Winter Preparedness and A&E performance

1. Purpose

The purpose of this paper is to describe to the actions taken since last winter and describe the position going into winter 2013.

2. Background.

The risk the trust carried through last winter in terms of patients waiting excessive times in the emergency department was too high. Whilst patient safety is the key priority, evidence shows that an overcrowded emergency department can increase patient mortality over the longer term. This is the evidence which supports the importance of delivery of the DH four-hour emergency target.

Since February 2013 the trust have taken a number of actions to:

a) increase physical bed capacity

b) improve flow through the emergency pathway

c) embed seven-day working

In addition, in June 2013 the board agreed to proceed at financial risk to put in place further capacity and actions to address on-going demand and capacity issues. These were agreed to further reduce the risk to delays to treatment and/or admission to the patients on the emergency pathway from that the trust carried in the winter of 2012.

3. Emergency department and acute medicine.

The following have been achieved since Feb 2013:

- Increased nursing staff and middle grade doctors
- Improved equipment and monitoring facilities as well as a refurbished Zone 2
- STARRs are present in the ED but their hours have now been extended. In addition a STARRS lounge is in place (funded by CCG) by a further 2 hours in to the evening
- GP in ED (CCG funded)
- There is a slightly expanded acute assessment unit and includes additional high dependency beds (6 additional trollies and 2 HDU beds).
- We are changing to a two consultant medical take as we have additional physicians during the day.
- Significant increases in ambulatory care management (CCG pump primed)
- Site practitioners supporting acute medicine out of hours enhancing hospital at night

4. Acute surgery and critical care.

The following is either already in place or in progress to be in place during November 2013:

- Urology team of the week in place
- Expanded surgical assessment unit as well as increased hours (hours increasing to 24/7)
- Extended opening hours of the Gynaecology Direct Referral Unit this means and additional 2 hours per weekday and 8 hours per day at the weekends.
- ENT Doctor cover in place overnight
- Additional 5 consultant emergency surgeons for 24/7 critical care outreach
- Additional evening CEPOD lists in place
- Additional anaesthetic consultant posts (7wte) out to advert

5. Improved flow and out of hospital.

Improved flow:

- Additional weekend radiology
- Additional seven day working in therapy services
- LAS North Brent Divert which means all patients picked up from a location in Brent go to CMH where clinically appropriate.
- Sickle cell passport so that these patients can be conveyed to CMH which is their normal place of care even when A&E is closed.
- CSPA navigation to non-Brent and Harrow patients to ensure community providers are contacted and delays for these patients are minimised.

Out-of-hospital:

- Redirection from UCC so patients use emergency facilities more appropriately and are given an urgent appointment at their GP.
- Primary care hubs (Brent) to provide as a minimum 12 hour per day access to primary care clinicians.
- Nursing home attendance avoidance Harrow to prevent patients having unnecessary hospital attendance and more robust planning to allow them to be maintained in the nursing home which is less distressing for patients.
- Integrated End of Life Harrow to have mulit-agency care plans to prevent admissions to die where this is not in the wishes of the patient.
- Frequent Flyers work (Trust, LAS and both CCG's) to put in place care plans for those frequently attending A&E or getting admitted to the Trust.

6. Bed capacity.

The table on the following page shows an outline of the change in capacity from last year to this year including both the acute and community capacity. Board members will recall that the Capita capacity modelling undertaken in the summer identified that the Trust had a shortfall in bed capacity of 89 beds as illustrated below.

Bed capacity 2012/13 compared with 2013/14

Acute Trust	2013-14						2012-13											
	Planned core bed capacity @ 31 Oct 2013			Planned additional contingency capacity for winter period (Nov 2013 - Feb 2014)			Bed capacity @ 31st Oct 2012			Additional contingency capacity for winter period (Nov 2012 - Feb 2013)			Current capacity compared to last year (e.g. col A minus col D etc.)			Planned additional contingency capacity - this winter compared to last year (e.g. col D minus col J etc.)		
	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU
	A	B	C	D	E	F	G	H	I	J	K	L						
NWLH	699	19	0	28	0	0	629	19	0	58	0	0	70	0	0	-30	0	0

Commentary

All 58 escalation beds from last year are now part of the core capacity in the Trust.

Additional Non-Acute Bed Capacity Commissioned (Trust or non-Trust) to address identified winter capacity gap for 2013

51beds are in the process of being put in place (identified) for this winter against the spot purchased capacity of 36 for last year. There will also be an additional contingent capacity to l be spot purchased if case mix demands further capacity (up to 22 extra beds).

Final Commentary

Even with the additional 70 substantive beds from last year's escalation remaining open the Capita demand and capacity model identified a further capacity gap of up to 89 beds As a result of the action above for the 51 beds, the Health economy will have closed the gap to a potential 38 beds shortfall at the winter peak assuming no reduction in LOS or QIPP delivery. There is however the potential for further external capacity of 22 beds.

7. Performance in September 2013.

During September performance was challenging for the organisation and showed a marked deterioration from performance in June, July and August. The reasons for this were multifactorial, including:

- Lack of bed capacity. Bed breaches have moved from 92 in Aug to 342 in September. 31% of all breaches were caused by lack of availability of a bed.
- DTOC's are rising (485 bed days in Aug to 772 in Sep). The reduction to 100 bed days (DTOC's) committed to by Commissioners in the recently submitted recovery trajectory plan to the TDA and NHS England have not been delivered. Patients not formally assessed as delayed but in reality are awaiting discharge add a further 400 bed days in September, double the previous months.
- Year-to-date, approximately 2000 patients are still attending ED when the HRG suggests they could be seen in the UCC at NPH and about 150 at CMH.
- Specialty breaches remained at approximately 16%.
- ED breaches were increased at 17%.

Improvement of breaches within the direct control of the hospital will be achieved by:

- Increasing the availability of surgical assessment unit and the Gynaecology direct referral unit. as described above for increased hours over the week.
- Increased senior management of the ED seven days a week.

8. Conclusion.

The trust has currently submitted a recovery trajectory which gives the year-end performance of 94.4% against a target of 95%. This assumes a number of actions outside of the control of the organisation are delivered including demand management schemes and reducing delayed transfers of care to 100 days per month. However, given performance on these to date there is a continuing risk in delivering the submitted trajectory.

Despite submitting a trajectory which shows non-delivery of key national target, the action taken by the organisation to date will assist the Trust in reducing the risk for patients and reducing pressure on staff. , Despite this the organisation will come under significant pressure to deliver the 95% target. Ultimately the key to unlocking delivery of this reliably and consistently is to increase the physical bed capacity on the NWP site for which a business case could be delivered for next winter however, all physical space on the Northwick Park site has been maximised for the current year. That said the Trust will continue to do all it can to achieve the 95% target and put in place all the actions described above that are under its direct control.

Tina Benson
Director of Operations
October 2013.