Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	25th January 2017				
Report Title:	Exception Report on Emergency care Standard (ECS) for November and December 2016 and Quarter 3 2016				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X	X	X			
Prepared by:	Shaun Milburn, General Manager Unplanned Care				
Executive Sponsor (presenting):	Stacey Hunter, Chief Operating Officer				
Appendices (list if applicable):	Appendix 1 – Emergency Care Standard Quarter 3 2016 position				

Purpose of the Report
To detail to the Board that we have failed to deliver the 4 hour Emergency Care Standard to patients in November and December and share the position for Quarter 3 2016. To acknowledge that this falls below the standard we aspire to deliver to our population who require the service To detail the context, contributing factors and mitigation in place to manage and improve the performance.

Key points for discussion
To acknowledge the Emergency Care Standard achieved for Quarter 3 2016 was 89.20%. Review this position relative to all acute providers in England in the same period given many of the challenges and constraints to delivery of this standard are consistent for acute providers. To apologise to those members of the public and their families that have experienced long waits in our Emergency Department. Note that despite significant focus and effort some of the challenges – rising number of delayed transfers of care , increases in the number of patients medically fit for discharge stranded in a hospital bed coupled with increased demand continue to have detrimental impact on both the experience of patients and their families and on our staff. Acknowledge the continued efforts and hard work of our staff working across emergency and urgent cares who are managing this on a day to day basis.

Recommendation
The Board is asked to receive and note this exception report

Appendix 1 Emergency Care Standard October 2016 position

Overview:

The Emergency Care Standard (ECS) achieved in Quarter 3 was 89.20% a breach of the 95% required (table 1). This falls short of the standards we aspire to deliver to our local population and we apologise to patients whose experience may have been impacted by having to wait in excess of 4 hours for their care. In addition to this it may have an impact on the Trust's governance rating and the access to the performance element of the Sustainability and Transformation Funding (STF). There will be an ability to appeal the STF trajectory as per Quarter 2 which we will progress.

Table 1 End of December 2016 position

Attendances/Breaches

	Total Attendances	Total Breaches	%
October (complete)	**4852**	**477**	**90.17%**
November (complete)	**4585**	**421**	**90.82%**
December (incomplete)	**5335**	**694**	**86.99%**
Quarter 3 2016 (incomplete)	**14772**	**1595**	**89.20%**
YTD_ 2016/17 (as of 16th January 2017)	**46065**	**4338**	**90.58%**

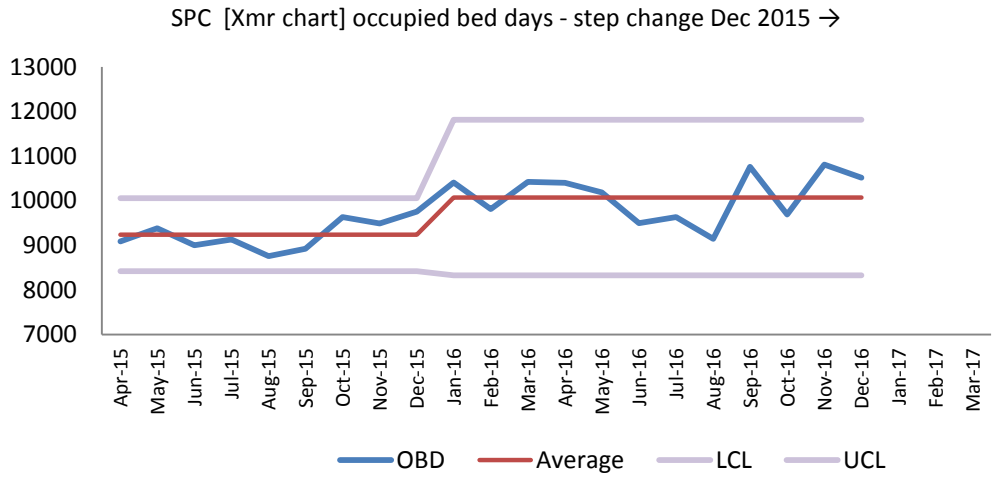
Background and Summary

It is well recognised that the current National picture for the Emergency Care Standard continues to be a challenge for 85% of acute providers in England. Each Trust receives a daily ECS position across England from NHSI. The current position across the West Yorkshire region shows that of the 6 acute Trusts that make up the West Yorkshire Association of Acute Trusts (WYAAT), none achieved the ECS standard during December. The Yorkshire and Humber average for December was 83.58% (against this Trust's December position of 87.34%). The England average was 83.60% for December 2016, (although data over the Xmas period is unavailable same period.) Information and intelligence sharing via A/E Delivery Boards demonstrates that the factors impacting on the ability to deliver this standard are the same across acute providers. The main factors are highlighted below:

- Sustained increase in Delayed Transfers of Care (DToC) and patients who are medically fit for discharge but have a delay in an assessment of need, care package starting, equipment being provided. This is having a significant impact on available bed capacity in the hospital on a day to day basis and causing delays in getting patients transferred from the Emergency Department (ED) once it has been determined they require admission. The bed occupancy figures have increased as a result of this issue, which is illustrated in graph 1 showing a stepped increase in

occupied bed days(OBD) with effect from November/December 2015 when DToC became an issue, (see previous Board papers).

Graph 1



- Continued increase in ED attendances (minor illness and minor injury), especially during the evening period. This is despite investment in alternative provision in primary and community care.
- Ongoing ED workforce challenges in respect of the level of medical cover required.
- Registered Nurse recruitment challenges which prohibit opening additional beds to respond to peaks in demand or increased bed occupancy

The factors in October are similar to those seen in Quarter's 1 and 2. **Bed holds*** have not improved and the analysis demonstrates that this is a significant change compared to the same period last year. If breaches due to bed holds were at 2015 levels then the ECS position would have been at 94.02% for Quarter 3 2016.

Added to this as shared in previous Board reports the ED medical team have been supporting gaps in their workforce over and above the level they had during 2015. This has been a significant constraint in respect of resolving the underlying capacity and process issues in the ED to provide an improvement in the delayed first assessment times.

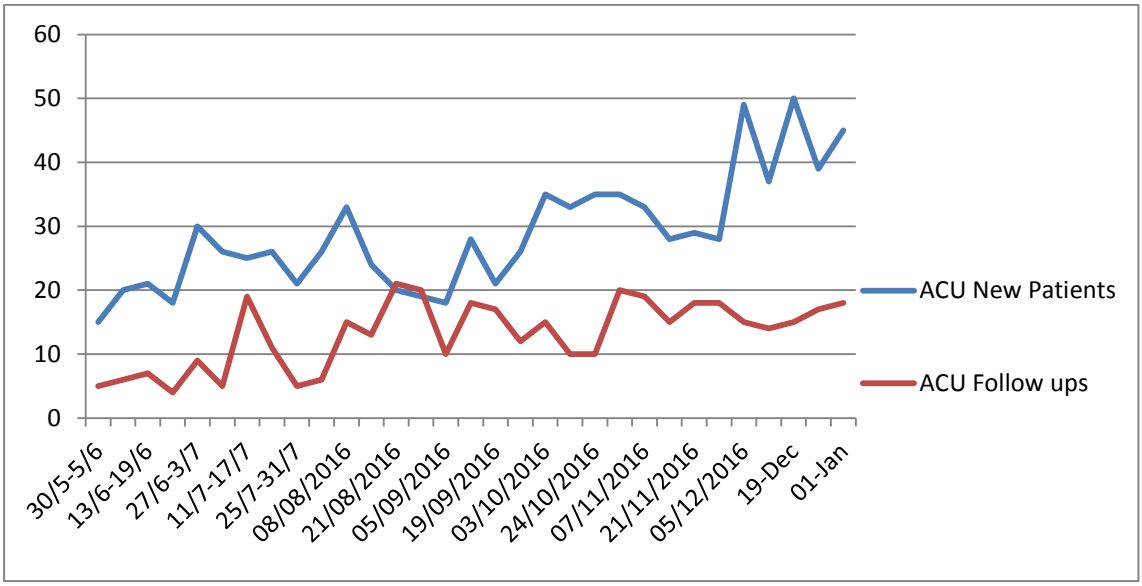
***bed hold** – if a patient has been seen and treated in ED and requires an admission to a hospital bed to continue care and that bed is not available within 4 hours of the patient attending ED, then the patient will breach the standard because of "bed hold".

Summary of Quarter 3 2016

1. **ED Attendances Quarter 3 2016 were 11.58% higher than the same period in 2015.** Some of this can be accounted for the fact that from December we were asked by NHSI to include patients who were seen in a secondary care setting who in the past would have otherwise attended ED (AMU direct admissions and ambulatory care patients as examples). However, excluding these patients like for like attendances were still 5.8% higher than over the same period in 2015.

2. **Admissions during Quarter 2016 were 4.21% lower than the same period in 2015.**

This is in part due to the continued success of our Ambulatory Care Unit, (ACU). The ACU take calls from GPs and from ED to triage those patients who can be who can seen in an ambulatory care setting instead of being admitted to AMU. The graph below articulates the increase in patients seen in ACU instead of being admitted to AMU.



If one assumed this ACU increase had not occurred (kept at 2016 baseline) and patients had to be admitted to AMU for their acute care, then admissions to AMU would have actually increased by 1.9%.

3. **Bed Occupancy**. During Quarter 3 2016, bed occupancy rates were averaging 96.73% compared to 95.46% during Q3 2015. This has been articulated in previous reports, in particular the impact that delayed transfers of care and medically fit patients in the bed base have on increased lengths of stay.

4. **Delayed Transfers of Care, (DToC)**. During Quarter 3 2016 the average bed days occupied by DToC patients was 74 days per week, (low 23 and high of 136). Over the same period in 2015 there were on average 60 bed days occupied per week. This is an increase of 23% and accounts for an additional 12 beds in our bed base. It is recognised that this is the root cause of exit block issues within ED and therefore bed hold breaches. If DToC were at the same levels as 2014/15 then re-assessment

of the YTD ECS performance indicates that we would be at 94.02% instead of 91.56%.

5. **Workforce gaps.** There are a number of gaps in both the consultant and middle grade shifts that although covered internally, they are placing significant strain on the substantive staff. This problem is a national picture and is now becoming sustained, system wide and although recognised as very challenging, there is not a quick fix solution to resolve the issues. The mid to long strategic plan for this is detailed in respect of the investment in an integrated front end the detail of which the Board are due to consider in the business case re the Acute Assessment and Care Hub at the Board meeting on the 25th January 2017.

The Clinical Director, General Manager and Matron for Urgent Care undertake detailed analysis of all the individual patients who have waited longer than 4 hours. This helps determine the underlying factors that have contributed to the failure to deliver.

Table 2
Breach analysis Quarter 3 2016.

Breach reasons	Total
Number of breaches associated with Bed holds	723
Bed holds as a % total breaches	45.33% (Q2 36%)
Number of breaches where Delayed assessments are associated with workforce capacity	572
Delayed assessment as % of total breaches	36.29% (Q2 44%)
Number of breaches where Other reasons are the primary cause	300
Other reasons as a % total of breaches – (e.g. clinical exceptions, diagnostics waits, waiting for YAS transport and mental health)	19.04% (Q2 19%)
Total breaches	1595
% ECS	89.20% (Q2 90.16%)
%ECS if bed holds were consistent with 2015 average (6%)	94.02% (Q2 94.6%)

Further actions (over and above plans reported in previous exception reports)

The Trust continues to push forward with delivery on the West Yorkshire Accelerator Zone work as previously reported.

Since mid-December the Trust has consistently been at Operational Pressure and Escalation Level (OPEL) 2-3 which requires instigating Silver Command. This is due to the following:

- Increased attendance and admissions (particularly GP admissions)
- Acuity (i.e. sicker patients consistent with a winter pattern of illness)
- Significant numbers of patients who have delays in their discharge arrangements (this is usual pressures plus bank holiday backlog , several private providers of care homes and care at home who have staffing problems and cannot support further demand and Norovirus at large in the community/care home beds which are then restricted).
- 39 beds over and above the winter plan open due to the above which is putting significant pressure on nurse and doctor staffing in particular.

We have been at OPEL 3 (scale 1-4) which is described in national guidance as sustained significant pressure since 2nd January and as such have been in Silver Command from that date.

Despite everyone's best efforts we have significant numbers of breaches of the 4 hour ECS and lots of patients/families waiting a long time particularly if they need an admission to hospital.

Actions implemented over the last 4-5 weeks:

- Matrons doing a 9pm – 3:30 am shift over the last 2 weeks to support /oversee nurse staffing given the additional number of beds open at present
- Where viable study leave /annual leave rearranged
- Daily conference calls across the system with the A/E Delivery Board – via these we have requested additional registered nurse staffing from the CCG and BDCFT. This has not yielded a huge amount given the respective pressures of other providers , but we have had community matron from BDCFT made available for a few hours each day which is welcomed
- Community ANPs are working in ED to support the team and wherever feasible get people back home from ED with support
- Non urgent elective activity has been cancelled (we had reduced the programme from the 19th Dec until 16th Jan as part of our plan anyway)
- General managers/service managers cancelled all non- urgent work to support patient flow
- Sought to source additional nurse and doctor capacity
- Messages to the public via all media channels re keeping well, not coming to ED unless an emergency/urgent. Yesterday I engaged with Stray FM (radio) and Look North to re-iterate messages

Summary

The delivery of the Emergency Care Standard remains a key priority for the trusts and significant resource in terms of staffing is focused on its delivery. The challenges will continue into the New Year. To date the January position currently stands at 85.54% (against a Yorkshire and Humber position of 82.53% and national of 80.63% as of 17th January). The General Manager for Integrated Care remains on secondment to provide senior oversight and there is now regular learning across the West Yorkshire network via the West Yorkshire Association of Acute Trusts (WYAAT) and the A&E Delivery Board.

West Yorkshire Acceleratory Zone work (WYAZ)

In light of a further deterioration of the baseline ECS during December and January we have been working collectively with WYAAT and revised our Accelerator Zone (AZ) ECS trajectory for March 2017.

The table below shows that with all our AZ schemes in place we will increase performance for March 2017 by a further 3.8% on our December 2016 baseline. This is a further reduction on the previously reported 93.71% we were reporting at December 2016. The Board will want to note all of the WYAAT Trusts have revised their trajectories for these reasons.

	Performance December 2016			March Predicted with Counting Changes Only (January submission)			Predicted March with Schemes Funded Only (January submission)			Predicted March with both actions implemented (January submission)			Predicted increase (January submission)
Trust	Total Activity	>4 hour activity	% Delivery	Total Activity	>4 hour activity	% Delivery	Total Activity	>4 hour activity	% Delivery	Total Activity	>4 hour activity	% Delivery	% Increase
ANHST	5,159	665	87.11%	5783	833	85.6%	5270	527	90.00%	5783	527	90.9%	3.8%