

One System

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Update on UHL Winter Plan 2018/19

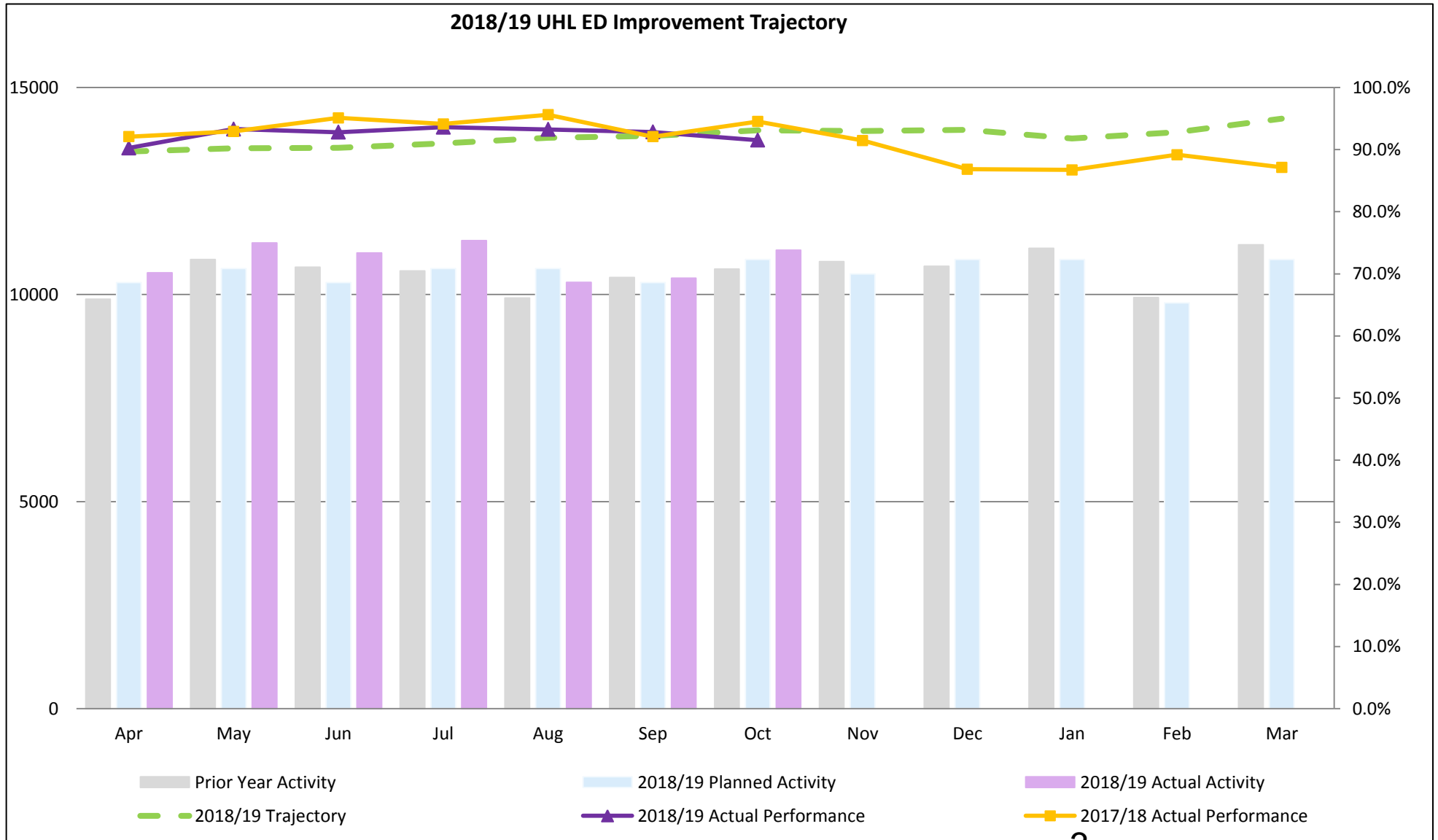
Healthier Communities Select
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Executive Summary: University Hospital Lewisham (UHL) Site

Key Messages

- UHL Site ED performance was 91.5% in October 2018 against a trajectory of 93.1%. While actual performance has deteriorated against the Q2 position the UHL Site remains one of the best performers against the ED standards across London and the best across in South East London.
- Slides 3 and 4 in this presentation set out in high level the YTD performance against the trajectory and the position for October 2018. The primary challenge for the site continues to be high numbers of patients presenting with mental health conditions and the difficulty in recruiting senior ED medical staff roles (national issue). In addition in October the site was particularly challenged as a result of the high volume of paediatric activity.
- In advance of Winter 2018-19 the Trust has been working closely with local partners to ensure we have as much resilience and additional capacity available over the winter period. Slide 5 & 6 set out some of the key actions we are taking and further detail is provided in the appendix
- While we continue to prepare and plan for the challenges of winter we recognise there are risks to these plans and they are set out in slide 7

UHL Site Performance against Trajectory to M07



ED performance – UHL October 2018

UHL: ED Performance to October 2018-19					
National Standards	Aug	Sep	Oct	YTD	YTD (2017-18)
UHL - Trajectory	91.9%	92.2%	93.1%	91.2%	93.0%
UHL - Actual	93.3%	92.8%	91.5%	92.5%	93.8%
12 Hour Trolley Waits	0	3	23	26	0
Ambulance Handover - % under 30 mins	98.4%	98.2%	94.3%	98.1%	98.5%
Ambulance Handover - No over 60 mins	10	8	17	46	28
ED Capacity & Flow					
	Aug	Sep	Oct	YTD 2018	YTD Change
LGT Attendances (including UCC)	10,293	10,399	11,073	75,853	2931
Blue lights	206	207	240	1,541	-43
Treatment within 60 mins	50%	36%	41%	38%	1%
No of emergency admissions	1,880	1,906	2,132	13,663	185
Patients waiting for bed at 8am (daily avg)	1	1	2	2	0
Breaches (including UCC)	694	746	939	5,672	1153
Non Admitted breaches	322	369	465	2805	954
Breach Reasons					
	Aug	Sep	Oct	YTD 2018	YTD Change
Beds / Transport	0.4%	0.5%	13.8%	3.6%	-1.6%
Clinical exception	30.0%	23.1%	22.7%	23.0%	8.2%
Diagnostics	1.0%	0.9%	0.5%	0.9%	-1.9%
ED flow	55.3%	65.6%	50.0%	58.4%	-1.5%
Specialty wait	7.5%	5.6%	7.5%	7.2%	-2.2%
UCC	5.8%	4.3%	5.5%	6.9%	-1.0%

Inpatient Capacity & Flow					
	Aug	Sep	Oct	YTD 2018	YTD Change
Bed Occupancy (Adult acute)	89.5%	89.8%	88.6%	90.1%	0
Discharges before midday	15.9%	15.8%	18%	20%	0
Admitted Stranded (LoS>7 local data)	123	131	149	137	46
Admitted Superstranded (LoS > 21 Local)	71	72	74	77	24

Key Improvement Actions over Q3.

1. To review all consultant job plans to ensure that the senior ED workforce meets changing demand.
2. To optimise the skills mix of the GP rota to support both adult and paed activity within main ED and UCC
3. To set up a Mental Health Board with System partners in order to improve quality and reduce variation in physical and mental health. Continue with planning for Mental Health Crisis Cafe
4. Roll out of SAFER and criteria led discharge on back end wards. Establish the Flow Centre to enable the reduction of stranded patients

UHL Position in M07:

Performance continued to fall compared to the 6 Week Average. Particular drivers of the M07 Position where

Paediatrics experienced a large volume of high acuity patients. These issues resulted in as high as 33 breaches on one day at the start of the month.

In M07 there were 23 mental health patients breaching a 12 hour wait which continues to impact on patient and staff experience in addition to the performance impact. During the second week of the month, approximately 50% of available majors capacity was being used by mental health patients.

Lack of Registers continues to limit time to initial assessment. Following recruitment in Q2 additional staff are expected to start in January however December will continue to be challenged

Winter Planning 2018-19: Key Areas of Focus

BED CAPACITY

SAFER – Programmes launched in November across 4 Wards and will be rolled out to remaining wards over Q3 and early Q4. Aim to improve discharge planning and reduce time patients wait in beds after being medically fit to leave.

Criteria Led Discharge – Linked to the SAFER programme the Trust is implementing processes to ensure that following Medical Review the process and actions required to discharge a patient are clearly set out and can be implemented by ward teams without needing a further medical input

Flow Centre – Bringing together existing teams across the hospital and partner organisations to support a more streamlined and effective pathway for patients being discharged from hospital. See slide 6 for further detail

Reducing demand for Acute ED Services:

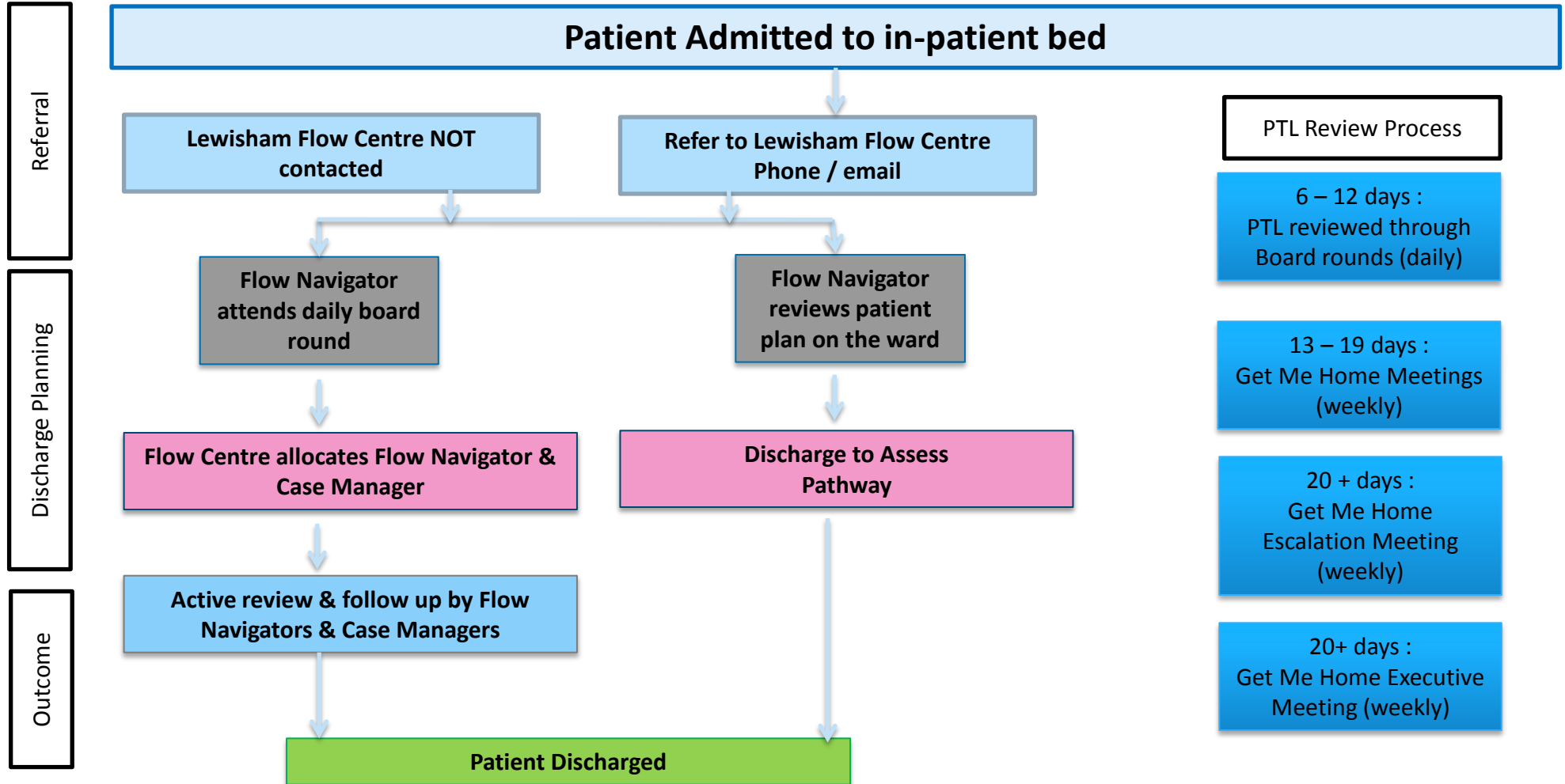
Crisis Café – Working with local partners we are going to create a safe space for patients who feel they are in mental health crisis. Patients can attend and receive support as an alternative to presenting at ED.

ED Streaming – Working with LAS, 111 and Primary Care to ensure that patients are using the most appropriate services for their conditions i.e. direct referrals to Surgical Assessment Unit, Ambulatory Care Centre and GP extended access services.

Supporting Primary Care – Extended Access to GP Services 8am to 8pm and ensuring rapid specialist medical/surgical advice available to GPs

Care Homes – Cross-sector group tasked with identifying ways to improve quality and support to local residential and nursing homes, to support admission avoidance and reduce LAS conveyances;

Flow Centre: Process



Risks & Mitigations

Risk	Description	Mitigation
Workforce	Lack of sufficient workforce capacity and skill mix will impact on performance and patient journey through ED and Hospital	Detailed rota for all clinical and relevant non-clinical staff being finalised at present for every day from mid-Dec to early Jan to ensure clarity on early identification of key gaps. Work ongoing with agencies and partner organisations to get staff into hard to fill roles.
Demand Management Schemes	Schemes to manage demand in the community do not result in reduced ED attendance or demand in secondary care	CCG led initiatives are monitored through individual governance structures and form part of the CCG's QIPP plan. CCGs will be continuously reviewing initiatives to support QIPP delivery and would be expect to introduce new schemes in-year should an agreed scheme not achieve the planned impact.
Clinical Information Systems	Lack of real time data/live bed boards will not allow staff to effectively track patients and bed availability	Additional analysts hired and working to utilise available tools to improve decision making at key meetings and in the operational setting
High bed occupancy	Excessive number of patients with extended LoS causing high bed occupancy and DTAs delayed in ED	Accelerated roll out of Criteria Led Discharge process and implementation of Flow Centre model. Continued work to embed SAFER to support morning discharges and improved use of discharge lounge.



Appendix 1: Summary of all Winter Actions

Demand Management	Avoid unplanned acute admissions	Reduce acute bed occupancy
<u>Objective:</u> reduce number of patients requiring attendance at an ED dept.	<u>Objective:</u> increase the number of patients cared for in the community.	<u>Objective:</u> ensure safe and timely admission to the right bed at right time.
<ul style="list-style-type: none"> Extended access to GP services 8am-8pm across 7 days 	<ul style="list-style-type: none"> Extended access to Ambulatory Care 	<ul style="list-style-type: none"> Discharge planning to deliver >35% of discharges by midday
<ul style="list-style-type: none"> Support from LAS and 111 to direct patients to alternative services 	<ul style="list-style-type: none"> Discharge to Assess at the front door of ED to support Frail Elders home 	<ul style="list-style-type: none"> Reduce number of bed days lost to patients medically fit for discharge
<ul style="list-style-type: none"> Enhanced support to Care Homes 	<ul style="list-style-type: none"> Frail Elders assessment pathway 	<ul style="list-style-type: none"> Discharge to Assess (supporting CHC flow)
<ul style="list-style-type: none"> Management of high intensity users 	<ul style="list-style-type: none"> Improved support for Mental Health attenders (incl. Crisis Cafe) 	<ul style="list-style-type: none"> Critical Care Bed Management
<ul style="list-style-type: none"> Optimised flow through the UCC 	<ul style="list-style-type: none"> Improved community support for End of Life Patients 	<ul style="list-style-type: none"> Introduction of the Flow Centre to reduce long hospital stays
<ul style="list-style-type: none"> GP Access to Specialist Advice 	<ul style="list-style-type: none"> Intermediate Care - improved flow through non acute beds (step-up access) 	<ul style="list-style-type: none"> Reduce LoS - both acute and community beds (enable step-down) diagnostics to reduce care delays

CCG/LAS : High Impact Changes



Interface: Community to Hospital



Interface: Hospital to Community

