Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**26 September 2018**		

Title of Report:	**Four Hour Improvement Plan 2018/19**
Status:	**For Action**
Board Sponsor:	**Francesca Thompson, Chief Operating Officer**
Author:	**Sarah Hudson, Divisional Manager Medicine**
Appendices	**Appendix 1: National letter dated 07/09/18**

1. Executive Summary of the Report

To update the Management Board on the 2018/19 RUH Urgent Care Collaborative Board programme performance. The report reflects information up to and including the 31st August 2018.

2. Recommendations (Note, Approve, Discuss)

The Management Board are asked to note the following:

- August 2018 four hour performance not achieved 81.8% (All Types)
- Performance did not meet the performance improvement trajectory of 90.0%

Factors affecting performance

- Ambulance conveyance activity +8.3% variance compared to 2017/18 for week ending 02/09/18
- Emergency presentations +6.3% year to date variance compared to last financial year
- Emergency Department attendances +5.9% year to date variance compared to last financial year
- There was a total of 279 beds closed in August due to infection (flu and norovirus)
- There were 29 patients reported in the August month end snapshot and 954 delayed days (5.3% reported, position has deteriorated compared to July 2018

Areas for improvement in September 2018

- Delivery of the weekly actions within the system wide 4 hour improvement plan including those to deliver the "10 by 10" objective
- Weekly urgent care performance meeting reinforcing action delivery against the 4 hour improvement plan
- System wide focus on patients with a length of stay of > 21 days, supported by the Integrated Discharge Service and Business Intelligence with daily reporting
- Super discharge week planning for w/c 22nd October 2018

3. Legal / Regulatory Implications

Care Quality Commission (CQC) Registration

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)

The 4 hour performance is currently on the risk register ID: 634

5.	Resources Implications (Financial / staffing)
Any requests for investment linked to this programme will continue to be reviewed monthly by the Urgent Care Collaborative Board and as directed by the Board, business cases taken through the usual Trust process.	

6.	Equality and Diversity
All services are delivered in line with the Trust's Equality and Diversity Policy.	

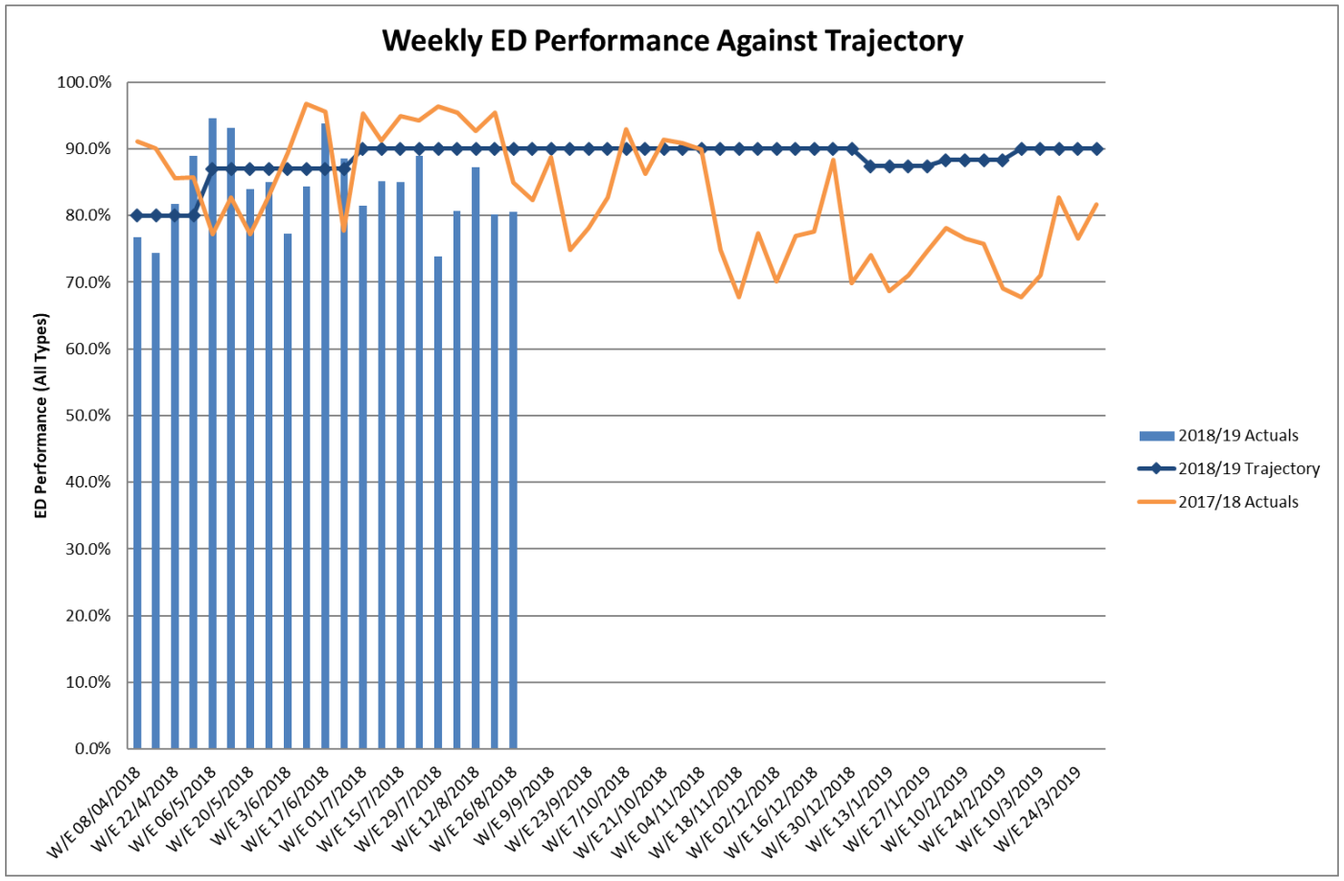
7.	References to previous reports
Monthly 4 hour performance reports and ECIP Recommendations.	

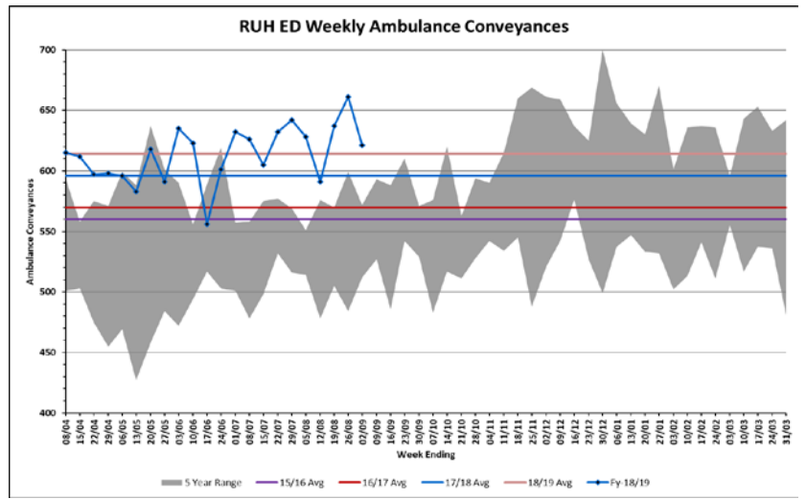
8.	Freedom of Information
Public	

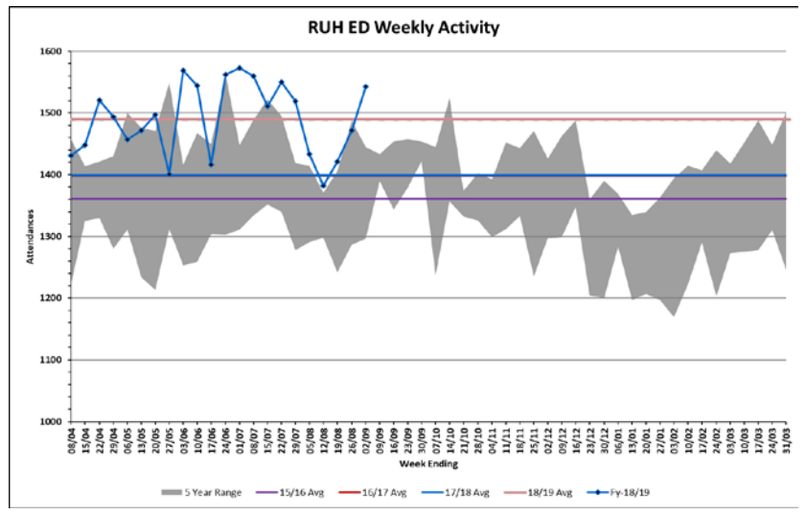
1. RUH 4 Hour Performance: August 2018 Month 5

Improvement Trajectory – Category 4

- August 2018 four hour performance not achieved 81.8% (All Types)
- Performance did not meet the performance improvement trajectory of 90.0%

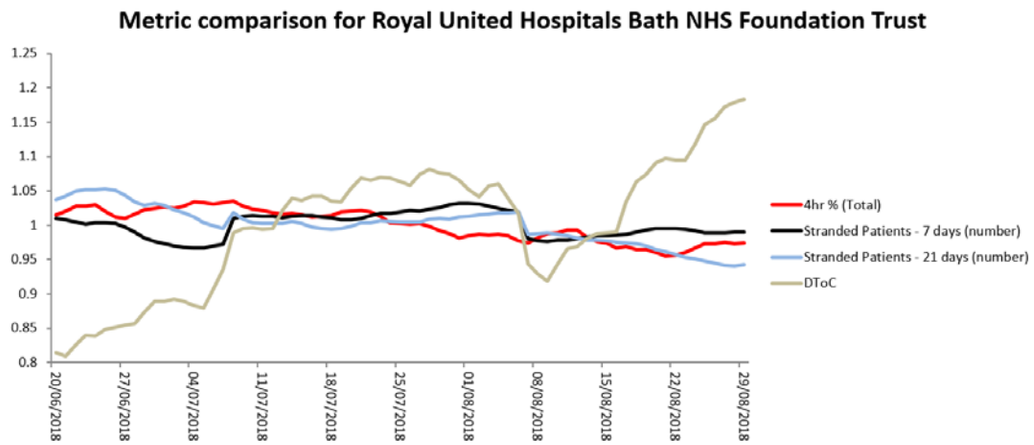






Key Diagnostics

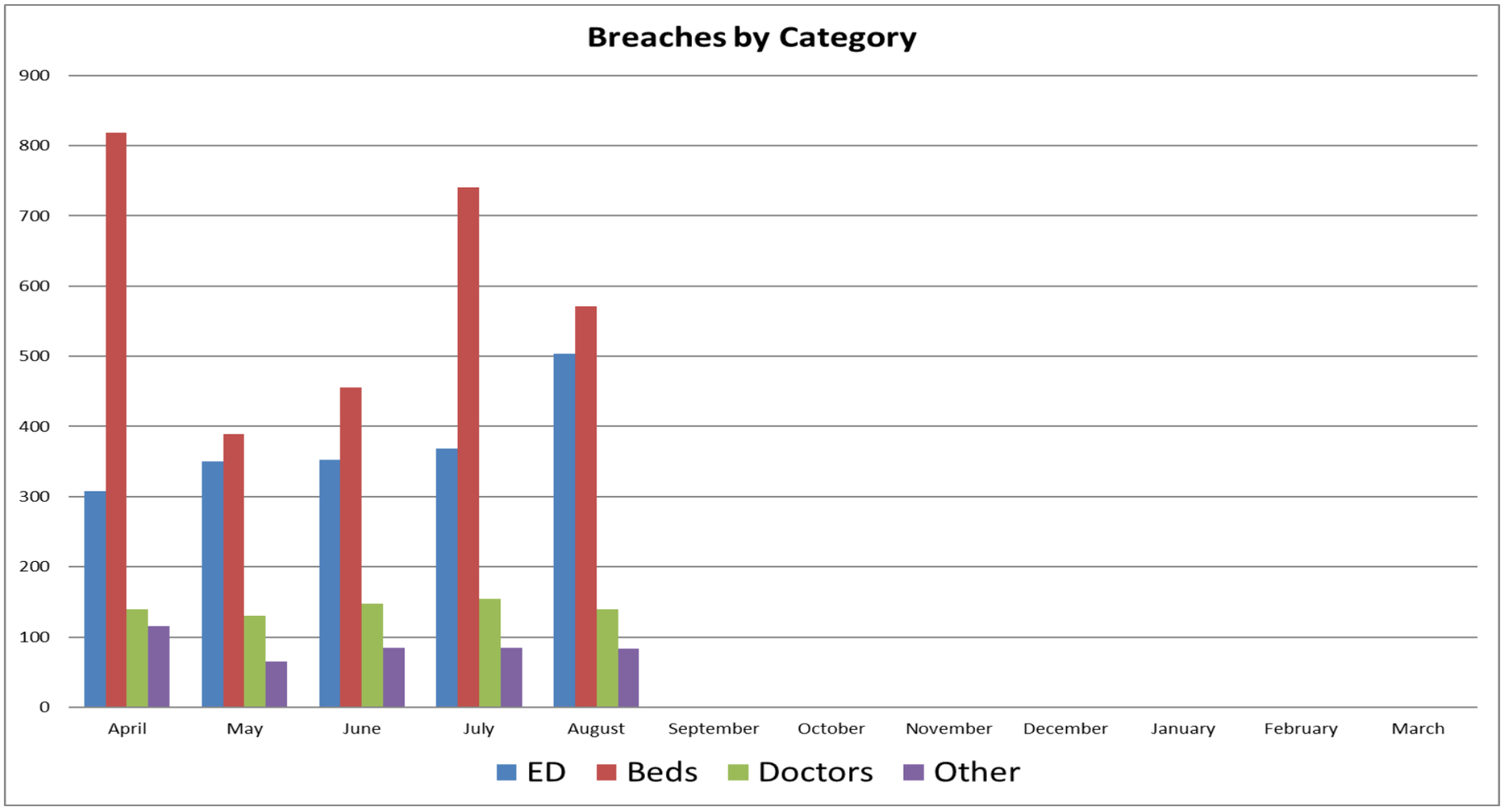
- Ambulance conveyance activity +8.3% variance compared to 2017/18 for week ending 02/09/18
- Emergency presentations +6.3% year to date variance compared to last financial year
- Emergency Department attendances +5.9% year to date variance compared to last financial year
- There was a total of 279 beds closed in August due to infection (flu and norovirus)
- There were 29 patients reported in the August month end snapshot and 954 delayed days (5.3% reported, position has deteriorated compared to July 2018



2. Four Hour Breach Reasons

Factors Influencing Breaches

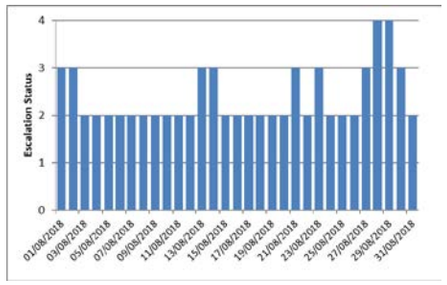
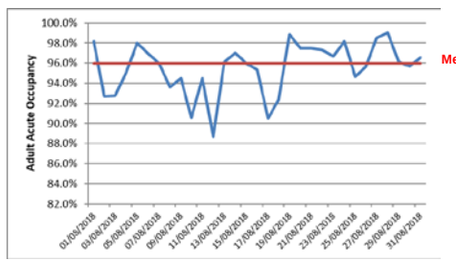
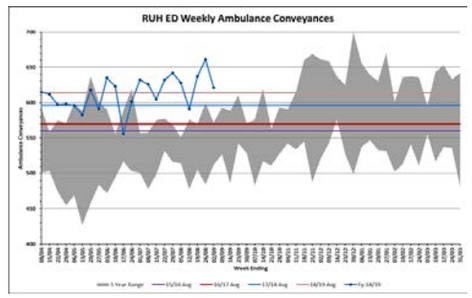
- Sustained high levels of ambulance arrivals in month
- Bed occupancy 96% resulting in a high numbers of bed breaches
- Flow and 4 hour performance negatively impacted by
    - High bed occupancy
    - High ambulance arrivals
    - High Emergency Department delays
    - >21 length of stay patients
    - DTOC
- The Trust declared OPEL 4 on two occasions in month with rapid recovery on the day
- A system wide 4 hour performance improvement plan is in place which has been recently revised. Weekly monitoring via the Urgent Care Task and Finish Group.



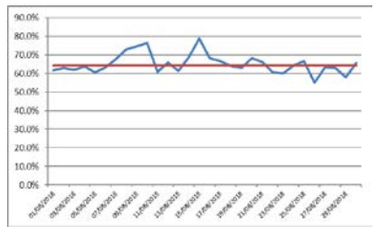
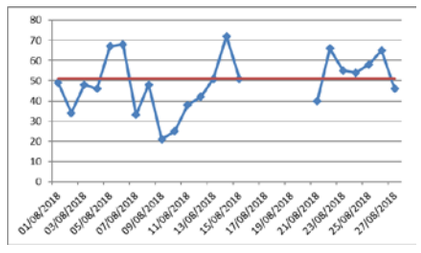
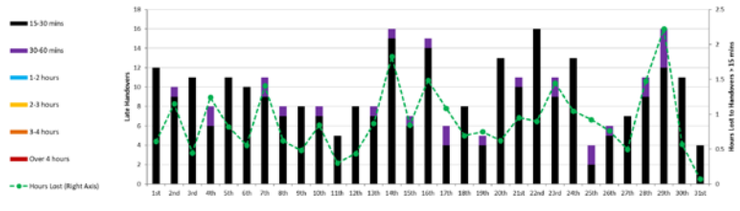
Category	Breach Reason	April	May	June	July	August	September	October	November	December	January	February	March	YTD
ED	ED Delays	233	242	281	260	417								1433
	Clinical Exception	75	108	71	109	86								449
Beds	Medical Bed	589	313	344	607	471								2324
	Surgical Bed	158	21	39	35	26								279
	Observation Bed	20	14	9	22	14								79
	Paediatric Bed	3	0	2	4									9
	Side Room	48	30	39	47	40								204
	Orthopaedic Bed	0	10	21	18	18								67
	Medical Bed Gender	0	1	1	7	2								11
Doctors	Medical Doctor	36	34	38	30	37								175
	Surgical Doctor	30	12	15	9	10								76
	Ortho Doctor	26	29	37	34	34								160
	Mental Health	18	34	27	42	35								156
	Radiology	30	21	31	39	23								144
Other	Other	86	59	71	77	77								370
	Unknown	29	6	14	8	7								64
	Total:	**1381**	**934**	**1040**	**1348**	**1297**								**6000**
OOH (7pm-8am) Arrival Breach Total:		**687**	**456**	**549**	**710**	**692**								**3094**
Evening (8pm-Midnight) Arrival Breaches Total:		**300**	**208**	**237**	**288**	**284**								**1317**

- *Change in IT system resulted in a period of non capture of breach codes (classified as unknown).*
- *There are also additional breach codes available which for the purposes of this report have been grouped as "other"*

3.1 Monthly Urgent Care and Flow Dashboard – Diagnostics

Description	How We Did	In Month Trend	Key Actions	Target
Escalation Level OPEL = Operating Performance Escalation Levels 1 – 4 (Highest)	**OPEL 2** The Escalation level was OPEL 3 + for 10 days in August, recovery and de-escalation improved compared to July		• Opel 5 reflects Internal significant incident declaration. Note, data sourced from clinical site team update of the RUH intranet OPEL status, data gaps relate to days where the OPEL status has not been updated i.e. remains unchanged	**OPEL 1- 2**
Bed Occupancy % of Adult Occupied Beds	**96.0%** For the latest month, occupancy was 96%. This position has deteriorated compared to July by 1.2% Peaked at 99% at the end of August. . Flow can be maintained when occupancy is at 92% and does not exceed 96%.		• Internal professional standards embed practice for timely referral and escalation to specialty teams – standards need to be live and monitored to demonstrate improvement • System wide focus on DTOC and patients with a length of stay exceeding 21 days.	**92%**
Ambulance Conveyances The number of weekly ambulance arrivals to the Trust	**627** The Trust continued to receive high number of ambulances conveyed in August compared to the last 5 years, sustained throughout the month, peaking at 661		• Conveyance rates per CCG reviewed by the A&E Delivery Board • SWAST prediction and escalation modelling required to support RUH planning an outstanding action with ECIP and A&E Delivery Board	**590 per week**

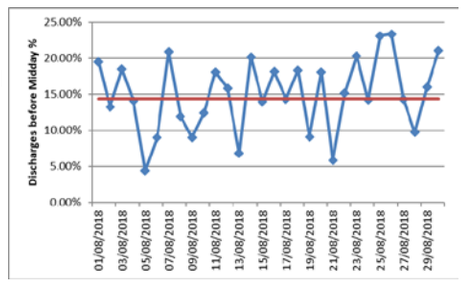
3. 2 Monthly Urgent Care and Flow Dashboard – SAFE (requires improvement)

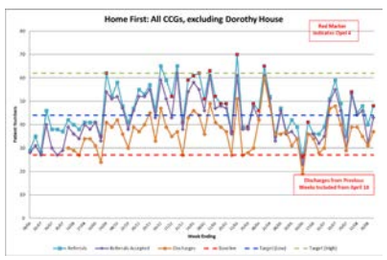
Description	How We Did		In Month Trend	Key Actions	Target
Emergency Department Time to Triage	The % of patients that are triaged within 15 minutes of arrival to the Emergency Department	**65.52%**	Millennium changes implemented 26/02/18. Data quality issues remain, identified and included on IT improvement plan. Time to triage range 549% - 81.6%, median 65.52, improvement of 6% overall and in the lower range value.		• Data quality issues remain, identified in IT improvement plan,. Priority to make time fields mandatory with daily validation reporting to improve data quality • Meeting with Executives, medicine division and ED triumvirate and IT lead continue to be held reviewing actions and progress to resolve IT and ED workflow	**95%**
Frailty Flying Squad (FFS)	Patients over 75 years attending ED with a frailty score of >5 receive a speciality multidisciplinary review by the Frailty Flying Squad	**108**	108 patients seen, including patients who are still an inpatient. The majority of weekdays covered by Frailty Flying Squad throughout August. Manual data capture in place and testing automated capture in ED, further KPI analysis through Frailty Big Room to determine admission avoidance rate and overall impact on length of stay with early intervention		• Manual data capture in place, frailty marker on Millennium • Fast log in for Flying Squad in ED and ability to record flying squad reviews, data reporting process established PDSA methodology applied. Process with MAU in progress. • Frailly Flying Squad in place in the Emergency Department weekdays	**65 per month**
Patient Environment	Number of patients in month that ED cared for queuing in the department	**18.6%**	1326 patients spent part of their attendance outside of an ED cubicle (18.6% of all ED attendances in month). Deteriorated by 1% compared to July 2018 performance		• Tactical flow meetings (Medicine & Surgery) to identify discharges and barriers to discharges to support planning for next day and enabling early flow • Super Discharge week focused on fit to sit and the use of the Observation Unit, further work required supported by ECIP • HALO and SWAST duty manager support during periods of highest demand	**0%**
Ambulance handovers	All handovers should be within 60 minutes	**99%**			• Maintain high level of handovers from ambulance to ED and minimise ambulance delays • Maintain good relationships and communication with SWAT • Ambulance challenge audit completed, outcome and recommendations shared with A&E Delivery Board	**Benchmark in top tensile regionally**

3. 3 Monthly Urgent Care and Flow Dashboard – Well Led (requires improvement)

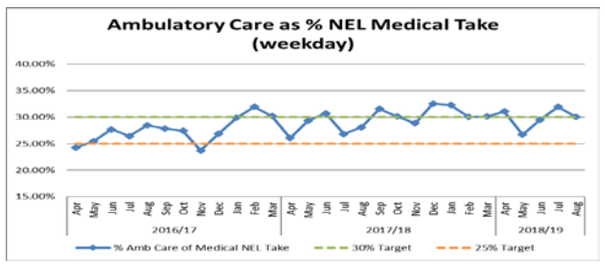
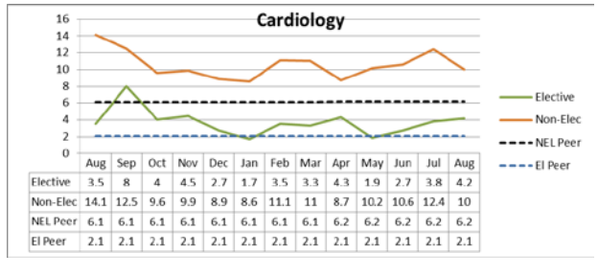
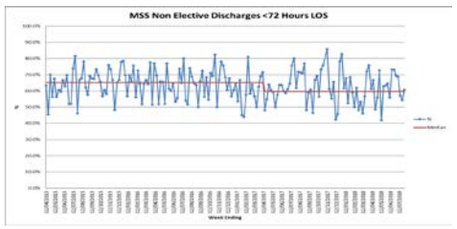
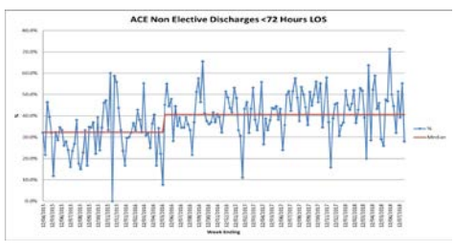
Description	How We Did	In Month Trend	Key Actions	Target
Nursing staffing rota coverage in ED	The percentage of registered nurse shifts in the Emergency Department that are filled with substantive or bank staff – Day and Night Shifts	90% (Day) / 87% (Night)	• RUH has a Nurse Staffing Authorising process 7 days per week to support nurse staff allocation. This is a senior nurse.	>85%
Medical staffing rota coverage in ED	The percentage of doctor shifts in the Emergency Department that are not filled with substantive or bank staff	Currently unable to report	• Consultant hours extended to midnight 7 days per week • Middle grade rota gaps remain an issue, mitigation through use of locum/agency where available • Coverage of rota will be available for August reporting	>85%
National Early Warning Score	National Early Warning Score (NEWS) compliance Emergency Department	94%	• Quality improvement team continue to work in the Emergency Department to improve performance and compliance.	>90%
Discharges by Midday	The % of Non-Elective inpatients discharged by Midday	14.3%	14.3% of discharges occurred before Midday, deteriorated by 2.4% compared to July Patients identified at Divisional Tactical Flow meetings to support early flow out of the Emergency Department.	33%
Mean number of days from referral to discharge with Home First	BaNES 3.5days; Wiltshire 5.8 days; Somerset 2.0 days; South Gloucestershire 5.0 days		• Weekly home first group in place. Focus on referral, capacity. Overall performance in month has deteriorated. • Data now more accurately based on mean days over 2 weeks (previously 1 week).	1 day

Jan 18	Feb 18	March 18	April 18	May 18	Jun 18	July 18	Aug 18
94%	100 %	100 %	96%	93%	100 %	100 %	94%





3. 4 Monthly Urgent Care and Flow Dashboard – Effective (Good)

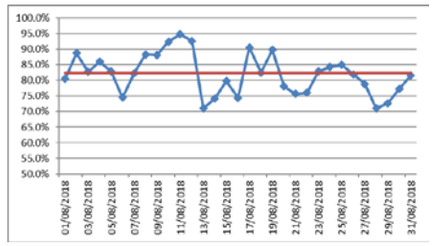
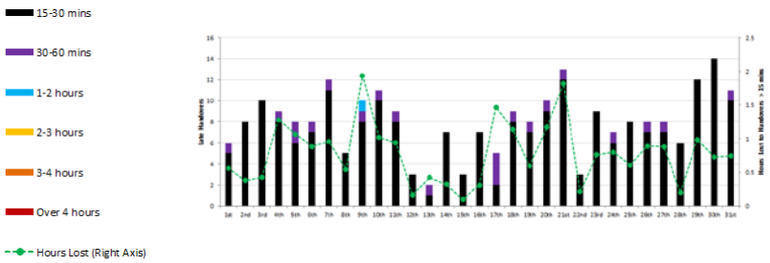
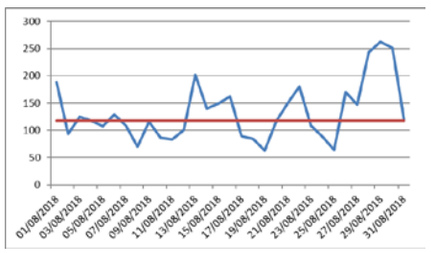
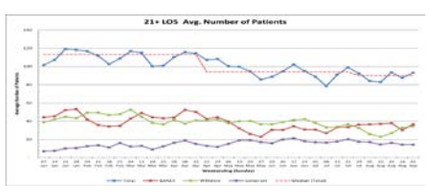
Description	How We Did	In Month Trend	Key Actions	Target
Ambulatory care	Medical Ambulatory Care as % of Adult Non Elective Medical Take (weekday)	**30.0%** ↓		• Ambulatory care additional capacity to open - 2 consulting rooms and additional waiting area	**30%**
Specialty Review	The number of 4 hour breaches due to specialty doctor review delays	**81** ↓	See table below	• Internal professional standards, embed escalation with ED team – further work required to ensure consistency of escalation • Monitoring of the response within 60 minutes of request by the ED team • T&O response improved, Ambulatory care PDSA to commence end of August 2018	**20**
Length of Stay Cardiology	The median length of stay for patients admitted to Cardiology will have a length of non-elective stay of 6.1 day on line with peers	**10 days** ↑	Non-Elective length of stay improved by 2.4 days in month, Elective deteriorated by almost 0.5 day		• Review of process for the management of patient on outlying wards requiring cardiac input and or procedure • Surgical pathway to Barts Health NHS Trust when Bristol Heart Institute unable to accept for surgery • Tactical flow engagement and LoS improvement trajectory against peers	**6.1 days**
Length of Stay MSS	The median length of stay for patients admitted on Medical Short Stay Unit will be less than 72 Hours	**68.6%** ↑	68.6% of patients discharged from the Medical Short Stay Unit had a Length of Stay of < 72 hours in August 20188 peaking at 73.2%. Impacted by poor trust wide flow and high occupancy.		• Opportunity identified to increase throughout, currently limited by patients awaiting cardiac procedures • Clinical lead for cardiology supporting work to prioritise non-elective procedures within 72 hours of request and cath lab efficiency	**66.7%**
Length of Stay ACE	The median length of stay for patients admitted on Frailty Short Stay Unit (ACE) will be less than 72 Hours	**44.4%** ↑	44.4% of patients discharged from the Frailty Short Stay Unit (ACE) had a Length of Stay of < 72 hours in August 2018 (peaked at 71.4%). Impacted due to poor trust wide flow early in the month.		• Frailty Big Room weekly review of data and applying QI methodology to continually improve position and patient throughput • Earlier discharge Impacted by limitation in Home First Capacity	**66.7%**

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr 18	May 18	Jun 18	July 18	Aug 18
Medical Doctor	14	27	28	18	23	34	29	21	25	36	34	38	30	37
Surgical Doctor	37	41	55	39	62	52	65	41	41	56	41	52	43	44

Performance remains below internal standard, negatively impacting on 4 hour performance

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Elective	3.5	8	4	4.5	2.7	1.7	3.5	3.3	4.3	1.9	2.7	3.8	4.2
Non-Elec	14.1	12.5	9.6	9.9	8.9	8.6	11.1	11	8.7	10.2	10.6	12.4	10
NEL Peer	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.2	6.2	6.2	6.2	6.2
El Peer	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1

3. 5 Monthly Urgent Care and Flow Dashboard – Responsive (requires improvement)

Description	How We Did	In Month Trend	Key Actions	Target
4 Hour performance	The Trust should see 95% of all patients (type 1 and 3) within 4 hours from arrival to admission, transfer or discharge **81.8%**	August 2018 four hour performance not achieved 81.8% (All Types) Performance did not meet the performance trajectory of 90.0%	 • A system wide 4 hour performance improvement plan is in place with weekly monitoring via the Urgent Care Task and Finish Group and weekly reporting to the A&E Delivery Board	**95%**
Ambulance handovers	All handovers should be within 60 minutes **99%**	 	• Maintain high level of handovers from ambulance to ED and minimise ambulance delays • Understanding of SWAST demand predictions is required, was July conveyance rate predicted? A&E Delivery Board action	**Benchmark in top tensile regionally**
Decision to Admit (DTA) to Admission	Median wait from DTA to Admission should not exceed 120 minutes **117 minutes**	In August median trolley wait was 117 minutes. This has improved compared to July 2018 by 9 minutes.	 • Specialty response time and internal professional standards require embedding and recoding of review in the ED (IT solution has been agreed) • Fit to sit opportunities and referral to ambulatory care for patients in hours awaiting results being tested with ECIP support.	**120 minutes**
Direct Admissions MAU	Total number of direct admissions to MAU **38**	Direct admissions to MAU when flow allows assessment capacity to be held for expected patients. Deteriorated position compared to July	 • Senior Decision makers increased at the Front Door • PDSA to support protection of direct admit capacity in MAU planned to start September 2018 • W/C 22nd October MAU Area B launch	**87**
Length of stay >7 Days	Median Number of Patients with a LOS 7+ days **277**	August median was 277 peaking at 282 for admission after week ending 02/09/18	 • System wide review of all patients with a > 21 day length of stay • Tactical flow review of > 7 day of stay • Daily data reporting of all > 7 day length of stay to each CCG (replacing the “green list”)	**250**
Length of Stay >21 Days	Median Number of Patients with a LOS 21+ Days **90**	August median 90 peaking at 94 in month of patients with a LoS exceeding 21 days	 • Improve assessment of stranded and super stranded patients • Escalate delays in assessment and discharge plans via Silver call • Gold focus on system wide improvement plan	**82**

3. 6 Monthly Urgent Care and Flow Dashboard – Caring (Good)

Description	How We Did	In Month Trend	Key Actions	Target
Friends and Family Test	Response rate of > 20% for Front Door Services Emergency Department and Medical Assessment Unit	ED 2.3% MAU 4.5% SAU 6.5% August position deteriorated compared to previous month. Overall Front Door Response 2.3% (	• Focus across the Front Door to increase distribution of FFT cards	>20%

FFT Board Report for Emergency Dept for Aug 2018

	Aug 2018			
	Total number of patients eligible	No of Responses	Response Rate	% Recommending
A&E	4106	93	2.3%	98
Medical Assessment Unit	199	9	4.5%	78
Surgical Admissions Unit	309	20	6.5%	100
UTC	803	2	.2%	100
Emergency Dept Total	5417	124	2.3%	97

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Friday 7 September 2018

To: Chairs of A&E delivery boards
Chief Executives of acute trusts
CCG Accountable Officers
Directors of Adult Social Services
Chief Executives of community, ambulance and mental health trusts
Regional Directors of NHS England & NHS Improvement
STP chairs

Dear Colleague

Supporting the delivery of elective and emergency care

Last winter was challenging and it is thanks to the efforts and dedication of hard working frontline staff, more people were seen in A&E and admitted or discharged within four hours every day than last year. We know there are ongoing demand challenges and we need to continue working towards achieving clinical standards over this coming winter.

Following the publication of the national planning guidance on 2 February 2018 and the letter from Ian Dalton to trust chief executives on 18 April 2018, the focus has been on the development and delivery of annual demand and capacity plans. You are continuing to work with your system partners and regional directors to ensure ongoing refinement of your plans.

As a reminder, operating guidance asks you to deliver 90% performance against the four-hour operational target over winter with the majority of trusts expected to achieve 95% performance in March. Your plans also commit you to ensuring that the number of patients on an incomplete elective pathway will be no higher in March 2019 than in March 2018. As part of the long-term plan, we are looking at whether there are any ways to improve the standards, but throughout this year the NHS will continue to focus on the current standards for emergency and elective care.

To deliver, we understand that trusts will need to maximise the flexibility of the clinical workforce, enabling staff to respond to times of increased workload. Trusts should consider annualised clinical job plans, with capacity for amendment/ redeployment and effective, electronic systems of e-rostering and leave planning.

Reducing the number of long-stay patients in hospital

In June I wrote to you about reducing long stays in hospital. Our ambition is to reduce the number of beds occupied by long stay patients by 25%, freeing up at least 4,000 beds compared to 2017/18. This capacity is required by December 2018. Since then, many of you have made significant progress to achieve this ambition. However, as

you know, we need to make faster progress, including enhanced winter support from local social services, and this needs continued attention.

This includes helping to move patients out of the acute setting and to help prevent patients arriving there. To close the capacity gap, community providers also need to free up bed capacity, reduce length of stay and ensure that a greater proportion of patients receive the appropriate level of care, including in patients' own homes. We need each local system to identify and implement a set of interventions designed to do this over the coming months. This needs to include the winter contribution that local authorities will make in commissioning appropriate care packages.

To support your work, we have provided some materials including: an improvement guide; repurposing the Emergency Care Intensive Support Team (ECIST); and a dashboard for operational use and for board reporting. Follow links to the dashboard and guidance:

https://analytics.improvement.nhs.uk/#/workbooks/250/views

https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/

A small number of you have been in ongoing dialogue with regional directors about specific capital asks to increase capacity and patient flow in the areas of greatest need ahead of winter. Where we have been able to support these through budgeted capital, trusts have been notified separately. These recipient trusts are required to ensure that these schemes are operational by Christmas, and if not delivered on time, the capital funding will be reclaimed.

Triaging patients away from A&E departments and admitted pathways

The best performing A&E departments and hospitals owe their success partly to triaging patients into other pathways. These include:

- using primary care streaming for minor illnesses and injuries;
- consistently treating and discharging over 99% of non-admitted patients in less than four hours. This helps reduce risks of overcrowding that can otherwise be a safety concern, to support this work, we have set up a small intensive support team.
- managing up to 50% of acute medical referrals via non-admitted care pathways. This is often preferable for patients and reduces the pressures on in-patient beds.

We ask trusts to review their existing A&E patient pathways against these best practices, taking into account the needs of their local populations.

For more information follow this link:

https://improvement.nhs.uk/documents/2982/AEC_Managing_increased_demand_winter_illness_June2018.pdf

It is a significant concern that during last winter, due to high levels of bed and emergency department occupancy arising from poor flow, patients were receiving care in corridors. Your work to close your local capacity gap should help eliminate corridor care which is inappropriate and avoidable, but it is important that we make rapid progress. Corridor care also affects patients waiting in ambulances, who may be very sick. Ambulances that are waiting in hospital car parks are not able to respond to emergency calls.

In support of this we are continuing to work with the 40 most challenged trusts on ambulance handover delays; we have established an intensive support team to work with trusts, focused on eliminating corridor care; we are continuing to work with CQC, which considers when assessing trusts whether corridor care has occurred; and we continue to advocate the use of the ED patient safety checklist.

Healthcare worker flu vaccination

Alongside this letter, Trusts will have also received a letter regarding flu vaccination for healthcare workers. Your ambition should be to achieve near universal flu vaccine uptake by healthcare workers. This has the backing of the professional and clinical bodies and trade unions. In higher risk areas, trusts should also take robust steps to move quickly to 100% staff vaccination uptake, including ensuring easy access to the vaccine, and notification from staff as to whether they have been vaccinated. We expect trusts to take steps to protect patients in higher-risk clinical areas, including consideration of changing deployment of staffing in these areas if compatible with maintaining safe operation of the service to limit the exposure of the most vulnerable patients to unvaccinated staff. Trust boards should publicly assure uptake of the flu vaccine and opt-out of healthcare workers.

This year, we are continuing the social workers flu vaccine scheme and encourage staff in care homes, nursing homes and hospices to go to their GP or pharmacy for vaccination.

Primary care

Primary care plays a fundamental role in managing increasing demands over winter. By October 2018, everyone across the country will have more convenient access to GP services, including access to appointments during evenings and weekends, which will provide more than 9 million additional appointments. This should reduce the impact on other parts of the system and reduce attendances at emergency departments.

As part of the work on extended access, this autumn, NHS England will have made available a tool for every general practice to measure appointment capacity and utilisation. This tool is designed to help practices better understand their demand and capacity, including over the bank holiday, Christmas and New Year periods.

Commissioning teams are reminded to ensure the NHS website Directory of Services (DOS) is up to date and accurate for urgent treatment centres (UTCs), general practice and dental services opening times, including the new evening and weekend services. CCGs will not only need to ensure there is adequate capacity in primary care

and UTCs but also that there is good public awareness of what is available over the peak periods, particularly at the weekend and during holidays.

Mental health

Urgent and emergency mental health services should be included in local planning. Please work with your local system to ensure that you identify gaps in capacity, specifically at the interface between mental health services and A&E pressures by:

- increasing capacity in community mental health crisis services, as well as alternatives to A&E that can provide a more suitable service for many people who would otherwise attend A&E,
- moving towards provision of 24/7 liaison psychiatry to provide safe care in A&E and general hospital wards, as well as preventing avoidable emergency admissions via A&E and facilitating earlier discharge,
- ensuring sufficient capacity in core community and acute mental health services so that people are able to access local beds when needed, and can be transferred from A&E in a timely manner.

We ask mental health trusts to work closely with their local acute trusts to help deliver significant improvements to A&E care for these vulnerable patients, particularly in areas where patients have experienced unacceptably long waits.

Underpinning all the above, should be improved local data collection, and monitoring of key metrics across these parts of the mental health system to understand where improvements to local pathways are needed.

National Escalation Pressures Panel

Finally, I would like to inform you that after introducing NEPP to provide national expertise and advice last winter, we have decided to continue this arrangement this winter, as it has proved to be invaluable support for national policy-setting.

Success this winter is dependent on continuing transformation work and having real operational grip led by all of you as system leaders.

Yours sincerely

Pauline Philip
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NHS England and NHS Improvement