Meeting: CloS System Mortality Group

Date of Meeting: 07 December 2023

Item Number:

Title of Report: ED Crowding and mortality

Executive Director Lead: Robin Jones/Allister Grant

Author and Job Title: [redacted] Head of Clinical Effectiveness

Email Address: [redacted]

Purpose of the Report:

Decision ☒ **Discussion** ☒ **Assurance** ☐ **Information** ☐

The purpose of this report is to analyse the effects of ongoing overcrowding in the Emergency Department regards their effects on mortality. The report sets out the approach taken by the RCHT to date and proposed actions forward.

Consultation:

The risk (see Appendix 1) has been approved through the Speciality and Care Group Governance process and scrutinised by the Executive Risk Board in August 2023. This is under on-going review.

Other enclosed materials have been discussed at various Mortality Review Oversight Group meetings during 2022 and 2023.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	
Quality Impact Assessment completed?			x	
Data Protection Impact Assessment completed?			x	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – *for reports requesting decisions only*:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its decisions on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

	Summary of considerations *(if one or more does not apply state 'not applicable')*
Health and wellbeing of the population, including inequalities and wellbeing	n/a
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	n/a
Sustainable and efficient use of NHS resources by RCHT	n/a

Recommendation(s):

The Group **is recommended to:**

- Note the extensive work undertaken to identify and mitigate risks related to delays and overcrowding.
- Note the impact of the risk across the Cornwall and IoS Health System should timely interventions not take place.

ED Crowding and mortality

1. Situation / Executive Summary

A key area of NHS Healthcare in Cornwall and the IoS that is affected by pressures across the system is seen in the Emergency Department setting, and access to this service. As such, the RCHT has a range of mitigations available along with measures and governance arrangements to ensure the best possible care is provided given the pressures and constraints on the service.

2. Background

The RCHT has the following arrangements in place to govern the pressures seen in the Emergency Care setting:

- Risk Management: A thorough review of the risk seen in ED Crowding was carried out at RCHT Executive Risk Board on 31st August 2023. This set out existing and planned mitigation to lower the risk rating as far as possible. See Appendix 1. This is under on-going review.

- Surveillance of incidents seen in the Ambulance sector: The monthly Mortality Review Oversight Group has a standing agenda item ("SWAST/ED update"). This examines any significant incidents from both SWAST and RCHT-ED and takes a moment to look at the overall position on a regular basis.

- Regular review of a "heat map" of mortality across RCHT services: The Mortality Review Oversight Group has a standing agenda item to review the crude mortality data across RCHT services. This looks back at trends and differences between and across years, along with factoring in the context of pressures on admissions and discharges (flow). See Appendix 2.

- Daily review of incidents: As part of the daily review of all incidents, any issue reported in the emergency setting is considered for further action. This can include discussion at Executive level, with commensurate actions being taken.

- Incident reviews within ED: All incidents and patient deaths within ED are reviewed by the ED Service. Any serious concern on quality-of-care results in an SJR (Standardised Judgement Review) being carried out. This is a thorough review of care for the patient concerned, and often identifies actions and interventions to improve care.

- Medical Examiner review of all deaths: Every patient death on RCHT sites is independently reviewed by the Medical Examiner Office. Primarily aimed to inform and support the bereaved, the ME Office also reports quality of care concerns to provider trusts and the Coroner's Office. These reviews provide additional and arms-length checks on deaths to identify any concerns on quality of care, whatever setting such issues have occurred within.

- National paper on ED Crowding (RCEM): "Right Place, Right Care: Learning the Lessons from the UK Crisis in Urgent and Emergency Care in 2022, published by the Royal College of Emergency Medicine" – providing a national context for harm being seen in ED access. RCHT staff contributed to this national paper, and the Trust is cognisant of the mitigating strategies described, helping the Trust put in place all it can to keep its patients safe.. See Appendix 6.

- National paper on ED Crowding: "Association between delays to patient admission from the emergency department and all-cause 30-day mortality" – providing a national context for harm being seen in ED access. This paper was noted in the Learning from Deaths quarterly report in June 2022. See Appendix 3.

- Learning from Deaths quarterly report: This paper is presented quarterly to Trust Board, including providing an update on the position for Emergency Care. The June 2022 edition particularly examined delays in ED - see Appendix 4, pp 11-12.

- Coroner's Office findings: Appendix 5 sets out the relevant cases that apply to RCHT services. Each case is (or will be following the inquest) reviewed thoroughly for any improvement of corrective actions that are appropriate.

- Operational Pressures Quality Review Paper: Appendix 7 sets out an example of a deep dive at the RCHT to look at the effects of operational pressures and the remedial and mitigating actions that can be taken.

3. Assessment

The range of scrutiny and governance arrangements is detailed above. This topic will continue to receive proportionate attention within the Trust's governance framework.

4. Risk

See Appendix 1.

5. Accountability

Robin Jones - Chief Operating Officer
Allister Grant - Chief Medical Officer

6. Recommendations

Note the impact of the risk across the Cornwall and IoS Health System should timely interventions not take place.

Note the extensive work undertaken to identify and mitigate risks related to delays and overcrowding.

Appendix 1

One + all | we care

Royal Cornwall Hospitals NHS Trust

Meeting: Executive Risk Board

Date of Meeting: 31 August 2023

Item Number:

Title of Report: Risk 9048 ED Crowding

Executive Director Lead: Robin Jones

Author and Job Title: [redacted]

Email Address: [redacted]

Purpose of the Report:

Decision ☒ **Discussion** ☒ **Assurance** ☐ **Information** ☐

The purpose of this report is to highlight the ongoing overcrowding in the Emergency Department. To re-evaluate the current risk assessment and refresh the mitigations and actions in place to support current ED challenges – links to Risk 4301 (ED exit block).

Consultation:

The risk has been approved through the Speciality and Care Group Governance process.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	
Quality Impact Assessment completed?			x	
Data Protection Impact Assessment completed?			x	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – *for reports requesting decisions only*:

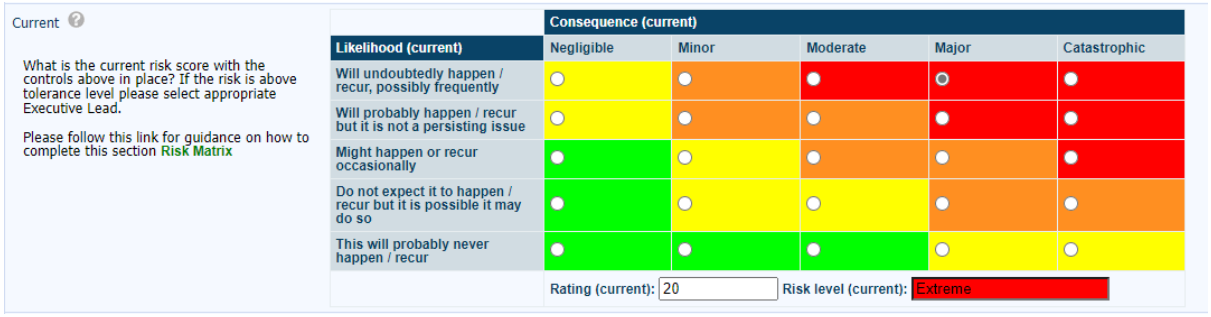
As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its decisions on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

	Summary of considerations *(if one or more does not apply state 'not applicable')*
Health and wellbeing of the population, including inequalities and wellbeing	ED crowding, use of the ED as a receiving ward by many surgical specialties and by medicine when SDMA is closed or deemed to be too busy, exit block due to increasing length of stay on AMU and base wards contribute to poor staff morale, poor patient experience, outcomes and higher mortality rates. Increased population of Cornwall during holiday months. Increased aging population. Increased mental health presentations. Increase in social/economic difficulties.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Due to the service being overwhelmed this is resulting in delays to be seen by ED and for reviews by all specialties with patients in the ED, and delays commencing clinical investigations and treatment, thereby degrading service provision. Assessments, treatments and care for patients is being provided in the escalation areas of the main Corridor, minors corridor, ADL and on the ambulances due to overcrowding. Delays to treatments and pathways. Delay to release ambulances out to the community.
Sustainable and efficient use of NHS resources by RCHT	The service's capacity and resource is insufficient to meet the demands of the population at risk if ED crowding is not resolved.

Recommendation(s):

The Board is recommended to:

- Note the impact of the risk across the Cornwall and IoS Health System should timely interventions not take place.
- The current risk score is 20 (extreme risk); the score could be reduced to 8 (high) if all the planned actions are completed.



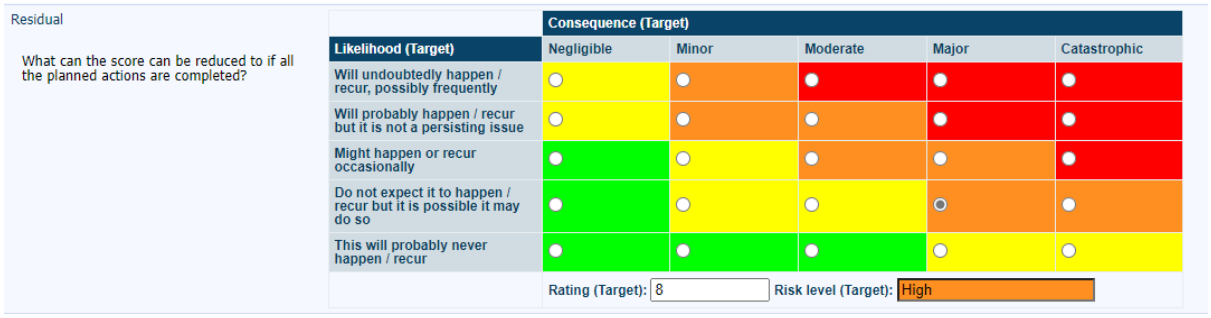
Current

What is the current risk score with the controls above in place? If the risk is above tolerance level please select appropriate Executive Lead.

Please follow this link for guidance on how to complete this section Risk Matrix

Likelihood (current)	Consequence (current)				
	Negligible	Minor	Moderate	Major	Catastrophic
Will undoubtedly happen / recur, possibly frequently	○	○	○	◉	○
Will probably happen / recur but it is not a persisting issue	○	○	○	○	○
Might happen or recur occasionally	○	○	○	○	○
Do not expect it to happen / recur but it is possible it may do so	○	○	○	○	○
This will probably never happen / recur	○	○	○	○	○

Rating (current): 20 Risk level (current): Extreme



Residual

What can the score can be reduced to if all the planned actions are completed?

Likelihood (Target)	Consequence (Target)				
	Negligible	Minor	Moderate	Major	Catastrophic
Will undoubtedly happen / recur, possibly frequently	○	○	○	○	○
Will probably happen / recur but it is not a persisting issue	○	○	○	○	○
Might happen or recur occasionally	○	○	○	○	○
Do not expect it to happen / recur but it is possible it may do so	○	○	○	◉	○
This will probably never happen / recur	○	○	○	○	○

Rating (Target): 8 Risk level (Target): High

- Review the risk score.
- Approve the addition of the risk to the Corporate Risk Register.

Title of Report

1. Situation / Executive Summary

Due to operational challenges in the Trust, flow out of the Emergency Department is challenged. Patients who have been seen by an ED clinician and referred to a speciality are unable to progress through the hospital due to bed availability. This results in ED crowding, where patients are cared for in escalation areas and on the back of ambulances. The current ECAS target is to be discharged or transferred out of the department within 4 hours of arriving. This creates additional work for the staff of the ED who are left caring for many patients who should be in a bed on an inpatient ward.

Patients currently exceed their 4-hour discharge/transfer target and the ED performance ranges from 20% to 50% routinely (average for July 23 is 47%). Patients are currently exceeding a 12-hour length of stay and a 12-hour DTA breach (12 hours after being referred to the speciality) length of stay. Patients have occasionally exceeded 3 days in the ED waiting to be transferred to mental health placement and patients have waited over 2 days in ED whilst awaiting a speciality bed in RCHT.

The ED can safely care for approximately 50 patients at any one time, including 21 majors cases and 6 resus cases, the remainder being in Paediatric ED, treatment areas in minors or the waiting room.

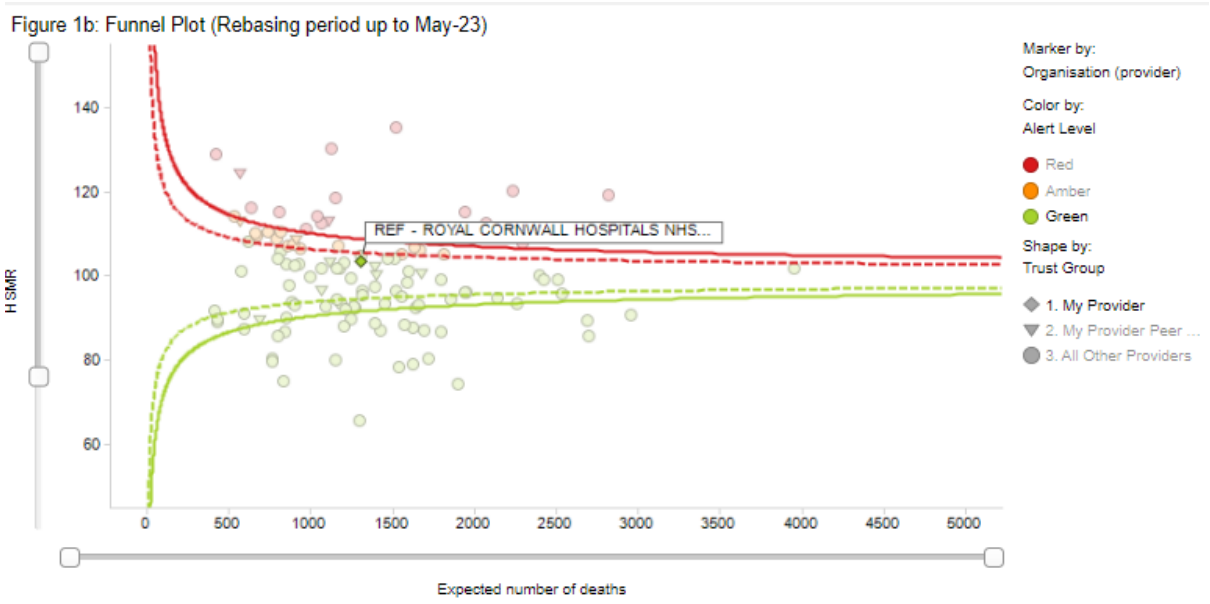
ED occupancy exceeds 50 patients most evenings, and invariably will rise above 80. The maximum ED occupancy in the last year was 132 patients being looked after by the ED staff. Most mornings the ED starts with 30-50 patients at 0700.

Whilst improvements in the system are being regularly explored and implemented, currently multiple specialties use ED as their receiving “ward” bringing more patients to ED who do not need ED care, and many specialties use ED as their receiving ward when their own unit closes due to their opening hours, staffing or number of patients in department.

HSMR data

Hospital Standardised Mortality Ratios (HSMRs) adjust death data (referred to as mortality data) to take account of some of the factors known to affect the underlying risk of death. The graph below shows the overall position for HSMR/RCHT, being just above the 100 median for the country.

Funnel plot: 12-month HSMR June 22 – May 23



The table below shows in descending order, the diagnosis groups that have been alerting (in red) . Delays in ED contribute to some of these groups where pathways are time sensitive & the HSMR illustrated above.

2. Background

Since Summer of 2020 there has been a significant increase in crowding and exit block and the use of escalation spaces impacting on the ability to provide optimum care to patients, which can increase the risk of harm and death to patients.

Peak crowding was in March and April 2022 with both months showing more than 30,000 hours of patients staying in ED after referral. This is the equivalent of occupying 41 cubicles in ED 24 hours per day for the whole month, running this 41 bedded ward, and still having to manage the emergency attendances. There are only 21 majors and 6 resus cubicles.

Whilst there have been some improvements from the end of winter 2022 in July 2023, the total amount of time waiting for beds or transport after decisions to discharge from ED (grey on Oceano) totalled 14,666 hours, a small rise on June's figure. This is the equivalent of 19 cubicles being closed to ED and run as a ward for 24 hours a day for the whole month. To provide 1:4 nursing staff for these patients just for the greyed-out time would have required 293 extra nursing shifts.

The total time patients spent over 4 hours in ED (adding on delays by ED, specialty teams, discharged after referral etc) came to 21,650 hours – 29 cubicles per day and 433 extra nursing shifts for the month.

3. Mitigation

Current processes in place in ED to mitigate risk:

- ADL (Ambulatory Discharge Lounge – 4 chaired spaces) and the ED corridor (5 trolley spaces) are now routinely in use but remains an unfunded resource, staffed with temporary staffing. 19/6 funded and there is an unfunded roster to support 21/7 staffing under operational pressures.
- Escalation policy for both ambulance handover and ED surge. Additional work required to ensure staff are compliant with this policy and escalate accordingly.
- Attendance at daily bed management meetings of ED nurse in charge to escalate pressures and concerns.
- ED re-direction SOP v2 in place. (Only used as part of the ED surge plan).
- A flexible mobile nurse triage team who aim to achieve 15 minute triage and handover target with daily reporting and validation.
- Sepsis performance monitored and actions taken to ensure all patients receive treatment within 1 hour.
- SWAST HALO (Hospital Ambulance Liaison Officer) attends department to support handover daily from 1200.
- Computers at patient side in each area to assess patient need.
- Weekly operational meeting in place with SWAST. Electronic handover from ambulance crews implemented in RATS bays, COWs to enable same process when in periods of high demand. (Electronic handover no longer functional due to IT issues at SWAST – could remain unavailable for several months.)
- Ambulance hold protocol in place and operating.
- New role of CPOC (Clinical Point of Contact) by day (Mon – Fri) & trial by night currently under review.
- MS Teams AMU/ED ‘live’ allocation of beds to allow quicker flow.
- Perfect handover week repeated w/c 14/08/23
- UEE Mini Multi Agency Discharge Events to expedite discharges.
- Mental Health TEAMS channel to improve communication with CFT psych liaison
- 12 hr DTA recovery plan implementation with agreed escalation protocol (including Deputy COO and COO).

Current processes in place in the Trust to mitigate risk:

- Both internal and external actions robustly followed & enacted e.g. flow in/flow out programme - the admissions avoidance pillar of the flow programme, a regular review of all patients > 21 days LoS and the implementation of the AMU medical model. Also there is an ICB commitment to reduce the volume of medically optimised patients awaiting pathway 1, 2 or 3 discharge. Furthermore, there is a renewed focus on mental health conveyances and how they can be seen in a timely manner.
- Boarding and holding protocol embedded. AMU have 2 holding and 2 boarding spaces, Phoenix have 4 boarding beds. CIU, Roskear, Wellington, Trauma 1 & Trauma 2 & GLU have 1 boarding a 1 holding bed, Grenville have 1 boarding bed. ESU, Pendennis, St Mawes, Med 1 and Med 2 have 1 boarding space only. This additional capacity is regularly utilised with no additional capacity available when full.
- SDMA A&B bay to be ringfenced to ensure the medical take is out of the ED.
- SDMA C&D bay opened as a discharge lounge.
- Up to 4 FSDEC spaces ringfenced daily to ensure timely flow and in-reach into ED for frail patients first thing in the morning
- All elective activity reviewed daily against capacity of in-patient beds.
- Associate Medical Director for urgent care is supporting actions within the ED and SDMA to increase efficiency both within the department and SDEC pathways.
- Strategic and multi-agency meetings to problem solve complex issues – mental health conveyances.
- System wide daily tactical calls are in place to enhance partnership working across the whole health economy.
- ED improvement plan drafted; to be presented to COO on the 20th September 2023 (including action plan from ambulance handover perfect week).

Actions

- Investment case for nursing and medical recruitment in ED (Consultant and MG) MJ leading.
- ED Paediatrics expansion business case in review phase.

Future gaps to review to improve ED crowding:

Internal:

- Paeds ED capacity is unable to cope with the size of the demand, especially when Paeds are unable to take ED patients and drop their take.

- The discharge lounge facilitated a 'perfect week' approach for 2 weeks in August; this incorporates Jr Dr support readily available to support TTO's, discharge summaries etc. Better communication will help improve movement out of the department, particularly ambulatory patients who are going home.
- Continue to work with ECIST (emergency care improvement support team) to understand better the volume of walk-in patients that could be streamed elsewhere (outcomes dependent on time of day and opening hours of alternatives and ad hoc temporary closure). ECIST visits to be every 2/3 weeks for the foreseeable future.
- WTBS & decision times particularly overnight continue to be challenging, whilst the median WTBS during daytime hours is currently 158 mins (vs 60 mins target) it drifts out later in the day. Work is underway to understand the root causes of this and implement potential recovery actions. An analysis has been completed of peak times / demand and staffing levels which shows a mismatch.
- A 4 hour recovery programme from an ED perspective will support reduced delays; this will take the form of an incremental approach; initial focus will be 12 DTA breaches, followed by 12 hour department stays and finally 4 hour breaches.

External:

- Lack of consistency in referrals from primary care – too many GPs or their deputies send patients to ED when they could safely be referred to IP teams and bypass ED altogether.
- Staffing on surgical and medical admission areas/opening hours is not aligned with workload, resulting in closure and redirection of patients to ED almost routinely on a daily basis for surgery; work is ongoing pan Care Group to understand the volume / nature of expected patients & potential solutions (> 300 per month). Concrete actions to be mutually agreed by the end of Q2.
- Surgical admission lounge SOP prevents admission from ED on weekends.
- No surgical on take register.
- TAU direct access.
- No internal radiology escalation resulting in ED policing the waits.
- Lack of provision of extended opening hours, staffing and radiology support for key MIUs/UTCs meaning flow increases to ED in the evening. Also poor comms when DoS reduces.
- Flow out from ED.
- Substantial funding is required to facilitate a permanent home for the Frailty SDEC area; it is currently funded until 29th February 2024 only; a fully

functional FSDEC open 8am-8pm could potentially stream circa > 15 patients per day away from ED. Robust medical staffing is likewise a key determinant to a successful frailty pathway.

- A clinical review of low NEWS scores for IP 18 years and above with a score of 0,1 or 2; how can this cohort of patients be managed differently?
- Cardiology are working on an action plan; visibility and shared learning from this piece of work will help mitigate this risk.
- A mental health admissions area separate to ED; appropriately staffed with a security presence which allows mental health patients with both physical and non-physical needs to be seen, diagnosed and treated in a timely manner.

Risk

The ED team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

This is caused by:

Internal issues:

- Delayed transfers of care from the Acute setting, resulting in patients being held in ED waiting for admission.
- Late allocation of beds to allow flow out of ED.
- ED capacity and resources unable to meet the demand.
- Surgical and Medical takes regularly 'dropping' to ED, less frequently women's and children's services too.
- Other specialties utilising ED as an admission area for community referrals (Orthopaedics, ENT and Oral Surgery).
- Various other challenges illustrated above **in section 3.**

External issues:

- GPs/ community paramedics directing patients to the ED rather than referring direct to specialties.
- Suboptimal MH in-patient provision.
- Lack of alternative provision in the county (MIU opening hours and facilities).
- Various other challenges illustrated above in **section 3.**

This could lead to:

Issues for patients:

- Poor patient experience.
- Patient's being held in ambulances.
- Patient safety concerns.
- Delay to triage, review and definitive pathway management.
- [redacted]

Issues for staff:

- Increase in violence and aggression incidents towards staff.
- Staff burnout/moral injury.
- Poor retention and recruitment.
- Worsening relationship with SWAST and RCHT specialties.

Issues for the department:

- Poor performance: failure to hit local and national key performance indicators.
- Reputational damage.
- Increase in complaints and litigation.

4. Accountability

Responsibility for implementation:

Robin Jones Chief Operating Officer

Allister Grant - Chief medical Officer

The Urgent Emergency and Elder Care triumvirate

The Emergency Department Specialty triumvirate

The Emergency Department Team

The Clinical Site Team and Deputy Chief Operating Officer

The Emergency Department performance is reported regularly to the Board/quality committee via a variety of metrics.

Recommendations

The Group is recommended to:

- Note the impact of the risk should mitigations not be sufficient.
- Approve the addition of the risk to the Corporate Risk Register.
- Review risk score.

Appendix 1

Extract from DATIX

Current Performance

ED over crowding continues to be a significant risk to patient safety. In 2023, the total amount of time waiting for beds or transport after decisions to discharge from ED (grey on Oceano) totalled 14,666 hours, a small rise on June's figure. This is the equivalent of 19 cubicles being closed to ED and run as a ward for 24 hours a day for the whole month. To provide 1:4 nursing staff for these patients just for the greyed out time would have required 293 extra nursing shifts. The total time patients spent over 4 hours in ED (adding on delays by ED, specialty teams, discharged after referral etc) came to 21,650 hours – 29 cubicles per day and 433 extra nursing shifts for the month. [redacted] This has moved us from the third quartile to the fourth for crowding related deaths when compared with other Trusts.

The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

Risk description

- Delayed transfers of care from the Acute setting, resulting in patients being held in ED waiting admission.
- Late allocation of beds to allow flow out of ED.
- ED capacity and resources unable to meet the demand.
- Suboptimal MH in-patient provision.
- Surgical and Medical takes regularly 'dropping' to ED, less frequently women's and children's services too.
- Other specialties utilising ED as an admission area from community referrals (Orthopaedics, ENT and Oral Surgery).
- Lack of alternative provision in the county (MIU opening hours and facilities).

- GPs/paramedics directing patients to the ED rather than referring direct to specialties.

This could lead to:

- Poor patient experience.
- Patient safety concerns.
- Delay to triage, review and definitive pathway management.
- [redacted]
- Increase in violence and aggression incidents towards staff.
- Poor performance: failure to hit local and national key performance indicators.
- Staff burnout/moral injury.
- Poor retention and recruitment.
- Patient's being held in ambulances.
- Worsening relationship with SWAST and RCHT specialties.
- Reputational damage.
- Increase in complaints and litigation.

Key controls currently in place

Flow in/flow out programme (outside EDs control).

ADL (4) is and corridor (5) now routinely in use but remains an unfunded resource, staffed with temporary staffing.

Boarding and holding protocol embedded. AMU have 2 holding and 2 boarding spaces, Phoenix have 4 boarding beds. CIU, Roskear, Wellington, Trauma 1 & Trauma 2 & GLU have 1 boarding a 1 holding bed, Grenville have 1 boarding bed. ESU, Pendennis, St Mawes, Med 1 and Med 2 have 1 boarding space only. This additional capacity is regularly utilised with no additional capacity available when full.

SDMA A&B bay to be ringfenced to ensure the medical take is out of the ED.

SDMA C&D bay opened as a discharge lounge.

All elective activity reviewed daily against capacity of in-patient beds.

The patient flow programme which has the medical model, admissions avoidance and length of stay and enablers as the workstreams. AMD for urgent care is supporting actions within the emergency department and SDMA to increase efficiency both within the department and SDEC pathways.

Escalation policy for both ambulance handover and ED surge.

Attendance at daily bed management meetings of ED nurse in charge to escalate pressures and concerns.

ED re-direction SOP v2 in place.

A flexible mobile nurse triage team who aim to achieve 15 minute triage and handover target with daily reporting and validation.

Increased nurses establishment to recognise increased attendances 19 and 6 to – 21 and 7.

Sepsis performance monitored and actions taken to ensure all patients receive treatment within 1 hour.

SWAST HALO attends department to support handover daily from 1200.

Computers at patient side in each cubicle to assess patient need.

Weekly operational meeting in place with SWAST. Electronic handover from ambulance crews implemented in RATS bays, COWs to enable same process when in periods of high demand.

Ambulance hold protocol in place and operating.

Strategic and multi-agency meetings to problem solve complex issues

System wide daily tactical calls are in place to enhance partnership working across the whole health economy.

New role of CPOC by day embedded by night currently under review.

MS Teams AMU/ED ‘live’ allocation of beds to allow quicker flow.

Perfect handover week being repeated 14/08/23

ED min MADE events to expedite discharges.

Gaps:

- Paeds ED capacity is unable to cope with the size of the demand, especially when Paeds are unable to take ED patients and drop their take.
- Lack of consistency in referrals from primary care – too many GPs or their deputies sending patients to ED when they could safely be referred to IP teams and bypass ED altogether.
- Staffing on Surgical and Medical admission areas/opening hours. Take dropping to ED is routinely on a daily basis for surgery.
- Surgical admission lounge SOP prevents admission from ED on weekends.
- No surgical on take register.
- No consistent TAU direct access in a timely manner.
- No internal radiology escalation resulting in ED policing the waits.
- Lack of provision of extended opening hours, staffing and radiology support for key MIUs/UTCs meaning flow increases to ED in the evening. Also poor comms when DoS reduces.
- Consistent flow out from ED.