To:	Trust Board
From:	Dr Kevin Harris, Medical Director
Date:	28 June 2012
CQC regulation:	

Title:	Emergency Care Delivery

Author/Responsible Director:
Dr Kevin Harris, Medical Director

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	x	Endorsement	

Summary / Key Points:
Achieving the emergency 95% target and clinical indicators in a consistent manner within UHL is THE major priority for the local health economy. Any Emergency Department is a "complex system" – with performance not just relating to Inflow, ED efficiency/processes and Outflow but also to a whole array of other services and departments within the trust that interface with the ED. All of these must be aligned and optimised to allow the system to see and admit/discharge patients within 4hrs 24/7 365. It is these complex and dynamic inter-relationships which has made achieving the required level of performance a challenging task.

UHL has committed to consistently achieving the 95% target by Q2 and this objective is currently the main focus of executive activity within the Trust.

The CCGs have indicated that they will levy the fines as permitted within the contract should there be non delivery of the ED target.

Recommendations:
Trust Board members are asked to receive and note this report.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications

Equality Impact

Information exempt from Disclosure

Requirement for further review?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**Trust Board**
REPORT FROM:	**Kevin Harris, Medical Director**
REPORT SUBJECT:	**EMERGENCY CARE DELIVERY**
REPORT DATE:	**28 JUNE 2012**

1.0 INTRODUCTION

Achieving the emergency 95% target and clinical indicators in a consistent manner within UHL is THE major priority for the local health economy. Any Emergency Department is a "complex system" – with performance not just relating to Inflow, ED efficiency/processes and Outflow but also to a whole array of other services and departments within the trust that interface with the ED. All of these must be aligned and optimised to allow the system to see and admit/discharge patients within 4hrs 24/7 365. It is these complex and dynamic inter-relationships which has made achieving the required level of performance a challenging task.

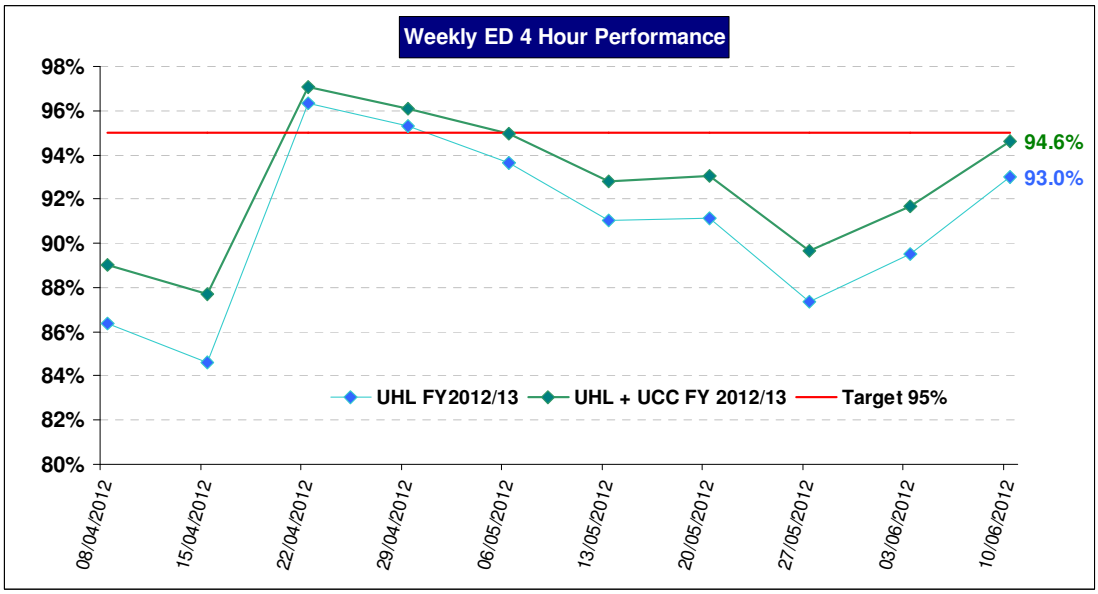
UHL has committed to consistently achieving the 95% target by Q2 and this objective is currently the main focus of executive activity within the Trust.

The CCGs have indicated that they will levy the fines as permitted within the contract should there be non delivery of the ED target.

2.0 CURRENT ACTIVITY AND PERFROMANCE

There has been a significant improvement in performance over the past weeks (Figure 1), although the target has not yet been met consistently. However there remains significant and unacceptable day to day variability in performance.

Figure 1. Overall Weekly ED Performance to Week Ending Sunday 10th June 2012



A detailed analysis of ED metrics is provided in Appendix 1. Key issues which continue to challenge the achievement of the target by UHL include, a continual rise in the volume of patients presenting to the ED and the timing of these presentations (increasingly late in the evening)

3.0 THE EMERGENCY CARE STEERING GROUP

The emergency care steering group has been established to ensure UHL can sustainably deliver the 4 hour emergency department target and associated quality indicators within the required timeframe. The terms of reference are attached as Appendix 2. The group meets weekly and to date has met three times. It has developed a workplan consisting of immediate, short and medium term objectives

3.1 Immediate measures (being implemented now)

- Creation of an "emergency care" CBU within the Acute Division. This is now headed by Dr Nick Moore who will oversee the required changes across the acute pathway.
- Regular meetings have been established with the senior ED clinicians and MD to provide the necessary support to the implementation of the required changes. In addition the MD will meet as required with other clinicians to support the proposals coming from the emergency care steering group. For this to be successful it is essential that all clinicians recognise their part to play in delivering this target and that they own and fully support the changes required. To date the MD has received strong support for what is required from the relevant clinicians.
- Divisional Directors meet weekly to ensure cross Divisional changes which may be acting as an impediment to progress are rapidly resolved.
- Increasing staffing within ED and aligning provision of staffing to demand.
- A significant change in ED process's including streaming at ambulance doors.
- Repair Blood Chute in ED.
- Ensure guaranteed outflow to all admissions areas including ACB, monitored and side rooms with predetermined meaningful hospital response to aid ED if this is not the case 24/7.
- Laboratory and Radiology commitment to provide the shortest possible turnaround in diagnostics.

3.2 Short term measure (timeframe 8 weeks)

- Viewing area within resus converted into a low dependency resuscitation bay to allow 7 patients to be treated within resus. Out of hours mortuary technicians would need to be employed to allow 24/7 use of mortuary viewing room (or could become role of duty manager).
- Additional capacity & more efficient flexing of EDU/EFU beds to prevent unnecessary admissions to wards and prevent breaches of patients who have to remain in ED whilst awaiting a bed.
- Fast track development of Same Day Emergency Medicine ambulatory pathways
- Appoint Locum ED Consultants via locum agency's to bring ED up to establishment. Construct 24/7 Consultant rota and fill night shift gaps with Locum shifts from Midlands/EoE substantive ED Consultants.

3.3 Medium term measure (timeframe 12 week):

- Appointment of two paediatric emergency medicine consultants and APNPs who in combination with existing post holders would provide a more integrated paediatric emergency service. Funding and job plans have been agreed.
- Appointment of a project manager whose primary objective is to deliver improvement in Post-Graduate Education, creating a brand ensure improved future recruitment of medical staff to ED.
- Moving fracture clinic to clinic 5, releasing the space currently occupied by fracture clinic to be used for the emergency process. This will allow the clinical model of expansion of the EFU and physicians at the front door to be delivered.

The group is conscious that the required timeframes for action are short. At all times it acts to ensure changes are subjected to the appropriate UHL governance and are consistent wit the longer term vision of UHL (supported by the Health economy), to establish an "emergency floor" on level 1 of Balmoral. However, delivery the emergency floor in its entirety cannot be realised until 13/14 and therefore is part of the longer term solution. It will encompass cross community and divisional emergency specialities (including the frail elderly) to support the assessment, deflection and admission of patients - adult and paediatrics. The emergency floor model has yet to be determined but will focus on the provision of a Single Point of Access for urgent and emergency care on the LRI site inclusive (not exhaustive) of:

- Urgent and Emergency Care combined front door
- Emergency Department with front door triage
- Speciality Assessment Areas, Adults and Paediatrics
- Ambulatory Care
- Primary Care Assessment Area
- Imaging Support
- Pharmacy Support

4.0 KINGS COLLEGE VISIT

A team from Kings College will visit UHL on 12-13 July 2012. A report will be presented to the 26 July 2012 Trust Board, including feedback on the performance of the early triage system.

5.0 PROGRESS AGAINST ED ACTION PLAN

A brief update of actions taken against the remedial action plan and performance against the agreed trajectory is shown in Appendix 3.

6.0 NEXT STEPS

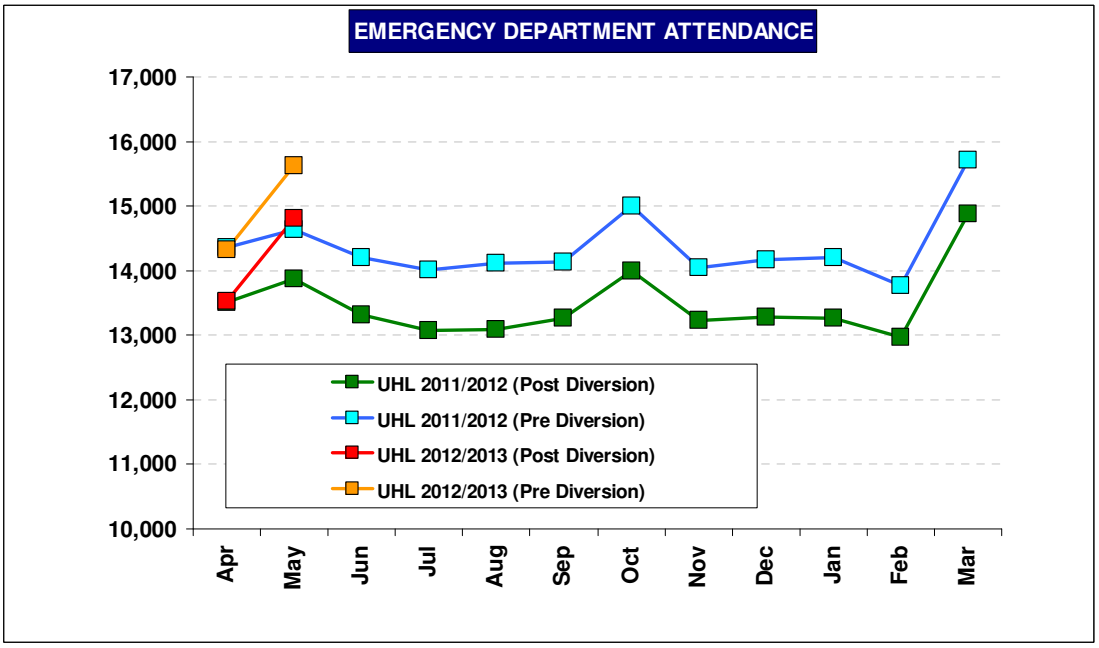
An ED summit is planned for 26th June. This will be led by the CCGs with input from all health and social care organisations across LLR.

The CCGs have indicated that it is their priority to support UHL in delivering the 95% ED target both in the short term and to ensure that this delivery is sustained long term.

Appendix 1

Overall ED Pre and Post Diversion

EMERGENCY DEPARTMENT ATTENDANCE							
	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			
Jul	12,983	14,100	13,075	14,014			
Aug	12,544	13,757	13,086	14,109			
Sep	12,726	13,720	13,270	14,142			
Oct	12,918	14,022	14,002	15,000			
Nov	13,057	13,963	13,226	14,051			
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	28,351	29,965	



CLINICAL QUALITY INDICATORS

PATIENT IMPACT

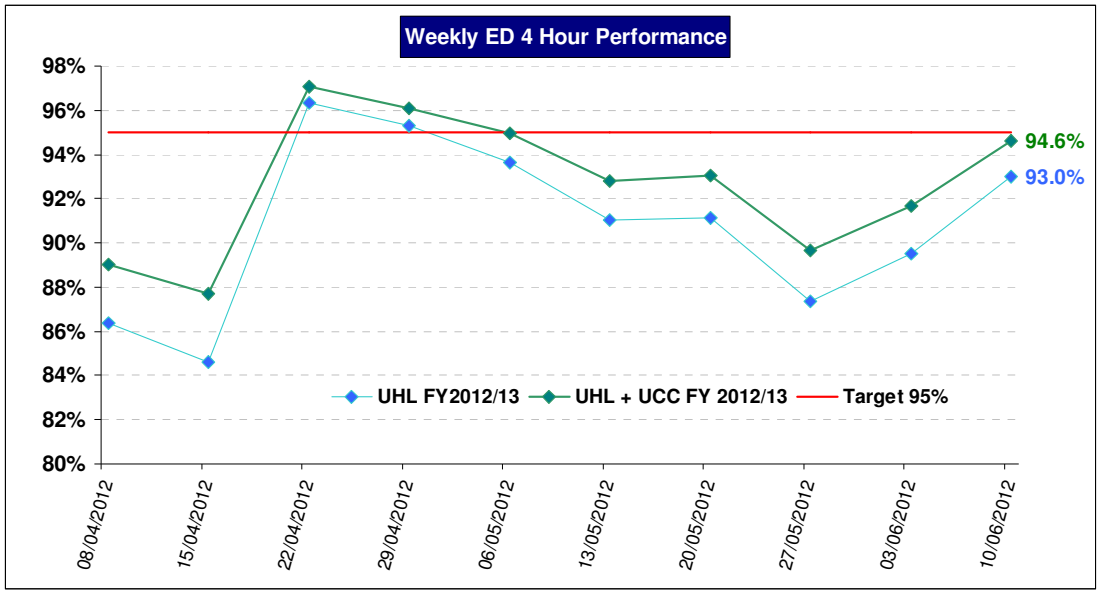
	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	TARGET
Left without being seen %	2.9%	2.0%	2.3%	2.1%	2.4%	3.6%	2.8%	3.0%	<=5%
Unplanned Re-attendance %	6.0%	5.7%	5.4%	6.1%	6.1%	6.6%	6.2%	5.9%	< 5%

TIMELINESS

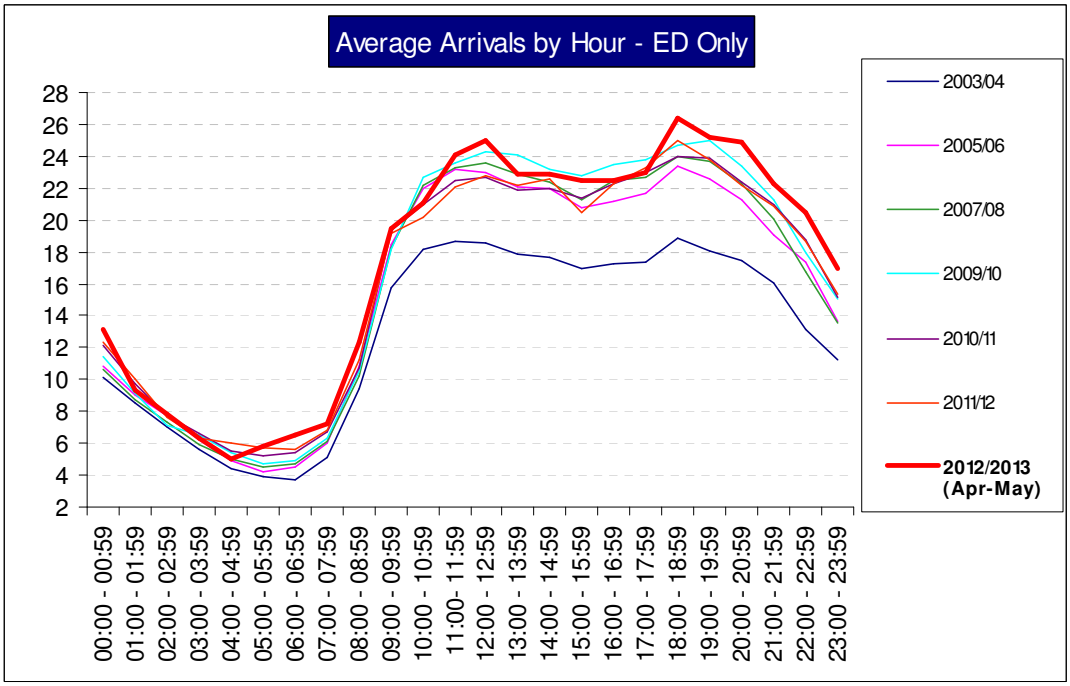
	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	TARGET
Time in Dept (95th centile)	341	288	240	264	331	331	320	317	< 240 Minutes
Time to initial assessment (95th)	61	48	42	32	34	40	34	31	<= 15 Minutes
Time to treatment (Median)	44	43	42	42	54	61	45	49	<= 60 Minutes

Appendix 1

Overall Weekly ED Performance to Week Ending Sunday 10th June 2012

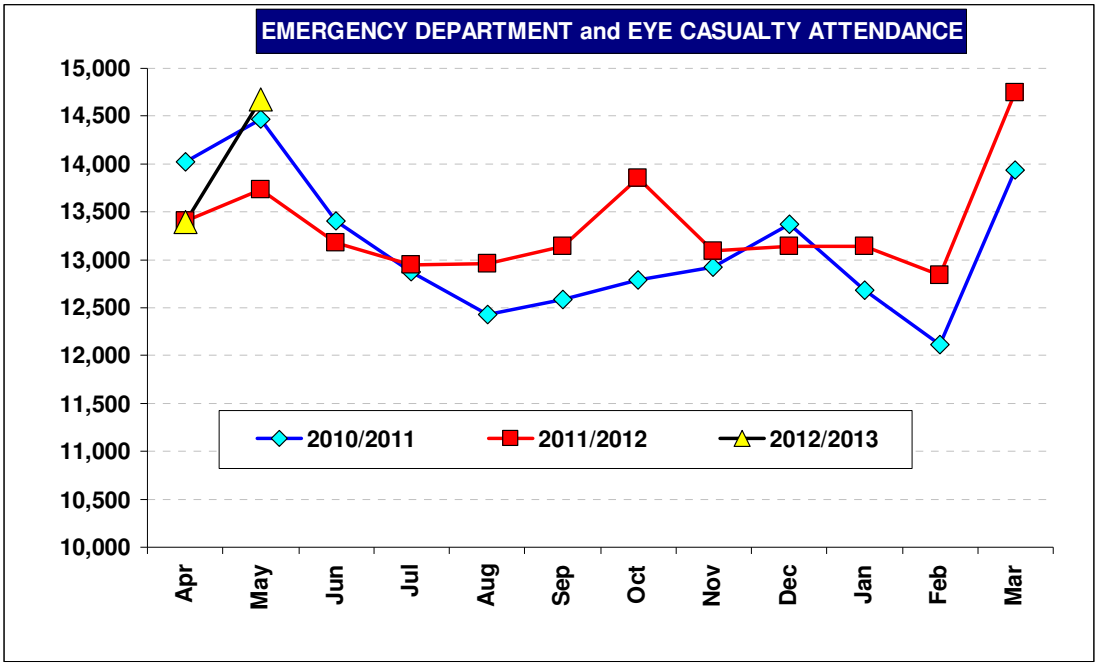


Type 1 Arrival Patterns



Appendix 1

ED and Eye Casualty Attendance



1pm Discharges

	Dec	Jan	Feb	Mar	Apr	May
Acute Care	22%	22%	20%	20%	19%	21%
Planned Care	20%	18%	22%	22%	19%	21%
Women's and Children's	20%	21%	24%	16%	14%	21%

	Dec	Jan	Feb	Mar	Apr	May
Cardiac/Renal/C. Care	25%	25%	22%	24%	19%	22%
Medcine	20%	20%	21%	19%	20%	24%
Respiratory	21%	22%	16%	16%	16%	16%

Appendix 1

Type 1 Breach Reasons – weeks ending 6th May to 3rd June

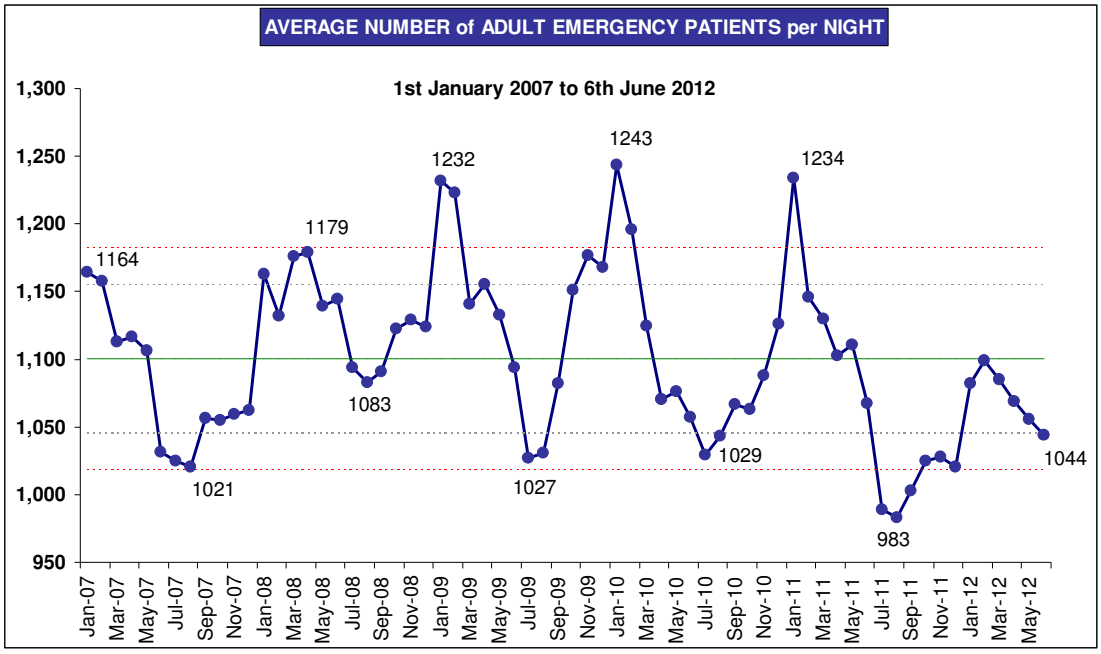
Delay Reason	06/05/2012 (Sun)	13/05/2012 (Sun)	20/05/2012 (Sun)	27/05/2012 (Sun)	03/06/2012 (Sun)	Sum:	Cumulative %
Bed Breach	36	82	45	75	88	**326**	**21%**
ED Process	27	44	42	56	35	**204**	**13%**
ED Capacity (Cubicle Space)	1	3	5	24	7	**40**	**3%**
ED Capacity (Inflow)	61	33	108	127	126	**455**	**30%**
ED Capacity (Workforce)	9	1	1	45	21	**77**	**5%**
Clinical Reasons	23	37	26	30	29	**145**	**9%**
Specialist Assessment	7	10	4	13	7	**41**	**3%**
Specialist Decision	1	11	2	7	3	**24**	**2%**
Investigation (Imaging and Pathology)	21	37	28	14	14	**114**	**7%**
Transport	11	30	16	26	11	**94**	**6%**
Treatment	3	7	5	4	2	**21**	**1%**
	200	**295**	**282**	**421**	**343**	**1541**	**100%**

Appendix 1

Average Number of Breaches per Hour – 5 weeks Mon 30th April to Sun 3rd June

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00:00 - 00:59	2.2	5.0	4.4	4.2	4.0	2.2	1.2
01:00 - 01:59	3.2	6.0	3.8	8.0	2.8	2.0	1.6
02:00 - 02:59	2.8	7.0	4.2	5.4	5.6	1.2	2.6
03:00 - 03:59	3.6	6.0	4.6	6.0	6.2	1.4	1.8
04:00 - 04:59	4.6	6.8	3.8	5.0	4.6	1.2	2.4
05:00 - 05:59	4.2	2.4	4.6	3.4	2.2	1.4	1.0
06:00 - 06:59	2.0	1.8	2.4	2.2	1.2	1.0	0.8
07:00 - 07:59	1.4	1.4	2.0	2.4	1.6	0.4	0.8
08:00 - 08:59	1.2	1.2	0.6	1.6	1.2	0.8	0.8
09:00 - 09:59	0.6	0.8	2.0	0.8	1.6	1.2	1.2
10:00 - 10:59	0.6	0.2	1.2	1.2	0.6	1.4	0.4
11:00 - 11:59	0.2	0	1.0	0	0.8	1.0	0.2
12:00 - 12:59	1.0	0.6	0.4	0.6	0.4	0.4	0.4
13:00 - 13:59	1.2	0	0.4	1.6	0.6	0.2	0.2
14:00 - 14:59	0.6	0.4	1.2	0.4	0.6	0	0.8
15:00 - 15:59	1.8	0	1.2	0.8	1.4	0	0.4
16:00 - 16:59	2.0	0.8	2.2	1.4	1.4	0.4	0.4
17:00 - 17:59	1.6	1.0	1.2	1.4	1.2	0.4	0.6
18:00 - 18:59	1.8	1.0	1.4	1.0	1.6	1.0	0.8
19:00 - 19:59	0.8	0.2	1.0	1.2	1.0	1.8	1.4
20:00 - 20:59	1.6	0.6	2.8	1.6	1.0	1.0	1.4
21:00 - 21:59	3.0	2.0	1.4	1.4	2.0	1.4	2.2
22:00 - 22:59	3.8	1.8	4.4	2.6	2.2	1.2	1.2
23:00 - 23:59	4.6	2.2	4.0	3.6	4.0	0.6	1.2

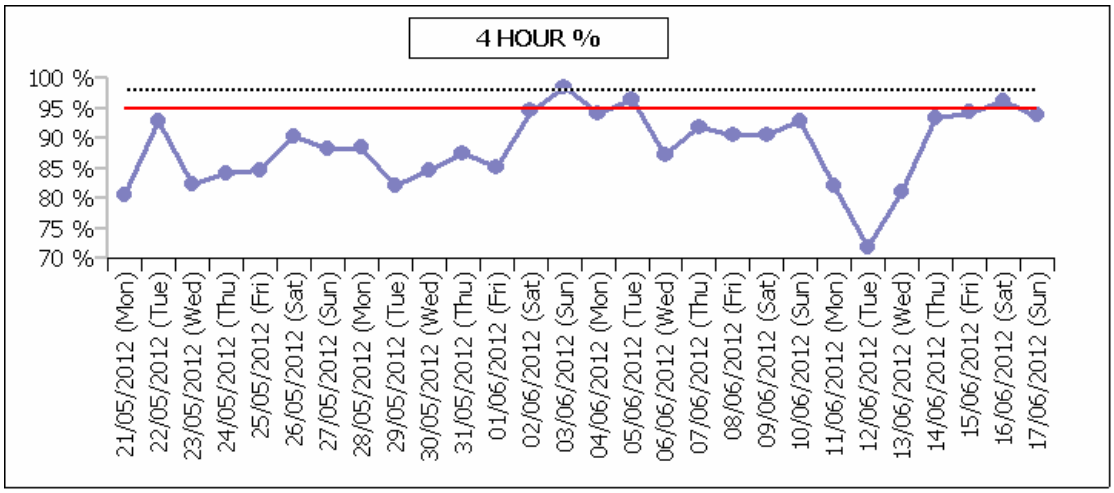
RED >=2 AMBER 1-2 GREEN <=1

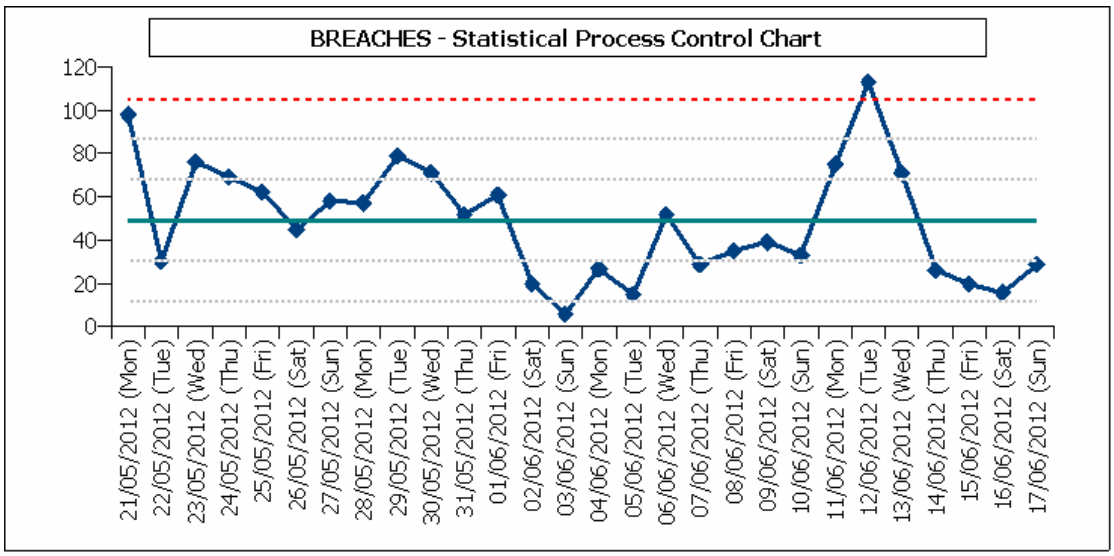


Appendix 1

ED TYPE 1 PERFORMANCE

28 DAYS MONDAY 21st MAY to SUNDAY 17th JUNE





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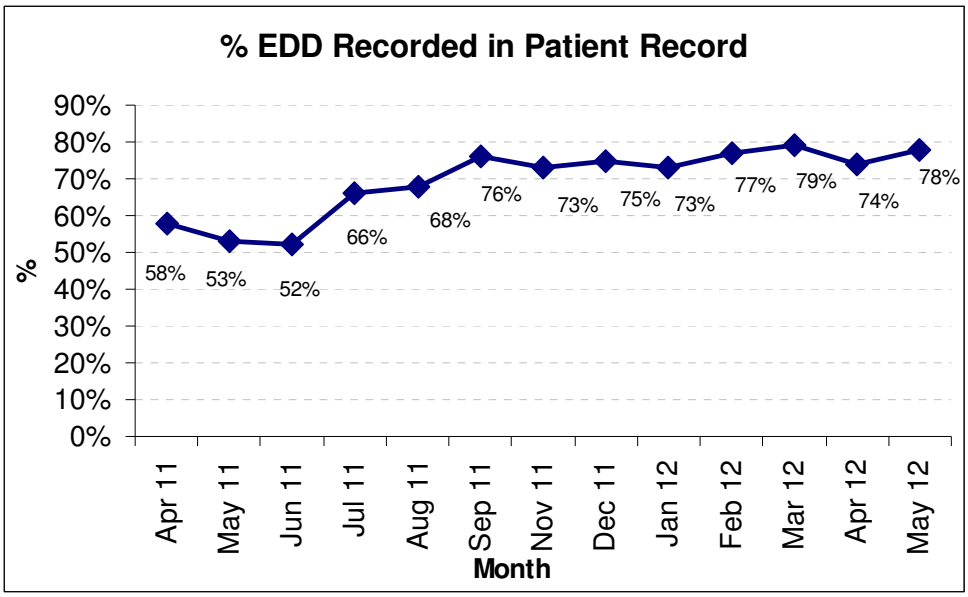
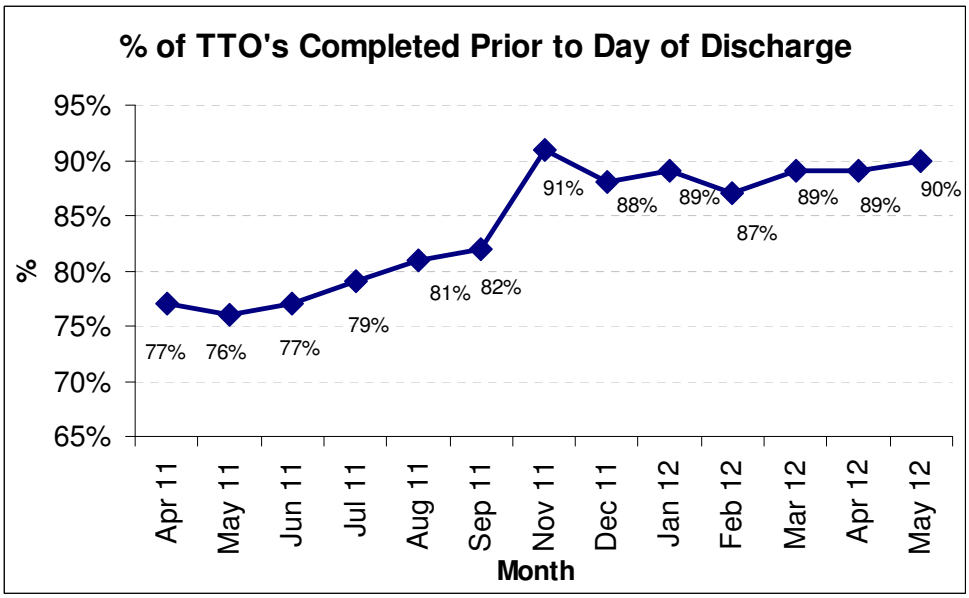

% EDD Recorded in Patient Record
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
%
58%
53%
52%
66%
68%
76%
73%
75%
73%
77%
79%
74%
78%
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Apr 12
May 12
Month


% of TTO's Completed Prior to Day of Discharge
95%
90%
85%
80%
75%
70%
65%
%
77%
76%
77%
79%
81%
82%
91%
88%
89%
87%
89%
89%
90%
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Apr 12
May 12
Month

Appendix 2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Emergency Flow Steering Group
Terms of Reference and Membership

The improvements to emergency flows will be overseen by the Emergency Flows Programme Board chaired by the Chief Executive.

Responsibility
The Programme Board is and internal Trust group with the key responsibilities of :

- Ensuring the project plan is fit for purpose
- Hold to account Divisions to deliver against the agreed Emergency Flow action plan

Role

1. Seek assurance from the Divisions ability to sustainably deliver the 4 hour emergency department target and associated quality indicators.
2. Make decisions on escalated issues in relation to the delivery of sustainable performance improvement.
3. Make recommendations on the prioritisation of the use of project resources
4. Ratify future the proposed model of emergency care for all specialities and associated plans for implementation.
5. Ensure congruence with plans to deliver performance improvement across LLR including ECN recommendations and site reconfiguration
6. Ensure alignment between short term capital plans and the longer term aspirations for developing an emergency floor.
7. Ensure maximum benefit from other internally focussed projects and other transformation schemes
8. Oversee the effectiveness of internal and external communications with key stakeholders
9. Ensure overall business assurance of the programme that it remains on target to deliver performance improvements, in line with SHA and CCG expectation, completed within agreed timescales.

The Programme Board has overarching accountability for the connectivity of the individual projects and delivery of plans to improve emergency allows throughout the Trust and into the community.

Membership (November 2011)

Malcolm Lowe Lauri – Chief Executive (Chair)
Abi Tierney – Director of Strategy & Innovation
Kevin Harris – Medical Director
Phil Walmsley – Head of Operations
Sue Carr – Director of Medical Education

Communications - TBC
Patient Advisor - TBC

Acute care Division
Doug Skehan – Divisional Director
Monica Harris – Divisional Manager
Sue mason – Divisional Head of Nursing
Jane Edyvean – Head of Strategic Change

CSD
Shona Campbell – Divisional Director
Neil Doverty - Divisional Manager

W&C's
Pete Rabey - Divisional Director
David Yeomanson - Divisional Manager

Planned Care
Andrew Furlong **-** Divisional Director
Nigel Kee - Divisional Manager

Representation from each of the Project Groups

Appendix 3

Whilst this plan is predicated on UHL, it must be acknowledged that there are factors within this Emergency care plan where a wider LLR approach is need to facilitate delivery. The need to work in partnership is paramount to ensuring its successful implementation.

Examples in which UHL will need support include:
Discharge processes; EMAS delivery times, managing attendance, maintaining flows for dementia patients, mental health in-reach
Managing attendance to the most appropriate source is widely understood and the need to work with our partners including George Elliott - Urgent care, GP/community referrers for emergency care and the wider public is a key action.
UHL welcomes the opportunity to work closely with LLR in the joint and successful delivery of this plan.

Key to Grading

Red indicates that there is a delay in implementation due to difficulties being experienced – the reasons will be highlighted below the indictor

In process but is awaiting for completion of another action in the plan but does not necessarily mean it has been delayed or there is a delay due to complexity or concern of an unexpected happening – the reasons will be highlighted below the indictor

On target or met.

Department	Action	Enablers	Short term Achievement Q1	Metrics	Progress against action	Overall lead	RAG
Leadership	Dedicated clinical and managerial leader for the full Acute pathway review	• Established, and experienced leaders able to engage and motivate teams to deliver	Identify persons Ensure appropriate skills and competencies – Identify training needs Corporate and divisional support Report into ED Steering group	Clinician and manager identified Achievement of project plan to timescales set Evidence of engagement and feedback Staff and patient satisfaction	**New structure for CBU agreed . Awaiting management of change process to support implementation** **Seconded CBU clinical leader in post**	D Skehan	 In process of rebasing CBUs
All	Establish Single Clerking notes	• Agreement on single paperwork	Implementation of single clerking paperwork in medicine	100% used for patients on the acute pathway on all sites	Pilot delayed to early July	C Free	 Medical illustration to complete graphics

Appendix 3

Ambulatory	Develop Ambulatory services to support in-reach for GPs and an alternative to admission-OPD assessment and treatment service	• Clinic space (longer term strategy of acute floor). • Expand on current PE,DVT, Chest Pain, etc ambulatory pathways • Manpower multi-disciplinary – demand and capacity requirements – Nurse led/consultant led services	Define the ambulatory model – plan environment FBC complete in May	• Number of clinics established • Utilisation of ambulatory care • Patient, consultant and GP feedback • Benchmark national trends and compare services • Implementation for developing services – monitored at subgroup of steering group	Transformation bid to be developed in collaboration with CCG's. Steering group established. Work underway with clinical leads	N Langford M Wiese	 Recruitment in progress. Difficulties fulfilling all shifts required to deliver the RAT process

Note: Single action plan – all specialities contributing to delivery against this action plan

Appendix 3

Emergency Department	Full workforce review	• Workforce strategy to support difficult recruiting to medical and nursing posts	• Define workforce strategy to bridge the gaps • Undertake full staffing review including job planning and a review of all support services • Acute physicians to support Senior consultant cover in Majors • Re-advertise ANP/ENP, Jnrs and Senior Trust grade • Use GPs within ED	• Formal review of staffing levels • Monitor vacancies • Full recruitment of consultants • Full recruitment to ANP/ENP • Extend working hours to 24hrs • Recruitment Where short falls occur look to support with acute physicians for additional medical cover and other supporting professionals	Job planning waiting for divisional sign off Educational lead appointed and in post wef 18.6.2012 OOPE posts to be signed off and advertised in the next 2 weeks. Medical Education Project Manager Post currently out to advert closing date 25.6.2012 1 ANP recruited due to start Sept 12 CT1 posts for August to be interviewed 26.6.12 and 27.6.12. Acute physicians continue to support ED with 6pm – midnight, Fill rate inconsistent. Additional registrar cover on late shift – fill rate inconsistent. Paediatric Consultant for the peads ED Single Front Door JD and PS to be sent to the Deanery Medical Director for sign off, then to go to advert Nursing RN and HCA advert to be advertised again to fill shortfall	B Teesdale J Halborg	

	Patient handover from Ambulance team by Nurse in the red/blue team	• Review roles of red and blue teams to enable them to take handover • Review of co-ordinator role	Completed within one month	• Handover time <10 minutes • 15minutes to first assessment	EMAS paperless system now live. All handovers times recorded electronically. Number of ambulances on way to UHL now easily identifiable Further work between EMAS and ED is required to prevent delays at point of patient being unloaded from Vehicle	M Watts	

	STAT and treatment plan devised	• Review of hybrid STAT system and signposting • 24/7 Consultant available within the department at all times • Acute Physician presence in majors with allocated juniors • Geriatric In-reach • Surgical in-reach • In-reach of other specialities	• Immediate review and implementation • Locum Acute physician in majors • Protocol for transfer • Establish data collection to measure performance	• Assessment within 15mins • Evidence of signposting within 30 minutes • Monitor assessment time • Minimum staffing levels maintained • Evidence of Multi-disciplinary staffing which reflect demand • Physician and Geriatrician provide in reach • National Quality indictor time to assessment achieved (NQI) Q1 • National Quality indictor time to treatment (NQI Q1	• Dedicated RAT team implemented for majors, initial review of 2 week pilot demonstrated positive outcome. Main challenge is fill rates unpredictable for nursing and medical staffing • 3 Dedicated Assessment teams supported by: • dedicated ED middle grade/Consultant and • PSA's from 2pm – midnight. RAT already in place for Minors, paediatrics and Resus Acute physician continues 6pm – midnight Case of Need in progress re permanent staff recruitment for ED RAT process. Capital build plan re increased space for RAT process at ED front door submitted to Divisional Managers meeting, further work to be completed in line with capital ED reconfiguration.	B Teasdale	 Workforce requirements insufficient to provide robust cover Still awaiting external assessment of clinical processes

Appendix 3

	Diagnostics – hidden waits removed.	• Clinical reporting of diagnostic tests within 30 minutes with full • Formal reporting within 2 hours • Tube working 95% if the time • Define tests which need to be reported on and those that do not • Rationalise diagnostics by implementing protocols to ensure request based on need rather than uncertainty • Agreement to and monitoring against internal professional standards • Electronic requesting	• Review of point of care testing • Rationalisation of tests via protocol • Diagnostics being undertaken 45 minutes of being requested • Additional PSAs to compensate for when tube non functional • Electronic requesting and reporting delivered by end of April	• Diagnostics undertaken within 30 minutes from the time of being requested • Reporting of diagnostic tests within 30 minutes • Clinical reporting • National Quality indictor (NQI) achieved for arrival to treatment • Tube working 95% if the time	Express air tube to be installed – Operational early July – on target Audit of diagnostic pathways and turnaround times underway ICE live in Minors ED for 4 week pilot ,. (to determine ED speed of implementation).	J Edyvean N Doverty Lead Nurse BTeasdale	 Air tube system failures still being experienced by ED Work is on going but there are challenges installing electronic ordering - this will improve process and monitor performance

	• Patients have a definitive plan and plan for discharge or admission arranged within 180 minutes	• Patients have a decision after being 180 mins in the department • PSA attendance 100% • Access to transport within one hour of being requested • All requests for radiology are responded to within 30 minutes • Patient arrives on assessment unit within 30minutes of request • Return to community services within one hour of request • NQI total time in department admitted and non admitted	• Patients have a decision after being 180 mins in the department • PSAs report to the main ED to book in and are based within • Establish talks with EMAS to agree short term standard • Transfer within 30minutes • NQI non admitted target met	• Patients have a decision after being 180 mins in the department • PSA attendance 100% • Access to transport within one hour of being requested • Patient arrives on assessment unit within 30minutes of request • Return to community services within one hour of request • Achievement of NQI performance compliance	Cumulative Last 28 days Arrival to bed request 170mins	B Teasdale	

Appendix 3

Flow	Patients are moved within 30 minutes of • a non monitored bed being identified • a discharge being identified • a monitored bed (non ITU) within 30 minutes of request	• Having sufficient staff to be able to transfer patients in times of high demand • Having available capacity in the appropriate destination • Escalation when difficulties in meeting requirement • Availability to monitored beds • Development of fast track clinical protocols	• Transfer team established • Demand and capacity to ensure capacity is in the right place • Escalation in times of difficulty clearly established • Define criteria for monitored beds • Clinical Protocols developed	• Transfer time compliance times monitored • 95% accuracy when requesting a monitored bed • Patient moved within 30minutes of request. • Reduced delays due to monitored or AEB beds	Significant operational and managerial support in place to maintain flow whilst processes are changed **Additional duty manager support provided to ED 4pm – 12 mn to support flow** **Additional bed base agreed for medical specialities (Odames ward and 10 beds Ward 1)** **Plans confirmed for the relocation of fracture clinic to allow increased capacity to support outflow from Majors** Escalation plans to be revisited Demand and capacity analysis for Acute Division completed	Lead Nurse for each area	 Not always the bed base Some delays with discharges

	Speciality pull	• Acute physician allocated to majors with supporting juniors • Signposting/fast track appropriate medical patients to assessment area • Medical and Surgical opinion within 30minutes of request	• Acute physician allocated to majors with supporting juniors • Medical Assessment unit open • Protocol to move patients to assessment units where medical in-reach is not possible	• Monitor variation and practice and performance • Responsiveness of medical and surgical opinion	Acute physicians continue to support majors 6m – midnight. Medical Registrar support agreed some problems with covering shifts Fast track processes in place for AMU's Ambulatory care/Urgent medical clinics supporting early discharge from AMU	N Langford	 Not always the bed base Awaiting demand and capacity

	To assess patients within 30 minutes of arrival on fast track Assessment Unit (FTAU)	• Ability to accept patients that have not been worked up in ED • Appropriate staffing to enable assessment • Diagnostics able to respond to assessment unit (AU) • Maximum time within the unit is 90 minutes • All receiving areas to take patients within 30mins of request • Patients on trolleys must by monitored to include the time in ED	• Patients signposted and transferred to AU • Undertake staffing review • Diagnostics able to respond in 45 minutes • EDIS installed within AMU/(FTAU)	• Time to transfer from ED from request • Time for diagnostics to be returned to the clinician • Time spent in the unit > 90mins • Time to transfer to ongoing ward • Assessment time • Treatment plan with EDD	EDIS in place on CDU and AMU's . Campus design for SAU complete	N Langford	 Process in place Not always the bed base to transfer patients awaiting demand & capacity beds 1/6/12
Medical Admissions Units **Extension of EFU**	Patient stay no longer than14 hours on medical admissions	• Base wards have the capacity to accept the patients • Discharge lounge able to take beds/trolleys • No delays in discharge • Senior medical assessment available 24/7 • Speciality in-reach for	• Aim to have 10 beds free by 11 am and 15 beds free by 4pm • Transport, TTOs and GP letter completed the day before discharge • Discharge lounge able to accept trolleys opened • Speciality in-reach established	• EDD identified for 98% patients • Patient stay<14hrs • Time to review • All patients have treatment plans • Evidence of nurse discharge according to protocol • Transport and TTO's and GP letter organised the day before	Significant management and operational effort continues to ensure capacity on base wards and AMU Ability to achieve 10 beds consistently available on AMU is challenging. Senior nurses on AMU's to lead on managing capacity on MAU New processes	C Shatford K Johnston	 Awaiting demand & capacity beds 1/6/12

		opinions • Escalation and risk • Ability to maintain flow • Access to therapy as/when necessary to support discharge from MAU / EFU /EDU			implemented LRI for promoting discharge actions the day before discharge		
	Accepts patients from the assessment unit within 30 minutes of request	• Ability to maintain patient flow essential • Availability to discharge lounge • Speciality in-reach • 24/7 consultant availability	• Formalise an escalation policy re bed availability • Review workforce and requirements of multi-disciplinary team	• Time to transfer • Use of discharge lounge • Monitor variation in response times	Communication between teams managing flow and capacity improved. AMU and CDU continuously aware of bed availability on base wards. Bed modelling commenced as a precursor to workforce remodelling	K Johnston	
Short Stay	Accepts patients from within 30 minutes of request	• Have the capacity to accept patients • Twice Daily board rounds and multiple ward rounds with Senior review	• Establish bed base requirements and implement	Monitor bed requested to move time	Short stay implemented Daily board and ward rounds established Early evaluation of effectiveness completed Criteria for short stay not always adhered to	N Langford	

	Maximum 48hr stay following which they are transferred a base ward.	• Consultant ward rounds 8am and late afternoon daily • Availability to physiotherapy and OT early • Discharge by 10am where possible	• Review workforce and requirements of multi-disciplinary team • Early discharge process in place • TTO, Transport and GP letter prepared the night before • EDD	• Evidence of documented ward rounds • EDD • Discharge dates	Short stay implemented Daily board and ward rounds established Early evaluation of effectiveness completed – actions to improve concept underway SOP agreed - not always beds available	N Langford	Proc in plac do not always have enough beds
Base wards (including sub specialities)	Accepts patients from the assessment or admission unit within 30 minutes	• Discharge lounge able to take beds • Plans for discharge created in advance • EDD monitoring • Transport order day before • TTO's written the day before • Medicine Discharge team to work 24/7 • Discharge planning and EDD linked to nurse handover	• Discharge lounge available • Discharge planning undertaken	• EDD identified for 98% patients • 25% patients in discharge lounge by 10am moving to a stretch target of 40% • 90% patients transported by EMAS on 10am vehicles • 50% TTO's written the day before and 100% before 11am on the day	See above Odames ward no longer available as a discharge lounge facility forbeds/stretcher patients Discharges before 11am and 1pm promoted daily Accelerated action plans developed for medicine to improve outflow. BEDS project being rolled out across acute division	K Johnston	Process in place – do not always have enough beds – awaiting demand & capacity beds 1/6/12
	Specialities manage their own patients within their allocated bed base. Focus on expediting discharge	• Remodelling of sub speciality bed base • Concept of outliers removed • Clinicians responsible for managing their own patients if	• Demand and capacity undertaken • Plan to rebase beds • Review workforce and requirements of multi-disciplinary team • Senior review on every ward	• 0% Outliers • Bed base matches demand by speciality • % Patients managed outside speciality bed base • 95% consultant ward rounds • Discharge performance	Bed base remodelling completed	J Edyvean	

		bed base exceeded and patients need to be cared for in another bed base • Daily consultant ward rounds – prospectively covered • Nurse discharge					
	Create capacity to deal with seasonal variation	• Winter capacity planning and regression analysis • Flexible staffing to manage variation in demand Proactively identify potential discharge delays • Promptly manage delays in discharge • Escalation and risk • Clinical sign off for speciality plans	• Clinical sign off for speciality plans • Winter summer modelling • Divisional discharge group established to manage medical needs • Escalation policy agreed and implemented	• Operating within financial plan • Additional/seasonal capacity matches demand	High level seasonal variation modelled as part of demand and capacity work – this will form part of the winter planning Escalation and ability to flex is being investigated tested	M Harris S Mason J Edyvean	
Discharge and Back door	Improve capacity to minimise occupation of acute facilities when not needed	• Work in partnership with Commissioners so that there is appropriate capacity to meet patient demand • Work in partnership	• Agree SLA/expectation • Review need to establish discharge facility within UHL – develop plans	• Agreed capacity numbers • Utilisation • Criteria meets demand • Application process to access services timely (metrics to be defined)f • Stay in discharge facility • Accuracy of EDD dates	EDD dates to be updates after board rounds Daily lists Ward Matrons supporting wards to prepare day before to ensure early discharge	Matron J Edyvean	 Heavily reliant on partners Unsure of their buy in

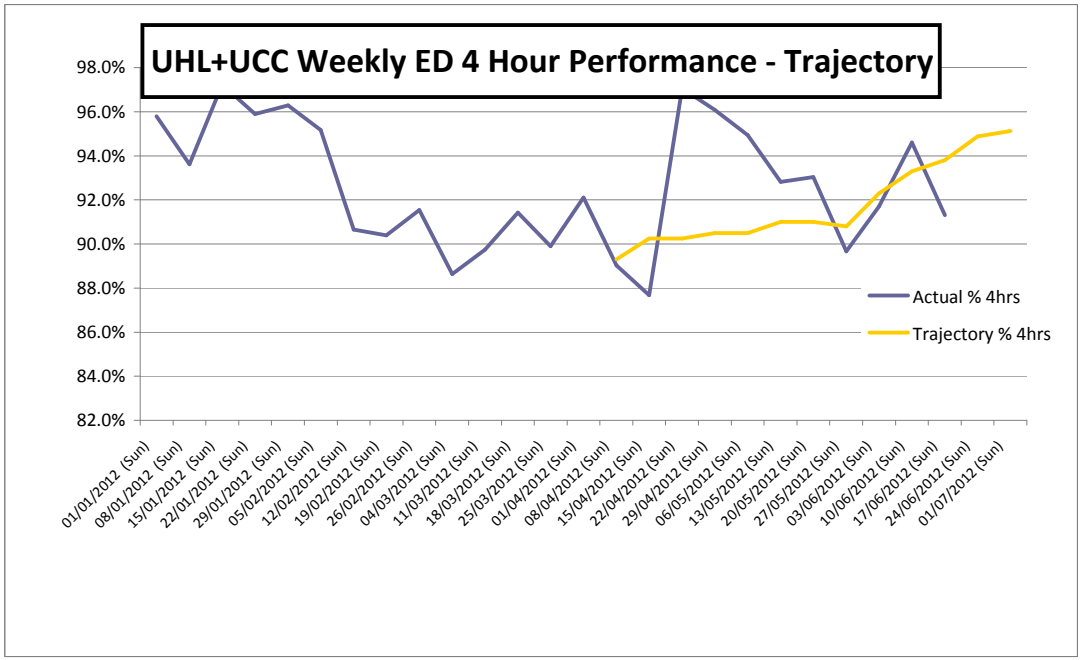
		across the whole health economy to deliver this • Ensure access criteria meets demands • Agree protocol to establish access to admit to community hospitals • Establish a divisional discharge team which directly links to primary care professionals • Establish a concentrated discharge facility with LOS <36hrs stay (if appropriate) • Escalation of delayed discharges to community partners • Review of Choice issues and effective management • Senior medical decision makers/medical review available 7/7		• Discharge letters are received by GPs electronically on the day • No patients moved wards more than twice • No patient is delayed greater than 24hrs in an acute bed • Daily discharge figures set	Establish a plan that defines capacity required in the community. Current work being undertaken to review options to resolve issues of delays in acute beds Plan and timelines to be monitored via steering group and this action plan	Discharge team	

Appendix 3

The whole system	Continuous monitoring of risk and escalation as a means to mitigate risk to promote safety	• Maintain change	• Emergency Steering Group (ESG) with sub-groups ED, Ambulatory care, Tertiary Flows, Discharge flows, Acute Floor and internal waits. • Link to ECN	• Progress against plan • Iterative process • Monitoring long term performance • Involvement across divisions • Linking with external stakeholders	Steering group and working groups established Development fo Emergency Flows dashboard under development to monitor and manage performance	D Skehan J Edyvean	
LLR Partnership working	To provide seamless care across health boundaries To ensure the right care is delivered in the right setting by the right health care professionals.	• The need to be transparent to support delivery • The need to be able to flex resources in response to demand • Minimize delayed discharge	• Establish capacity requirements • Devise action plan/ key contacts/actions/dates and milestones	•	Attendance at various external groups – network, SOG, CCG. Demand and capacity underway will determine requirements from our partners. Separate action plan will be developed, agreed and circulated with partners – Timelines in plan will then be monitored as part of this plan	D Skehan M Harris P Walmsley	 Plan to be agreed Awaiting demand and capacity modelling

UHL ED+UCC 4 HR ACTUAL vs TRAJECTORY

Week Ending	Actual % 4hrs	Trajectory % 4hrs	Attendances	Breaches
01/01/2012 (Sun)	95.8%		4,070	171
08/01/2012 (Sun)	93.6%		3,803	243
15/01/2012 (Sun)	97.2%		3,711	103
22/01/2012 (Sun)	95.9%		3,773	155
29/01/2012 (Sun)	96.3%		3,883	144
05/02/2012 (Sun)	95.2%		3,804	184
12/02/2012 (Sun)	90.7%		3,863	361
19/02/2012 (Sun)	90.4%		4,019	386
26/02/2012 (Sun)	91.5%		4,222	357
04/03/2012 (Sun)	88.6%		4,213	479
11/03/2012 (Sun)	89.7%		4,152	426
18/03/2012 (Sun)	91.4%		4,257	365
25/03/2012 (Sun)	89.9%		4,316	436
01/04/2012 (Sun)	92.1%		4,255	336
08/04/2012 (Sun)	89.0%	89.3%	4,003	439
15/04/2012 (Sun)	87.7%	90.2%	4,017	495
22/04/2012 (Sun)	97.0%	90.2%	3,898	115
29/04/2012 (Sun)	96.1%	90.5%	3,909	153
06/05/2012 (Sun)	94.9%	90.5%	4,008	203
13/05/2012 (Sun)	92.8%	91.0%	4,260	306
20/05/2012 (Sun)	93.0%	91.0%	4,090	285
27/05/2012 (Sun)	89.7%	90.8%	4,335	448
03/06/2012 (Sun)	91.7%	92.3%	4,345	361
10/06/2012 (Sun)	94.6%	93.3%	4,267	230
17/06/2012 (Sun)	91.3%	93.8%	4,035	351
24/06/2012 (Sun)		94.9%	3,900	200
01/07/2012 (Sun)		95.1%	3,900	190



Performance		
Excellent	Acceptable	Poor
G	A	R

EMERGENCY FLOW
Quarter 1 01/04/2012

				Performance				Week ending:												
				Month		YTD		08/04/2011	15/04/2011	22/04/2011	29/04/2011	06/05/2011	13/05/2011	20/05/2011	27/05/2011	03/06/2011	10/06/2011	17/06/2011	24/06/2011
								Week 1	week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
95%	94-95%	<94%	ED 4 hour target		90.4%		89.6%	84.6%	82.8%	95.9%	94.8%	92.8%	90.0%	90.0%	86.0%	88.5%	92.1%	87.7%		
<5%			Unplanned reattendances		6.83%		6.14%	6.76%	6.21%	6.44%	5.2%	6.30%	6.21%	5.54%	5.51%	7.25%	6.18%			
<5%	4-5%	>5%	Left without being seen		2.5%		2.8%	3.0%	3.3%	2.3%	2.6%	2.6%	3.1%	2.6%	3.1%	3.2%	2.3%	2.8%		
<=240	>240		Time in department (minutes) - 95th percentile		330		320	365	367	240	240	284	317	304	336	330	295	371		
<=15	>15		Time to initial assessment (mins)		27		31	35	46	25	28	29	29	32	37	26	19	30		
<=60	>60		Time to treatment (mins) - median		56		49	47	47	42	44	41	49	45	50	63	53	59		
<=360	360-1400	>1400	Maximum time in department		796		1471	1256	1025	713	730	616	889	1471	737	683	736	796		
<= 180 mins			Timeliness of decision making																	
<= 180 mins	180-360	>360	Arrival to bed request		165		173	191	186	162	169	167	175	172	179	175	158	173		
100%			Bed availability																	
< =10 mins	10-30	>30	Request to allocation		35		27	38	41	8	11	14	23	24	38	36	37	32		
<=30mins	30-60	>60	Allocation to departure		35		34	43	34	31	29	34	33	34	39	32	33	38		

ED QUALITY INDICATORS

DEFINITIVE PLAN

FLOW