated establishment and investment. As with medical staff, the staffing must align with the sections of the ED, and provide sufficient capacity to manage the level of activity.

Both medical and nursing workforce capacity and expertise in ED are fundamental in achieving timely patient assessment and treatment. However, there are a number of other workforce pressures that are pertinent to the urgent care performance:

- Acute medicine capacity including Ambulatory Emergency Care (AEC). This service can be run with a combination of acute physicians and GPs. The current establishment of doctors is 8.5 WTE, with some fragility in the current workforce. However, this does not fully meet the 5 day service needs we currently provide; additional capacity is required to not only provide the service over 7 days, but also extend into the twilight period (which coincides with peak levels of referral demand from Primary Care). The Unscheduled Care Group, working with national experts, is reviewing the options for the operational model of care (including combining with a frailty service) as well as how to combine functions in one area. However, investment in staff and recruitment will be required to increase the service.

- Wider medical specialty consultant capacity (including greater in-reach to ED and 7 day cover). A number of specialties could contribute to greater specialty support to ED; Respiratory capacity would be an immediate priority. Further work is needed to confirm the broader service demand, and identify optimum staff models to cover ED, wards as well as outpatient and other service demands. However, a number of specialties are not currently able to provide services across 7 days.

Demand

The 18/19 operational plan was based on a level of demand seen in recent years, and the expected demand was used as the basis for the winter plan. The growth through the course of 18/19 has been higher, with the latest figures showing a year-on-year increase (M1-9) for non-elective admissions only of 7% (excluding PRH CDU activity). Ambulance demand has increased, with January 2019 activity between 10 and 15% higher than last January, with particular increases on Sundays. Attendances overall to ED have also increased by circa 10-15% (although there has been increased use of the Urgent Care Centres this year, with the new facility at PRH open and functioning).

Management of demand is notoriously challenging, but further work is needed with Primary Care and Clinical Commissioning Groups (CCGs) to better understand the nature and patterns of the demand, and with the West Midlands Ambulance Service (WMAS) to understand the drivers for increase in ambulance numbers. This analysis would enable not only a better matching of staffing to peaks in activity, but also allow SATH to plan capacity accordingly. In addition, the CCGs will be able to consider alternatives to acute care, as part of 'Care Closer to Home' and 'Neighbourhood' community resource team service planning for a range of services, including out of hours, for patients that currently access ED. More redirection of activity will be required.

Physical Capacity

The Trust is also aware, reinforced by external visits and reviews, that capacity in ED and Acute Medical Assessment Units (AMUs) is less than required. Whilst the future configuration of the hospitals will provide a sustainable plan, in the meantime options to increase ED capacity at the Royal Shrewsbury Hospital (RSH) site are underway (with conversion of retired theatres space into a Clinical Decisions Unit). The CDU at Princess Royal Hospital (PRH) is staffed for 12 hours at present, and the nursing workforce plan is aimed at upgrading this to 24 hours.

Acute assessment capacity for medicine remains below the level required, according to recent analysis; in addition, within this cadre, there is potential for a greater volume of ambulatory emergency care (AEC) patients, which are also constrained by capacity (albeit also by staffing resource).   The plan to introduce extra capacity on the RSH site (ward 35) and the developing plan to increase

capacity at PRH will both support expansion of AMU and AEC services.

The detailed capacity and demand analysis as part of the 2018/19 operational planning, and system winter planning illustrate the shortfall in overall acute bed capacity, especially at the PRH site. The RSH site has seen a greater beneficial impact of the 'stranded patient' workstream, with reduction in LOS and bed days utilised, and with the support of national capital funding, RSH will benefit from an additional 30 beds from February 2019. PRH retains a predicted capacity shortfall during the winter months, and requires additional capacity (an extra ward) if the demand remains at planned or future increased levels. Both sites have been impacted by the demand growth during December 18 and January 19; at RSH, this has offset the benefit seen by reduction in LOS. Both sites have utilised the day surgery units as overnight bed capacity during winter 18/19.

It should be noted that the internal and system improvement work on stranded patient reduction, and the work of the system integrated discharge team have seen the numbers of patients over 7 days significantly lower than last year, and remain at this level during the winter. The number of patients on the system 'medically fit for discharge' (MFFD) list was also set at 70 for this winter (versus 110-120 last year); this has also been maintained. The work of the CCGs, Shropshire Community Trust, Powys Health Board and the Local Authorities have combined with SATH to achieve this.

Flow and Process

Further work is needed on all the main workstreams which form part of the Urgent Care Operational Group.

For ED, the presence of more substantive consultants should not be underestimated, and overall performance, quality of care and leadership of process and daily rhythm will all be enhanced. Nevertheless, consistency in daily processes, working on performance analysis, and liaison with the wider Trust specialties to maintain standards of support are all necessary.

For the ward flow, some progress has been made, and new ways of working including production boards and daily afternoon huddles are in place, and together with broader work on stranded patients reduction, the length of stay (LOS) has reduced. SATH compares well on overall LOS, and is now in the top 3 Trusts in England for improvement in 'super-stranded' patients (those over 21 days). The Standard Work Value Stream steering group meets every 2 weeks, with operational and clinical leads from all care groups and owns the programme and the changes. The Trust's 'standard work' methodology of improvement fits well with the ward 'daily rhythm required', and a number of qualified 'lean for leaders' are involved in directing the work. The operational teams have reviewed the work delivered to date, and updated the priorities and actions for the next period. Nevertheless, some aspects remain below target: Discharge before 1200 is a priority area, and all wards have targets; surgical wards have improved more quickly but still remain at circa 20% and below the national target of 30%. The improvements in the afternoon ward huddles have been one key driver of this change, although full multi-disciplinary attendance at the huddles and board rounds remains variable given some workforce fragility. The process needs ward leadership, but involvement from senior medical staff and their team, plus allied health professionals. The consistent use of the discharge lounge to create early flow has also improved, but again needs ongoing communication (and indeed during January has moved location to create additional bed spaces).

The process of setting a plan of care, with an expected date of discharge and criteria for discharge (to be carried out where appropriate by nursing or non-medical staff) remains variable. Different methods have been used in the clinical teams, alongside external support and advice on best practice. Despite continued Medical Director involvement, this aspect requires further focus in 2019, and the COO, MD and DONM will collaborate on this. The process of completion of the discharge is also being revisited, and pharmacy staff and other departments are included in the ward standard work meetings. Completion of the discharge documentation by the doctors also remains variable, leading to less timely pharmacy and other profession action and where necessary booking of transport, with resulting final discharge delays.

Flow, and clinical involvement in the timely and well-planned discharge, remains a significant factor in

the Trust's ability to manage the demand, and some processes are not fully delivered across 7 days due to factors outside the ward's control. The Trust completed a weekend 'multi-agency discharge event' (MADE) in November, and a number useful lessons and actions were identified. This includes the plan to change the level of admin support to the site management teams at the weekend, to enable more complex discharges and transport issues to be progressed. In additional, some medical specialties 'hand over' on Sunday/Mondays, creating inevitable delays on Mondays with full reviews, as well as lower potential for discharge at the weekend. The Care Group medical directors are reviewing this, and some specialties already change mid-week. However, a number of specialties do not have the level of staff required to support services across 7 days. Plans are in place to address the process issues, and options are being considered for staffing where relevant, including as part of operational planning for next year. This area also needs careful integration and planning with partner organisations that support flow, such as the Community Trust and Local Authorities.

Pathways

As noted above, AEC for medicine has insufficient infrastructure at present. Other pathways need to be progressed during 2019.

- Frailty services are nationally recognised as beneficial, especially to the patients. The service at RSH has been running for over 12 months, and has proved worthwhile. However, this will need to be funded on a recurrent basis to be sustainable. At PRH, funding remains an issue, although some short term improvement funds have been obtained by the CCG. SATH is currently working on delivery of a model. Here too, a recurrent model of care needs to be implemented. It should be noted that consultant Geriatricians are a rare commodity; but a clear vision and model of care would be attractive for their recruitment.

- Direct access pathways. As part of the work during the autumn, a number of direct access pathways were drawn up for consideration, including Stroke, Cardiology and Head & Neck. All rely on the right capacity to be in place on a reliable basis; these will be progressed during 2019.

Leadership & Culture

2018 has seen extremely busy teams, with limited substantive resource, aiming to maintain a safe service. It has been less easy to provide visible leadership on all areas of the service, including performance. A focus on development of leadership capability with support, as well as a challenge to variable practice is required. ED must drive the focus on ED performance, and influence the other specialties to provide the support necessary. Our medical and other clinical leaders play a vital role in setting the expectations and standards in pace of change, process and performance, and there is a need to reinforce the 'whole-Trust' approach to flow through all departments and wards. The Trust is working with a number of experts to drive this approach, including revision of the site safety meeting format and membership.

IT

Finally, our IT systems are in need of investment and updating. The ED patient record system still relies heavily on paper documents, later transcribed onto the patient information system. The objective is to move to a single integrated care record, giving consistency in the information all care professionals dealing with the patient will see and have access to. The Trust has embarked on a plan to introduce an electronic patient record (EPR), of which an ED IT system would be part. The IT department, with ED, has requested supplier information and is currently evaluating options to consider introduction of an ED system ahead of the EPR. There are both risks and benefits to the approach; the outcomes will be known later in Q4.

To achieve 80%

The Trust faces a number of challenges as described above. In order to reach 80% and above consistently, which the Trust should set as the initial threshold for improvement, the main factors will

be: sufficient key staff, including ED; a focus on performance management and analysis of breaches and trends, using the data to target actions; maintaining improvements in flow and ward processes; and sustaining the momentum on system-wide discharge processes and a lower acute length of stay. It will be very difficult to achieve over 80% during the mid-winter phase with the higher levels of demand (especially for admitted pathways), but the objective must be to improve performance swiftly after winter pressures subside.

The key areas of focus will also be included in 2019/20 operational plan.

Longer Term performance delivery

The future configuration planning will play a role with sustainable delivery of performance, but will also benefit in the next few years as the vision for services becomes clear, and acts to attract staff. In the meantime, actions are required in all areas identified in the paper, and many will also require discussion and prioritisation in next year's operational plan.

Recommendation

The Trust Board is asked to:

- Note the current programme of work on Urgent Care Improvement, including the role of the Value Streams

- Note the complex and interdependent range of factors which influence ED performance

- Note the requirement to prioritise key objectives within the operational plan for 2019/20.

Urgent and Emergency Care Programme

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Make It **Happen**
We Value **Respect**
Together We **Achieve**

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A&E Delivery Board

Executive Team Meeting
Chair: Chief Executive (SW)

Urgent Care Operational Group
Chair: Chief Operating Officer (NL)

A&E Delivery Group
Chair: Urgent Care Director (CO)

Site management and internal escalation
Chair: Sara Biffen

Escalation and Full Capacity T & F Group
Lead: Sara Biffen

Space utilisation and improved flow
Chair: Sara Biffen

Bed modelling / improved flow T & F Groups
Lead: Sara Biffen

ED Systems and Processes HIC
Chair: Nigel Lee

ED Value Stream
Lead: Sara Biffen

ED systems and processes Incl. streaming, breaches, alternative pathways
Lead: Carol McInnes

ED Workforce T & F Group
Lead: Victoria Rankin

Standard Work / SAFER/R2G HIC
Chair: Carol McInnes

Standard work Value Stream
Lead: Gemma McIver

Weekend / 7 day working acute T & F Group
Lead: Karen Barnett

Stranded Patients / Reducing LLOS
Chair: Edwin Borman

Stranded patients project group
Lead: Gemma McIver

Whole system escalation
Chair: Claire Old

Frailty HIC
Chair: Fran Beck

Integrated Discharge HIC
Chair: Tanya Miles

Complex Discharge RPIW T & F Group
Lead: Local Authorities

Weekend / 7 day working whole system T & F Group
Lead: Claire Old

Demand and Capacity HIC
Chair: Julie Davies

Named Improvement and Informatics support to each stream

Finance, HR, Communications

Urgent Care Programme Board

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Project Summary

Project Overview				Overall Project Status	
Project Title:	Project 1 – ED Systems & Processes (Command & Control)	**Deadline:**		**AMBER**	
Exec Lead:	Nigel Lee	**Project Lead:**	Rebecca Houlston/Kate Farrow		
Clinical Lead:	Dr Kumaran Subramanian	**Project Group:**	Urgent Care Improvement Programme		
Date of Report:	23rd January 2019	**% improvement in admitted performance target: Minors – 98% Majors as per trajectory**			

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Continued review/refresh of all ED SOP's and professional standards with sign of from CD and ED Matron with all re-circulated to staff. To be completed January 2019 Once revised non-compliance to be escalated accordingly (KF/VR/KS)
- Newly appointed Operational Lead Nurse continues to role model expected behaviours for co-ordinator function – focus upon PRH site initially (KF)
- Progression of plan to implement ED internal escalation triggers plan – original format circulated however electronic system is not on IT work-list (RH)
- Continuation of roll out of consultant in charge model with board rounds in line with SOP – working well to date. New confirmed rota to be circulated (KS)
- Further revision of ED minors validation process implemented – working well but further work required for non-admitted (RH)
- Daily patient safety huddles continue with a focus on workforce and appropriate actions required for the next 24 hours, new document now in place (KF/RH)

Urgent Care Programme Board

Key Issues/Risks

- Workforce gaps for both medical and nursing staff continue as per workforce report. This impacts upon ability to deliver improvement consistently
- Management of agency/temporary staffing consistently following ED processes
- Increased number of junior band 5's and 6's is having an impact upon consistent delivery of ED processes
- Maintaining implementation of key actions due to site pressures

All risks mitigated where possible.

Key items for next week

- Ensure compliance with revised SOPs (KF/KS/VR)
- Review requirement for additional SOP's (KF/KS/VR)
- Operational Lead Nurse to continue role model behaviours for Coordinator function (KF) (initially PRH)
- Identify clinical lead to support escalation triggers development following job plan review (RH/KS)
- Focus upon continued improvement against ED performance standards (from arrival to streaming etc) (KF)
- IT ED escalation system – to be reviewed as part of potential new IT system (RH)

Performance

Week commencing 14.01.19 (all) against agreed trajectory of 79%:

SaTH	PRH	RSH
64.54%	62.91%	66.45%

Patients treated in first 60 minutes:
40.66% against regional average of 41.98%

Urgent Care Programme Board

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Project Summary

Project Overview				Overall Project Status	
Project Title:	**Project 2 – Minors Pathway Improvement**	**Deadline:**	**January 31st 2019**		
Exec Lead:	**Nigel Lee**	**Project Lead:**	**Rebecca Houlston / Kate Farrow**	**AMBER**	
Clinical Lead:	**Mr Kumaran Subramanian**	**Project Group:**	**Urgent Care Improvement Programme**		
Date of Report:	**23rd January 2019**	**% improvement in minors performance target: 98%**			

Progress, Issues/Risks, and Decisions

Key items completed this week/since the last report

- Validation exercise has continued for PRH & RSH to include minors, UCC and Paediatric breaches. This includes review of all processes that currently impact on data quality (RH)
- Consistent process implemented to report on patients that leave without being seen – in place and included as part of daily validation of process to monitor compliance (RH)
- Full business case for interim workforce under development (KF/CMc)
- Progression of rota management to align demand with capacity (RH)
- ED Whiteboard session to improve consistency and standard practice – follow up session scheduled wc 24/01/19 (RH)
- ED Co-ordinator session scheduled for 05/02/19 – agenda under development (VR/KF)
- Implementation of changes to fit2sit at PRH
- Consultant review of minors categorisation (KS)

Key Issues/Risks

- Workforce gaps for both medical and nursing staff continue as per workforce report. This impacts upon ability to deliver improvement consistently
- Management of agency/temporary staffing consistently following process
- Increased number of junior band 5's and 6's
- Capacity within ED to maintain flow through the department

All risks mitigated where possible.

Key Items for Next Week

- Implementation of SOP's following PRH fit2sit and cubicles review at PRH (KF/VR)
- SHO roles and responsibility review (KS)
- Embedding roles and responsibilities to improve data quality (RH)

Performance Overview

- ED Minors performance (excluding UCC);

	SATH	No of breaches	RSH	No of breaches	PRH	No of breaches
14/01/19	93.14%	7	90%	4	95.16%	3
15/01/19	93.42%	5	96.55%	1	91.49%	4
16/01/19	97.59%	2	100%	0	95.92%	2
17/01/19	97.40%	2	97.67%	1	97.06%	1
18/01/19	95.31%	3	100%	0	92.86%	3
19/01/19	98.57%	1	100%	0	97.14%	1
20/01/19	95.29%	4	97.62%	1	93.02%	3
Overall performance	95.69%	24	97.14%	7	94.55%	17

Breach analysis

Total: 24 – majority out of hours

Action Taken: Lead Nurse for ED to review current ENP/ECP rota now all staff have had competencies signed off to ensure resource is in place to meet demand. To be fully in place for next rota publication.

Urgent Care Programme Board

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3A. Project Summary

Project Overview				Overall Project Status	
Project Title:	**Unscheduled Care Standard Work Value Stream**	**Deadline:**	**Phase 2 - April 2019**		
SRO Lead:	**Carol McInnes**	**Project Lead:**	**Gemma McIver/Kath Preece**	**Amber**	
Clinical Lead:	**Dr Perrot-Jones Gary Caton/ Kath Preece**	**Project Group:**	**Improving Patient Flow**		
Date of Report:	**30/01/2019**	**% improvement in admitted performance target 4%**			

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position

- The key implementation target for the roll out of the respiratory value stream was to improve pre 12 discharges and reduce LOS by 2 days on every ward. Since the roll out (August) of the Standard work value stream in USC an overall 2.5 LOS reduction has now been achieved

Metric (units of measurement)	Target	6	7	8	9	10	11	15	16	21	22r/27	24	27	28	32	Overall RSH	Overall PRH	Overall SATH USC
August (Base Line)	Reduction of 2 days	15	8		9	11	8	11	36	7	11	12		15		6	10	14	12
September		19	20		14	16	14	9	26	7	8	7		9	5	7	17	12
October		9	9	14	8	12	12	12	43	9	10	8	9	12	6	9	15	12
November		8	6	14	7	9	20	12	32	8	9	8	9	11	5	8	13	11
December		8	7	12	7	10	9	13	16	9	10	9	9	10	4	9	10	9.5

- Re measures are in process of collation to provide an overview of progress for January
- Pre 12 performance for January improved from December for The Trust: Dec 17% pre 12 and Jan 23% pre 12 (this includes both care groups and Gynae ambulatory care and CDU at PRH has been excluded) pre 12 data also includes transfers to discharge lounge
- Improved utilisation of the discharge lounge on both sites

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Key Items Progressed this Week
- PDSA utilising discharge lounge area to accommodate beds – further pathway and SOP to be explored
- Production boards updated and supported by Matrons to provide the required details for the 'new' site safety meetings
- 5S event arranged for ward 11 (20th February)
- Support to all ward areas and 1:1 meetings with medics to promote the Ward Round standard work
- Discussions commenced regarding amendment to Consultant rotation (moving from Monday- Monday transfer position)
- Standard work aligned with revised site management processes

Key Issues/Risks

- Wards have fed back that PM huddles are driving pre 12 discharge however with the Pm moves to ward 27, ward 8 and DSU those identified as definite discharges for the following day are often moved – escalation areas are then unable to fulfil the plans for pre 12 due to limited pharmacy cover and a change in the coordinator/ turnover of the ward this impacts pre 12 performance
- A key metric for delivery in the standard work value stream is all MDT members present at board round this currently cannot be met due to the fragility/ vacancies in therapies pending a time table for when therapy can attend board rounds
- Commencement has taken place to roll out standard work ward rounds – this compliments/ reflects the SAFER model – variable engagement across both site continues.

Items for Escalation
- MDT attendance at board rounds due to vacancies and workforce fragility – pending plan to address
- Future location and space for discharge lounge at RSH

Key Items for Next Week

- Further work to standardise and improve the effectiveness of the PM huddle – particularly aligning this to the requirements for the Site Safety meetings
- Completion of Value Stream report to be prepared and presented through Guiding group following collation of re measures
- Kaizen event planning for renal pathway to support criteria led discharge post dialysis

Performance – Pre 12 Metric – Week Commencing 01/01/2019- 30/01/2019

Percentage of Discharges and Transfers to Discharge Lounge before 12:00
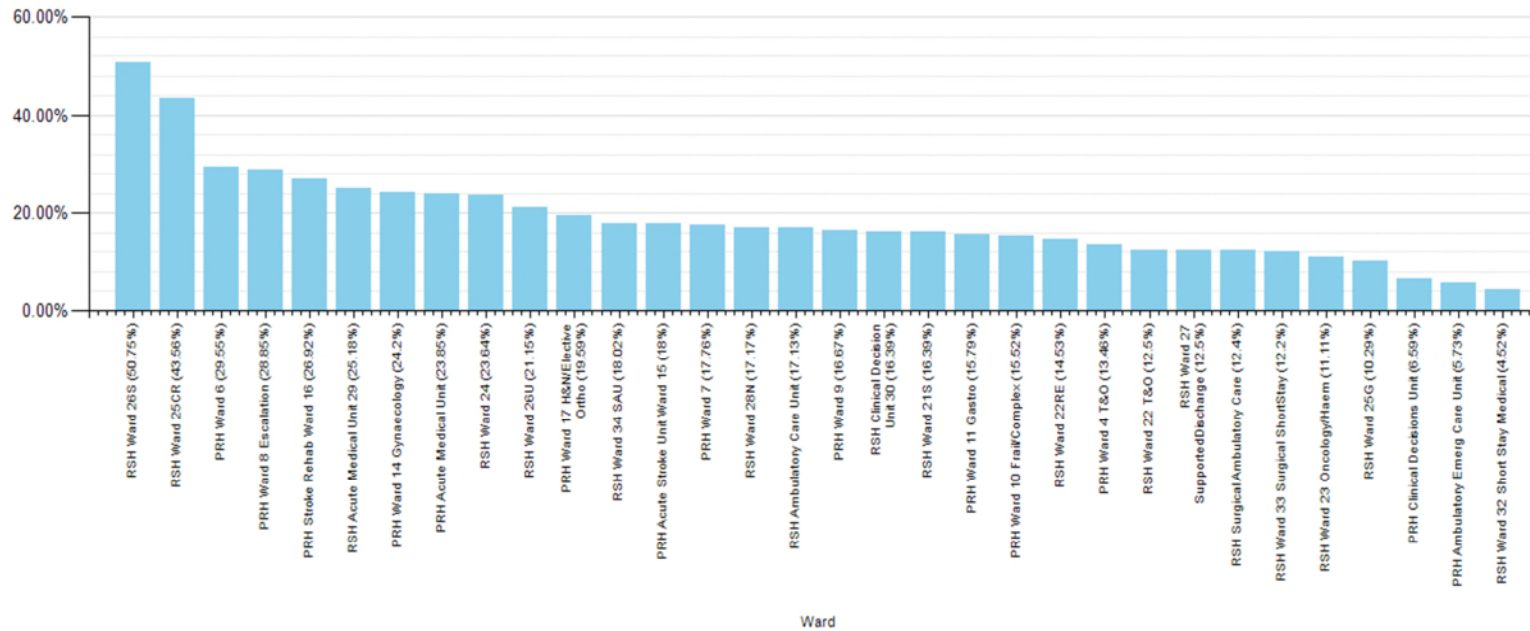
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3A. Project Summary

Project Overview				Overall Project Status	
Project Title:	**Stranded Patient Reduction Project**	**Deadline:**	**On-going**		
Exec Lead:	**Edwin Borman**	**Project Lead:**	**Gemma McIver**	**Amber**	
Clinical Lead:	**Gary Caton/ Kath Preece**	**Project Group:**	**Improving Patient Flow**		
Date of Report:	**23/01/2019**	**% improvement in admitted performance target 4%**			

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position

- Performance for Monday 28th January 281 (51 Super Stranded), 31 above internal target however as demonstrated below, the significant step change in performance has been maintained so far
- The last 3 weeks has remained fairly static in terms performance despite the increase in activity. Last year there was a consistent increase each week in January with the final week spiking at 399. For the w/c 28th January SaTH have demonstrated a 20% improvement in comparison to figures last year
- Lowest point this week has been Sunday 27th with performance at the start of the day 233
- Super Stranded Patients performance (patients at 21 days and over) has improved significantly from this time last year. Currently continuing to deliver a reduction of 40% against a nationally agreed target of 21%

Key Actions

- Email discussion and conference calls with Stoke to further maximise on the Stoke cardiology pathway
- Agreement in place with ward 27 for medics to not review 'medically fit' patients in ward round unless specifically requested at board round
- Plans in place through task and finish group for therapy and nursing to populate the medical notes to ensure a holistic record and prevent unnecessary barriers between the MDT
- Case management of super stranded patients reduced to 14 days
- Friday Check Chase Challenge changed to support weekend planning and drive weekend actions
- Super Stranded escalation meeting and task and finish group re arranged for Thursday PM to support with engagement, weekend planning and feedback directly any requests from urgent care programme board

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Key Issues/Risks

- Membership at the weekly stranded patient escalation meeting has declined both internally and externally – mitigation taken has been to rearrange time and day of meetings to maximise engagement
- Potential hidden delays in the system following the launch of SaTH2Home beds – mitigation taken has been to escalate these through the system conference calls
- Therapy workforce fragility/ vacancies impacting on discharge planning and progression of patients across medicine wards – Discussed with Care Group Director and escalated to Executives December 2018

Key Items for Next Week

- On-going support from SaTH2Home with additional bed based provision to prevent unnecessary delays
- Daily additional support to ward 15 and 16 to reduce super stranded numbers
- Social workers to continue with attendance at Check Chase Challenge – enhanced planning for weekend discharges from Wednesday
- Continue PDSA of Check Chase Challenge on the wards at PRH
- Check Chase Challenge to support weekend action lists

Performance

**Emergency Care
Intensive Support Team**

Safer, faster, better care for patients

**NHS
Improvement**

Management in confidence

Simon Wright, Chief Executive Officer
Nigel Lee, Chief Operating Officer
Shrewsbury and Telford Hospital NHS Trust

18th October 2018

Dear Simon and Nigel,

Patient flow gap analysis: Shrewsbury and Telford Hospital NHS Trust –

17th September 2018

Overview

In August 2018 the annual review of the systems that the emergency care intensive support team (ECIST) will work with was undertaken. I am pleased to say that, because of that review we will be working with Shrewsbury and Telford Hospital NHS Trust and system partners to review and support improvement across urgent and emergency care.

We agreed some initial priorities with the trust and completed a gap analysis of these against the Good practice guide: Focus on improving patient flow on the 17th September 2018. This report summarises that analysis and provides initial recommendations to the trust and wider system and outlines the support available from ECIST.

The review was structured around a clinical walkthrough of the patient pathway across the hospital's urgent and emergency care system. This included meeting with clinical and managerial staff across urgent and emergency pathways. The report builds on the initial verbal feedback provided at the end of the visit and aims to provide practical recommendations and support.

Lucy Roberts (ECIST improvement manager), Pete Gordon (ECIST senior improvement manager), Dr Jyothi Nipanni (ECIST regional clinical lead), Lisa Christensen (ECIST social care lead), Andy Aldridge (ECIST improvement manager), Dr Dan Smith (ECIST clinical associate), Garry Swann (ECIST clinical associate) and Chris Green (ECIST informatics lead) conducted the visit.

Summary

We recognise the current challenges of the system and are grateful for the welcome and engagement of the staff involved in the visit, it was noted the trust has made good progress in various areas over recent years and is still on an improvement journey. Good practice was reported in relation to the commitment of staff who often work beyond expectations particularly in the emergency department; the trust value stream programmes; and the development of frailty and ambulatory emergency care (AEC) services.

Our recommendations and support are focused on reducing unnecessary waiting for patients; keeping the priorities to a manageable level and, where appropriate, aligned with the system recovery plan shared by the Shrewsbury and Telford A&E delivery group.

Primary areas of focus:

- Review and improve **emergency and acute pathways** including; clinical pathways, staffing and skill-mix to match demand profile, internal professional standards and use of space.

- Review and improve use of **alternative pathways** to the emergency department (ED), including ambulatory emergency care (AEC), frailty and ambulance/community developments.

- Continue to improve **ward processes** with a focus on; clear clinical plans, expected date of discharge and clinical criteria for discharge, early pull and discharge timeliness.

- Continue to deliver improvements to **reduce long hospital stays** across acute and community sites.

- Review and **enhance frailty services** at both acute sites and work in collaboration with community, primary care and voluntary sector colleagues to further enhance provision.

ECIST offer of support:

ECIST clinical associates, subject matter experts and improvement managers will be assigned to provide support to the recommendations within this report, primary support to include:

- Completion of bed modelling
- Review and enhance emergency and acute pathways.
- Review and increase use of alternative pathways to the ED.
- Review staffing and skill-mix to match service demands.
- Lead patient flow event/workshops during October and November.
- Work with identified teams to improve ward processes.
  - support the use of PDSA cycles; e.g. for speciality pull, use of clinical criteria for discharge, etc.
- Support an improvement approach to implement clinical criteria for discharge to increase earlier in the day and weekend discharges.
- Support to further reduce long hospital stays across acute and community settings.
- Support weekend Multi-Agency Accelerated Discharge Event (MADE)
- Support to enhance and extend the existing frailty provision across Shropshire, Telford and Wrekin.

Other areas identified for support not covered as part of this initial review

- ECIST ambulance lead support the collaboration and improvement of ambulance conveyance and use of alternative pathways.
- ECIST therapies led to support the integrated therapies developments.

Findings by clinical area:

Following discussion with staff during the clinical walk through, we identified the following areas of focus.

Emergency departments (ED)

1. Workforce
   - We found the current levels of medical and nursing staff were having a significant impact on the teams' ability to consistently deliver the desired level of service in the departments, ensuring safety and supporting best practice pathways; e.g. streaming and pit stop.
   - We heard there is currently an increased amount of operational, administrative and audit activity being undertaken by senior staff which is resulting in reduced time to focus on service and quality improvements.
2. Clinical pathways and use of space
   - We identified good practice in terms of the newly initiated pit stop, however we found variation in staffing grades, experience, knowledge of/use of clinical pathways, and consistent use of space for the following areas; streaming, pit stop, clinical decision unit (CDU) and ambulatory emergency care (AEC). We also noted person dependence was a factor in accessing some of these pathways. We noted the CDU at the Royal Shrewsbury Hospital (RSH) is often used for acute medical unit (AMU) patients due to limited beds on the AMU.
3. Medical and Speciality In-reach
   - Excellent in reach service by on call medical team, however speciality in-reach is currently very limited, internal professional standards exist but are not followed.
4. Other
   - We heard of the good practice delivered by the rapid assessment interface and discharge (RAID) service, however staff identified there are further opportunities to streamline processes and improve timeliness of assessments.
   - We heard mixed reports relating to access for direct general practitioner (GP) referrals.

Recommendations:
- Review staffing and skill-mix to include use of alternative roles such as emergency nurse practitioners (ENP) / advanced clinical practitioners (ACP) and matching staffing to meet peaks in demand.
- Amend rotas to include streaming and pit stop establishment on the 'substantive' line rather than 'escalation line' as this will enable the team to staff priority areas consistently.
- Review opportunities to free senior ED nurses from the current levels of auditing and daily operational pressures to aid service improvement.
- Review the potential to re-introduce trackers in the departments as team members valued their input helping to reduce the number of breaches.
- Assess and test alternative clinical pathways and uses of space across the emergency and acute pathway, including assessment areas and areas located near the department. This should include clarifying the model and criteria for; streaming, pit stop, CDU and AEC and increased training and communication of these pathways.
- Streaming should be undertaken in a room where observations can be completed and clinical pathways to AEC can be implemented.
- Pit stop requires increased and protected staffing. To develop the capacity to support the provision of treatment and requesting of investigations, this could be supported with a cross-site ACP programme. It would also be beneficial to develop criteria in pit stop to guide urgent clinical involvement i.e. use of NEWS and specified clinical pathways.
- To improve use of alternative pathways, encourage further collaboration between ED, AEC and care groups so there is a proactive push and pull from ED to AEC/AMU and specialities.

- Continue with good medical in-reach and develop speciality in-reach (including internal professional standards) with all appropriate specialities to support earlier senior decision making, reduce admissions and length of stay for patients.
- Review opportunities and test changes to streamline RAID assessment processes.
- Review current routes for GP referrals as these should be admitted directly to assessment areas unless they require resus support in the ED.

Ambulatory emergency care (AEC)

1. Workforce, current model and capacity
    - Ambulatory care services have developed well over the past few years; however, it was noted that reduced GP hours has now limited the services provided at both sites.
    - It was noted there may be further opportunities to develop pathways and improve pulling of patients from the ED.
    - The conversion rate at RSH was noted as high, which is possibly explained by direct GP referrals accessing the hospital through this route.
    - We heard the AEC unit is frequently bedded resulting in reduced AEC capacity. The AEC unit should never be used for additional capacity as it impairs their ability to pull patients from the ED. The number of breaches caused by the inability of AEC to function will usually, by far, outstrip the capacity gained by using the space overnight. The timeframes for initial assessment and medical review in AEC should be like those in the main ED. Due to the bedding of the unit, some patients are delayed.

Analysis:

Graphs 1 - 4 illustrate in this system 25% Royal Shrewsbury Hospital (RSH) and 28% Princess Royal Hospital (PRH) patients have a zero day length of stay (LoS), often referred to as ambulatory. This is low compared with the national profile of 30%. The proportion of patients staying between 0-2 days (short stay / assessment patients). In this system, at both RSH and PRH 55% of patients on average have a 0-2 day LoS, whereas the national average is 65-70%.
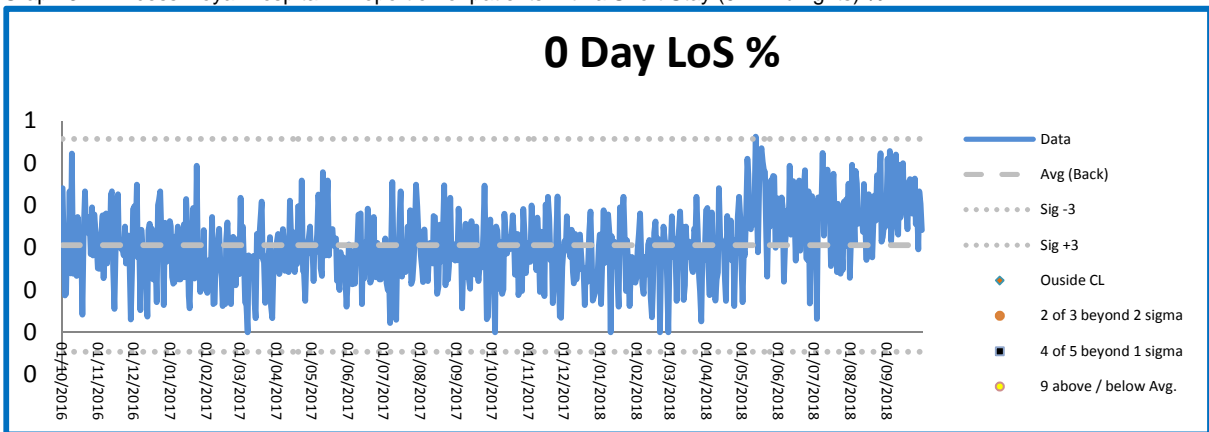
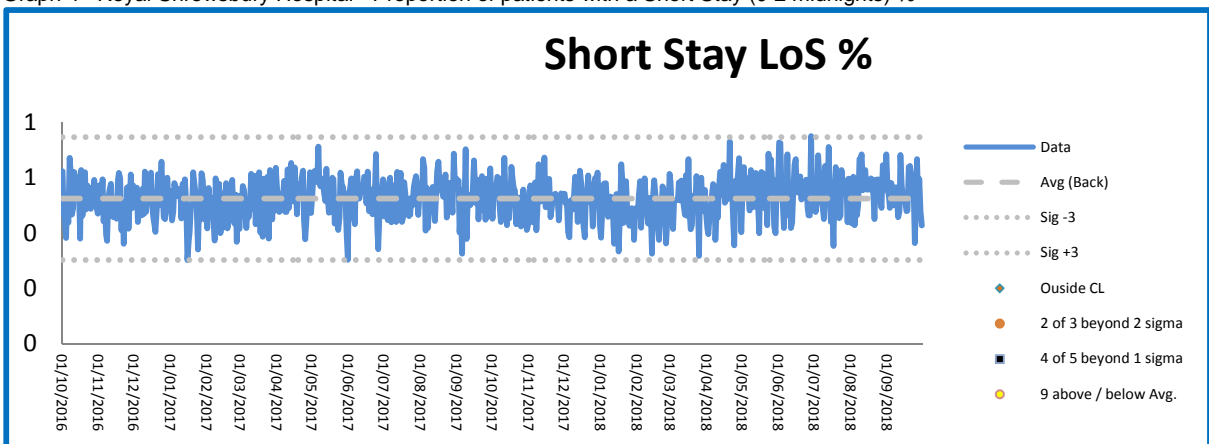Graph 1 – Princess Royal Hospital: Proportion of patients with 0 day length of stay %
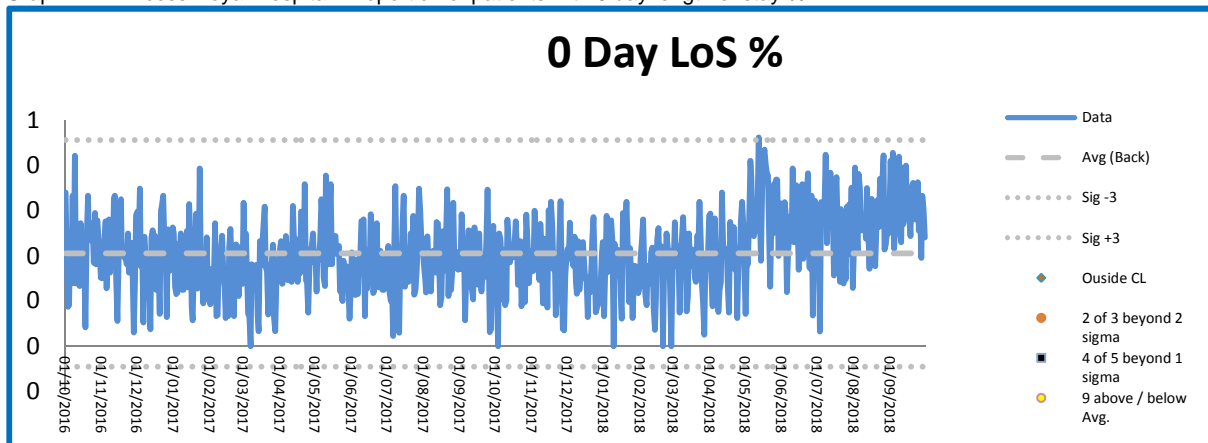
Graph 2 – Royal Shrewsbury Hospital: Proportion of patients with 0 day length of stay %
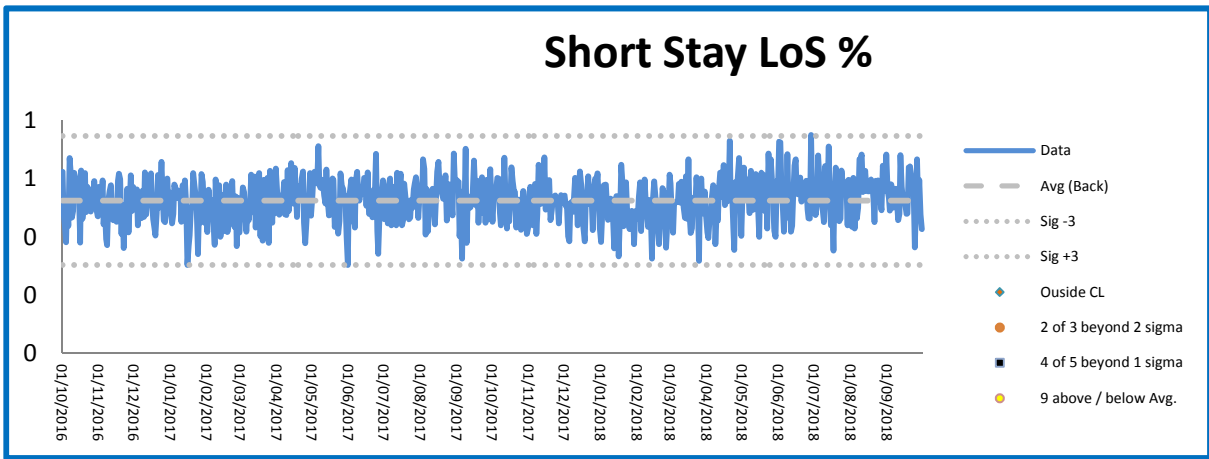
Graph 3 –Princess Royal Hospital - Proportion of patients with a Short Stay (0-2 midnights) %

Graph 4 –Royal Shrewsbury Hospital - Proportion of patients with a Short Stay (0-2 midnights) %

Recommendations:
- Complete a review of the AEC model to include capacity, staffing, hours of service, facilities and clinical pathways (push and pull).
- Review opportunities to further develop ambulatory pathways; e.g. ED responsible and nurse led discharge pathways i.e. low risk chest pain.

- Develop and implement a sustainable improvement approach including an improvement dashboard to ensure monitoring of process, outcome and balancing metrics for AEC as this will support continuous improvement.
- Develop internal professional standards and a training/ communication programme to enhance the use of AEC from the ED and primary care colleagues.
- Agree an approach to ensure AEC is not utilised for additional bed capacity as this will ensure its functionality is maximised.
- it is important to monitor and address any delays to initial assessment that may occur due to bedding the AEC.

Visit the [ambulatory emergency care](#) website for access to practical tools and resources, including the revised AEC directory (February 2018) which reflects new practice and examples of AEC, and identifies emergency conditions and clinical scenarios that have the potential to be managed in an ambulatory way.

Acute medical unit (AMU)

1. Workforce and model
   - Good mix of staffing, junior doctors very keen and motivated.
   - We heard of the recently started weekend discharge team which is recognised as good practice. However, weekend staffing for the hospital sites was raised by staff as a concern.
   - It was noted the AMU at RSH has 16 beds for approx. 50 admissions per day, therefore the CDU and AEC areas can often be used as AMU overflow.

2. Daily processes
   - There is significant variation in handover and board round attendance from nursing and consultants.
   - Patients are currently seen in geographical order rather than priority of acuity/discharges.
   - Staff shared the difficulties in requesting radiology as there are only 2 periods a day when a request can be made.

3. Speciality in-reach and referrals
   - Speciality in-reach is currently limited, although we heard of an individual cardiology consultant who regularly in-reaches to the department. The team appreciated this as it supports earlier senior decision making and reduces unnecessary waiting for patients. Internal professional standards exist but are not followed.
   - We heard of varied referral processes to each specialty with some processes taking 24 hours, gastroenterology has implemented electronic referrals which is working well.
   - We heard that specialty nurses (respiratory and cardiology) review patients but can't refer to consultants if advice is required.

Recommendations:

- Review hospital weekend staffing cover across sites. Compare medical staffing to RCP safe staffing guidelines https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing Consider out of hours cover by ACPs and increasing hours of Hospital Out Of Hours (HOOH) team.
- Continue with the discharge team at weekend and enhance opportunities by consistent use of clinical criteria for discharge in every patient's plan.

- Bed modelling/right-sizing to be completed to inform future acute pathway developments ensuring that the service design conforms to population needs and the recommendations within the RCP 2007 acute care taskforce.
- Ensure board rounds and handovers are attended by consultants and nurses as per the Royal College of Physicians (RCP) guidance and quality standards. Aim for 2 x acute consultant daily review as per acute medicine guidance.
- Patients should be seen in order of acuity followed by those with discharge potential before routine reviews of remaining patients.
- Develop and implement internal professional standards for radiology and other diagnostics to reduce delays.
- Fully implement expected date of discharge (EDD) and clinical criteria for discharge (CCD) to provide a clear plan and thereby reduce unnecessary waiting for patients.
- Agree and implement internal professional standards to ensure speciality in-reach, early identification and pull of appropriate patients. There should be daily visits to AMU by all specialties – initially once daily – aiming for twice daily.
- Implement electronic referrals for all specialities.
- Specialty nurses should refer to their own consultants which will reduce delays and duplication.

Frailty

1. Service model
   - We heard of the good progress in relation to the frailty service delivered at RSH with funding extended for 6 months, however the team did share that recruitment has been hindered by the short-term funding arrangements.
   - Princess Royal Hospital (PRH) completed a plan-do-study-act (PDSA) test of change of a similar model that has had positive benefits.
   - The current model has limited hours of service due to the level of staffing. Expansion of the service would allow for; accepting patients from ambulances, pulling patients from assessment areas, in-reach/out-reach support and extended Multi-disciplinary (MDT) provision.
   - There is limited access to community services out of hours to support admission avoidance pathways.
   - Current measurement of impact, outcome and balancing metrics is limited.
   - Staffing levels don't allow for shared learning and training across all wards, e.g. managing frail older adults, preventing deconditioning and home first.

Recommendations:

- Review opportunities to substantively fund frailty services at RSH and establish a model at PRH.
- Review current model and clinical pathways to enhance the frailty service provision, develop an agreed model, standard operating procedure (SOP) and communication strategy. Review to include; use of space, staffing complement, assessment areas, hours of service, best practice screening tool, access to diagnostics and collaboration with partners including the voluntary sector to enhance supported discharge and access to services out of hours.
- PDSA testing of service expansion to include; accepting patients from ambulances, pull of patients from assessment areas, in-reach/out-reach support and extended MDT provision.
- Informatics support to develop frailty service dashboard to promote continuous improvement.
- System partners to develop a medium to long term strategy for managing frail older adults across Shropshire, Telford and Wrekin.
- Team to develop training and education across all areas and wards to deliver best practice for all frail older adults.

*Visit the [Acute Frailty Network (AFN)](#) website for access to practical tools and resources.*

Ward processes

1. Improvement programmes
   - We heard of good practice relating to the standard work value stream, ED value stream, stranded patients, frailty and Red2Green days developments.
   - We found variable knowledge of 'why' improving flow is a priority for the system; i.e. preventing deconditioning, reduce unnecessary waiting, etc.

2. Workforce
   - Limited consultant of the week models, where there are higher numbers of consultants, their capacity is often taken up with clinics rather than ward duties.
   - Multi-disciplinary staffing is limited over the weekends.

3. Ward processes
   - Limited staff training in relation to cannulation and phlebotomy.
   - Mixed views of the check, chase and challenge process to reduce stranded patients.
   - Early identification and pull of patients from AMU pre 10am rarely happens.
   - Board round attendance and approach is variable.
   - Ward rounds starting with sick/dischargeable patients is variable.
   - There is variable use of expected date of discharge (EDD) and very limited use of clinical criteria for discharge (CCD).

4. Common constraints identified:
   - Clinical criteria for discharge, weekend plans and lack of ward rounds at weekends.
   - Pharmacy provision and hours of service.
   - TTO, discharge summary delays and provision of blister packs.
   - Diagnostics request process.
   - Speciality referrals and review.
   - Transport.
   - Community, nursing and residential home criteria, in-reach and access out of hours.

5. Movement of patients
   - Movement of patients, particularly at weekends can result in extending the length of stay due to poor communication of the clinical criteria for discharge. Patients are sometimes moved from AMU to short-stay to await take home medications which results in an unnecessary move and delays.
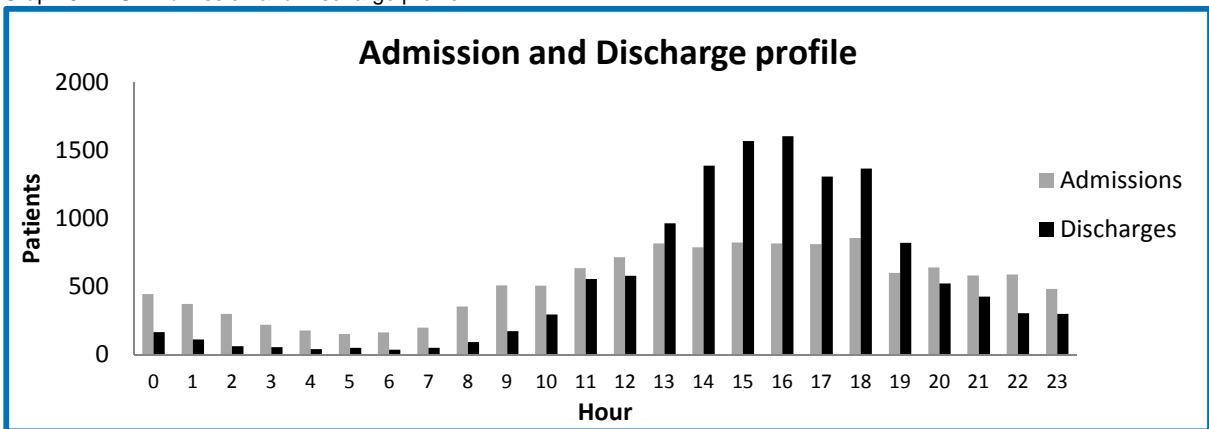
Analysis:

Graphs 5 and 6 shows the discharge profile for this system is shown by time of day. The initial peak of discharges peak between 3 and 4pm, which is later than we would expect.

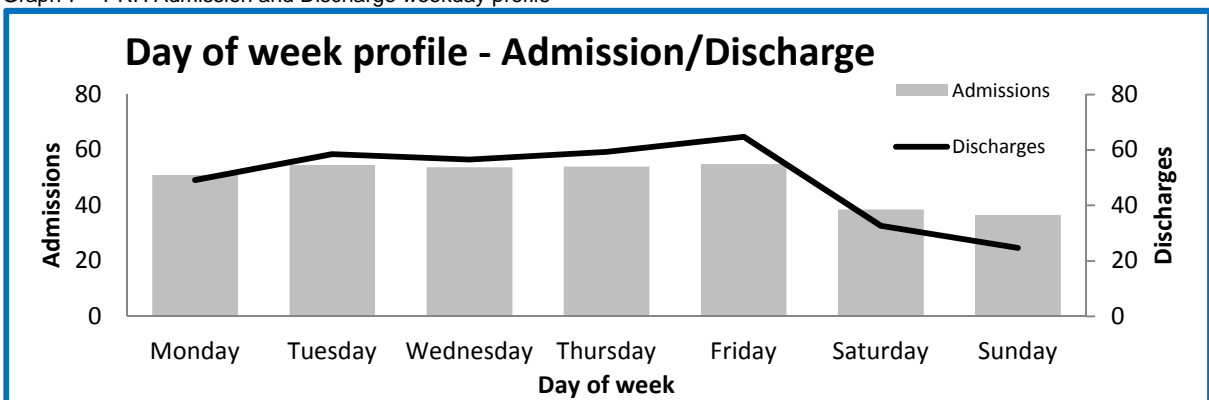Graph 5 – PRH Admission and Discharge profile
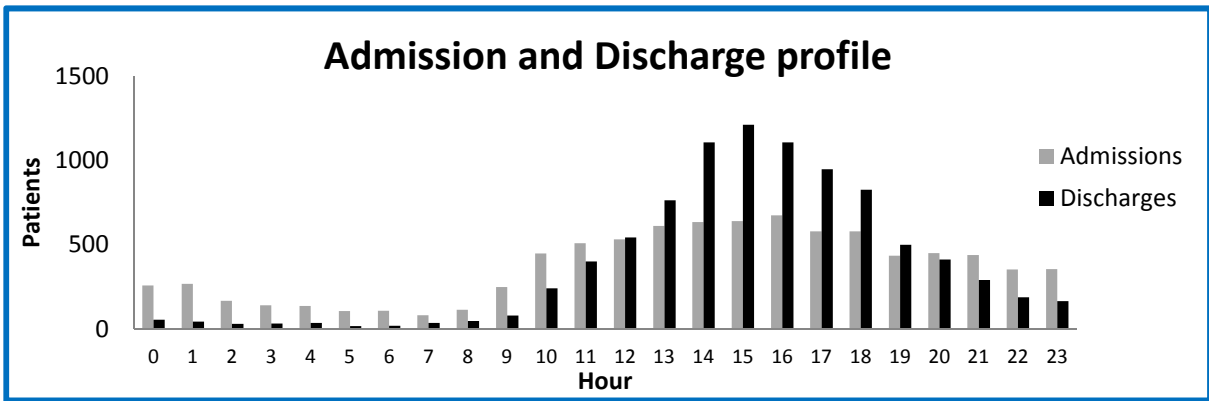
Graph 6 – RSH Admission and Discharge profile

Graphs 7 and 8 shows that discharges are heavily weighted to a Friday (peak at 64 PRH and 90 RSH) compared with Saturday (32 PRH and 50 RSH) and a low on Sunday of 40. This variation impacts on flow of patients through the emergency floor over the weekend and impacts negatively on patient outcome, with patients admitted over the weekend having a longer length of stay (LoS) than patients admitted on a Monday.

Graph 7 – PRH Admission and Discharge weekday profile

Graph 8 – RSH Admission and Discharge weekday profile

Day of week profile - Admission/Discharge
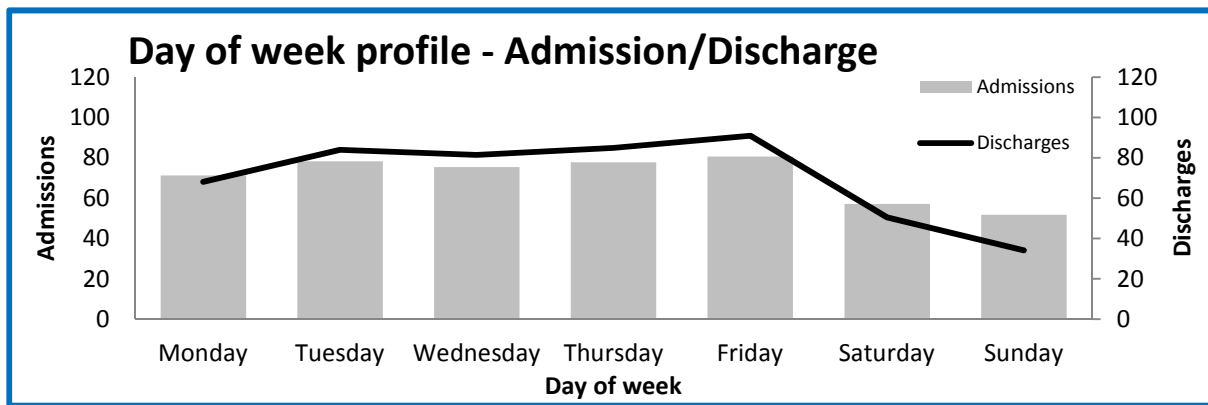
Further analysis has shown the impact that the patterns above have on 4 hour performance by day of week. It is very likely that the mismatch between admissions and discharges by time of day and day of week has an impact on the variation in performance. Reduced discharges over the weekend are likely to contributing to an increased bed occupancy and reduction in patient flow through the emergency pathway. Resolving this issue may go some way to helping the system to improve performance against the 4 hour emergency care standard.

Recommendations:

- Continuation of the standard work, ED value streams, stranded patients and frailty and Red2Green developments. Existing improvement programmes should be aligned to the trust's recovery plan and the areas identified within this report.
- Training and engagement with MDTs to develop understanding of the compelling story and approach to deliver improved patient flow.
- Review staffing models, e.g. consultant job plans to deliver increased ward cover.
- Review of weekend staffing and test changes to match demands.
- Increase the number of staff able to undertake cannulation and phlebotomy, this would reduce harm (time to first dose antibiotic for example) and therefore length of stay (LoS) as it would reduce deterioration on the wards.
- Review check, chase and challenge approach and test alternative ways of working; e.g. ward visits, peer to peer challenge.
- Initiate a targeted approach with ECIST to implement the principles of the SAFER patient flow bundle and Red2Green days approach on the two unscheduled care value stream wards.
- Complete PDSA cycles to test and improve the following:
    a. Pull from AMU
    b. Board and Ward rounds
    c. Use of expected date of discharge (EDD) and clinical criteria for discharge (CCD)
    d. Earlier in the day and weekend discharges
5. Review and monitor the movement of patients at the weekends, ensuring clear clinical criteria for discharge are set prior to any ward moves.
6. Review alternatives to AMU 'discharge ready' patients being moved to the short-stay ward, considering use of the discharge lounge.
7. Implementation of a standardised approach to escalation and constraint resolution, including the development of a programme (alongside the value stream programmes) to hold constraint resolution/improvement workshops for the areas identified.

Admission, transfer and discharge

These findings are based on a conversation with the Integrated Discharge Team (IDT) lead in PRH

1. Positive feedback in relation to discharge to assess pathways. Fact finding assessment form is recognised good practice as it is short and straight-forward to complete and is accepted prior to the patient becoming medically safe for transfer, however, best practice recommendation is for ward staff to describe the patient needs not prescribe which pathway is required.
2. There is variable feedback from wards, particularly regarding requests for additional information and changes to the current form.
3. Discharge to assess (D2A) pathways are in place for Shropshire and Telford patients, there is currently variation in the usage of pathways 1, 2 and 3
4. Good practice identified:
    - Established D2A pathways
    - Powys on-site team
    - Voluntary sector provision
    - SaTH to home provision (bridging service)
    - Trusted assessors commenced
    - Bed availability updates
    - RAID services
5. Areas for improvement identified:
    - Fast-track currently 4-5 days, longer for out of area patients
    - Out of area patients delayed due to varying processes
    - Clarity about the proportion of patients returning to their usual place of residence.
    - Potential over use of bedded pathways
    - Limited mental health provision and access to community beds

Recommendations:
- Review of MDT working, patient tracking and documentation.
- Clarification and simplification of discharge pathways with an emphasis on home first.
- Introduction of clear metrics and improvement dashboard to monitor number of patients accessing each pathway and number of patients returning to their usual place of residence.
- Training and awareness at ward level to include community and voluntary support services available to encourage further adoption of home first approach.

Useful Resources:

The following documents and websites provide practical tools and resources related to the recommendations within this report:

- Good practice guide: Focus on improving patient flow, NHS Improvement, July 2017.
- Guide to reducing long hospital stays, NHS Improvement, June 2018
- https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
- https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf
- https://improvement.nhs.uk/improvement-hub/emergency-care/
- https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/
- https://www.ambulatoryemergencycare.org.uk/
- https://www.acutefrailtynetwork.org.uk/
- https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/embracing-risk

- https://improvement.nhs.uk/resources/rapid-improvement-guides-urgent-and-emergency-care/
- https://improvement.nhs.uk/resources/safer-patient-flow-bundle-and-red2green-days-approach/
- https://improvement.nhs.uk/resources/criteria-led-discharge-improvement-collaborative/

I look forward to supporting the trust and wider system. I will be the system link for ECIST and will have the capacity to bring in extra support within specialist areas as necessary.

Yours Sincerely

Lucy

Lucy Roberts | **Improvement Manager**
Emergency Care Intensive Support Team (ECIST)
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NHS **Improvement**

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Emergency Department - National Priorities Report

A review of corridor care and avoidable breaches
Shrewsbury and Telford Hospitals NHS Trust

Emergency Care Intensive Support Team (ECIST)
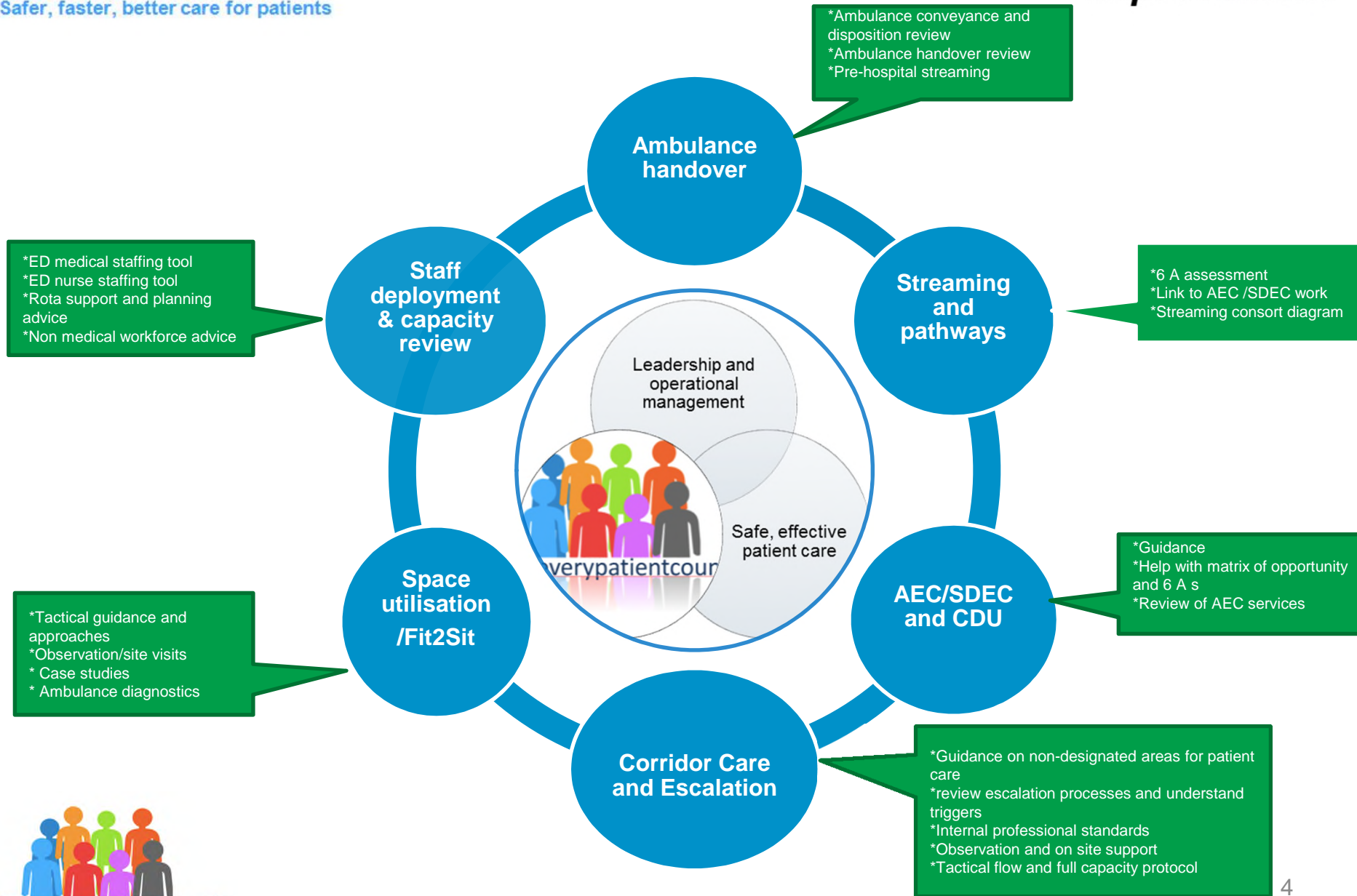[6th and 7th December 2018]

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Introduction

Emergency department (ED) crowding is a manifestation of a crowded urgent and emergency care system. The consequences are well described with delays in the delivery of time critical interventions, increased mortality for patients admitted or discharged from a crowded ED, increased length of stay for patients in crowded systems as well as the obvious impacts on patient experience, including privacy and dignity. Staff wellbeing and satisfaction are also affected by working in a crowded environment.

Approaches to prevent crowding, mitigate risks to patients and staff arising from crowding, managing the crowded hospital and recovery to normal operations are all important. A marginal gains approach is likely to be more successful than seeking out a magical solution to transform patient and staff experience.

Stephen Duncan- Deputy Director ECIST

Kevin Reynard- Clinical Director ECIST

Co-Leads National ED priority workstream

Abbreviations

AEC   – Ambulatory Emergency Care

AMU   – Acute Medical Unit

CDU   – Clinical Decision Unit

ECIST   – Emergency Care Intensive Support Team

ED   – Emergency Department

FOCUS – refer to appendices

HALO   – Hospital Ambulance Liaison Officer

PRH   – Princess Royal Hospital

RSH   – Royal Shrewsbury Hospital

SAU   – Surgical Assessment Unit

SDEC   – Same Day Emergency Care

SHOP   – Sick, Home, Other, Plan

UCC   – Urgent Care Centre

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Emergency Care Intensive Support Team

Safer, faster, better care for patients

NHS Improvement

Ambulance handover

*Ambulance conveyance and disposition review
*Ambulance handover review
*Pre-hospital streaming

Streaming and pathways

*6 A assessment
*Link to AEC /SDEC work
*Streaming consort diagram

Staff deployment & capacity review

*ED medical staffing tool
*ED nurse staffing tool
*Rota support and planning advice
*Non medical workforce advice

Leadership and operational management

Safe, effective patient care

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AEC/SDEC and CDU

*Guidance
*Help with matrix of opportunity and 6 A s
*Review of AEC services

Space utilisation /Fit2Sit

*Tactical guidance and approaches
*Observation/site visits
* Case studies
* Ambulance diagnostics

Corridor Care and Escalation

*Guidance on non-designated areas for patient care
*review escalation processes and understand triggers
*Internal professional standards
*Observation and on site support
*Tactical flow and full capacity protocol

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4

Summary of observations and recommendations

For the purpose of the visit to Shrewsbury and Telford Hospitals NHS Trust, the initial visit focussed on the following priorities:

1. Space utilisation
2. Emergency department (ED), corridor care, escalation and site management
3. Streaming and pathways
4. Assessment areas: ambulatory emergency care (AEC), acute medical unit (AMU) surgical assessment unit (SAU) and clinical decision unit (CDU)
5. Ambulance handover
6. Breach analysis

Priority Recommendations (1 of 3)

Workforce

- Staff consistently reported workforce shortages in the ED, AEC, AMU and short-stay wards across all disciplines (medical, nursing, therapies and allied health professionals). The teams we met all also reported a significant finance related culture (factually correct or perceived) which they felt was a significant constraint.

- The process and timeframe for developing business cases, gaining trust approval and initiating recruitment is not clear, even to enable recruitment to existing vacancies.

We recommend

- A review of all staffing requirements (to ensure capacity matches demand) across these areas is completed as a matter of urgency. This must ensure staffing establishment is based on safety, quality, national guidelines, best practice and account for changes in acuity and demand.

- The trust should make clear the standard process and timeframe for business case development and ensure transparency of the approval discussions; this transparency will ensure all staff are aware of decisions; i.e. finance and/or other factors. The trust should also establish a way of monitoring risks associated with workforce shortages.

Priority Recommendations (2 of 3)

Space utilisation (RSH & PRH)

- RSH: complete an options appraisal to enable effective use of space and right-sizing of the assessment areas, to include; AMU, Short-stay, SAU, AEC, CDU, ED and frailty. This should include consideration of the recent demand and capacity diagnostic and staffing models.
- PRH: complete bed modelling and space utilisation exercise.

Streaming (RSH & PRH)

- Complete staffing review for streaming and provide regular practice development support and coaching to all junior staff.

Crowding, Escalation and Site Management (RSH & PRH)

- Complete an ED workforce interim review and increase staffing and skill-mix as a matter of urgency.
- Review and agree approach to the ED clinical leadership across both sites.
- Review and improvement to ED escalation in collaboration with site management.
- Review of site management staffing and model (consideration of FOCUS model).
- Safe use of risk assessed areas as part of the full capacity protocol needs to occur asap.
- ED daily huddles to identify risks with the department – test and implement safety huddle tool 2 hourly.
- A reporting and governance process is implemented to monitor patients on the corridor.

Priority Recommendations (3 of 3)

Assessment Areas (RSH & PRH)

- Discontinuation of reverse queuing from the AMU to the ED with immediate effect as this is poor patient experience and results in increased time to be seen.

- Develop an electronic medical take list that assigns a clinical and time priority to each patient waiting to be seen regardless of location.

- Review potential use of the CDU as an alternative function due to current staffing constraints.

- Protect short stay beds from long stay patients.

- Review staffing options to optimise short-stay flow.

- Extend the hours of the medical staff within AEC and staff the unit fully on weekends to prevent unnecessary admissions.

- Review of AEC at RSH to reduce risks to patients managed in this area when the unit is bedded.

Ambulance (RSH & PRH)

- Direct access / streaming by ambulance crews to alternate depositions such as AEC, AMU, urgent care centre (UCC) as directed by a HALO (hospital ambulance liaison officer).

Breach Analysis (RSH & PRH)

- To start using the breach analysis tool provided as part of a multi-speciality / disciplinary workshop to work through the issues that the breach analysis tool identifies.

Space utilisation (RSH)

Assessment	Space utilisation
Observation	Recent demand and capacity analysis has identified the AMU at RSH does not have the capacity to manage the daily take which results in the CDU being utilised as extra AMU capacity and the AEC being bedded with in-patients on a frequent basis. The team reviewed alternative use of space available at the RSH site. The team discussed current staffing constraints in the ED and medical teams which are affecting flow; e.g. staffing models and shortages within the ED, AMU and short-stay ward.
Impact	Current AMU space constraints are resulting in: - Crowding in the ED. - Delays from decision to admit to admission. - Bedding of AMU patients in other areas; CDU and AEC. - Delays in time to be seen and treatment commenced.
Recommendation	**Complete an options appraisal to enable effective use of space and right-sizing of the assessment areas on site, to include; AMU, short-stay, SAU, AEC, CDU, ED and frailty. This should include consideration of the recent demand and capacity diagnostic and staffing models.** *Space utilisation was not reviewed at PRH but should also be completed to review opportunities as identified above.*

Emergency department, corridor care, escalation & site management – RSH and PRH (1 of 2)

Assessment	Corridor care and escalation		
Observation	Escalation on both sites is not fit for purpose. ED crowding has become normalised.	The computer system in use makes oversight of each area in the department challenging.	The department has no sight of; numbers of patients cared for in corridors, length of stay for this cohort of patients, no reporting and lack of governance for these patients.
Impact	Affects of ED crowding is harmful to both patients and staff well being.	Staff are using the IT system differently for different purposes. The system is not used in real time, therefore it is impossible to actually see where the greatest risks are in the department.	Difficult to manage risks in the department and ensure continuous improvement.
Recommendation	ED section of escalation policy needs tightening up including the ability of the ED to move patients unilaterally to assessment areas during periods of heightened escalation. **Safe use of risk assessed areas as part of the full capacity protocol needs to occur as soon as possible.**	We recommend each area of the emergency department develops its own escalation triggers and actions. These get fed to the nurse and doctor in charge to escalate to the site team when necessary.	**We recommend a reporting and governance process is implemented to monitor patients on the corridor.**

Emergency department, corridor care, escalation & site management – RSH and PRH (2 of 2)

Assessment	Corridor care and escalation		
Observation	The nurse in charge was extremely busy which makes coordination and keeping oversight of the whole department very challenging. It was not possible to identify the nurse or doctor in charge on the day we visited.	Nursing and medical staffing constraints on both sites. Limited senior nursing staff and skill-mix to manage clinical pathways effectively.	During the site meeting we observed a brief exchange of information without a clear plan or accountable actions. The site management team is currently under-resourced to provide the support required to the ED and hospital.
Impact	A helicopter view of the whole department is essential for safety and responsiveness. This causes confusion and roles become blurred.	Reduced staffing capacity to manage demand.	In busy challenging EDs it's very easy to get pulled into delivering care. It is essential that the site team have a clear picture of the ED, the whole hospital and what the constraints are and it is their role to ensure flow is maintained.
Recommendation	**We recommend 2 hourly safety huddles take place with the nurse and doctor in charge.** **We recommend a departmental dashboard is implemented.** The nurse and doctor in charge should be clearly identifiable with clear roles and responsibilities.	**We recommend the completion of an ED workforce interim review and increase staffing and skill-mix as a matter of urgency.**	**We recommend the FOCUS site management tool (see appendix 1) to develop and improve site management processes.** **We recommend a review of staffing to support effective site management.**

Streaming & Pathways (RSH and PRH)

Assessment	Streaming (PRH)	Streaming (RSH)
Observation	No streaming nurse was present and all patients were being bottle necked through triage. There was a significant wait to be triaged. We were told the nursing workforce is very junior and therefore unable to confidently stream patients who do not require triage. There are no visual aids to identify what patients are waiting for in the main waiting area.	Staff reported streaming is not always in place and staff members are pulled to support other areas in the department Nursing workforce is junior.
Impact	Triage is a much longer process and not all patients require a full triage. It was not possible to determine who in the waiting room had been assessed placing the unassessed patients at risk. Creates delays for assessment and places a high level of responsibility on the triage nurse. The opportunity to reduce ED crowding by using the primary care resource is not being realised effectively.	Delays in being assessed and increased through-put to the ED.
Recommendation	Ensure a senior nurse is always available to stream consistently. Colour code chairs in the ED waiting room to enable sight of assessed and unassessed patients. **Complete staffing review for streaming and provide regular practice development support and coaching to all junior staff.**	Streaming needs to be consistent and occurring at all times led by a senior nurse. Review opportunities to directly accept patients to specialities. Review potential to increase throughput +/- opening hours for co-located GP. **Complete staffing review for streaming and provide regular practise development support and coaching to all junior staff.**

Assessment areas- AEC, CDU, AMU (PRH)

Assessment	AEC	CDU	AMU
Observation	We observed a highly motivated dynamic approach to AEC. We were advised AEC staff will pull patients from AMU beds and the ED when they can.	Only one patient on the unit and whilst we were there the staff were pulled back to the main department due to staff shortfalls. There is strict criteria for entry.	We were advised the patients in the corridor were expected by medics and directed to the AMU by the care coordinator. We were told at about 19:00, patients waiting are sent back to the emergency department. Specialities in reach to the assessment unit at different times of day.
Impact	It was reported that up to 40% of the medical take go through AEC. This is good practice and promotes a Fit2Sit culture in the assessment unit.	A very crowded ED. CDU resource not being fully utilised.	There is not clear oversight of who is waiting where or in the greatest need which is a very poor patient experience. Variable specialty in reach means some patients receive more efficient timely care than others.
Recommendation	**Extend the hours of the medical staff in AEC and staff the unit fully on weekends to prevent unnecessary admissions.** We recommend the AEC pull function is formalised and occurs a minimum every two hours.	The CDU area utilisation needs to be reviewed and then staffed consistently to enable pulling of patients from the ED. **Review potential use of CDU as an alternative function due to current staffing constraints (i.e. frailty assessment unit).**	**Develop an electronic medical take list that assigns a clinical and time priority to each patient waiting to be seen regardless of location.** **Patients waiting to see medical staff in the AMU should NOT be redirected to the emergency department.** Reduce variation and ensure all specialities in reach to the assessment unit early every day.

Assessment areas- AEC, CDU, AMU (RSH)

Assessment	AEC	CDU	AMU	Short-stay
Observation	The AEC was unable to fully function as there were inpatients bedded there. AEC was being utilised for inpatient beds. Staff reported this results in some patients being managed in inappropriate areas.	There was one ED patient within the CDU and the remainder were medical inpatients.	Without really good patient flow the AMU is unable to function effectively within its current bed base. We were advised the patients in the corridor were re-directed back to ED in the evening.	The short stay unit has numerous long stay patients on it therefore it does not fully utilise its flow potential. Ward rounds are not undertaken using SHOP principals therefore the benefits of early discharges are not always realised. Limited consultant staffing currently in place, weekend cover variable.
Impact	If AEC does not function more patients are bedded and then require admission which exacerbates the crowding in the hospital. This impedes flow and AECs ability to function	The CDU is being used as an extension of the assessment unit and not for its intended purpose.	Patients back up in the emergency department.	Less discharges occur because the acute physician is managing long stay patients Sick patients should always be seen first , discharge patient thereafter as it can take time to arrange transport etc. This also allows improved flow of take out medicines to the pharmacy.
Recommendation	**Review options to protect AEC from inpatients.** Consider an additional curtain rail between AMU and AEC beds to enable at least 2 spaces to function. **Review of AEC at RSH to reduce risks to patients managed in this area when unit is bedded.**	**Review potential use of CDU as alternative function due to current staffing constraints (i.e. frailty assessment unit).**	Undertake an options appraisal exercise to optimise utilisation of space. **Patients waiting to see medical staff in AMU should NOT be redirected to the emergency department to form one queue.**	**Protect short stay beds from long stay patients**. Bed managers should prioritise moving long stay patients to base wards to enable this unit to turn churn discharges Ensure ward/board rounds are conducted using the SHOP principals. **Review staffing options to optimise short-stay flow.**

Ambulance handover and Fit2Sit (PRH)

Assessment	Ambulance handover and Fit2sit
Observation	Ambulance arrivals make up approximately 25-28% of total attendances, with 33% experiencing delays of over 30minutes (see ECIST dashboard). A system is available to ED staff to view incoming ambulance arrivals only. Ambulance crews were not using alternate streaming depositions to the ED such as AEC, UCC. There was no HALO diverting patients to alternatives at PRH- as observed in RSH. Diversion by a HALO is a key role, especially at times of pressure and is a key omission . Ambulance handover takes place in two pitstop bays, however these are often occupied and ambulance handover defaults to majors or the corridor. Patients are often transferred from an ambulance trolley to an ED trolley in the corridor. This is compromising patient privacy and dignity. Fit2Sit has 2 observational cubicles and an 8 chaired seating area. We did not observe ambulance arrivals transferred appropriately to this area and the assessment cubicle had a patient occupying it during our review.
Impact	All ambulance arrivals going through ED leads to: • ED crowding • Delays to patients following the appropriate pathways
Recommendation	**Direct access / streaming by ambulance crews to alternate depositions such as AEC, AMU, UCC directed by a HALO.** **Ensure that the mindset of pitstop is to move patients onto appropriate pathways as soon as assessment has been completed, to ensure there is capacity for new ambulance arrivals.** **Implement privacy screens for patients in the corridor and / or suitably risk assessed areas.**

Breach analysis

Assessment	Breach Analysis
Observation	The current IT system in the ED has limited functionality and is not used by all clinicians resulting in poor data quality. In discussion with the ED and the informatics team, we identified the current assigning of minors / majors breaches by acuity is not providing an accurate picture of current performance.
Impact	Poor data quality has led to no breach analysis currently being completed and therefore a limited approach to understanding constraints and continuous improvement.
Recommendation	We have agreed with the trust to review data quality and collection and suggest using the breach location instead of acuity as this provides a more accurate picture of current breaches. **Start using the breach analysis tool provided as part of a multi-speciality / disciplinary workshop to work through the issues that the breach analysis tool identifies.**

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Stephen Duncan- Deputy Director, ECIST Stephen.duncan2@nhs.net

Appendices and Resources Section

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Appendix 1

Five guiding principals - FOCUS

F - Front door position and triggers - Current position and actions.

O – Operational oversight and management of whole hospital constraints.

C – Challenge patient plans and pathways.

U – Understand actions required and agree accountability.

S – Site plans, escalation and report.

ECIST emergency department review - Dec 2018

Resources

The following documents and websites provide practical tools and resources related to the recommendations within this report:

- Royal College of Physicians (RCP) Acute Care Toolkits - link
- Royal College of Emergency Medicine (RCEM) guidance - link
- Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018 - link

NHS Improvement resources:
- Safer, faster, better: good practice in delivering urgent and emergency care – link
- Good practice guide: focus on improving patient flow – link
- Case studies: focus on improving patient flow - link
- Guide to reducing long hospital stays - link
- Rapid improvement guide: maximising AEC services - link
- Rapid improvement guide: the 6 As of managing emergency admissions – link
- Reducing ambulance handover delays – link
- Are your patients fit to sit (fit2sit)? – link
- Safer patient flow bundle - link
- Safer patient flow bundle – ward rounds - link

More resources can be found on the NHS Improvement Hub - https://improvement.nhs.uk/improvement-hub/

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Goal: **To improve the performance against the national Emergency Department (ED) 4hour target and to continuously improve the ED processes to benefit patients.**

Executive Sponsor:	Sara Biffen

Sponsor Team:

Sara Biffen (Executive Sponsor); Rebecca Houlston; Carol McInnes; Jan McCloud; Kumaran Subramanian; Vanessa Roberts;
Jon Lacy-Colson; Karen Thompson; Ed Rysdale; Lucy Roberts

KPO Support:
Louise Brennan

Aim Statement/Target Condition

NHS England have set the standard that all patients presenting to ED should be seen and discharged within 4 hours, or if admitted transferred to a ward within four hours of the decision to admit.
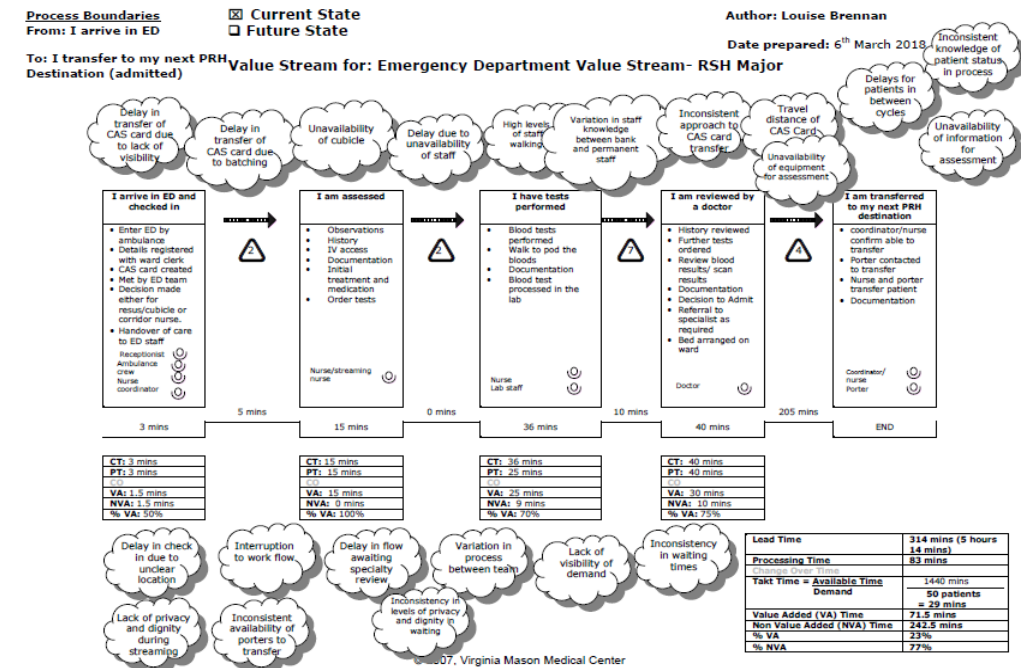
The Plan to Improve:

RPIW Topic	Sponsor	Process Owner	Date
RPIW #1 Specialty Review RSH	Rebecca Houlston	Clare Emery	30th April- 4th May 2018
RPIW #2 Front Door Streaming PRH	Vanessa Roberts	Angie Boulds	9th-13th July2018
RPIW #3 Documentation RSH	Jan Mccloud	Lisa Mathews	24-28th September 2018
RPIW #4 Transfer to X-ray PRH	Sara Biffen	Jan Mccloud	15-19th October 2018
RPIW #5 Flow of Minors RSH	Ed Rysdale	Kim Humphreys	10-14th December 2018

Kaizen Plan

Month	RPIW – Topic and Date	Link to value stream cycle box	Genba	Sponsor	Process Owner	L4L
March 2018	**SDD**					
April 2018	Specialty referral of ED patient 30th April- 4th May	Cycle box 4	ED RSH	Rebecca Houlston	Clare Emery	
May 2018						
June 2018						
July 2018	Front Door Streaming/ Ambulance Hand Over 9th July- 13th July	Cycle box 1	ED PRH	Vanessa Roberts	Angie Boulds	
August 2018						
September 2018	Topic: Documentation 24th-28th September	All cycle boxes	Genba: RSH ED	Sponsor: Jan Mccloud	Process Owner: Lisa Matthews	Jan Mccloud

October 2018	Topic: Radiology Requests 15-19th October	Cycle box 3-4	Genba: PRH ED and Radiology	Sponsor: Jon Lacy Colson	Process Owner: Jan Mccloud	Lara Wynn Jan Mccloud
November 2018						
December 2018	Minors Pathway RSH 10-14th December	Minors Value Stream map	Genba: RSH Minors	Sponsor: Ed Rysdale	Process Owner: Kim Humphries (PO), Julie Talbot (Co-PO)	
January 2019	Kaizen event- white board usage		Genba: PRH ED	Sponsor: Sara Biffen	Process Owner:	

Value Stream Action Plan

Focus Area	Activity List activities in support of the focus areas.	Target Completion Date	Completed
Update and revise value stream boundaries	• Discuss boundaries at Value stream sponsor team meeting • Agree revised boundaries at Guiding Team Meeting (GTM) • Update VSM and display within genba and accountability wall	• Thursday 10th January 2019 • Thursday 17th January 2019 • Thursday 17th January 2019	
Production Board and Peoplelink training session for ED staff	• Review KPO capacity to provide 1 hour training sessions. • Discuss at next ED VSST regular genba walks within each ED • Liaise with managers to identify staff to attend training	• Wednesday 16th January 2019 • Thursday 24th January 2019 • Thursday 24th January 2019	
Create a staff engagement metric that can be measured in real time	• VSST members to develop metric with staff in ED. • To collect during team meeting.	11th February 2019	
Roll out of RPIW kaizen work to opposite site	• Test of new documentation, PDSA and then roll out. • Share new X-ray request card with ED team at huddle • PO and Sponsor for RPIW #5 to roll out improvements to PRH site	• Mid February 2019 • Immediately • Mid February 2019	
Metric A. Volume of waiting time for patients within the process boundaries.	• Raise profile of specialty review SOP within medical meetings • PDSA the SOP and display within the genba • ED improvement event exploring the use of the whiteboard. • Recruitment of ED staff to support early assessment	• Action completed • Action completed • Monday 14th January 2019 • Ongoing	
Metric B. Lead Time arrival to transfer to next destination	• Increase in lead time at PRH site prompted the review of the process boundaries to understand where the constraint is within the process. • Share learning's with the standard work value stream to highlight and support flow issues.	• Thursday 24th January 2019 • Mid February 2019	
Metric C. Arrival to DTA	• The value stream map boundaries are to be adjusted to end point of DTA to focus the improvement work. • To continue to measure transfer to next destination time • Reduction in metrics between Q1 and Q2 demonstrating removal of waste in the process. • Demonstrated further value stream improvement events required to meet target.	• Thursday 24th January 2019 • End March 2019 • Next RPIW May 2019	
Metric D. Ambulance hand over time	• Reduction in handover times for both sites. • VSST aware that Pit stop process not consistently used. To review and explore who could champion the work to ensure the process is used. • VSST Executive sponsor to investigate how a reduction in handover time has impacted corridor hand over fines	• End January 2019 • Thursday 24th January 2019	

Metric E Minors pathway Lead Time	• Roll out minors pathway learning from RPIW #5 to PRH site • Continue remasures for next 60 days • Present metrics on peoplelink board	• End January • 18th March 2019 • End January	

Targets

Metric	Baseline	Target	Q1 (July-September 2018)	Q2 (Oct-Dec 2018)
A. Volume of waiting time for patients within the process boundaries. 1. RSH 2. PRH	1. 242.5 minutes 2. 320 minutes	120 mins	1. 357 mins 2. 297 mins	1. 230 mins 2. 529 mins
B. Lead Time arrival to transfer to next destination 1. RSH 2. PRH	1. 314minutes (5hrs 14 minutes) 2. 383 minutes (6hrs 23 minutes)	3 hours 59 mins	1. 404 mins (6 hours 44 mins) 2. 323 mins (5 hours 23min)	1. 360 mins (6 hours) 2. 619mins (10hrs 19 mis)
C. Arrival to DTA 1. RSH 2. PRH	1. 180mins (3 hrs) 2. 170 mins (2hrs 50 mins)	120 mins	1. 280 mins (4 hours 40 mins) 2. 235min (3hrs 55 mins)	1. 170 mins (2hours 50 mins) 2. 176 mins (2 hrs 56 mins)
D. Ambulance hand over time 1. RSH 2. PRH	1. 35 minutes 2. 32 mins	15 mins	1. 20 mins 2. 25 mins	1. 2.16 mins
E. Minors Pathway Lead Time RSH From: I am triaged in ED reception To: I leave ED minors	78 mins	60 mins	N/A	21 mins (30 day remeasures)

Value Stream Executive Sponsor Comments

What has gone well?

• Reductions on Lead time from arrive to DTA for both sites demonstrating a reduction in waste through the TCPS.
• Minors pathway RPIW- leadtime reduced from 78 mins to 21 mins and 0% defects in the process at RSH.
• Support from Kate Farrow (Operational ED Nurse) to drive improvements and support the team
• Great engagement from the VSST to continue to meet fortnightly and address outcomes and actions in a timely manner
• Moorhouse workshops- good engagement from ED staff and recognition of the value stream work done to date. Opportunity to use share and spread the work

What could have gone better/ Where do I need support?

• Support to implement and sustain the pit stop process.
• RPIW #4-Business case for radiology assistant pending.
• Timely gathering of metrics

What are my actions?

• Follow up on gathering the outstanding value stream metrics
• Ensure the Moorhouse project work supports the value stream work
• Establish regular genba rounding to help the development of the peoplelink board in both sites.
• Identify the next improvement event topic and scope.

Urgent and Emergency Care Programme

A&E Delivery Board

Executive Team Meeting
Chair: Chief Executive (SW)

Urgent Care Operational Group
Chair: Chief Operating Officer (NL)

A&E Delivery Group
Chair: Urgent Care Director (CO)

Site management and internal escalation
Chair: Sara Biffen

Escalation and Full Capacity
T & F Group
Lead: SB

Space utilisation and improved flow
Chair: SB

Bed modelling / improved flow
T & F Groups
Lead: SB

ED Systems and Processes HIC
Chair: NL

ED Value Stream
Lead: Sara Biffen

ED systems and processes
Incl. streaming, breaches, alternative pathways
Lead: Carol McInnes

ED Workforce
T & F Group
Lead: VRankin

Standard Work / SAFER/R2G HIC
Chair: Carol McInnes

Standard work Value Stream
Lead: Gemma McIver

Weekend / 7 day working acute
T & F Group
Lead: Karen Barnett

Stranded Patients / Reducing LLOS
Chair: Edwin Borman

Stranded patients project group
Lead: Gemma McIver

Whole system escalation
Chair: Claire Old

Frailty HIC
Chair: Fran Beck

Integrated Discharge HIC
Chair: Tanya Myles

Complex Discharge RPIW
T & F Group
Lead: Local Authorities

Weekend / 7 day working whole system
T & F Group
Lead: Claire Old

Demand and Capacity HIC
Chair: Julie Davies

Appendix 3

Named Improvement and Informatics support to each stream

Finance, HR, Communications

Urgent Care Programme Board

Project Summary

Project Overview				Overall Project Status	
Project Title:	**Project 1 – ED Systems & Processes (Command & Control)**	**Deadline:**			
Exec Lead:	**Nigel Lee**	**Project Lead:**	**Rebecca Houlston/Kate Farrow**	**AMBER**	
Clinical Lead:	**Dr Kumaran Subramanian**	**Project Group:**	**Urgent Care Improvement Programme**		
Date of Report:	**16th January 2019**	**% improvement in admitted performance target:**			

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Continued review/refresh of all ED SOP's and professional standards with sign off from CD and ED Matron with all re-circulated to staff. To be completed January 2019. Once revised non-compliance to be escalated accordingly
- Newly appointed Operational Lead Nurse continues to role model expected behaviours for co-ordinator function – focus upon PRH site initially
- Plans to include 2 cross-site sessions being arranged with ED Coordinators (5th February 2019). This will include whiteboard standardisation expectations and circulation of all professional standards and ED SOP's.
- Progression of plan to implement ED internal escalation triggers plan
- Continuation of roll out of consultant in charge model with board rounds in line with SOP – working well to date
- Further revision of validation process implemented – working well
- Daily patient safety huddles continue with a focus on workforce and appropriate actions required for the next 24 hours, new document being trialled

Key Issues/Risks

- Workforce gaps for both medical and nursing staff continue as per workforce report. This impacts upon ability to deliver improvement consistently
- Management of agency/temporary staffing consistently following process
- Increased number of junior band 5's and 6's

All risks mitigated where possible.

Key items for next week

- Ensure compliance with revised SOPs
- Operational Lead Nurse to continue role model behaviours for Coordinator function (initially PRH)
- Identify clinical lead to support escalation triggers development
- Focus upon continued improvement against ED performance standards (from arrival to streaming etc)

Performance Overview

- SaTH majors performance for wc 7th January was 29.45% with 805 patients breaching the 4 hour patient safety target
- SaTH attendances were up 13% in comparison to the same period in 2018
- SaTH ambulance activity was up 15% in comparison to the same period in 2018

- RSH majors performance for wc 7th January was 30.31% with 377 patients breaching the 4 hour patient safety target
- RSH attendances were up 14% in comparison to the same period in 2018
- RSH ambulance activity was up 18% in comparison to the same period in 2018

- PRH majors performance for wc 7th January was 28.67% with 428 patients breaching the 4 hour patient safety target
- PRH attendances were up 13% in comparison to the same period in 2018
- PRH ambulance activity was up 12% in comparison to the same period in 2018

The Shrewsbury and Telford Hospital **NHS**

NHS Trust

Emergency Department Workforce Overview and Update
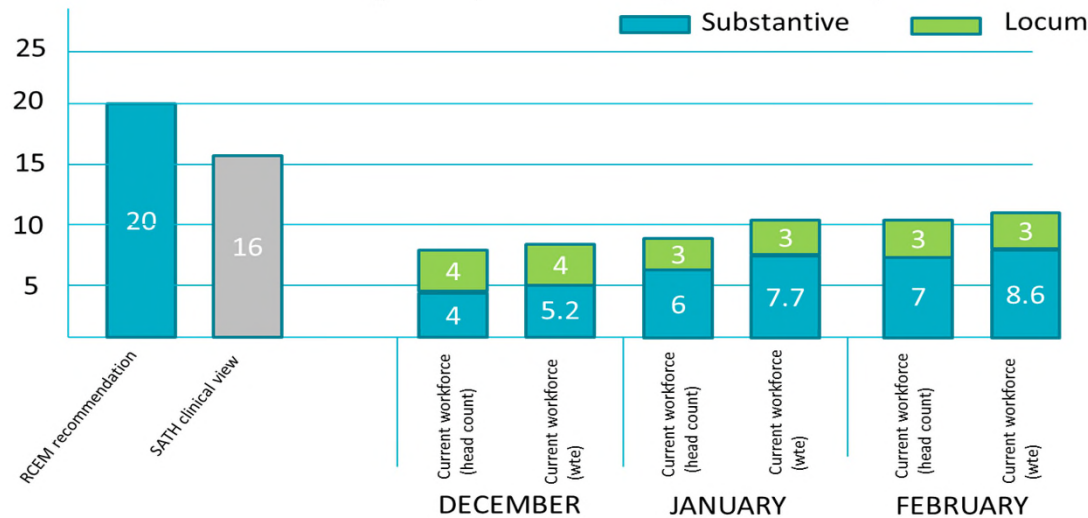# January 2019

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Medical - Consultant

Current Workforce Position and Forecast

We have two substantive Consultants starting in January, which takes our substantive consultants to 6, and we have maintained three Locum consultants. We have one further (part time) consultant staring with us in February.

Our current 6 (headcount) consultants are all paid additional PA's than the 10 PA standard contract and as such the 6 (headcount) consultants are paid 7.2wte.

With the additional consultants starting, by March we will have 7 (headcount) substantive consultants, but will account for 8.2wte.

If we maintain the locum consultants to maintain 10 (headcount) consultants, we will have the equivalent of 11.6wte consultants.

Recruitment Actions and Activity

There has been extensive recruitment activity in an attempt to fill the gaps within our Emergency Department and has included the following:
- Launch of a bespoke recruitment campaign
- Golden hello's offered as part of remuneration offer.
- Development of new roles to support the department such as ED Flow Coordinators, Emergency Care Practitioners, Advanced Clinical Practitioner, Simulation Fellow, Clinical Fellow.
- Enhanced rates offered to doctors into Emergency Medicine.
- All long term locums have been met with to discuss substantive options and discussions are continuing.
- Rolling request for agency cover at all levels in place.

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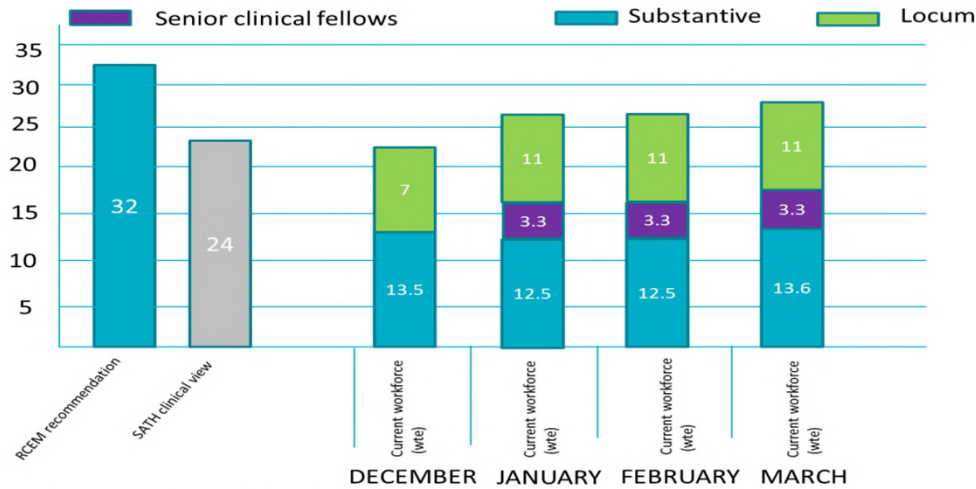We Value **Respect**
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Workforce Capacity Improvement

Consultant Recruitment 18/19

2
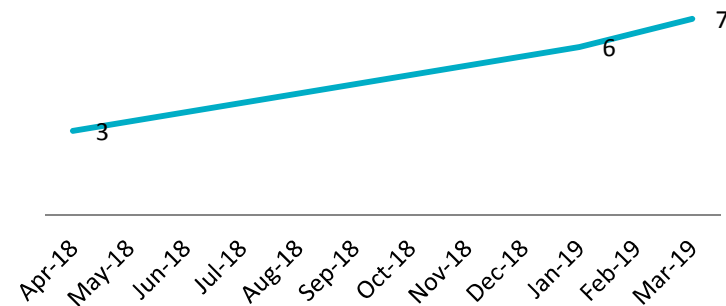
Medical – Middle Tier

Current Workforce Position and Forecast

There are 4 new Middle tier doctors confirmed to start with the Trust, 2 senior clinical fellows arrived in the country and will be on the MT rota during the day with consultant supervision and will be able to cover SHO level responsibilities at night. 1 further senior clinical fellow is still confirming start date.
1 specialty doctor, who can take the full MT rota responsibilities once assessed by our consultant body, is awaiting a confirmed start date.

10 doctors were interviewed in December. 7 of these have been offered Specialty doctor roles and we are awaiting confirmation from them that they have accepted the offer.
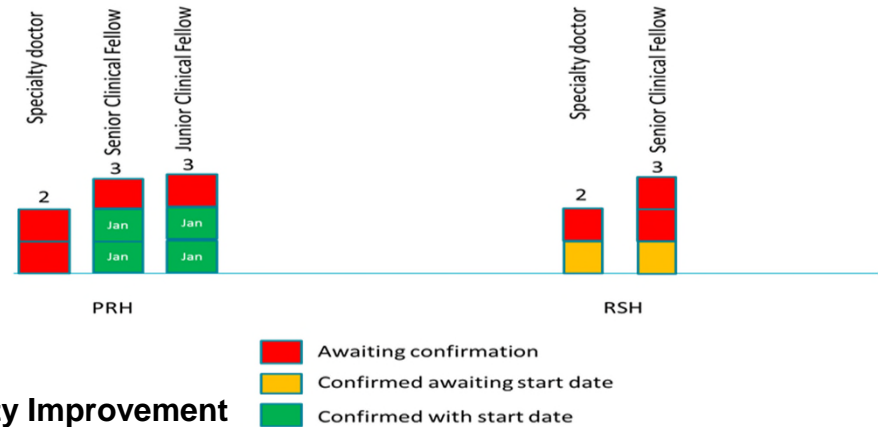
Our current substantive middle tier workforce is 13.5wte, with the additional locum staff appointed the workforce will rise in December to 23.5wte.

When the new specialty doctor and senior clinical fellows join us the middle tier workforce will rise to 26.8wte.

Recruitment Activity

Workforce Capacity Improvement

Middle Tier Recruitment 18/19

3
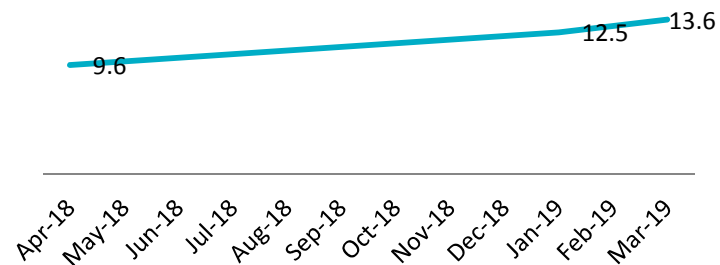
Medical – Junior Tier

Current Workforce Position and Forecast
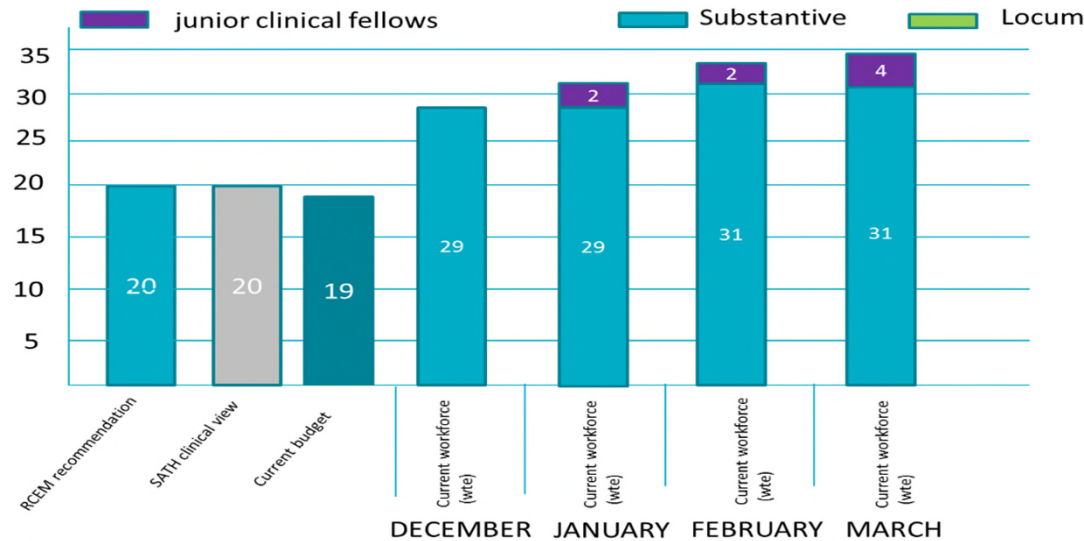

The junior tier rota will be supported by substantive appointments that have been made recently as well as the full compliment of doctors joining through the training programme (Health Education England) from February. Three senior clinical fellows are joining the organisation in January. These are middle tier level doctors that require a 3 month induction prior to them being able to work on the floor as middle tier doctors.

The current substantive workforce is 29wte. With the additional Junior clinical fellows joining the Trust in January this will rise to 32.3wte.

- 2 doctors who had applied for middle tier roles have been offered, and accepted, Junior clinical fellow roles with the Trust – these will be included on the SHO rota.
- 4 further Trust doctors have been appointed. The February HEE fill currently has no gaps in our training place allocation.
- From the interviews in December, 2 doctors were offered Junior clinical fellow roles – we are awaiting confirmation of their acceptance.
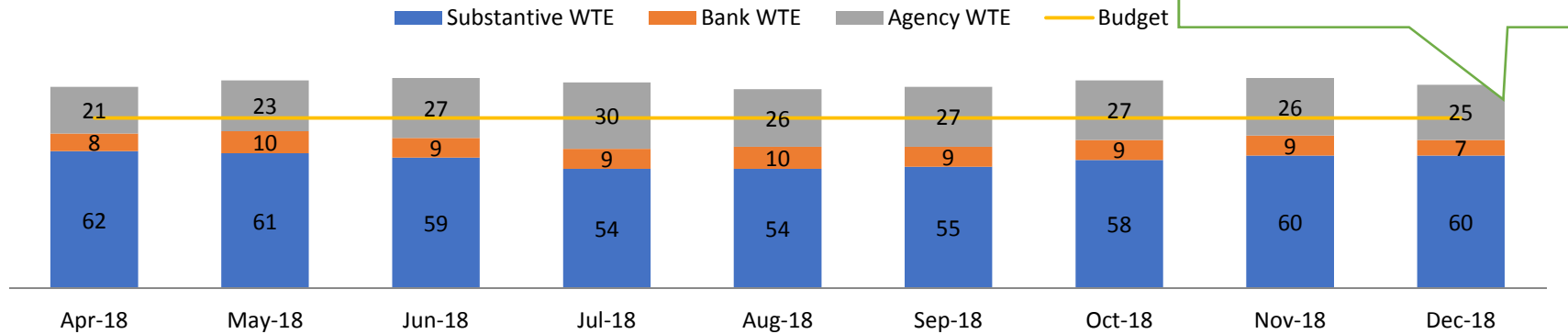
Recruitment Actions and Activity

The recruitment for Consultants has been a continuous rolling programme over the last 12 months. This has included an investment of over £40,000 in advertising costs and agency introductory fees which has been spent on a broad marketing and advertising campaign. The detail of this recruitment activity has included:
- Target email to ED Consultants throughout the country
- Colour adverts in BMJ online and journals
- Campaign press releases
- Enhanced social media usage
- Candidate pack developed
- Professional Adverts developed by Clear Design
- Use of international recruitment agencies to source candidates
- Supporting overseas doctors through visa applications
- Networking with local GP's to assess potential for recruiting overseas doctors e.g. from Nigeria
- Engaging the following agencies for substantive recruitment Medacs Healthcare, ID Medical, Remedium

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4

Nursing – Band 5 and 6

ED Nursing Workforce

Legend: Substantive WTE | Bank WTE | Agency WTE | Budget

Currently have 16 wte vacancies but consistently using an average of 25 wte agency.

Month	Agency WTE	Bank WTE	Substantive WTE
Apr-18	21	8	62
May-18	23	10	61
Jun-18	27	9	59
Jul-18	30	9	54
Aug-18	26	10	54
Sep-18	27	9	55
Oct-18	27	9	58
Nov-18	26	9	60
Dec-18	25	7	60

Recruitment Actions and Activity

Recruitment of registered nurses is a centralised function and run as part of a continuous programme of events throughout the year. This includes open days and recruitment events which are run as a 'one stop' event where they are interviewed and undertake assessments on the same day. The Emergency Department has also invested in a nursing campaign specifically for ED. This has included the development of a professional advert and candidate pack advertised on line via the RCN and Nursing Times.

In addition, we have held regular ED Recruitment events for Nursing which is designed to promote the department and recruit nurses specifically interested in a career within emergency medicine.

The events have involved:
- Advertising in support of recruitment Day
- 'One stop shop' event. (interviewing and making offers on same day as recruitment event)
- Using SaTH's legacy 'campaign' theme. This is a tailored marketing campaign designed to attract candidates to our Emergency Departments.
- Creating marketing materials, posters etc. specifically for event.

SaTH Campaigns	Number of Times Post Advertised	Number of Appointments
Previous 6 Months	14	13
6 to 12 Months	10	8

Introduced the following roles throughout the year:
- ED Flow Coordinators
- Emergency Care Practitioners
- Emergency Nurse Practitioners
- Advanced Clinical Practitioner
- Clinical Fellow

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