To:	Trust Board
From:	Jeremy Tozer, Interim Director of Operations
Date:	December 2012
CQC regulation:	As applicable

Trust Board Paper W

Title:	Emergency Department Performance Report

Author/Responsible Director:
Jeremy Tozer

Purpose of the Report:
To provide an overview and update on the Emergency Care Delivery for UHL.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

- November has been a challenging month which has seen a further deterioration in performance to 89.4% for ED type 1 and 2 attendances
- Only 1 out of the 5 quality indicators has been achieved for the month of November.
- Internal action plans have been established to help address the deterioration in performance.
- The Right Place Consulting team have started work on 2 priority workstreams focussing on ED processes and assessment units. Some early changes should take effect as early as January and February 2013
- The trajectory for performance has been revised again with the Trust facing a potential scenario of no more than 18 breaches per day with immediate effect.
- The CCG collaborative have endorsed the internal steps taken by UHL to improve performance through the programme of work to be facilitated by Right Place Consulting and have identified actions to be taken by external agencies.

Recommendations:
The Trust Board is invited to receive and note this report.

Previously considered at another UHL corporate Committee N/A

Strategic Risk Register Yes	**Performance KPIs year to date** Please see report

Resource Implications (eg Financial, HR)
Monthly contractual penalties for non-delivery of target.
Resource implications of implementing ED action plans including capital schemes.

Assurance Implications
The 95% (4hr) target and ED quality indicators.

Patient and Public Involvement (PPI) Implications
Impact on patient experience where long waiting times are experienced

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review ?
Monthly

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**TRUST BOARD**
REPORT FROM:	**JEREMY TOZER, INTERIM DIRECTOR OF OPERATIONS**
REPORT SUBJECT:	**EMERGENCY FLOWS**
REPORT DATE:	**20 DECEMBER 2012**

1.0 INTRODUCTION

Sustained performance improvement across UHL's emergency processes and the ability to achieve the emergency 95% target on a sustainable basis remains a top priority for both UHL and the local health economy. Of equal priority is the need to deliver high quality, safe care to all patients presenting for emergency care and treatment. Over the past month there have been renewed efforts to deliver some of the key changes required in order to deliver the necessary performance improvements that are fundamental to the future success of the organisation.

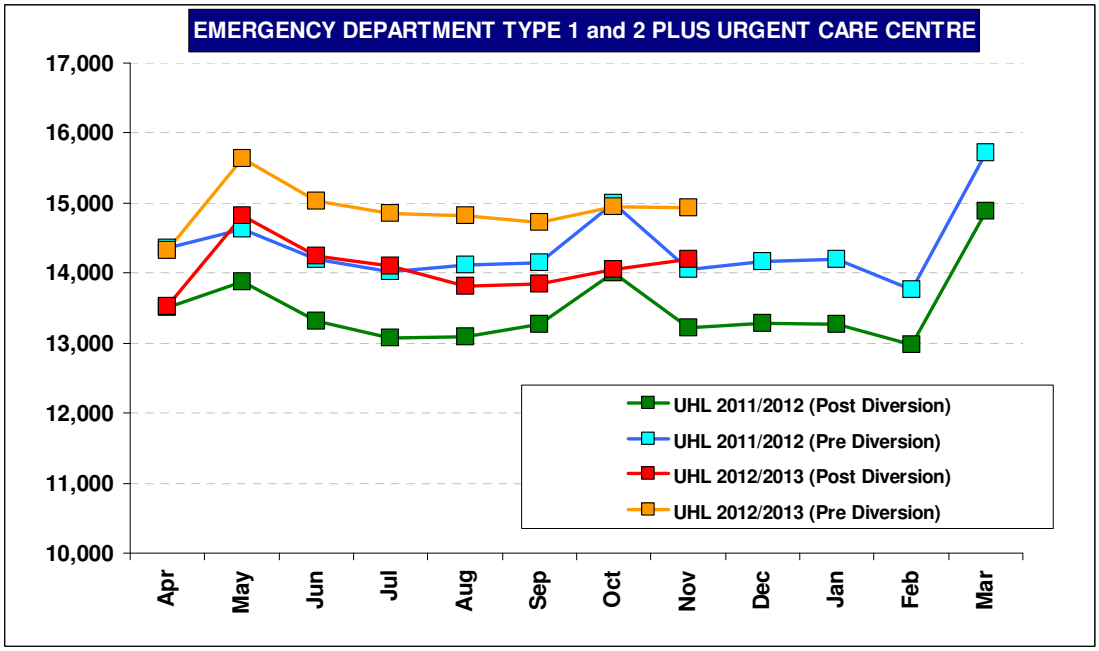
In November the Trust continued to strive to achieve both the 95% emergency target and the clinical indicators. In month the Trust saw a continued decline in attainment. Performance for UHL Type 1 and Type 2 activity was 89.4%, and the UHL + UCC performance was 91.6%. In addition the Trust only achieved 1 out of the 5 ED quality indicators. This report provides details for the current level of performance and most importantly focuses on some of the significant measures that are now being introduced with renewed focus both internally and with CCG support.

2.0 CURRENT ACTIVITY AND PERFORMANCE

2.1 Attendance rates

In line with reports from previous month's ED attendance rates remain consistently above attendance rates seen in 2011/12 even when pre diversion rates are taken into consideration as shown in figure 1 below.

Figure 1: ED Attendances April – November 2012



In November the Trust saw a reverse in activity trend with 14,201 attendances which is higher than average when compared to a monthly average of 13,949 attendances. Further to this activity is 6.3% higher when compared with the same period last year and is the second highest rise in activity in month for the year.

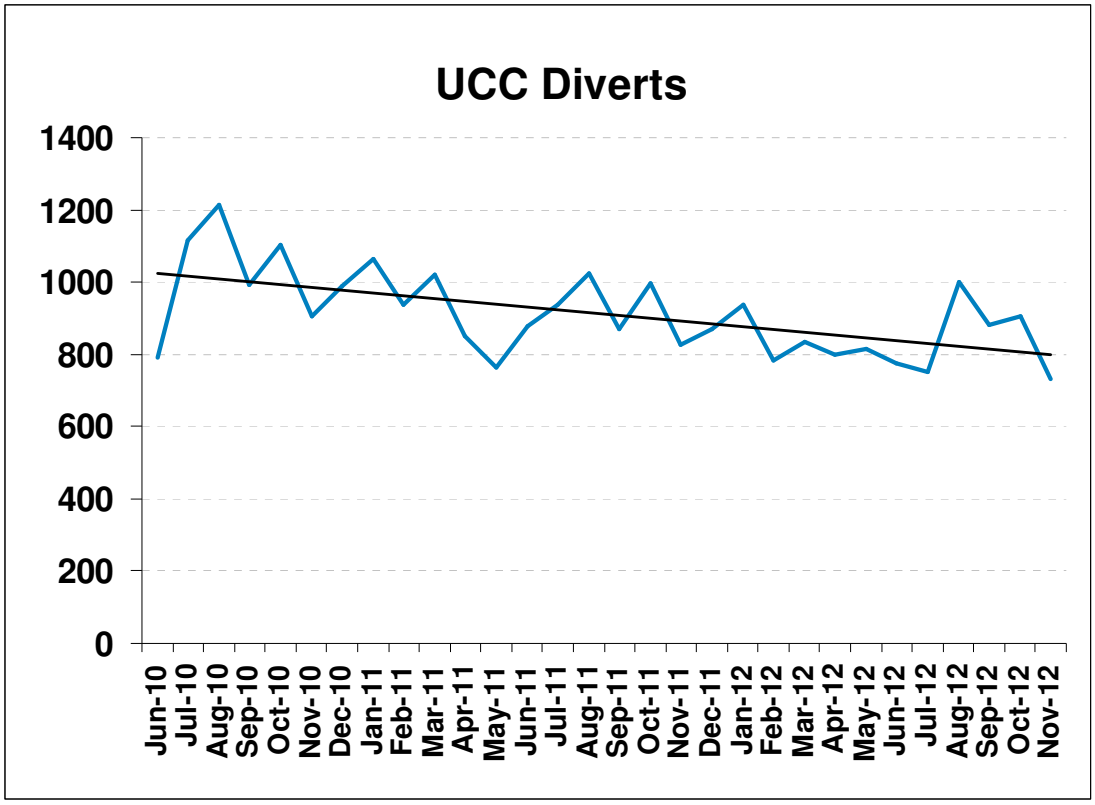
Table 1: ED Pre and Post Diversion Attendances April – November 2012

EMERGENCY DEPARTMENT TYPE 1 and 2 PLUS URGENT CARE CENTRE							
	UHL 2010/2011 (Post Diversion)	UHL 2010/2011 (Pre Diversion)	UHL 2011/2012 (Post Diversion)	UHL 2011/2012 (Pre Diversion)	UHL 2012/2013 (Post Diversion)	UHL 2012/2013 (Pre Diversion)	Overall % Change 12/13 vs 11/12
Apr	14,117	14,117	13,507	14,358	13,532	14,332	-0.2%
May	14,574	14,574	13,871	14,636	14,819	15,633	6.8%
Jun	13,509	14,298	13,318	14,197	14,248	15,022	5.8%
Jul	12,983	14,100	13,075	14,014	14,107	14,860	6.0%
Aug	12,544	13,757	13,086	14,109	13,816	14,818	5.0%
Sep	12,726	13,720	13,270	14,142	13,839	14,719	4.1%
Oct	12,918	14,022	14,002	15,000	14,051	14,955	-0.3%
Nov	13,057	13,963	13,226	14,051	14,201	14,933	6.3%
Dec	13,500	14,488	13,291	14,162			
Jan	12,830	13,893	13,260	14,196			
Feb	12,263	13,202	12,978	13,762			
Mar	14,100	15,119	14,884	15,719			
Sum:	159,121	169,253	161,768	172,346	112,613	119,272	

2.2 UCC Diversion rates

Numbers of patients diverted to the UCC continue to remain lower than the previous 2 years.

Figure 2: UCC Diverts June 2010 to November 2012



Post diversion activity is once again above pre diversion activity levels for the same period in 2011/12. Further analysis of this position shows that diversion activity continues in a downward trend. In November 2010/11 6.5% of attendances were deflected. This shifted to 5.9% in 2011/12 and this year the figure stands at 4.9%. There is a similar trend with overall activity and the position year to date. In 2010, 6.0% of overall activity was deflected whereas 5.6% is currently deflected overall.

Collective action has been agreed between UHL and the CCG collaborative to address this issue in the context of CCG commitment to addressing attendance levels overall. Active dialogue continues with our external partners to review the concept of a 'single front door' aimed to change existing pathways to maximize deflection.

2.3 ED 4 Hour Performance target

November has continued to test the Emergency Department in achieving the 95% target. In month there has been a further deterioration in performance to 89.4% for ED type 1 and 2 attendances and 91.6% when UCC activity is taken into account, as shown below:

Table 2 Overall ED Performance November 2012

Nov 12

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	14,201	1,422	89.99%
Urgent Care Centre	Type 3	3,707	3	99.92%
UHL + UCC Total	All	17,908	1,425	92.04%

Quarter 2

Nov 12

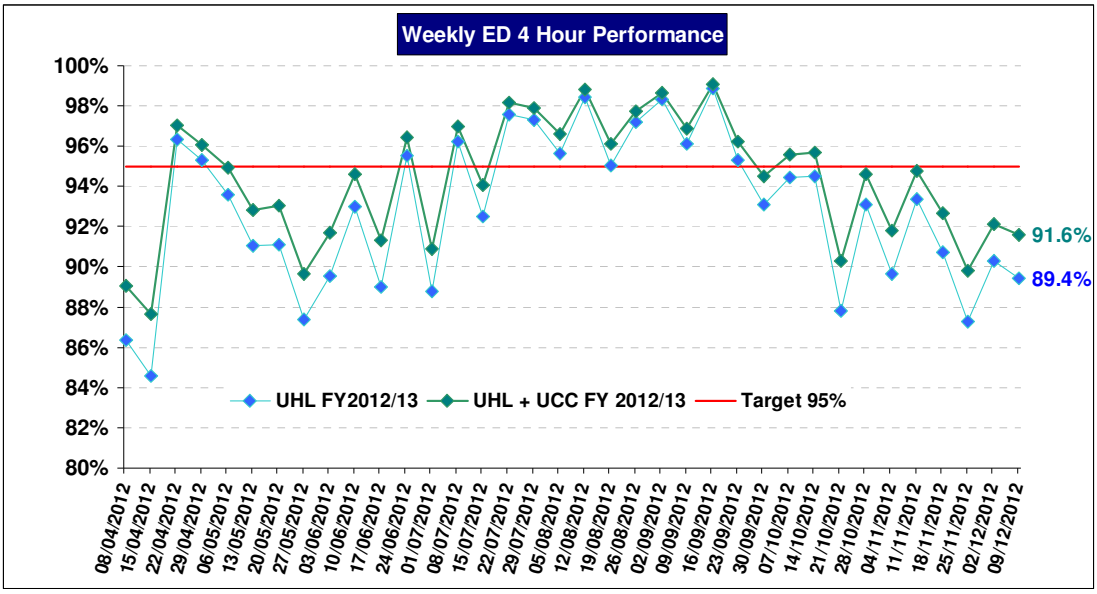
Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	28,252	2,458	91.30%
Urgent Care Centre	Type 3	7,498	7	99.91%
UHL + UCC Total	All	35,750	2,465	93.10%

Full Year to Date

Nov 12

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	112,612	7,927	92.96%
Urgent Care Centre	Type 3	30,029	72	99.76%
UHL + UCC Total	All	142,641	7,999	94.39%

Figure 3: Overall Weekly ED Performance to Week Ending Sunday 9th December2012



Based on performance in November the SHA via the LAT and CCG's asked for a corrective joint plan and trajectory for recovery and delivery of the target. This plan and trajectory are attached to this document.

There is an understanding amongst CCG colleagues that despite the programme of support offered through the Right Place Consulting, and rapid changes to the emergency processes, it is unrealistic to plan on a scenario that will deliver immediate delivery of the 95% target. CCG's support the Trust in that a more realistic scenario of a trajectory based upon gradual improvement and an assurance of 95% performance as a minimum from Mid February 2013 is more appropriate. At the time of writing this report no formal feedback has been received from the SHA and it may well be that the SHA ask the health economy to revisit the trajectory as the present trajectory does not bring the year end performance figure to over 95%.

2.4 Breach analysis

The most significant breach numbers continue to appear within the majors area of the department, totalling 873 in the month of November 2012, significantly higher than the month of October. Between October and early December, 63% of the total number of breaches occurred within the majors area of the department. A further 23% of breaches occurred within the resus area where breach numbers as a percentage of the total resus activity is known to be high. For further details see table 2 below:

Table 3: Breach analysis by allocation:

Allocation	Oct-12	Nov-12	Dec-12	Total	%
CHILDREN	52	72	29	153	6%
MAJORS	620	873	209	1702	63%
MINORS	79	118	42	239	9%
RESUS	233	305	81	619	23%
Total	**984**	**1,368**	**361**	**2713**	**100%**

Whilst the Childrens and the Minors areas of the emergency department are performing better, action is being taken to ensure that these areas strive for a zero tolerance of breaches.

The top 3 reasons for breaches are summarised as:

- Bed breaches 31.7%
- ED process 27.9%
- Clinical reasons 13.6%

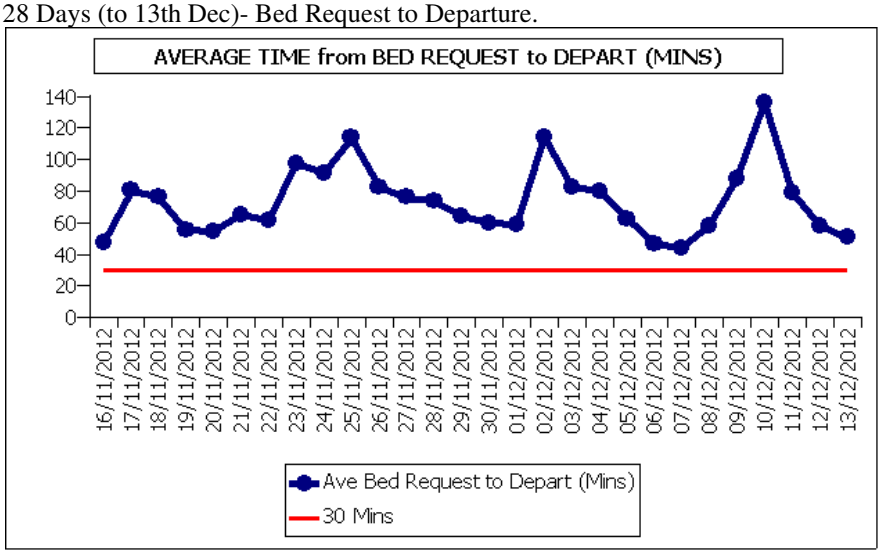
Table 4: Type 1 Delay Reasons in Quarter 3 to Sunday 9th December (Excluding "Unknown")

Delay Classification	Oct-12	Nov-12	Dec-12	Total	%
Bed Breach	312	434	105	851	31%
ED Process	259	382	41	682	25%
ED Capacity (Cubicle Space)	28	8	2	38	1%
ED Capacity (Inflow)	36	94	101	231	9%
ED Capacity (Workforce)			1	1	0%
Clinical Reasons	161	187	58	406	15%
Specialist Assessment	36	32	16	84	3%
Specialist Decision	9	8	1	18	1%
Investigation (Imaging and Pathology)	62	80	13	155	6%
Transport	68	104	13	185	7%
Treatment	13	39	10	62	2%
	984	**1,368**	**361**	**2713**	**100%**

This picture is consistent with previous monthly reports although the percentage of delays due to capacity and inflow has reduced. More emphasis is being placed upon recording such issues as related to ED process. Of particular note is the significant and increasing number of breaches that are transport related.

The continuous availability of beds on assessment units and access to speciality beds is a key element to allow the timely flow of patients out of the Emergency Department. Both the availability of beds at the time of request and the ability of the emergency department to transfer a patient from the department without delay once a bed is available result in lengthy waits for patients. The average wait between the request for a bed and the patient leaving the emergency department continuously exceeds 30 minutes and in early December rose to 140 minutes delay.

Figure 4: Last 28 Days (to 13th Dec)- Bed Request to Departure.



A Significant programme of work is being led by the Interim Director of Operations in conjunction with the Divisional Manager for the Acute Care Division. As part of this programme there are a number of projects aimed at improving ward processes:

Work stream	Facets of streams	Lead Manager
Hidden waits	Diagnostic waiting times Therapy reviews Transport	Chris Shatford
LOS & ward processes	Hidden waits; EDD – availability, accuracy; Real time bed state; Ward dashboards; TTOs, DL, & Transport completed >24hrs in advance discharge B4 11am; Ward rounds/Board rounds; Clinical engagement; Fast Tracking protocols; incremental steps for achievement; incremental steps for achievement ; audit and compliance	Jane Edyvean
Simple Discharge	Process review; Roles and responsibilities; communication (Information pack); Leadership at ward level;7 day service; discharge checklist; incremental steps for achievement; Audit and compliance;	Sue Mason
Complex Discharge	Process and early identification; EDD; Communication with stakeholders	David Yeomanson

A series of key performance indicators are being developed to measure the impact of these actions.

The CCG collaborative have agreed with the Interim Director of Operations that they also have a role in reducing the number of patients with a delayed discharge who no longer require acute care. To this end they have agreed to place 20 patients within this group in appropriate community settings.

2.5 ED Quality Performance Indicators

Only one of the clinical quality indicators was met in November as shown in figure 5 below. Time spent within the department has increased considerably and are at the highest level since April 2012. The reasons for this are multi faceted and include higher levels of attendance, poor ED processes, lack of outflow associated with lack of bed availability and staffing levels as reported in October. Similarly time to treatment (median) is at the highest level recorded for this year.

Figure 5: ED Quality indicators January 2012– November 2012

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	TARGET
Left without being seen %	2.8%	3.0%	2.7%	2.4%	2.1%	2.2%	2.7%	2.5%	<=5%
Unplanned Re-attendance %	6.2%	5.9%	5.9%	6.4%	5.6%	5.3%	5.0%	5.2%	< 5%

TIMELINESS

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	TARGET
Time in Dept (95th centile)	319	317	322	240	238	240	298	326	< 240 Minutes
Time to initial assessment (95th)	34	31	25	20	15	16	23	24	<= 15 Minutes
Time to treatment (Median)	45	49	59	57	53	58	64	69	<= 60 Minutes

2.6 Staffing Impact on performance

Vacancy levels continue to remain high for the Emergency Department despite rigorous recruitment and retention activities supported by the Deputy Director of human Resources. In order to maintain throughput, clinical quality and patient safety there is therefore a necessity to use significant numbers of bank and agency staff. This necessary use of bank and agency staff presents a risk to throughput and decision making within the department, as temporary staff are less familiar with the environment and protocols. To mitigate this a singular contract for nurse agency staff is being used in order that some continuity can be achieved in terms of staff working within the department. Further to this there is a fully established induction programme for temporary staff.

The ability to recruit to posts will continue to be impacted by the national difficulties in recruiting to posts within Emergency Departments for the foreseeable future. Fortnightly recruitment strategy meetings will continue with Senior HR input, to look at recruitment alternatives and creative recruitment solutions. The department continues to advertise for permanent and locum consultant positions. Retention initiatives for all staff groups form part of the department's recruitment plans. The department is working to ensure that the engagement agenda also informs any plans.

3.0 REVIEW OF NON ELECTIVE FLOWS

The CCG collaborative recognise the opportunity the Trust has to resolve longstanding inefficiencies across the non elective pathway through the appointment of Right Place Consulting. The Team will work in partnership with clinical groups and managers across the Trust to facilitate and deliver changes to the way in which emergency care is delivered within UHL between November 2012 and June 2013. A launch event was held on 11th December 2012.

Initial work has commenced within two priority workstreams – ED Processes and Assessment Units. Both groups have had their inaugural meeting and the future state of the processes have been articulated. Work will continue at pace with the aim of early implementation in January and February 2013. Supporting this work is a further workstream to review demand and capacity across the medical bed base.

A firm governance structure is in place to oversee the work with the Acting Chief Executive, Medical Director and Director of Right Place Consulting as accountable

officers. Each workstream is held to account through the Emergency Care Programme Board chaired by the future Divisional Director for the Acute Care Division with Executive support from the Interim Director of Operations.

A Project Update will be given at each Board meeting and is attached to this report

4.0 ESTATES SOLUTIONS

In previous reports a number of interim estates solutions had been identified to support process changes across the emergency flow in 4 particular areas. It is likely that some of these will undoubtedly be impacted by emergency flow process changes, however the status for each of the schemes is summarised below:

- Relocation of the fracture clinic – Scheme complete. The fracture clinic service has been running from the new location since 25th November 2012 with significant patient and staff benefits.
- Discharge lounge expansion at the LRI – Awaiting final capital funding approval. As soon as the scheme is given final approval the scheme will be tendered with construction commencing from April 2012.
- ED enabling schemes – The assessment bay development and redevelopment of the vacated fracture clinic area will be reviewed once the impact of process changes facilitated by the Right Place Consulting team is fully understood.
- Emergency flow CT Scanner – Business case presented to the Commercial Executive Committee14th November 2012.

Board members are asked to:

- Note the content of this report;
- Note the revised trajectory for improvement;
- Continue to support the revised programme of improvement recognising the opportunity created through the right place consulting work;
- Agree that some previously agreed plans and capital schemes will necessarily need to be on hold until the impact of the process redesign work is understood;
- Note CCG support and recognition of the internal efforts to achieve a sustainable level of performance improvement.

Project Highlight Report

Project Name: *Emergency Care Pathway Implementation Programme*

Period:	19.11.12 to 13.12.12	**Summary position**	
Author(s) Programme Directors: Jez Tozer, Pete Rabey & Tessa Walton		Last period: G	This period: G
Accountable Officer review:		Jim Birrell & Kevin Harris	

1 - Status Update: Weeks 1-3

Stakeholder engagement:

- Held introductory engagement 1:1 meetings held with members of medical, nursing, therapy, managerial, pharmacy, pathology and radiology staff groups.
- Presented at physicians meeting with discussion and general agreement on overarching model, principles.
- Convened a multidisciplinary group (approximately 20 staff) including Interim Director of Operations, Head of Operations, Head of Nursing for Acute Division and medical representatives from speciality medicine, geriatrics, acute medicine, A&E to walk through elements of the target model to understand key concerns, areas of good existing practice to maintain in the new model and identify key interdependencies. Pete Rabey (Programme Director) chaired the group.
- Organised departmental and specific staff group forums to provide initial briefing and ongoing updates on progress.
- Held a launch event with presentations from the Interim CEO, MD, Interim Director of Operations and Acute Division Divisional Director held with good turnout (approx. 80 people) 11th December 2012.

Governance Structure:

- Established weekly meetings with Accountable officers – CEO and MD with Programme Director to monitor progress, ensure strategic fit, address escalated issues.
- Established regular meetings (3 times/week) with Programme Directors to provide leadership, decision making, enable access to the required people and resources, unblock issues.
- Finalised Programme Board and Workstream membership with clearly defined roles and responsibilities.
- Held inaugural Programme Board meeting 6th December with all future meeting dates finalised. Signed off, PID, Escalation plan, TOR and Communications Plan.
- Held first Workstreams meetings on 10th December 2012, signed off PID, Terms of Reference and detailed discussion around the future model design checklist. Work was set outside of meetings to draft the next level of detail of the model and to identify gaps between current and future working based on good practice guidelines and quality standards. All detailed design documentation will undergo a quality impact assessment in mid January prior to implementation commencing.
- Requested baseline data to define current performance and future performance and quality targets to enable illustration of improvements.
- Held introductory meeting with incoming CEO - John Adler to provide an overview and to confirm on going governance arrangements.

2 – Programme Risks

Description	Risk Rating (RAG)	Mitigating action	Owner	Review date
There is a risk of significant resistance from key stakeholders.	A	Early engagement of stakeholders and strong Programme board leadership. Robust use of Escalation Process.	Jeremy Tozer, Pete Rabey	Weekly ongoing during Programme Director meetings and fortnightly via Programme Board
There is a risk that programme momentum will degenerate once programme structure is removed.	A	Workstream meetings to embed accountability and sustainability from outset, informed by relevant performance metrics.	Workstream leads: Ben Teasdale and Catherine Free.	Fortnightly at Programme Board
There is a risk that the A&E target poor performance will require immediate actions which are out of synch with the implementation scope and timeframes of the Programme.	A	Regular communication and escalation where plans do not fit with the Programme scope of work.	Jeremy Tozer, Pete Rabey	18/12/12
There is a risk that a lack of clinical engagement and inability to obtain consensus on the medical model may impact on design and implementation of the Emergency Care Programme	A	Engagement through Workstreams and existing forums, e.g. physicians and nursing meetings to ensure wide communication of designs	Pete Rabey	18/12/12

R There are significant issues that require immediate remedial action.

A Issues have been identified that will require remedial action if project is to remain within tolerance.

G Project is progressing to plan.

NHS
Leicester City
Leicestershire County and Rutland

Accident & Emergency Performance Recovery Plan
December 2012

1 INTRODUCTION

1.1 This plan sets out the Leicester City, Leicestershire County and Rutland (LLR) recovery plan for the accident and emergency (A&E) 4 hour performance standard.

1.2 The plan focusses on the additional actions required to recover performance and builds on, rather than repeats, the existing 30 page LLR Urgent & Emergency Care System Improvement Actions list.

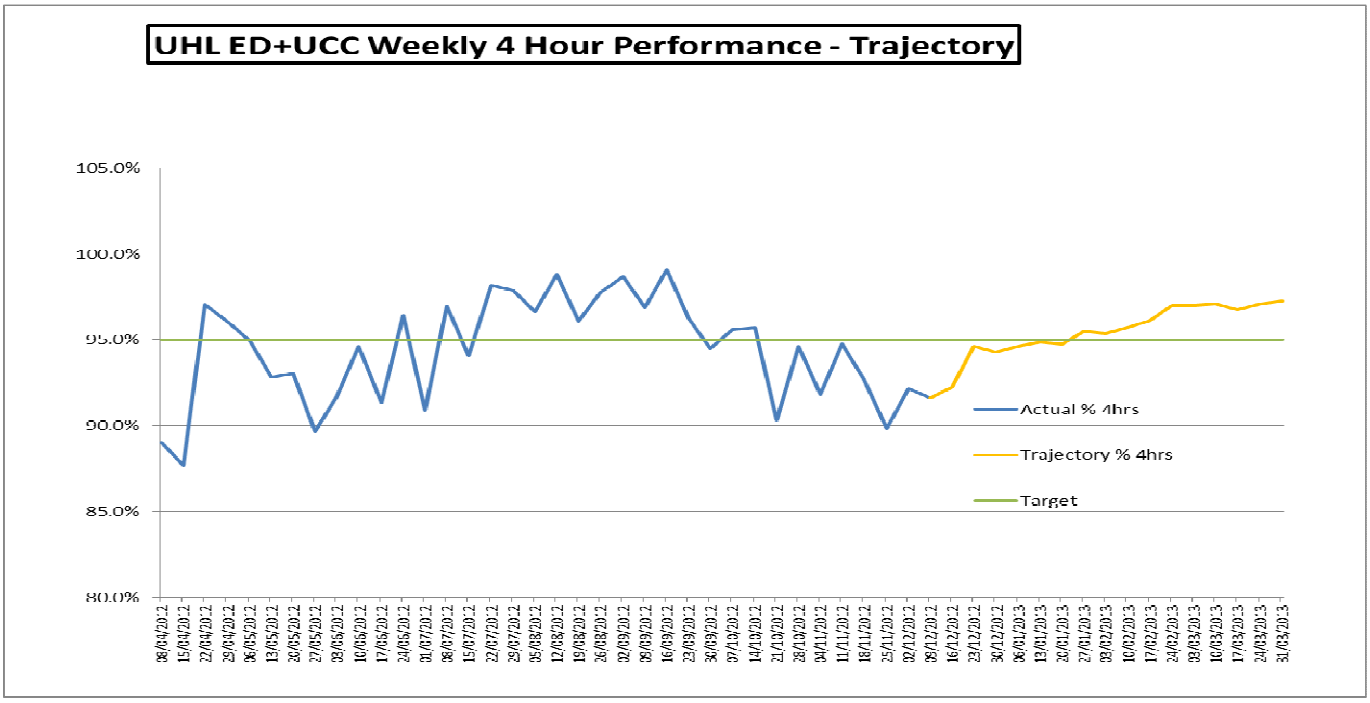
1.3 The remedial actions are divided into demand management, hospital flow (including wider-system discharge enablers) and contractual arrangements as requested.

2 EXECUTIVE SUMMARY

2.1 An externally supported UHL A&E performance recovery plan has been endorsed by the LLR Emergency Care Network (ECN) and incorporated into the wider health community system improvement plan.

2.2 The key milestones within the plan are as follows:

- ✓ System performance recovery (ED & UCC) from week ending (w/e) 27/01through coordinated non-recurrent urgent action / early implementation of system changes
- ✓ 1st sustainable step-change improvement with UHL delivery of 95% by w/e 24/02
- ✓ Sustainable on-going delivery of target (UHL and system) from the end of March 2013



3 DEMAND MANAGEMENT

3.1 The following system-wide actions have been agreed:

Area	Action	Impact	Timeline
Public Awareness	LLR Choose Better Campaign with a re-emphasis on targeting geographical areas and social & radio media.	Contributes to the 5% reduction in avoidable attendances	On-going to 03/13
Access to GPs	All CCGs have extended GP opening hours. The West Leicestershire (WL) CCG is leading an effectiveness review of the changes in meeting patients' needs	Contributes to the 5% reduction in avoidable attendances	On-going – any required changes implemented from 01/13
Appropriate Alternatives to ED & Admission	All CCGs have redesigned end of life care and advanced care plans (to be shared with the Out of Hours Service and EMAS) to be in place for all patients		01/13
Appropriate Alternatives to ED & Admission	All CCGs are working with care homes on advanced care plans for vulnerable patients and agreed escalation protocols		01/13
Appropriate Alternatives to ED & Admission	All CCGs have admission avoidance schemes with peer group review, performance dashboards and support		On-going
Appropriate Alternatives to ED & Admission and phasing of the flow	Investment in EMAS to fast-track the development of an urgent service (1,700 additional hours staff up to the end of March)	1) 5% increase in conveyance to community destinations 2) 80% of GP urgents conveyed within 2 – 4 hours to avoid "stacking" 3) 60% non-conveyance from the Leicester City and Loughborough Polamb services	12/12 – 03/13

3.2 In addition a range of Clinical Commissioning Group (CCG) actions are being progressed, including:

Area	Action	Impact	Timeline

Appropriate Alternatives to ED & Admission	East Leicestershire & Rutland (EL&R) CCG have introduced a care homes bed scheme	120 avoidable admissions during winter (1,700 bed days)	On-going to 03/13
Appropriate Alternatives to ED	EL&R are re-shaping local minor injury services to meet changing demand patterns		12/12
Appropriate Alternatives to ED & Admission	Leicester City (LC) CCG are introducing 4 Emergency Response / Care Home support GPs to reduce admissions		01/13
Appropriate Alternatives to ED	LC Alcohol engagement initiative – workers to engage with regular alcohol related attenders who are not the case load of an existing alcohol service		01/13
Appropriate Alternatives to ED & Admission	WL CCG have a EMAS pass-back scheme, where EMAS are able to pass-back appropriate patients to GPs after an assessment / interventions	146 successful pass-backs year-to-date	On-going
Appropriate Alternatives to ED	WL CCG has a IAPT pilot aimed at reducing high repeat attendances		On-going
Appropriate Alternatives to ED	Loughborough walk in centre is extending x-ray opening hours to Sunday mornings to meet demand		12/12

3.3 Priority medium term developments that will improve on-going resilience are:

- The introduction of 111 and its planned alignment with a single point of access for urgent care
- A single front door to ED / UCC
- The full introduction of the EMAS urgent service model
- Bounce back extended to cover ED as well as the UCC for all LLR patients
- Virtual ward development

4 UHL FLOW

4.1 The externally supported (Right Place Consulting) UHL performance recovery plan has 3 key improvement focuses, as tabled below:

Work stream	In scope
ED Processes (Minors, Majors, Resus, Bed Bureau – GP referrals)	• A&E majors and minors streaming • The removal of GP referrals from the A&E flow

	• The initial assessment process in Minors and Majors • Hourly MDT Board Rounds • Consultant led services • Effective patient flow management – floor coordination • Redefined roles and responsibilities across MDT • Matching resources to demand
Assessment Units (CDU, AMU, EFU, Short Stay)	• Creation of a right-sized assessment function • Rapid Assessment model (6-14 hours) with 60% discharge home rate • Consultant delivered patient management with standardised processes • Ambulatory Care Pathways (10 high volume) • Defined MDT roles and responsibilities • Joint working and clear pathways across ED, AMU, EFU, CDU • The interface with diagnostics services
Bed Configuration	• Review of the RPC bed model against current and planned bed configuration • Identification of opportunities for bed consolidation and rationalisation at improved LOS performance • Update of the Bed Model based on local specialty configurations and known service developments

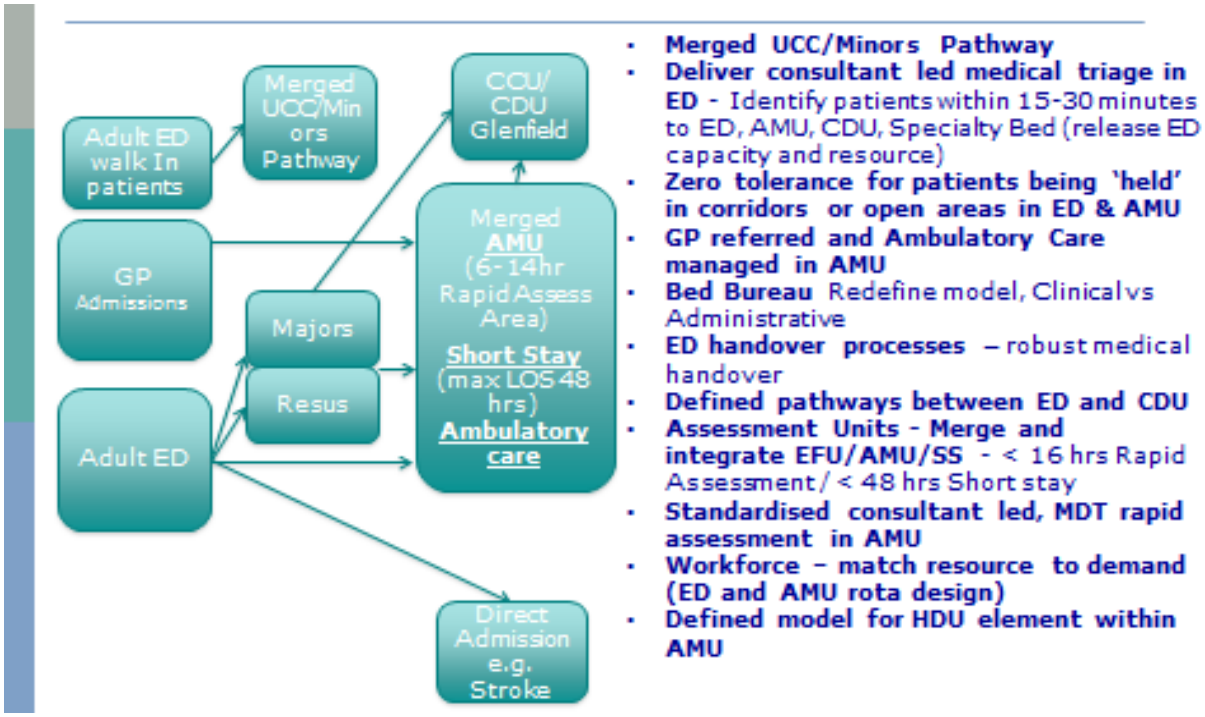
4.2 The mobilisation and implementation timelines are attached and marked Appendix 1.

4.3 Urgent non-recurrent UHL actions are being put in place immediately to improve performance for patients. These actions are focussed on temporary changes to staffing hours and additional support from clinical leaders whilst the new model is embedded.

4.4 These actions are being supported by a £1m transformation bid approved by commissioners to improve the acute pathway (and in particular to address diagnostic and therapy access issues), and increased community rehabilitation capacity in LC.

4.4 The sustainable new service model, which has been endorsed by the ECN, is summarised below:

The New UHL Emergency / Urgent Care Service Model



4.5 This model will be fully implemented by the end of March 2013.

4.6 The discharge elements of the UHL plan will be supported by wider-system actions being coordinated by the WL CCG, including:

- Implementation of the multi-agency discharge strategy launched December 2012
- Stream-lining of the continuing health care panel process from 01/13
- Main-streaming of the new reablement and non-weight bearing pathways
- Implementation of the Domiciliary Quality and Capacity Improvement Plan
- Implementation of the new DTOC plan
- A review of physiotherapy and occupation therapy capacity

5 CONTRACTUAL ARRANGEMENTS

5.1 UHL are currently in breach of the agreed remedial action plan for contractual A&E performance. The penalty for the breach in October 2012 and November 2012 is 2% of the total monthly contract value (c£688k per month).

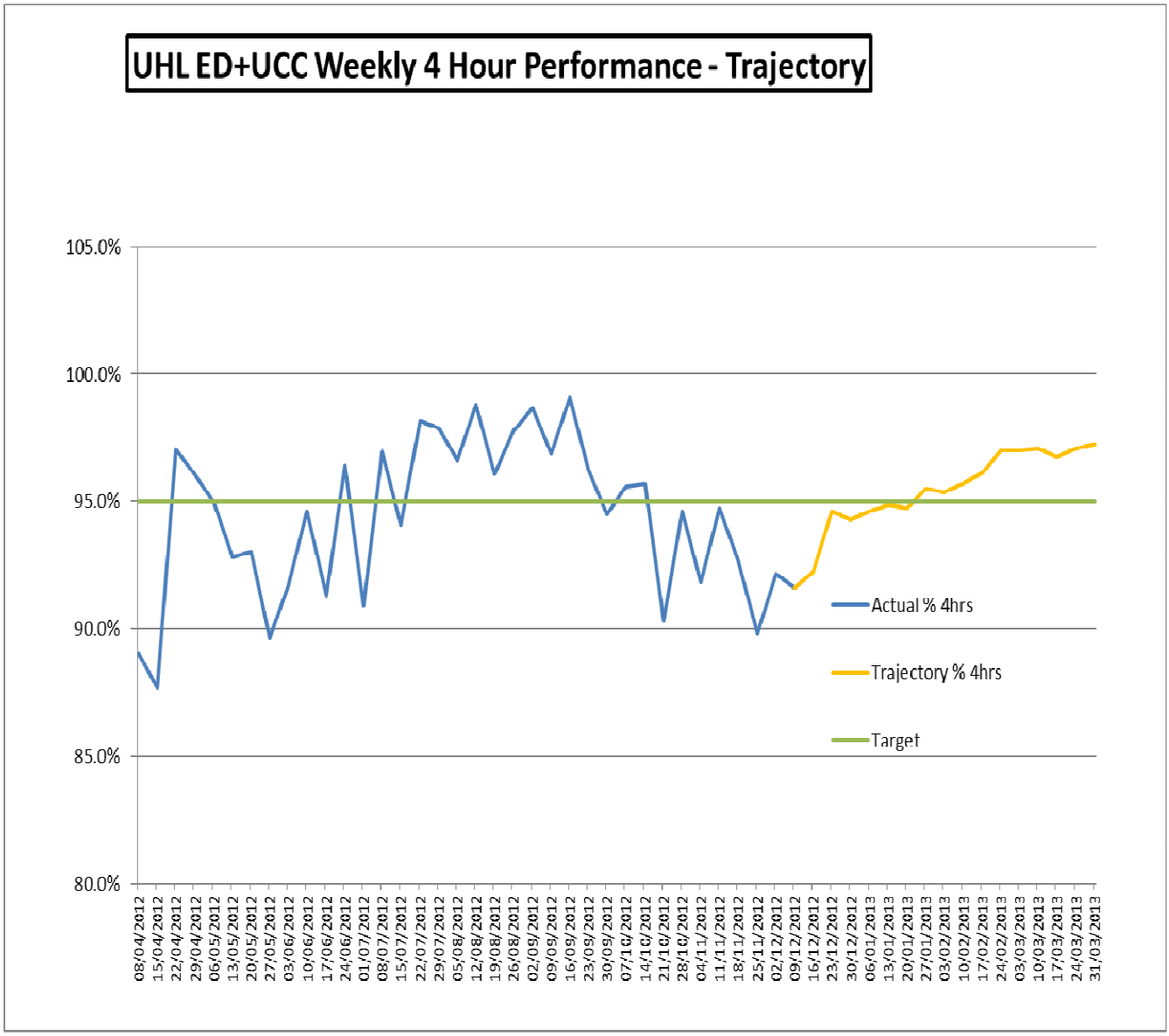
5.2 No conditions on the permanent with-holding or return of penalties was agreed within the remedial action plan. Any decision remains at the discretion of commissioners.

5.3 When UHL reported that the agreed trajectory would be breached in October Commissioners agreed to return the October penalty if performance was recovered in November. When UHL confirmed it would not recover performance in November, Commissioners informed UHL on 19/11/12 that the October penalty would be permanently withheld and that any further penalties would be raised on the same basis.

5.4 The national contract penalty (2% of service line, c. £26k) is being applied as per the guidance. No discussions have been held to-date as to what will be done with these funds.

6 RECOVERY TRAJECTORY

6.1 The recovery of the system-wide A&E 4 hour target will be delivered from w/e 16/12/12, as per the graph below. (Weekly numeric data is provided in Appendix 2).



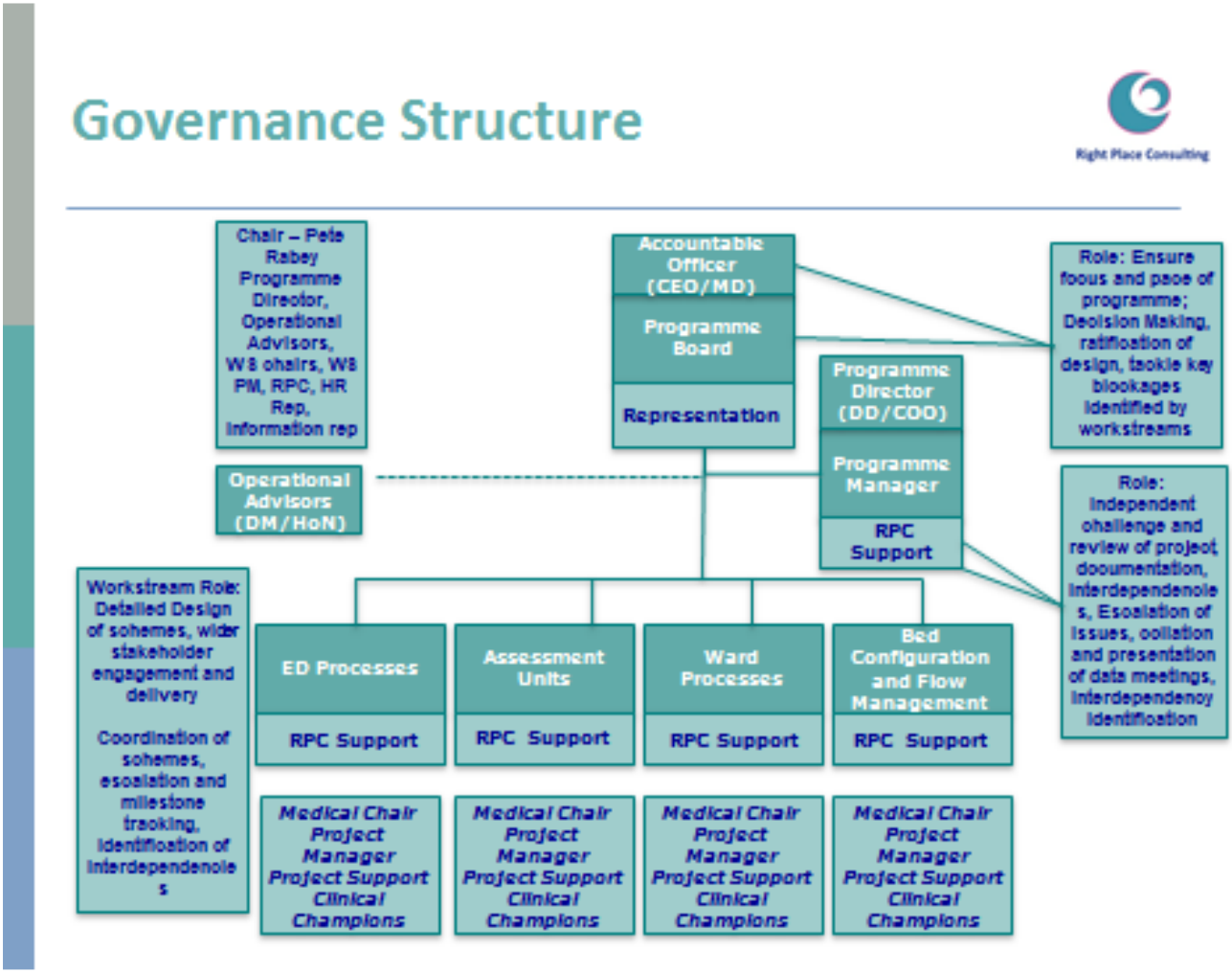
6.2 This trajectory will be underpinned by urgent non-recurrent actions that will be replaced by sustainable system improvements. The key tracking milestone for sustainable performance recovery is the delivery of 95% for UHLs ED (including eye casualty) from w/e 24/02/13.

6.3 Sustainable performance will be delivered from w/e 31/03/13.

7 PERFORMANCE MANAGEMENT

7.1 Due to the seriousness of on-going performance against the A&E 4 hour standard UHL's recovery is being managed by commissioners through the national standard contract mechanisms.

7.2 In terms of operational delivery governance UHL has established the following arrangements:



7.3 Wider system improvements and medium-term developments are being coordinated through the LLR ECN.

7.4 Overall performance will be measured against the weekly trajectory. However, on-going performance development will be underpinned through the metrics tabled below. A range of daily flash reports are routinely produced and a monthly dashboard reviewed at the ECN. Development work on a compressive daily run rate and statistical process chart report is being coordinated by commissioners to support the daily system management meeting.

A&E Performance Development Indicators

Indicator	Frequency	Threshold / Comment
Minor attendance performance	Daily	100%
Diagnostics availability	Daily	In development – UHL IT project to be completed in January
Bed Management Forward Plan (includes morning empty beds & morning discharges and contingency planning)	Daily (Monday – Friday. The PCT on-call director can call Saturday and Sunday teleconferences if required).	9:30 teleconference UHL planned & forecast discharges (if below 100 = escalation) LPT – Acute beds (if below 8 = escalation) LPT virtual community ward (if below 10 escalation) LPT MH beds (if below 6 = escalation) Information cascaded across health community at 10:00 LPT matron then updates UHL bed bureau every 2 hours
Discharge Lounge Activity	Daily	Dashboard of metrics
DTOCs	Daily	January – March (threshold +25 = escalation) Figures split as per DTOC definition then split between UHL attributed and community attributed.
Ambulance conveyance	Overall monthly GP urgent weekly	Overall threshold = 4% tolerance Daily reporting in development, with RCA for peaks
Diversions	UCC daily	UCC split between ED front door and ED triage Hot clinic reports in development
Peak hours	Daily	Profiles produced
Virtual wards	Daily	LPT established GP Pilot in WL CCG
Choose well	Weekly	Details on all planned activities
GP peer review		Pilot in WL CCG
Admissions	Daily	Data by admission method includes normal variation. All special cause variations are reviewed
Re-beds	Daily	Threshold = 0 Reporting by cause and RCA investigated
A&E Staffing levels	Daily	In development by shift, staffing type etc.

Michael Whitworth
12th December 2012

Appendix 1

UHL A&E Performance Recovery – Mobilisation and Implementation Timelines

Milestone no.	Description	Estimated Completion Date
	Mobilisation	
1	Draft Communications strategy	30-11-12
2	Defined Governance structure	30-11-12
3	Core medical model principals agreed	30-11-12
4	Work stream and key members identified and invites sent	30-11-12
5	Escalation Plan finalised	30-11-12
6	TOR & Draft PID drafted	30-11-12
7	First Programme Board meeting - PID signed off	07-12-12
8	Launch of Programme to the wider organisation	11-12-12

Milestone no.	Description	Estimated Completion Date
	Design and Plan Phase (Phase1)	
1	Work stream meetings commence	10-12-12
2	Workstream PIDs / Mind Maps finalised.	15-12-12
3	Communications Plan finalised	21-12-12
4	Gap analysis and implementation planning commences	15-12-12
5	Gap analysis completed	07-01-13
6	Milestone map and Quick wins implemented	21-01-13
	Detailed Design & Implementation (Phase 1)	
1	Commence Phase 2 planning	08-02-12
2	Communication Plan evaluation	08-02-12
3	Amend Phase 1 SOPs and analyse data following initial implementation	15-02-12
4	Evaluation outputs completed	22-02-12
5	Mobilisation of Phase 2	29-02-12
6	Finalise SOPs / End of Phase 1	29-02-13
	Phase 2	
1	Phase 2 commences	04-03-13

Appendix 2

LLR A&E Performance Recovery Trajectory – UHL ED & UCC

Week Ending	Actual % 4hrs	Trajectory % 4hrs	Attendances	Breaches
08/04/2012	89.0%		4,003	439
15/04/2012	87.7%		4,017	495
22/04/2012	97.1%		3,899	115
29/04/2012	96.1%		3,909	153
06/05/2012	94.9%		4,008	203
13/05/2012	92.8%		4,260	306
20/05/2012	93.0%		4,090	285
27/05/2012	89.7%		4,335	448
03/06/2012	91.7%		4,345	361
10/06/2012	94.6%		4,267	230
17/06/2012	91.3%		4,035	351
24/06/2012	96.4%		4,226	151
01/07/2012	90.9%		4,414	402
08/07/2012	97.0%		4,139	126
15/07/2012	94.1%		4,148	246
22/07/2012	98.1%		3,886	72
29/07/2012	97.9%		4,041	86
05/08/2012	96.6%		3,969	134
12/08/2012	98.8%		3,900	47
19/08/2012	96.1%		4,122	161
26/08/2012	97.7%		4,119	93
02/09/2012	98.7%		4,019	54
09/09/2012	96.9%		3,909	123
16/09/2012	99.1%		4,045	37
23/09/2012	96.2%		4,018	151
30/09/2012	94.5%		4189	230
07/10/2012	95.6%		4,028	178
14/10/2012	95.7%		4,073	176
21/10/2012	90.3%		4,132	400
28/10/2012	94.6%		3,888	209
04/11/2012	91.8%		4,079	334
11/11/2012	94.8%		4,248	223
18/11/2012	92.7%		4,188	306
25/11/2012	89.8%		4,213	429
02/12/2012	92.1%		4,089	321
09/12/2012	91.6%	91.6%	4,129	347
16/12/2012		92.2%	4,000	311
23/12/2012		94.6%	4,100	220
30/12/2012		94.3%	4,200	240
06/01/2013		94.6%	4,100	220
13/01/2013		94.9%	4,100	210
20/01/2013		94.8%	4,000	210
27/01/2013		95.5%	4,200	190
03/02/2013		95.4%	4,100	190
10/02/2013		95.7%	4,200	180
17/02/2013		96.1%	4,100	160
24/02/2013		97.0%	4,000	120
03/03/2013		97.0%	4,000	120
10/03/2013		97.1%	4,100	120
17/03/2013		96.8%	4,000	130
24/03/2013		97.1%	4,100	120
31/03/2013		97.3%	4,000	110
		94.7%	212,679	11,273

Christmas and New Year Arrangements out of UHL.

Social Services (Xmas Eve is a bank holiday for the local authority).
Social Services are providing a weekend service on Xmas Day, Boxing Day and New Year's day. The City also has a full service on Xmas Eve up till 14:00. There are additional staffing available for discharge after this time. A simplified process for accessing Social Services has been agreed for the bank holidays and weekends.
County Social Services HART (Home Care Assessment and Re-ablement Team) will be in place for Christmas Eve, bank holidays and weekends.
For both the City and County Social Services restarts of a Package of Care, if the patient is back to baseline and has had no changes, can be done by the wards directly contacting the relevant agency rather than the normal process of referring through the LA (if this works then it will be adopted as the process going forward).
Normal Service is provided on all other days.

General Practice
All areas (East, West and City) are providing full or almost full cover on Xmas and New Year's Eve. They will be providing a weekend service on Xmas Day, Boxing Day and New Year's Day.

Pharmacy
The City has pharmacies open on all days throughout the Xmas/New Year Period.
County pharmacies are largely closed on Xmas day, but open on Boxing Day and New Year's Day.

Other
The Oadby Walk in Centre is open all days throughout a Xmas Day, Boxing Day and New Year's Day
Arriva are providing a full service on Xmas Eve, a weekend service on Xmas Day and New Year's Eve and half the normal weekday service on Boxing Day.
CHC triage panels are sitting on the 24th, 28th and 31st and re-commence normal service thereafter

Overall the bank holidays are supported at a normal weekend level. Xmas eve is supported by all agencies, to a level that is suitable for this time of year. It is vital that we use all the additional resources (especially City LA Discharge) put on for the trust. UHL will continue to ask for additional resources on the days after the bank holidays to ensure discharge of any patients who have stayed in over the bank holidays.