Airedale NHS Foundation Trust
Board of Directors: 29 November 2012
Title: A&E 4 hour target performance report
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Executive Summary

The performance against the 4 hour maximum wait in A&E is monitored internally daily, weekly and monthly by the Trust and performance reported quarterly to the regulator, Monitor. The Monitor compliance framework standard is to meet 95% in each quarter. The Trust has delivered on the 95% of patients being treated or admitted within 4 hours for the first two quarters of the year. The performance has been 96.79% and 96.89% respectively.

At the time of writing this report (Monday 26 November), the position with the third quarter is extremely tight, and the Trust is only just maintaining performance, it has been challenging throughout the third quarter.

Given that Clostridium difficile numbers are now above the annual target, not achieving the A&E standard in Quarter 3 has the potential for Monitor to consider the Foundation Trust's overall position and give a rating of amber/red.

In terms of context, the following Monitor guidance states:

Failure of the A&E standard in any quarter leads to 1.0 penalty point being applied. In addition, Monitor may apply an automatic overall Red governance rating and escalate the Foundation Trust for consideration as to whether it is in breach of its Terms of Authorisation if;

- It fails the same standard for three consecutive quarters;
- It fails to meet the A&E target twice in any two quarters over a twelve month period and fails the indicator in a quarter during the subsequent nine month period or full year.

For the Medical Group, sustaining the required level of performance continues to be challenging. A 4 hour target action plan has been refreshed to reflect the most recent developments. The Trust Board is asked to receive and review the updated 4 hour performance action plan in Appendix 1.

Standard 4 hour maximum wait in A&E

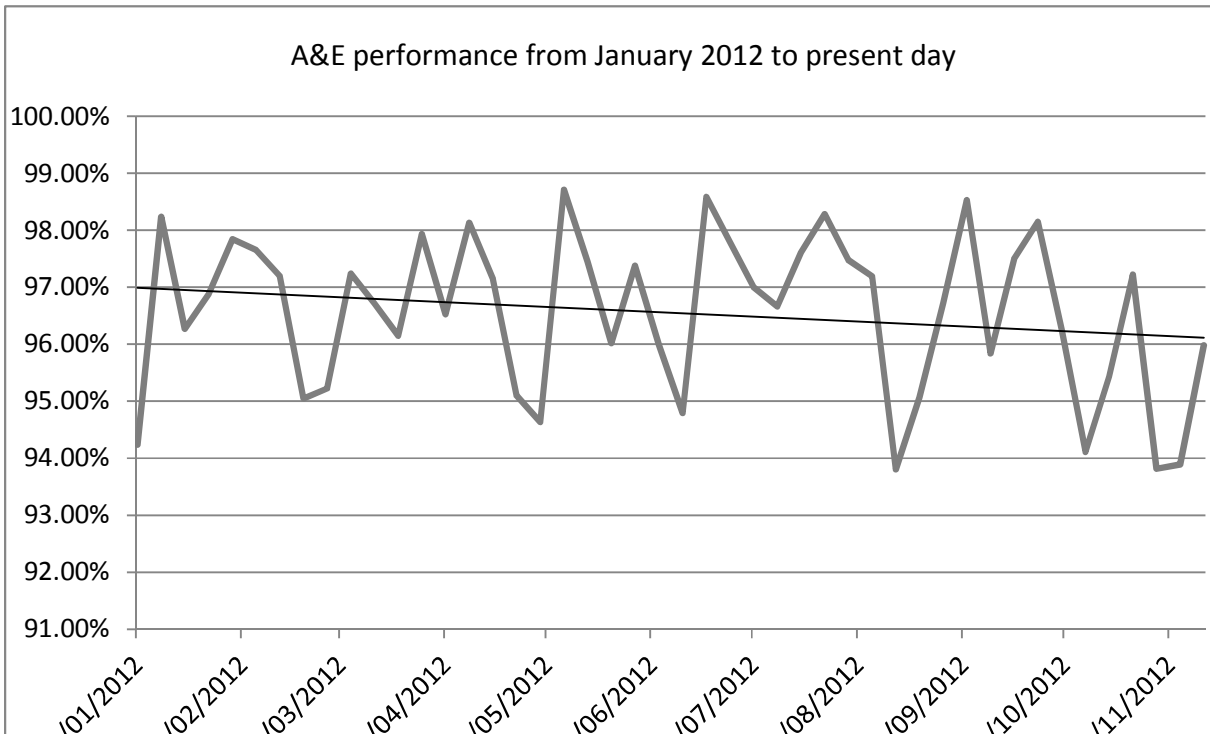
The original standard was introduced in 2004 by the Department of Health for National Health Service acute hospitals in England, that at least 98% of patients attending an ED department must be seen, treated, admitted or discharged in under 4 hours.

There is a generally held clinical view that the performance metric has driven improvements in care for patients as clearly no patient should wait for more than 4 hours to complete their care (with certain clinical exceptions).

The Department of Health amended the standard in 2010 and required each Foundation Trust to achieve 95% of patients attending A&E department to be seen, treated, admitted or discharged in under 4 hours. Internally, the Trust agreed that it would continue to strive to deliver against a 98% stretch target.

Historically, Airedale FT has consistently achieved a performance against the standard of 98%. Recent trends (figure 1) show that this performance has come under pressure and has been falling since October 2011 with a more significant fall from August 2012.

Figure 1 - 4 hour target trend since January 2012



The potential causes of a decrease in performance.

The decline in the performance against the standard is due potentially to:

- The conversion rate of A&E attendances to admissions has increased by 1% from last year which is an additional 600 patients which is 3,000 bed days (equivalent to 8 additional beds). The time in the department for these patients has almost doubled, whilst being assessed and waiting for admission.
- Emergency admissions have gone up by 8.4%, with GP admissions having gone up by 11.9%. The GP admissions are admitted to MAU, and these admissions will take priority over the A&E admissions and hence patient flow may be delayed from A&E. GP admissions have particularly gone up between Tuesday and Thursday.
- Admissions from A&E have significantly increased in 16.00 -17.59 time band (14.4%) and the 18.00-19.59 (16.8%); hence the flow of patients onto wards may not be so timely.
- Emergency admissions for patients over 85 years of age are up by 9% overall with the highest increase from A&E admissions (14.8%). These patients have more complex needs for assessment and have complex packages of care for discharge.
- The flow of patients from A&E to the assessment unit and onto wards is delayed due to the mismatch of bed availability and peaks in demand.
- The doctors and nurses in A&E rotas no longer match the peaks in demand
- Lack of comprehensive senior review or assess to admit along the urgent care pathway.

Figure 2 – acute admissions trend data

Medical Specialties NEL Admissions
2011/12 (Apr-Oct) compared to 2012/13 (Apr-Oct)

Year	BRADFORD	CRAVEN	EAST LANCS	OTHER	TOTAL
2011/12-ED	2378	812	619	191	4000
2011/12-GP	960	472	194	24	1651
2011/12-OTHER	207	90	35	6	339
2011/12-TOTAL	3546	1375	848	221	5990
	BRADFORD	CRAVEN	EAST LANCS	OTHER	TOTAL
2012/13-ED	2607	877	684	173	4341
2012/13-GP	1154	468	205	21	1848
2012/13-OTHER	186	82	31	9	308
2012/13-TOTAL	3947	1427	920	203	6497

Comparison 2011/12 v 2012/13 Increase/Decrease	BRADFORD	CRAVEN	EAST LANCS	OTHER	TOTAL
ED	9.63%	8.00%	10.50%	-9.42%	8.53%
GP	20.21%	-0.85%	5.67%	-12.50%	11.93%
OTHER	-10.14%	-8.89%	-11.43%	50.00%	-9.14%
TOTAL	11.31%	3.78%	8.49%	-8.14%	8.46%
NEL Admissions for Med Specs	BRADFORD	CRAVEN	EAST LANCS	OTHER	TOTAL
2011/12-TOTAL	3546	1375	848	221	5990
2012/13-TOTAL	3947	1427	920	203	6497
Increase/Decrease	11.31%	3.78%	8.49%	-8.14%	8.46%

Figure 3 Admissions via ED by Age Band

Total Admissions via ED by Age Band : Jun 11 to Sep 11

No of Admissions via ED	**Month**				
AgeBand	Jun-11	Jul-11	Aug-11	Sep-11	Grand Total
0-18	105	108	87	102	402
19-64	278	350	325	323	1276
65+	408	451	416	433	1708
Total	**791**	**909**	**828**	**858**	**3386**

Total Admissions via ED by Age Band : Jun 12 to Sep 12

No of Admissions via ED	**Month**				
AgeBand	Jun-12	Jul-12	Aug-12	Sep-12	Grand Total
0-18	120	114	107	159	500
19-64	396	339	369	360	1464
65+	425	462	481	461	1829
Total	**941**	**915**	**957**	**980**	**3793**

Action plan

The current action plan with outstanding actions only is shown in Appendix 1.

Our approach, of putting the patient at the centre and through engaged and effective health economy wide clinical leadership is:

a) Managing the **inflow of patients (demand)** by working very closely with primary care.
b) Managing systems, processes and clinicians in A&E.
c) Managing the **outflow** from A&E into the main hospital and bed availability.

The original 4 hour standard action plan pulled together 3 separate plans from:

1. A report form the Emergency Care Intensive Support Team, who were asked to visit the Trust in January and May of this year to examine patient flow (IST).
2. An internal A&E action plan designed to enhance medical and nursing care (Local) which builds upon the implementation of developing Internal Professional Standards.
3. A discharge process plan designed to improve patient outflow from hospital (Discharge work).

This action plan has been updated to reflect our innovative approach.

Additional support

The Trust has put the following in place over the past 3 months:

- Continuous strong Executive Focus on the 4 hour performance and patient flow.
- Summit meeting with CCG, Social Services and Continuing Care at CEO level to share data and work towards integrated solutions.
- Additional staff deployed at weekends in A&E and MAU (Doctors & Nurses).
- Extra consultant physician on duty on a Sunday to focus specifically on proactive discharging ahead of the predictable Monday admissions.
- An urgent care pathway workstream has been established led by the Medical Director and this involves nursing, medical staff and general managers.
- The weekly breach analysis meeting has been re-established to provide the focus to identify trends.
- First and second on call managers have commenced virtual flow meetings at weekend to provide support for the onsite managers.
- The structure of the daily bed meetings has been refreshed to improve flow and lines of communication across the site.
- Winter plan has been updated which includes the opening of a winter ward.
- An acute physician model will start January 2013 which will provide consultant presence on MAU incorporating short stay, ambulatory clinics, GP call screening, telemedicine and assessment and Post Take Ward Rounds (PTWR).
- The intensive support team including nursing and medical input has been requested to visit the Trust in December.

Monitoring and Progress

The progress of the action plan is monitored at a monthly meeting between relevant General Managers and Clinical Directors and since the original action plan of April 2012 was created there have been some positive developments and these have been removed from the action plan.

The action plan has evolved further this month and the most recent version is presented (appendix 1). This captures the only those elements of the plan which are still outstanding and also flags up whether the action relates to hospital patient “flow” or a specific “ED” related issue or actions with primary care.

This will now be performance managed through the monthly DAG (assurance group).

Item	Focus	Recommendation (IST) / Local Action	Considerations	Achievable / Actions	Comments	Deadline	Owner
Manpower	ED	Adoption of Advanced Nurse Practitioners within department should be maximised to improve timely patient flow (IST).	The ACCT could provide an opportunity to add value in A&E by reviewing patients in A&E and assess whether some patients could be treated in the department and then released into the care of ACCT to avoid an admission.	ACCT team having a greater presence within A&E.	Discussions have now taken place with ACCT team and a service is likely to start in Dec/Jan.	Jan 2013	Director of Nursing
Capital	ED	The development of a new ED unit to create a larger working area to deal with the increased activity especially at peak times.	The Strategic outline business case goes to November Board. Work commences on 1st December on OBC.	Strategic outline business case on November Board agenda.		29 November	General Manager/ Head of Estates
Capital	ED	Review of existing space as breaches involving minors occur as a result of insufficient space in which to review patients following investigation.	Office accommodation could be temporarily converted into clinical space .	This is achievable although alternative space will need to be found for office accommodation.	Consider as part of the capital programme and A&E capital task group.	December 2012 to identify space	General Manager/ Head of Estates
Manpower	ED	Shift pattern changes. The activity within the unit in recent months has increased during the midweek afternoons which may be out of alignment with the staffing levels (Doctors and Nurses).	Recent analysis by GM to map demand with levels of medical and nurse staffing – some imbalance noted.	Rotas being reviewed External assistance from IST also being provided.	IST nursing assistance obtained but still require medical assistance.	January 2013	Consultant and Matron in ED
Manpower	ED	Review of nurse access to training and professional development .	Opportunities exist within the A&E for nurses to participate in CPD to enhance skill set and raise standards.	Nurses can attend in house ALS and ALTS courses or high fidelity simulation at BTHFT. Training plan to be in place.	Access to courses would enhance professional relationships and team building and build skills and competencies.	January 2013	Matron
Manpower	ED	Appointment of pharmacy MTO to aid drug restocking and release nurse leadership time.	Top up stock and put away. Pharmacy Assistant Band 3 x 0.24 WTE @ £1.5k / 3 months.	Release Band 6/ 7 nursing staff time to be redirected to patient care, thus reducing the risk of breaching 4 hour target -Better organisation of stored medicines / regular checks of expiry dates / tighter stock control: reduce over ordering,	Pharmacy staff available for project starting mid-December.	December 2012	Chief Pharmacist

				req'd stock levels maintained.			
Manpower	ED	Appointment of a new Matron.	Enhanced professional leadership is absolutely essential – key appointment.	Unsuccessful in November.	Need to reconsider role and requirements and temporary arrangements.	January 2013	Director of Nursing/ Senior Matron
Manpower	ED	Extend opening hours of minor patients stream.	Reduce waiting times for first assessments in the evening.	Temporarily enhancing Dr shift cover into the weekday evenings. Implementation of escalation policy.	Need to consider long term solution.	December 2012	General Manager/ CD A&E
Manpower	ED	Review of junior doctor productivity and efficiency.	Evidence suggests a two-fold variation in JD throughput of patients (performance typical of junior staff elsewhere).	Data is collected and shared with juniors. Consultant view is that juniors could be more effectively deployed on clerking in ED to maximise throughput.	Significant cultural shift required in JD thinking with longer term opportunities to redefine JD workforce with other professional groups.	Feb 2013 to implement JDs working differently on new clerking proforma (and longer term to re-profile JD roles)	All ED consultants and Medical Director
Process	ED	Implementation of new front end adult clerking proforma.	Based on SystmOne adoption. Patients clerked in ED resulting in enhanced flow through system and less delays for patients and more accurate history taking.	New form devised and approved by CDs at SMLT in November 2012.	Improved data quality and medicines reconciliation.	Jan 2013	Interim Deputy MD
Process	ED	Review clinical interface between senior nurses and doctors.	Shop floor relationships are seen as good, but opportunity exists for consultants and senior nurses to jointly lead on ED management issues and ownership of this plan.	Review of interface to be part of IST support.		Jan 2013	EMD, DOO and DON
Process	ED	More effective utilisation of Local Care Direct.	Audit data shows that LCD see approximately 80% of refers from ED. Remaining 20% are not seen as LCD do not have capacity.	2 recent meetings with CCG and LCD. Strong executive influencing of LCD position to provide sufficient capacity to see all ED referrals and ease early evening surge and weekend peaks.	Urgent care contract with LCD is complex and being reviewed.	March 2013	Medical Director

Process	ED	Release A&E CD from most clinical duties to provide leadership for urgent care flow.	Medical director has held 1:1s with all A&E consultants to explain proposed arrangements and attempt to understand concerns.	Likely outcome will be that A&E consultants share responsibilities and spread the workload.	Lack of 1 person challenges managers to 'work across' but may ease pressures by distributing the work.	Dec 2012	Medical Director & Director of Operations

1. ACTIONS TO BE TAKEN IN MAU & ON WARDS

Item	Focus	Recommendation (IST) / Local Action	Considerations	Achievable / Actions	Comments	Deadline	Owner
Pathway	Flow	Build senior clinical leadership to drive through pathway changes and foster consultant clinical engagement with flow changes.	Appointment of interim deputy medical director with responsibility for flow and pathways for 4 months in the first instance.	The clinical engagement challenge is very considerable and key to effective management is sufficient clinical manager time and focus to drive though change.	CD will take up this appointment from 1st December 2012 for 4 months on a 4 day (8PA) contract.	1 December 2012	Medical Director
Pathway	Flow	The relationship between emergency, acute and speciality medicine appears progressive with shared vision and objectives. (IST comment).	The internal professional standards group has been established which will quickly present the issues and move to solving solutions within 2 meetings.		The recent appointment of CD for medicine will support the introduction of the IPS across the Trust.	January 2013	Clinical Directors & Medical Director
Comms	Flow	Internal Summit meeting with CEO with Clinical Leads and Senior Management representatives. External summit meeting with CEO, social services and CCG.	Number of workstreams as mentioned above have come from these summit meetings.		Summit meetings continue.	Continuous	Clinical Director

Pathway	Flow	There should be an integrated and performance managed approach to short stay (IST).	Short stay can be best achieved through a degree of segmentation of admitted patients into streams, namely short stay, sick specialty, sick general and complex.	Short stay ward area.	The Medical Division have identified a short stay ward area on Ward 18 and this commenced 7 days a week from mid November. It will be formalised in January with acute physician model.	January 2013	Clinical Directors and General Managers
Workforce	Flow	Enhanced Consultant Physician presence on MAU.	Design rota for consultants to deliver 8am to 9pm consultant presence on MAU incorporating short stay, ambulatory clinics, GP call screening, telemedicine and assessment and Post Take Ward Rounds (PTWR).	Consultation process completed and rotas being designed.	Final sign off via SPP and Physicians meeting in December.	Anticipated rota start date early January 2013	Clinical Directors
Discharge Work	Flow	Ensure internal and external processes are contributing to the overall aim of reducing the length of stay and improving the patient experience.	Meeting has occurred between Airedale and social care. However Dr Foster benchmarking shows lower than expected readmissions. NHS benchmarking shows low LOS [2012 dataset].	Review nursing needs assessment process. Timely assessments by all health professionals.	New process in place and regular dialogue at operational level is happening.	Project completed in December .	Senior Matron
Discharge	Flow	A full review of the discharge work stream will be undertaken by Senior Matron in Medicine.		New action plan produced.		December 2012	

2. ACTIONS TO BE TAKEN IN PARTNERSHIP WITH PRIMARY CARE

Item	Focus	Recommendation (IST) / Local Action	Considerations	Achievable / Actions	Comments	Deadline	Owner
Comms	Flow	Close working and influencing / supporting CCG leadership thinking.	Available data shows significant upward shift in referred GP activity thought secondary to behaviours:	CEO has chaired and directed 2 urgent care summits, sharing performance data at practice level with CCG AO and		On-going	CEO

			workload and case complexity / multimorbidity / over 85 year olds.	challenging higher than expected referral rates.			
Comms	Flow	Close working and influencing / supporting YORLMC leadership with performance data and trends.	Ditto above	EMD and DOO attended November YORLMC and shared upturn in GP activity. Encouraged GP providers to support FT and agree to triage back to primary care (see below).		On-going	Medical director
Pathway	Flow	Front end triage back to primary care.	Undertaken previously in two Trusts.	Securing protocol from neighbouring Trust. Decision to be made in January 2013.		January 2013	A&E consultants GM
Comms	Flow	Clarity of messaging with primary care through robust understanding of the A&E performance data and how individual GP practice referral rates.	Highly complex analysis of trends – if CCG engagement is to be effective, data must lead to reliable conclusions when securing trust and confidence.	Detailed analysis undertaken by information department at request of DOO shows themes and trends to explore with ED consultants and CCG.	Multiplicity of explanations for observed themes and trends – open to interpretation.	First cut complete Nov 12 and send to CCG leaders on weekly basis	DOO and EMD
Pathway	Flow	Developing ambulatory emergency care pathways with primary care.	Already underway but move to a basket of 20 conditions in the first instance. Key aim is to reduce conversion rate by 2%.	Link to TRANSFORM work and building on current DVT and cellulitis pathway. Good CCG engagement.	Making emergency care an ambulatory speciality.	On-going	Interim Deputy MD
Pathway	Flow	Developing innovative approaches to primary care demand management – telemedicine access in high volume primary care settings.	High volume users of acute care identified and offered access to acute physician opinion remotely as an alternative to admission.	Technology in place. Work on new physician job plans on track for Jan 13.	CCG-AO is liaising with respective surgeries.	On-going	Telemedicine lead
Pathway	Flow	Improving access to specialist acute medical opinion for primary care.	Access to acute physician by mobile phone to aid signposting and admission avoided. Also investigating role of e- consultation.	Similar concept to the effective and GP rated ‘stroke line’.		January 2013	Interim Deputy MD

Pathway	Flow	Telemedicine units in nursing homes.	Telemedicine units have been installed and workshops being held to increase uptake.			On-going	Telemedicine lead
Pathway	Flow	Working with CCG and YAS to avoid Green 1 and 2 admissions (GP in hours pathways).	Complex piece. Good evidence from South Coast Ambulance Trust that low category ambulance calls can be safely triaged to GP as an alternative to ED.	Clinical joined leadership of YAS MD, EMD and CCG AO in hand.		On going	Medical director