4 hour Admission to Discharge Pathway in Emergency Department – Whole System Recovery Plan.

April 2013

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- **Whole System Lead: Martin Wilkinson, Chief Officer - NHS Lewisham Clinical Commissioning Group**

1. Preface

Lewisham Healthcare NHS Trust has failed to achieve the target of 95% of people being seen, treated and discharged within 4 hours of arrival to the Emergency Department.

Given the recent operational pressures and under performance, the purpose of this plan is to clarify the actions being taken to ensure sustainable delivery of this core standard.

2. Background

As a result of sub standard performance levels in the final stages of quarter 3 and into quarter 4, 2012/13, an internal action plan was developed with the intention of improving performance in quarter 4 and the year, on aggregate, whilst avoiding 60 minute LAS breaches, unfortunately despite best efforts in relation to sustainability, Q4 and subsequently the year, were not delivered at the contracted performance standard.

The initiatives are owned and managed by a range of senior staff throughout the Trust reflecting the responsibility in delivering the 95% performance across the whole organisation.

Whilst the under achievement of performance was multi-factorial, analysis of Emergency Department breach data indicates that since December, January and February, delays to first assessment and bed availability account for a significant proportion of the total breaches.

3. Activity

During December A&E activity increased by 10%, when compared to the same period 2011/12, in addition the impact of "out of borough" patients attending the department and being admitted had risen significantly. The delivery of the target has been significantly hampered by:

- A severe Norovirus outbreak in December and early January, which considerably impeded performance for that period,
- Mental health activity, during the period 3rd December 2012 to 31st March 2013 there were 608 patient arrivals who required specialist referral to the Mental Health Team. Of the 608 arrivals 241 breached the four hour performance standard, or 39.64% of patients.
- There were 22 London Ambulance Service (LAS) notified diverts away from other Trusts to Lewisham for the period December 1st to date, this is well above the average of 3 diverts, for the period, compared to previous years.

4. Whole System

Whilst every endeavour to restore performance is being undertaken internally, the sector and whole system influence is notable. LAS local intelligence suggests there were/are multiple 'soft/informal' diverts away from South London Trust through December and January, that may have been as a direct result of 86 step-down beds on the Queen Mary's Sidcup site being closed in November.LAS anecdotally report daily queues to offload developing at QEH Emergency Department and subsequently LAS crews are requested to avoid QEH.

Delays in transfer of care for patients requiring continuing and end of life care within the borough of Lewisham remains a challenge which is being jointly addressed on a daily basis via robust networks with Social Care colleagues. A 50 bed nursing home permanently closed in December 2012, and St Christopher's hospice (48 beds) has temporarily closed with reprovision of 14-16 beds at Lewisham Hospital.

5. Recovery

a. Lewisham's proposed recovery trajectory is based on achieving 95% by w/e 2nd June 2013 and sustaining the contracted level of performance thereafter
b. Ongoing monitoring and internal review of performance with detailed analysis takes place on a daily basis. The Trust Executive will determine if further support is required via a diagnostic exercise undertaken by the Intensive Support Team in the week commencing 6th May 2013.

Action No	Action	Proposed Intervention	Anticipated Outcome	Lead	Current Status and Review Date	Outcome Measures			
	Emergency Department Processes								
1	Increase the senior nursing presence on the shopfloor during 0800 to 2000; this was previously 0800 to 1700.	1. Matrons have provided shopfloor support Monday - Friday from 0800 to 20:00 from 08/01/13 2. All non essential leave has been cancelled. 3. All non clinical time has been sanctioned by HoN.	**Medium Impact** Increase the Senior Nurse shop floor coordination to support flows and the role of the Nurse in Charge in managing operational issues.	Sive Cavanagh/ED Matrons	Matrons are currently available Monday to Friday 08:00-20:00 and is an ongoing supportive action	This is a qualitative contribution to the turnaround in performance			
2	Enhance the Senior ED Medical supervision of the shopfloor out of hours.	1.Additional consultant cover has been in place between 20:00-23:00 on a seven day a week basis since 9th January 2013 2. Additional SPR shift put in place for peak period of 18:00-02:00 in particular to manage the lengthy queues that can generate in UCC at this time	**High Impact** 1.Reduction in breaches for patients overall, but specifically in the Group 2 (ED patients) category especially during the peak hours of 18:00-02:00 2.Availability of Senior Decision makers to support junior medical staff in the management of patient flow and prioritising of presentations. 3. Reduce the number of patients who breach as a result of a delay in ED first	Elizabeth Aitken	1.The additional consultant shifts have been covered for 98% of the period to date and are ongoing. 2.The SPR shifts have a fill rate of 90% due a lack of suitable locums at this grade This initiative has been ongoing since January 2013 . **This is reviewed weekly as part of the breach review**	w/c	1st Assx breach	GP 2 pts	% in 4 hrs
						31 Dec	70	1232	94.2%
						7th Jan	3	1254	92.7%
						14th Jan	24	1080	97.7%
						21st Jan	22	1217	98.0%
						28th Jan	12	1247	99.1%
						4th Feb	17	1206	97.2%
						11th Feb	3	1183	95.0%
						18th Feb	33	1223	97.3%
						25th Feb	50	1198	97.4%
						4th March	22	1158	96.1%
						11th March	23	1080	93.7%
						18th March	46	1234	96.0%
						25th March	23	1061	96.3%
						1st April	82	1047	93.8%

			assessment.		**meetings.**	
3	Increase analysis of 4 hour breaches to develop a proactive preventative environment	1.Daily, Senior Clinician led breach analysis meeting established (Mon-Fri at 13:00) commenced January 2013 2. Clinical review of performance and associated validation of long waits 3.Review of Internal actions and added value to support recovery	**Medium Impact** 1.Reduction in the numbers of avoidable breaches. 2.Sustained improvement against 4 hour target	Elizabeth Aitken	Daily breach meetings will continue until 95% performance is achieved and sustained. **Reviewed weekly – frequency of meetings to be reviewed once sustained performance is achieved.**	Current performance has been managed by exception consistently since January 2013.

4	Development of robust internal Escalation plan in support of operational pressure management	1. Trust Internal Escalation plan has been developed. 2.Draft has been circulated for agreement by all specialties	**High Impact** 1. Agreement of response required by all teams in relation to the Trust Operational Status 2. Ensure all specialties contribute operational support when required 3. Ensure robust and timely escalation is utilised internally and externally with other agencies	Elizabeth Aitken	1. Draft Escalation plan circulated. 2.Provision of Escalation bleeps for each service to have a central point of escalation during working hours . These will be circulated week commencing 15th April 2013. **Review w/c 13/05/13**	Qualitative contribution to the Trust performance and operational efficiency
5	Enhance the Management Support within ED	1. Appointment of dedicated ED Business Manager to work alongside the ED Team and the service since 28/01/13	**High Impact** 1. Co-ordination of the 4 hour Recovery Programme 2. Act as a conduit for escalation, operational issues and business continuity	Katy Wells	Jo Gennari appointed on 28/01/13 **Completed**	Qualitative contribution to operational performance
6	Co-ordinated approach to managing performance as a Trust wide responsibility	1.Relaunch of the 4 hour project group as the 4 hour Recovery Group - with membership across all internal stakeholders. 2. Development of an evolving recovery programme - from which this action plan has been developed.	**High Impact** 1. Increase engagement across internal stakeholders to ensure subspecialty responsibility for breach prevention and contribution to recovery plan. 2. Successful implementation of works which lead to reduction in breaches	Elizabeth Aitken	1.Group relaunched as of 25th March with engagement from all stakeholders. 2. Recovery Action plan signed off at Trust level. **Reviewed weekly within 4 hour Recovery Group Meeting – Meeting**	This will be evidenced as a quantitative improvement in the performance standard on a sustainable basis as of 12th April 13 – Quarter 1 is at 88.58% Analysis submission to the NTDA projected a robust solution from June 1st 2013. If a significant improvement in performance cannot be met within 2 weeks (ie: 22nd April) then further diagnostic support may be support by

					will continue until performance sustained.	the DOH Intensive Team.
7.	Avoidance of multiple queues to be seen in UCC	Trust Pilot of rapid triage utilising ENP's who will where appropriate, filter patients from the full triage queue.	**High Impact** This initiative will reduce the wait for triage and minimise the wait for first assessment	ED Matrons	Pilot commenced on 25/03/13 **Review 30/04/13**	Reduction in the waiting times for UCC patients
	Clinical Support Services in ED					
8	Reduce the numbers of patients breaching 4 hours whilst waiting for diagnostic results prior to discharge home	1.Development of 2 chairs within RATU for ambulant patients awaiting results but expected to go home rather than require admission	**Medium Impact** 1.Reduction in breaches for patients awaiting blood/ radiology results who then go home	ED Matrons	1.Chairs are in use and available when appropriate patients need housing in RATU and there are sufficient nursing staff to man the additional capacity. **Review 31/05/13**	We are currently monitoring the numbers of breaches avoided as a result of this initiative

9	Reduce haemolysed bloods causing delays in obtaining results	1.All patients are now be cannulated with a green cannula or larger to minimise the likelihood of bloods haemolysing	**Medium Impact** 1.Reduction in the numbers of haemolysed samples requiring a second sample - leading to reduction in delays waiting for results	Nigel Harrison	1.implemented in March 2013 **Reviewed as part of daily breach review. This is a change of practice not a pilot**	This is a quantitative contribution to the reduction in breaches and the number of haemolysed samples are being monitored
10	Establish provision for D-Dimer tests to be undertaken within the ED department (currently undertaken in pathology)	1.D-Dimer strips have been ordered 2.Machine calibrated to allow for near patient D-dimer in ED. 3.Development of protocol is underway to ensure that D-dimer only ordered by ED SPR or above under strict criteria	**Medium Impact** 1.Reduction in number of d-dimer requested 2. Reduction in number od d-dimer that are undertaken in pathology 3. Reduce waits for diagnostic tests	Nigel Harrison	1.The protocol is in development 2.Equipment ordered **Review date 03/06/13**	This is a quantitative contribution to the reduction in breaches caused by delays in access to diagnostics
	Specialty input into Emergency Department					
11	Efficient access to on call teams during ward rounds	1.Since January the Medical SPR has carried a dedicated bleep and been responsible for answering all ED bleeps during ward rounds as a single point of access	**High Impact** 1.Reduction in delays for review and decision making during ward rounds 2.Provide an escalated single point of access to medical teams and reduce hierarchical bureaucracy	Elizabeth Aitken	1.this has been implemented as of January 2013 **This is a change in practice not a pilot, reviewed as part of daily breach meeting in the event of any failures to respond**	Reduction in waits for medical subspecialty review in the ED and decisions to admit.

12	Reduce delays for those patients who require referral to Surgical Specialties	1. Surgical Escalation plan developed and circulated February 11th 2013 2. Dedicated escalation bleep to be provided week commencing 15th April as a single point of escalation during working hours	**High Impact** 1.Reduction in times from referral to DTA / Discharge	Katy Wells/ Ben Stevens	1.Escalation plan circulated and signed off. 2.Escaltion bleeps to be launched week of 15/04/13 **Review 03/06/13**	This is a quantitative performance improvement which will be evidenced within the reduction of the times for referral to DTA/Discharge.
13	Reduce delays for those patients who require referral to Gynaecology	1.Development of Gynae Escalation Plan – circulated via the 4 hour recovery plan 2. Dedicated escalation bleep to be provided week commencing 15th April as a single point of escalation during working hours	**High Impact** 1.Reduction in times from referral to DTA / Discharge	Katy Wells/ Ben Stevens	1. Escalation plan circulated and signed off. 2.Escalation bleeps to be launched week of 15/04/13 **Review 03/06/13**	This is a quantitative performance improvement which will be evidenced within the reduction of the times for referral to DTA/Discharge.
14	Reduce delays for patients with a #NOF and reduce the numbers housed in RATU	1.The pathway for #NOF has been developed and is being utilised.	**Medium Impact** 1.Reduction in numbers of patients with #NOF using RATU or outlying on other wards. 2.Reduction in LOS for this patient group	Elizabeth Aitken	1.The fast track pathway was relaunched on 05/03/13 **Review utilisation 03/06/13**	This is a both a quantitative and qualitative measure that will reduce #NOF outliers in RATU and enable them to get to the appropriate ward for treatment swiftly.
15	Reduce the number of breaches in UCC ,in particular, for patients referred to ENT	1.Development of protocol for the use of the Cedar /ENT Clinic room	**Medium Impact** 1.Reduction in breaches for patients requiring ENT intervention and subsequently discharged home	Elizabeth Aitken / Tony Jacobs	1.Development of Protocol in progress with support from Surgical HoN to ensure safe staffing level **Review date to be**	Numbers of patients receiving treatment in ED by ENT and then being discharged w/c 21 Jan 11 28 Jan 12 4 Feb 19 11 Feb 19 18 Feb 14 25 Feb 12 4 Mar 23 11 Mar 21 18 Mar 21 25 Mar 15

No.	Objective	Actions	Impact	Lead	Progress	Measure
					agreed once protocol commences	1 Apr 27 Nb – the % of these patients who breached is being collated.
16	Reduce waiting times in UCC by filtering children from the UCC waiting room into paediatric ED when waiting times build in UCC	1.Paediatric ED staff to pull children from the UCC waiting room and manage them in paediatric majors when capacity allows freeing up UCC staff	**High Impact** 1.Reduction in breaches in UCC 2. Reduction in mean wait in UCC		1.ongoing **Reviewed daily by Matrons from both areas.**	Quantitative measure to reduce the waiting times in UCC and breaches during peak periods.
	Discharge Processes					
17	Increase utilisation of the Discharge Lounge	1.Improve the environment of the Discharge Lounge with minor modifications to the estates. 2. Increase patient comfort with the provision of a housekeeper/porter role to support the nurse with Hospitality and non clinical tasks 3.Increase the opening hours of the Lounge to provide an earlier service and free up ward beds	**High Impact** 1.Increase numbers of patients utilising the lounge on daily basis 2. Increase the numbers of patients using the lounge before noon	Sive Cavanagh /Jo Gennari	1.Estates have visited the Lounge to review the area and a contractor is visiting on 17/04/13 to cost works which will be undertaken as a matter of urgency. 2.Housekeeper role commenced in the Discharge Lounge as of 02/04/13 3. Staffing review underway **Weekly review meeting alongside transport meeting. Estates work to be**	The utilisation of the Lounge is increasing significantly and is being monitored in terms of both times of usage and numbers. It is anticipated that the numbers using the Lounge in the early morning will increase as soon as staffing can be sought to open the Lounge at 0800

					reviewed once contractors visited – likely completion of work during May 2013	
18	Flatten the variance between weekday and weekend discharges	1.Implementation of consultant led discharge rounds at weekends. 2.Provision of additional medical registrar at weekends to support discharge processes.	**High Impact** 1.Increase weekend discharges to reduce the variance between weekday and weekend discharges	Elizabeth Aitken	1.Implemented 12th January 2013 **Reviewed as part of weekly 4 hour Recovery Group**	6 weeks discharges by day to 14th April – daily average: Monday 40.5 Tuesday 45.1 Wednesday 46.5 Thursday 52.3 Friday 49.8 Saturday 28.5 Sunday 19.8
19	Increase the efficacy of Discharge Planning Arrangements	1. Dedicated Discharge Team has been developed with Consultants, Pharmacist and Case Manager to review patients each morning to expedite discharges who are at or beyond their Expected Date of Discharge 2.Review use of the weekly Multi Disciplinary Meetings to improve discharge Planning.	**High Impact** 1. Reduce LOS for in and out of borough patients 2. Individually case manage complex discharges to minimise the risk of failed or delayed discharges. 3.Increase patient flows by releasing bed capacity	Elizabeth Aitken	1.Discharge Ward rounds are ongoing 2.OPAL model to commence w/c 23/04/13 3.Productive ward boards have been trialled and are rolling out across all wards since April 2013 **Review as part of the**	Evidenced by reduction in Length of Stay, reduction in readmissions and increased patients flows thus contributing to the reduction in breaches.

					4 hour Recovery Group as Discharge Planning key agenda item.	
		3.Development of Patient Productive Ward Boards to focus the ward teams and allow for increased planning. 4.Adopt the OPAL model from 23rd April to review on a case by case basis those patients with a Length of Stay in excess of 7 days.				
20	Reduce the significant delays and cancelled discharges due to arrival of late transport	1.Ongoing work with G4S to improve service by attending bed meetings so they understand bed state on daily basis. 2. Site Managers have been provided with access to transport system so that they can view planned journeys. 3.Increased usage of the Discharge Lounge will ensure quicker turnaround for transport vehicles	**Medium Impact** 1.Reduction in numbers of aborted journeys due to late transport. 2.Swifter turnaround of vehicles leading to more completed journeys each day	Jo Gennari	1.there is an established weekly meeting with Director of Estates to review performance 2.Any transport failures are reported via the Incident reporting process and are followed up immediately **Reviewed weekly**	This will be evidenced by a reduction in the number of cancelled discharges as a result of failure of transport as well as a reduction in aborted transport journeys

21	Improve efficacy of Bed Meetings	1.Bed Meetings rescheduled to 08:30 and 15:00 to allow for better forward planning. 2.Admissions predictor developed so that all staff understand likely demand on a daily basis.	**Medium Impact** 1.Proactive approach to managing the bedstock twice daily using predictive tools and an action led approach. 2.Reduce the reactive crisis management approach at midday		1.Bed Meeting times changes as of 25/03/13 **This is a change in practice and not a pilot.**	This is a qualitative contribution to deliver increased patient flows
	Whole Systems Actions to support emergency flows					
22	Engagement with Social Services in Discharge processes	1.Dedicated Social workers aligned to each ward 2.Daily delays in transfers of care identified and sent to Joan Hutton et al. 3.Daily list of patients awaiting placement or brokerage intervention identified and sent to Joan Hutton et al. 4.Out of Borough networks – specifically Greenwich and Bexley to be established	**Medium Impact** 1.Proactive approach to managing discharges whereby assessments are undertaken in a more timely way 2. Ability to identify the blocks that are causing the delays. 3. Develop systems to remove the identified blocks 4. To develop relationships with out of borough local authorities in order to improve the discharge for these patients	Joan Hutton	1. The Tracker meeting takes place twice weekly Tues and Thursday attended by the multidisciplinary team to provide an up date on progress. 2. Daily update from brokerage to ensure a whole system approach **Review 03/06/13**	This will be evidenced by a reduction in the number of patients awaiting placement, bed days saved and length of stay

23	Clinicians from Primary and Social Care have joined the 11am multidisciplinary post take meetings at Lewisham	Senior Clinical and Social Care input to LHNT post take meetings. Insight of common issues to drive whole system improvement.	1.Information from the meeting will feedback into planning and whole systems support	Diana Braithwaite Director of Commissioning CCG	These have been in place since 25/03/13 Insight to be shared with CCG Clinical Directors Meeting and any new actions to be agreed at Whole Systems Group on 30/05/13	
24	Continuation of winter schemes remain in situ	Winter Schemes extension to Easter agreed (see above) Key learning for Winter 13/14 agreed	**High Impact** 1.The BSU funded winter schemes to support the Trust in improving ED performance were in situ and funded until March 31st 2013. These schemes remain ongoing in support of the 4 hour target, at Trust risk.	Martin Wilkinson Accountable Officer CCG	Key learning to be shared across SE London. 29/04/13.	
25	Extended local incentive scheme for extra urgent care slots with Primary Care	Urgent Care slots agreed as part of winter schemes. Provides extra capacity for potential attendees at ED abd Urgent Care Centre.	**Low Impact** Scheme ran from 25/02/13 to 04/04/13. Evaluation for potential scheme for 13/14	Diana Braithwaite, Director of Commissioning.	Evaluation complete to report to May CCG Delivery Committee and to be shared at 30/05/13 Whole Systems Group.	
26	The development of an Emergency Care dataset.	A data set has been populated using the template from the Modernisation Agency Emergency Care Collaborative Programme	**Low Impact** To assist in the analysis of ED performance data	Katy Wells and Trust Informatio nTeam and Mike Hellier, CCG Head	Data set populated and sent to CCG for review – completed 05/04/13 Agreed Set with CCG 19/04/13.	

			of System Intelligence.		
27	Reduce the number of Mental Health breaches	1.Establish a mental health sub group	**High Impact** 1.support rapid assessment and treatment of patients with mental health conditions	Dee Carlin	Meetings commenced on a monthly basis as of January 2013	During the period 3rd December 2012 to 31st March 2013 there were 608 patient arrivals who required specialist referral to the Mental Health Team. Of the 608 arrivals 241 breached the four hour performance standard, or 39.64% of patients.
28	Reduce the TSA impact on morale	1.Regular staff briefings on a formal and informal basis from the Chief Executive and via the Communications Department 2.Regular staff email briefings to establish work in progress and the promotion of the "Business as Usual" campaign 3.Directorate Senior Management team available to all staff to discuss any concerns they may have	**Medium Impact** To ensure that all staff feel valued and motivated to deliver business as usual and quality pathways for patients during this challenging period against a backdrop of intense winter pressures.		This will be monitored on a monthly basis as part of the Directorate Performance Meetings and by utilising the Workforce Scorecard. In particular we will be seeking to reduce staff turnover, monitor sickness rates against the Trust average and monitor the efficacy of recruitment campaigns. We will also monitor the temporary staff fill rate for both internal	This is a qualitative response

		4.Reinforcing the value of staff retention initiatives and ongoing staff recruitment			locum and via external agencies.