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

TRUST BOARD
25th October 2012

TITLE	**Emergency Care Pathway**
EXECUTIVE SUMMARY	The Trust implemented a new model for emergency medical care on 8th October 2012. This is the first significant change to be delivered as part of the unplanned care programme of work and a step towards sustained delivery of the 4 hour standard for waiting times in the Emergency Department. Delivery of this change represents the culmination of over 6 months of planning and preparatory work. The detailed planning in the days leading up to go-live went very smoothly and early indications suggest that the changes have had a positive effect on capacity and flow in the hospital.
BOARD ASSURANCE (Risk) / IMPLICATIONS	Compliance is reflected in the Board Assurance Framework. BAF Risk 1.1 National targets and priorities.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient expectations in terms of access are reflected in NHS performance targets.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	The risk of failure to meet the four hour standard for waiting times in ED creates a potential regulatory issue for the Trust.
The Trust Board is asked to:	Note the report.
Submitted by:	Valerie Bartlett, Deputy Chief Executive Claire Braithwaite, Associate Director of Operations
Date:	16th October 2012
Decision:	For Noting.

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TRUST BOARD, 25th October 2012

EMERGENCY CARE PATHWAY

1 INTRODUCTION

The purpose of this paper is to update Trust Board on recent significant changes to the medical model for emergency care and to provide a detailed overview of current performance against the four hour waiting time standard for the Emergency Department (ED).

2 CHANGES TO THE MEDICAL EMERGENCY CARE PATHWAY

On Monday 8th October the Trust implemented significant changes to the medical emergency care pathway at Pt. Peter's Hospital as part of the Unscheduled Care Programme. The changes were agreed following visits and recommendations from the Department of Health Emergency Care Intensive Support Team (ECIST) and on the basis of clear and compelling national evidence that overcrowded EDs lead to worse patient outcomes. Under our existing systems patients were experiencing long waits in ED and for an inpatient bed, and some were staying too long in hospital.

The changes mean that there are now clear pathways for urgent medical patients, with early senior assessment and decision-making, ensuring that patients go to the right place first time. This includes:

- Early decision-making by experienced consultants seven days a week, supported by an enhanced multi-disciplinary team, to identify care needs and ensure patients are on the right pathway first time.

- Sending all GP referrals and medical referrals from A&E directly to the Medical Assessment Unit (MAU) for assessment.

- Creating a new Medical Assessment Unit (MAU) with 21 trolleys, and a new Short Stay Unit with 38 beds in the area previously used for medical assessment.

These changes represent a first and significant step in the redesign of emergency medical care pathways as part of the Unscheduled Care Programme.

Delivery of this change represents the culmination of over 6 months of planning and preparatory work. This includes:

- Making the clinical case for change.
- Completing a formal consultation with the consultant physicians.
- Analysing patient flow in detail to agree the correct allocation of beds.
- Changing timetables for 20 consultant physicians.
- Changing the level of consultant support available in the evenings at weekends.
- Reallocating the nursing teams from 2 wards to align with the new MAU and SSU structure.
- Working with social care and community services to agree their input.
- Redesign of the therapy service to support the new model with senior resource front-loaded on MAU and in SSU.

- Agreeing the counting and contracting approach and amending systems for data capture accordingly.
- Developing and implementing the new operational policy for MAU and SSU.
- Identifying and ordering the equipment required to support the new pathway.
- Vacating 20 beds over the weekend of 6th October in readiness for go-live.

Although this has at times been challenging, the detailed planning in the days leading up to go-live on 8th October 2012 went very smoothly and early indications suggest that the changes have had a positive effect on capacity and flow in the hospital.

Success to date is not only due to the vision, hard work and dedication of the teams within the Division of Medicine in implementing this new model of care, but also a reflection of the whole-hospital focus that has enabled the changes to happen. The other Divisions and all of the corporate areas each had their own action plan outlining what they needed do to support the change.

3 CURRENT PERFORMANCE AGAINST THE 4 HOUR STANDARD

Figure 1 shows the percentage of patients that were admitted or discharged from the ED at St Peter's Hospital within 4 hours of arrival from 1st April 2012.

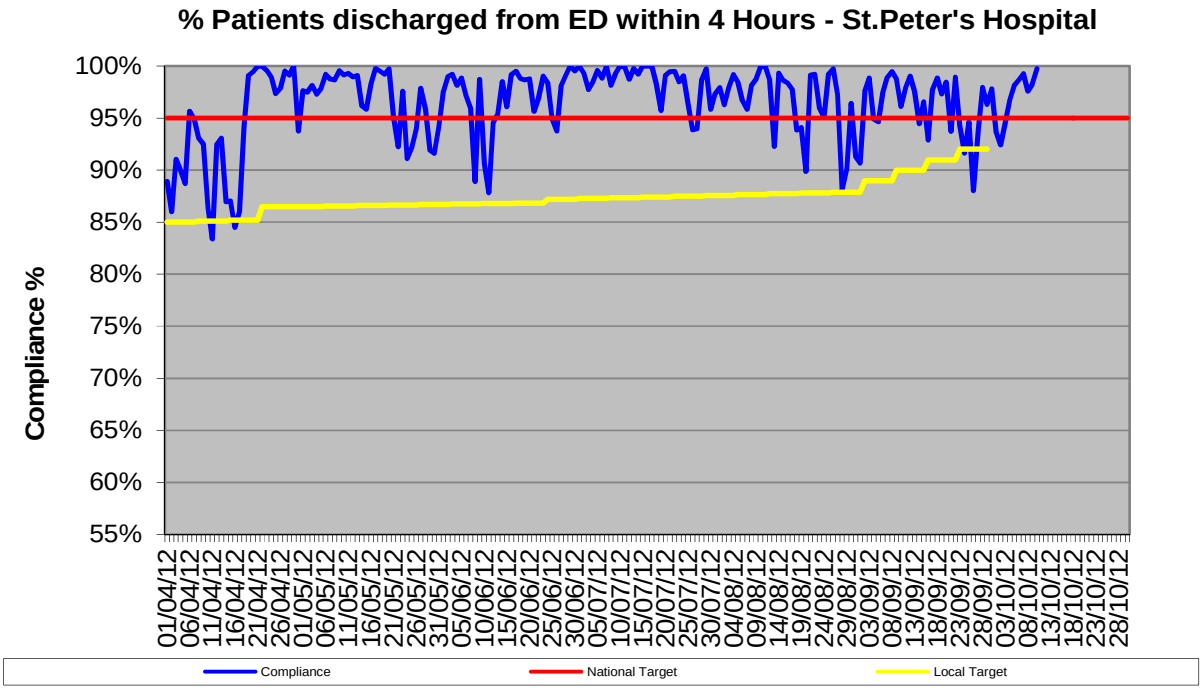

Figure 1

The improvement in waiting times seen in quarter 1 has continued and was above both the internal recovery trajectory and Compliance Framework Standard for quarter 2. Performance for quarter 2 as a whole was 97.1%. Performance for quarter 3 to date stands at 96.6%.

Figure 2 shows performance by month against the Monitor Compliance Framework standard (which includes activity for Ashford and St. Peter's Hospitals) and the standard used for contract monitoring (which only includes activity for St. Peter's). Performance at the St. Peter's site for October already shows a significant improvement on that for August and September and is linked to the implementation of the new emergency medical pathway of care.

Period	CONTRACT Position	COMPLIANCE FRAMEWORK Position
April	89.79%	93.10%
May	95.32%	96.77%
June	95.42%	96.86%
Quarter 1	**93.61%**	**95.63%**
July	97.82%	98.50%
August	94.89%	96.49%
September	94.50%	96.16%
Quarter 2	**95.77%**	**97.08%**
October to date	95.80%	96.56%
Quarter 3 to date	**95.80%**	**96.56%**

Figure 2

The number of breaches of the four hour standard at St. Peter's hospital for the week commencing 1st October 2012 was 117 and this fell to 49 for the week following the implementation of the new medical model.

Although performance has improved, achieving the 95% standard for quarters 3 and 4 remains a challenge. During September and early October delivery of the 4 hour target was compromised on a number of very difficult days. Whilst the recent changes to the medical emergency pathway of care will improve system resilience and its ability to respond when under pressure, further work is needed. A continued focus on the completion of the unscheduled care programme of work is central to successful and sustainable delivery.

4 CLINICAL QUALITY INDICATORS

There are dangers in focusing too heavily on just the time spent in ED because the four-hour standard does not differentiate between the time when someone is receiving active treatment and the time when they are just waiting for the next step in their care. For this reason, the Department of Health introduced a number of clinical quality indicators as part of the NHS Outcomes Framework for 2011/12. The purpose of these is to provide a balanced and comprehensive view of the quality of care, including outcomes, clinical effectiveness, safety and experience, as well as timeliness, and to remove the isolated focus on faster care. Although Trusts are not currently required to formally report performance against the indicators, they are encouraged to monitor them locally to obtain a balanced view of the quality of care.

Performance against the Clinical Quality Indicators at St. Peter's hospital is shown in Figure 3.

Problems with data capture continue with the "time to initial assessment" indicator and the significant deterioration in performance from June is a reflection of this. The IT Department is working with the team in ED to agree a solution and in the meantime local audits suggest that performance remains within the 15 minute standard.

The Trust also failed to achieve a 95th percentile total wait in ED of less than 4 hours in September. It is anticipated that the implementation of the new pathway for emergency medical care on 8th October 2012 will address this.

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Information Services: A&E Performance report - Clinical Quality Indicators Dashboard - ALL

Monitor Targets - St Peter's Data Only

Data refreshed on 15/10/2012

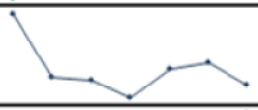
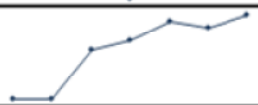
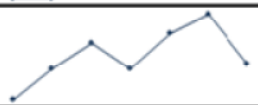
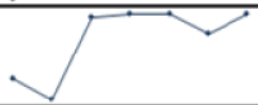
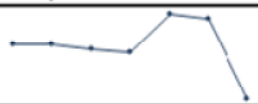
Description	Performance Measure	Target	Trendline by month	April	May	June	July	August	Setember	October
Patients seen < 4Hrs	MONITOR Compliance (SPH,GUM,EPU,ASH)	<=04:00:00		✗ 93.10%	✓ 96.77%	✓ 96.86%	✓ 98.50%	✓ 96.49%	✓ 96.16%	✓ 96.56%
Total Time in A&E	95th percentile	<=04:00:00		✗ 7:23:00	✗ 4:47:00	✗ 4:39:00	✓ 3:58:00	✗ 5:08:00	✗ 5:23:00	✗ 4:28:00
Time to initial assessment	95th Percentile	<15 min		✓ 0:07:00	✓ 0:07:00	✗ 0:41:00	✗ 0:48:00	✗ 1:01:00	✗ 0:57:00	✗ 1:06:00
Time to treat	Median	<60 mins		✓ 0:42:00	✓ 0:48:00	✓ 0:53:00	✓ 0:48:00	✓ 0:55:00	✓ 0:59:00	✓ 0:49:00
Unplanned reattendance	%age	Between 1% and 5%		✓ 2.9%	✓ 2.0%	✗ 5.5%	✗ 5.7%	✗ 5.7%	✓ 4.9%	✗ 5.7%
Left without being seen	%age	<5%		✓ 0.9%	✓ 0.9%	✓ 0.9%	✓ 0.9%	✓ 1.1%	✓ 1.1%	✓ 0.5%

Figure 3

5 KEY MILESTONES

Figure 4 shows a summary of the key unscheduled care programme milestones delivered in September and early October and the interventions planned for October and early November.

Project	Milestones completed this month	To be completed next month
ED PERFORMANCE: Developing and supporting staff in the ED to deliver an improved service, supporting flow and excellent patient experience	• Live audit of ambulance conveyances and walk-in attendances to A&E by SECAmb and SCH completed • 7th A&E consultant now in post	• Consultant interviews scheduled for 17th October • Submit business case for phase 2 development of A&E to TEC for approval • Agree workforce and OD programme
DISCHARGE MANAGEMENT: Improving the quality and efficiency of internal discharge processes	• Weekly weekend planning meeting initiated • Weekly "Ready to Go" meetings chaired by Chief Nurse commenced	• Launch of "Ready to Go" discharge project on Kingfisher, Swan and Falcon wards
IMPLEMENTING MAU AND THE ECIST MODEL: Redesign the model of care to focus on short-stay beds and fewer specialty beds, including the new MAU model	• New model of care for emergency medicine including a new Medical Assessment Unit and Medical Short Stay Unit implemented from 8th October 2012 • Staff engagement campaign complete	• Hold staff engagement campaign debrief event • Implement and monitor internal professional standards • On-going review and refinement of new medical model • Document "lessons learnt" from implementation of new model • Document entire change process as a case study • Implement hot clinics on MAU
BED ALLOCATION AND NURSING ESTABLISHMENTS: Capacity and demand analysis leading to rebalancing beds across the Divisions; and reconfiguration of nursing establishments	• Data pack for review of surgical model of care complete • Project team for review of bed allocation in surgery convened	• Convene project team for review of speciality bed allocation in medicine • Agree plan for relocation of cardio-angio unit and reopening of DSU at St. Peter's
EXCELLENCE IN THEATRES: II: Increasing capacity and improving flow through redesign of theatre timetable and new working practices	• Utilisation workshop for Specialist Medicine and Specialist Surgery held on 27th September 2012 • Go-live of extended day pilot in Orthopaedics • Comprehensive review of planned care pathway from referral to admission underway	• Finalise and publish Theatres dashboard (delayed from previous months) • Utilisation workshop for Colorectal Surgery planned for 16th October
REALTIME PHASE II: Embedding and exploiting the new software to improve processes and reduce length of stay	• Usage stats and Ward-based KPIs published	• Sign off changes required for IPL migration and agree timetable for implementation

Figure 4

6 CONCLUSION

The Trust met the four hour standard for waiting times in ED in quarter two and is currently on track to deliver in quarter three.

The Trust implemented a new model for emergency medical care on 8th October 2012. This is the first significant change to be delivered as part of the unplanned care programme of work and a step towards sustained delivery of the 4 hour standard for waiting times in ED.

Delivery of this change represents the culmination of over 6 months of planning and preparatory work. The detailed planning in the days leading up to go-live went very smoothly and early indications suggest that the changes have had a positive effect on capacity and flow in the hospital.

7 ACTION REQUIRED

The Trust Board is asked to note the significant changes made to the pathway of care for emergency medical patients.

The Board is also asked to note that the continued delivery of 4 hour standard remains a challenge and completing the implementation of the unscheduled care programme of work is the key to sustainable delivery.