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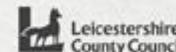
Leicester, Leicestershire & Rutland health and social care

URGENT CARE SYSTEM PERFORMANCE AND THE IMPACT OF THE OPENING OF LRI EMERGENCY DEPARTMENT



Urgent Care System Performance: Summary

Urgent Care performance in LLR has been historically poor

Key issues are:

- Long waiting times in ED: 2016/2017 = 79.6% against 95% 4 hour target, YTD 79.5%
- Demand for ED and UCC attendances (7.5 % in 16/17, c 2% decrease in 17/18)
- Long ambulance handover times at the LRI: Target 15 mins, 49% against target in July
- Poor response times by EMAS: Red 1 67.2% 16/17, target 75%
- Relatively low DTOC rates, but significant rise 2016/2017: 5.76% bed days were delays, target 3.5% in 2017/2018

Despite some improvements in March and early April, the opening of the new LRI ED saw performance drop significantly.

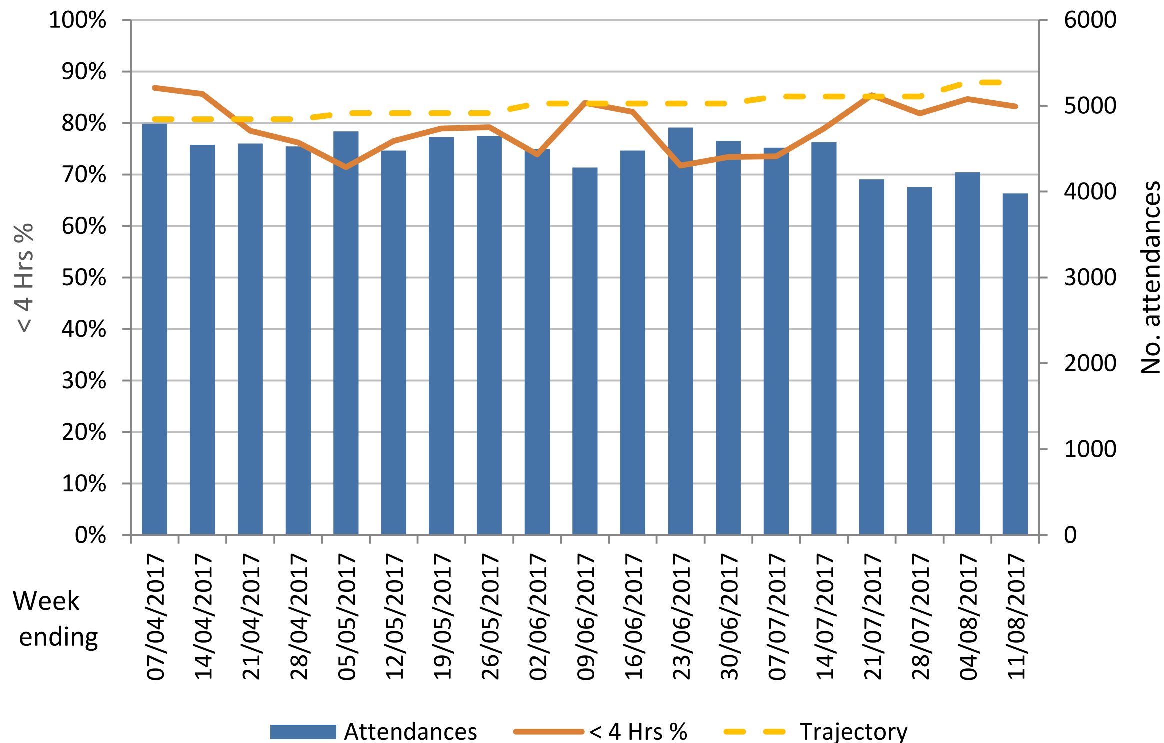
As new ED processes bed-in performance has improved (August month to date 85.5%) but there is still a high degree of volatility and variation in performance, with particular issues overnight, at weekends and on Mondays . UHL are below trajectory for meeting the national standard in June and July

Ambulance handover times at LRI significantly improved since the opening of the new ED

System target and actual performance (ED 4 Hour wait)

Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department												
Standard	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
Target	80.7%	81.9%	83.8%	85.1%	87.9%	90.0%	90.1%	90.2%	90.1%	90.1%	90.3%	92.2%
Actual Performance	81.0%	76.3%	77.6%	79.8%								

5YFV Next Steps requires all Trusts to achieve 90% by Sept 2017, majority of Trust to achieve 95% by Mar 2018 and 95% average overall by Dec 2018



- UHL performance deteriorated immediately after the opening of the new ED on the 26th April and continued to be very poor in May and June
- ED four hour wait below trajectory, but is improving in the last month (Aug MTD 85.5%)
- Demand at the LRI site appears to be dropping, or compared to increases in demand in previous years (2.2% reduction Apr- July)

Urgent Care System Performance: ED 4 hour wait

Key Issues identified by AEDB

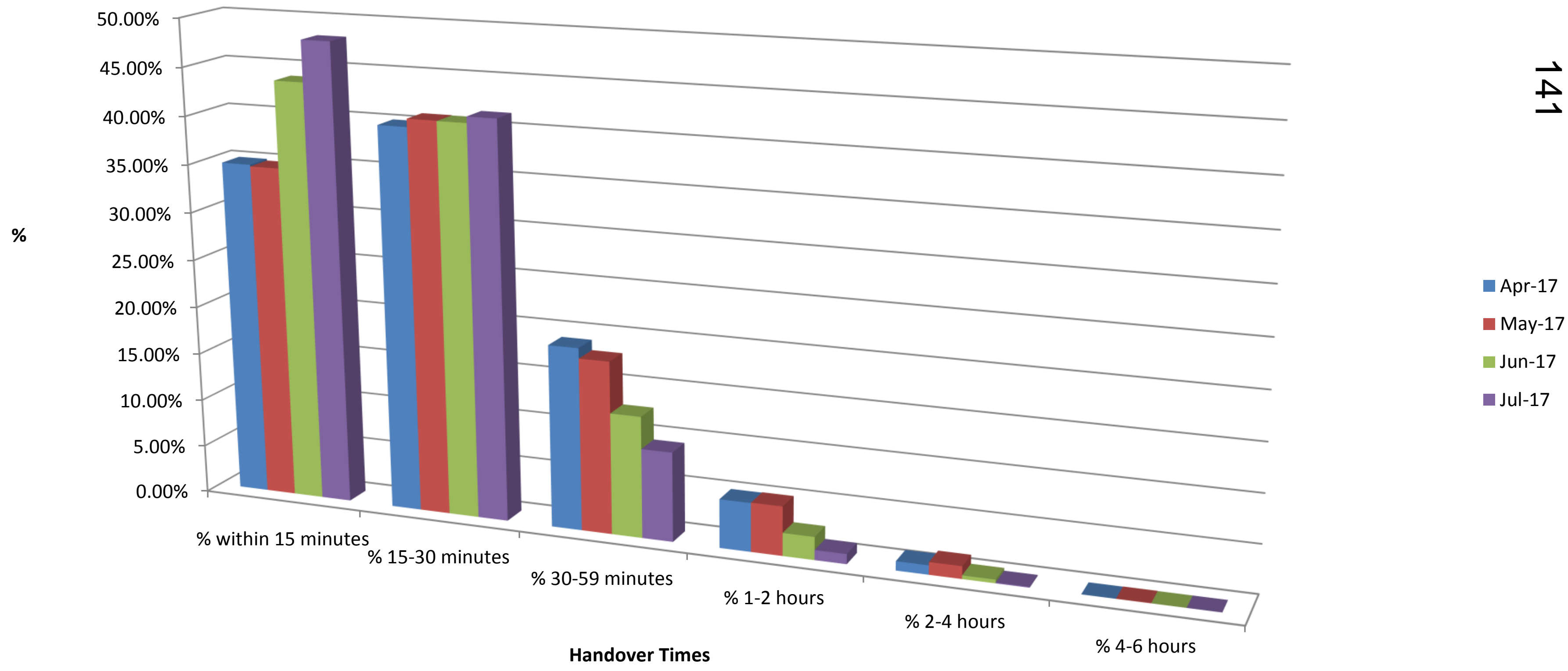
- Majors capacity was reduced in first few weeks of opening, until GP Assessment Unit moved out of the majors suite, increasing beds and enabling improved ambulance handover.
- Process issues in ED:
  - Assessment/primary care zone (long wait for assessment, high non-admitted breaches)
  - Majors, long waits to be seen, long wait to be admitted
- Staffing capacity (both nursing and medical) particularly overnight in comparison to day time. Majority of breaches happen in the evening/overnight.
- Bed capacity and flow within hospital – SAFER and R2G being implemented, UHL DTOCs remain low (less than 3%), external delays have reduced and remain low.
- AEDB has oversight of the Recovery Action Plan to improve performance

Ambulance handovers (1)

There has been a marked improvement in numbers of patients handed over to ED in the target time of 15 mins, and a corresponding decrease in long waits of 30mins and above

Leicester Royal Infirmary - Handover Times

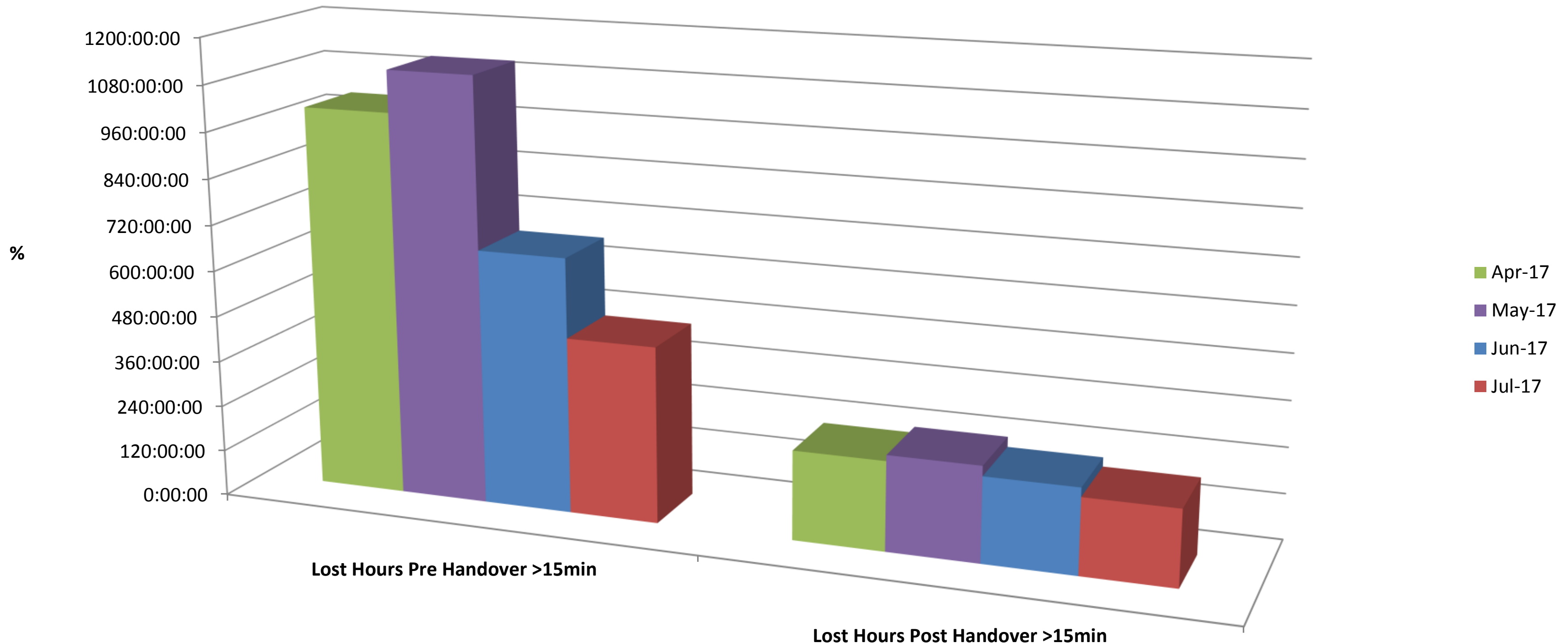
	% within 15 minutes	% 15-30 minutes	% 30-59 minutes	% 1-2 hours	% 2-4 hours	% 4-6 hours
Apr-17	34.95%	40.00%	19.03%	5.07%	0.96%	0.00%
May-17	34.78%	40.83%	17.96%	5.11%	1.30%	0.02%
Jun-17	43.79%	40.80%	12.64%	2.39%	0.38%	0.00%
Jul-17	48.09%	41.46%	9.31%	1.04%	0.09%	0.00%



Ambulance handovers (2)

Reductions in handover delays of over 15 mins leads to a reduction in EMAS lost hours, and hence to EMAS ability to meet response times targets.
LRI now in top quartile of EMAS patch EDs for handover times.

	Lost Hours Pre Handover >15min	Lost Hours Post Handover >15min
Apr-17	1005:07:08	233:13:13
May-17	1114:40:00	248:46:31
Jun-17	668:22:55	222:33:20
Jul-17	460:59:17	198:48:16



Urgent Care System Performance:

AEDB Role and Action Plan

- AEDB has oversight of the Recovery Action Plan to improve performance
- Chaired by John Adler, CE of UHL. Exec level membership from each LLR organisation
- Monthly escalation meetings with NHS Improvement and NHS England Regional Directors to challenge and assess system progress

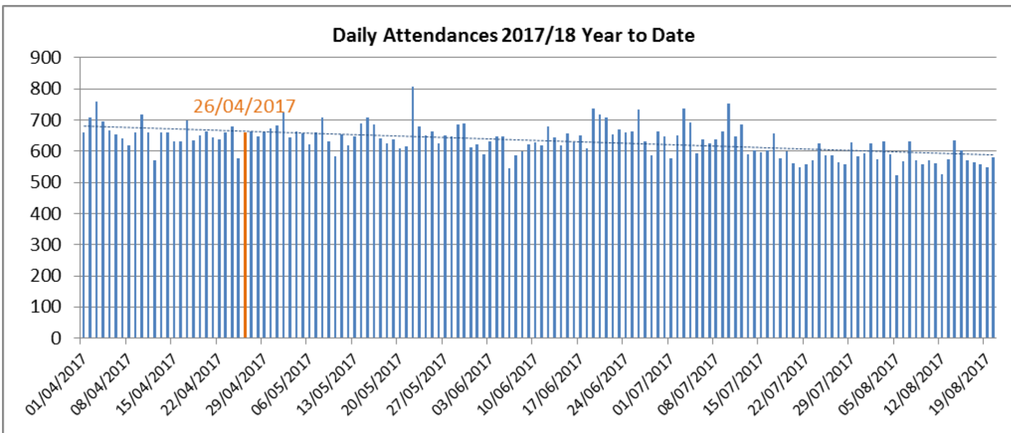
AEDB Action Plan Focus Area	Main actions
Inflow	Reducing attendances through clinical navigation Minimising presentations by ambulance and from nursing homes
ED Flow	Streaming at the front door of ED Staffing and process consistency
Hospital Flow	SAFER, R2G
Discharge (Outflow)	Integrated Discharge Team CHC process improvement Discharge to assess pathway

Pre-ED – Reducing Attendances

Issues

Historically we have seen a rise in demand at ED, overall **7.5% rise** in ED attendances in 16/17 compared to previous year

All walk- in patients streamed through the UCC since November 2016, high levels of onward referrals to the ED are factors contributing to the increase



Actions

Introduction of clinical navigation from December 2016 – clinical triage of calls from NHS 111 reducing both ED and Green ambulance dispositions from 111.
LLR has the lowest rate of ED dispositions in the country at 5.1% in Q1

Of patients triaged, **79.4%** diverted from ED
80.1% avoided transfer to 999

ED attendances **decreased** by 1.7% in Q4 compared to previous year, and are down c. 2.2% 17/18 ytd

New ED has integrated model and eliminates referrals between ED and UCC

New community Urgent Care services in place from 1/4/17 (home visiting, WLCCG, City hubs)

ED waiting times and ambulance handovers

Issues:

- Performance improvements in March and April prior to new ED opening. Elective capacity taken down to enable performance gains. Direct impact on elective waiting times.
- Dip in performance 26/4 to 9/5
- Initial teething problems with IT, equipment, staff understanding process
- In first week, long waits, high numbers of breaches in assessment zone & long handover delays
- Flow out of the ED a problem – particularly up to 3/5
- Majors capacity reduced due to GPAU
- Overnight performance remains a problem

Actions:

- GPAU moved to Blue Zone to free up majors cubicles; greater base & escalation capacity leading to much better ambulance handovers
- Aligning all GP resource into 'one team' to make primary care capacity more streamlined
- Other adjustments to initial assessment process, including triage within 15 mins of arrival
- Reviewing night medical staffing, aiming to increase SpR each night
- Increasing skill mix of nursing to strengthen night time performance
- No patients held/treated outside rooms/cubicles - much better patient experience

Hospital Flow – a combination of bed capacity shortfall & sub-optimal processes

Issues:

- Overall shortage of 105 beds against predicted demand (mainly medical beds at LRI & Glenfield)
- Process issues, including waits of diagnostics , medical review and TTOs
- Late pm discharge profile (average 13% of patients discharged before noon compared to 33% target)
- Transport interface problematic leading to re-beds
- Flow slows down over weekend/BH and when staffing levels low
- Embedding SAFER requires significant culture change, staff training and communications

Actions:

- Plan to bridge gap through 50% extra beds & 50% process improvement
- More robust approach through "Organisation of Care" programme & Director of Operational Improvement
- Implementing SAFER and R2G across both UHL and LPT
- All medical wards at UHL now covered by R2G,
- Daily Board rounds on most wards, daily involvement of system partners
- Assistant practitioners on wards co-ordinating discharge
- Number of 'Red' delays and LOS of delayed patients has reduced
- LRI wards aiming for 'golden patient' first discharge before 10am, increase in morning discharges in August to above 33%, increase d use of discharge lounge
- Integrated Discharge Team being piloted on 8 LRI wards

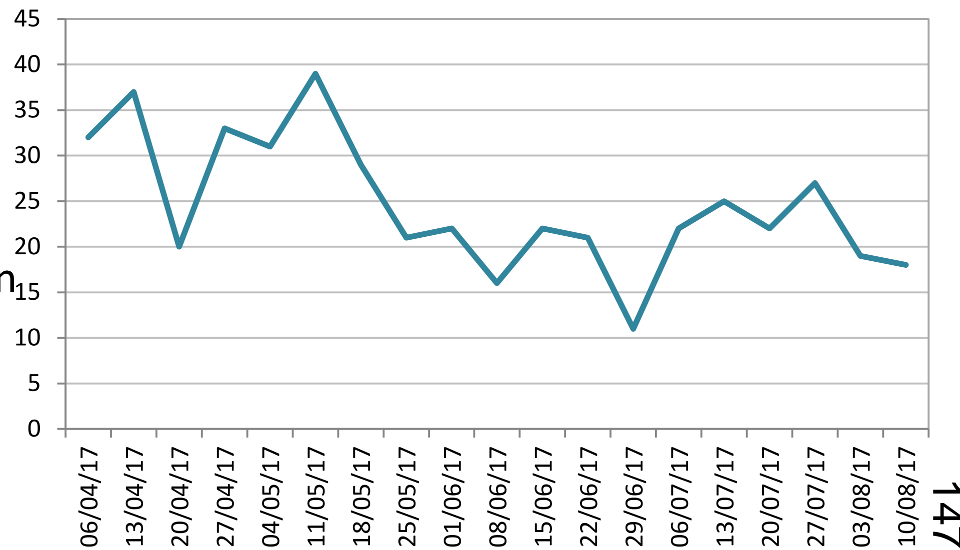
Discharges and DTOC

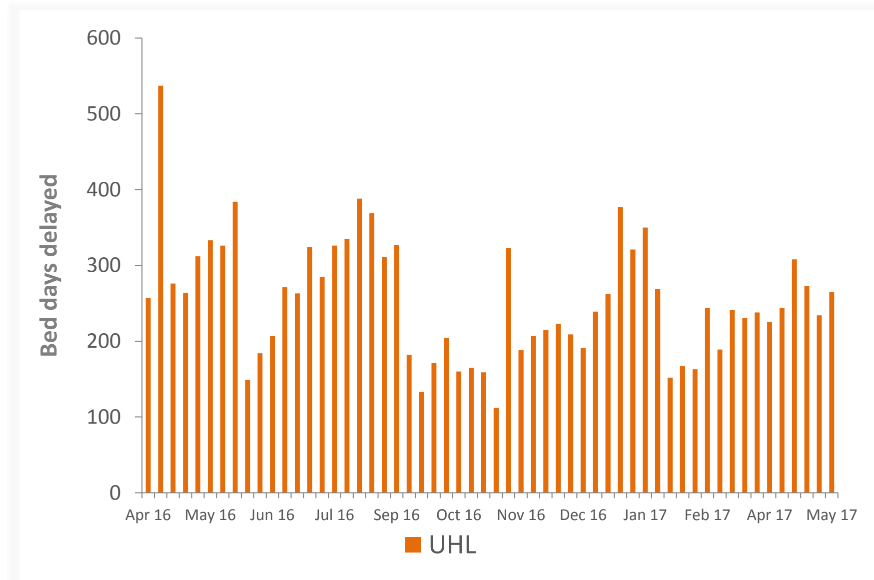
LLR DTOC rates historically low compared to national, but rising. Q4 LLR performance was 5.76% against a target of 3.04%,
Increases seen in DTOCs in both City and County, although County rose more sharply than City, 4.35% to 6.26% in Q4 – impact of HTLAH.

The greatest rate of increase has been in LPT DTOCs (rose from 8.77% in Q1 to 13.7% in Q4, 56% increase) - esp MH and LD clients
Social care DTOCs generally low.

Discharge processes and communication improved in recent months, linked to R2G and escalation processes. New CHC provider engaging with process improvement but end to end process not in place until end August

Some reablement bed capacity in place in Q4 but discharge to assess a key gap. Business case for expansion to be considered Aug/Sep





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