Trust Board Paper S

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**20 December 2013**
CQC regulation:	**As applicable**

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

Purpose of the Report:
To provide an overview on ED performance.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in November was 88.50%
- Performance year to date is 87.95%
- Emergency admissions continue to increase creating significant capacity problems
- A resilience checklist has been refined for use in the site meetings
- There is an increased focus on non-admitted breaches
- A senior site manager and deputy site manager have been externally appointed with start dates in 2014
- Improvement is still far too reliant on key individuals
- Performance continues to come under considerable external scrutiny.

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)
Yes

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

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REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**20 December 2013**

Introduction

UHL's performance continues to vary against the four hour emergency care measure. Plans for performance improvement including the 'Hub' integrated plan have been updated since the last Trust Board. This report provides an overview of performance for November and December 2013.

Performance overview

In November 2013, 88.50% of patients were treated, admitted or discharged within four hours. This was deterioration in performance from the previous month. December 2013 performance, month to date, (up to and including 15 December 2013) has dropped to 87.56%. Year to date performance is 87.95%.

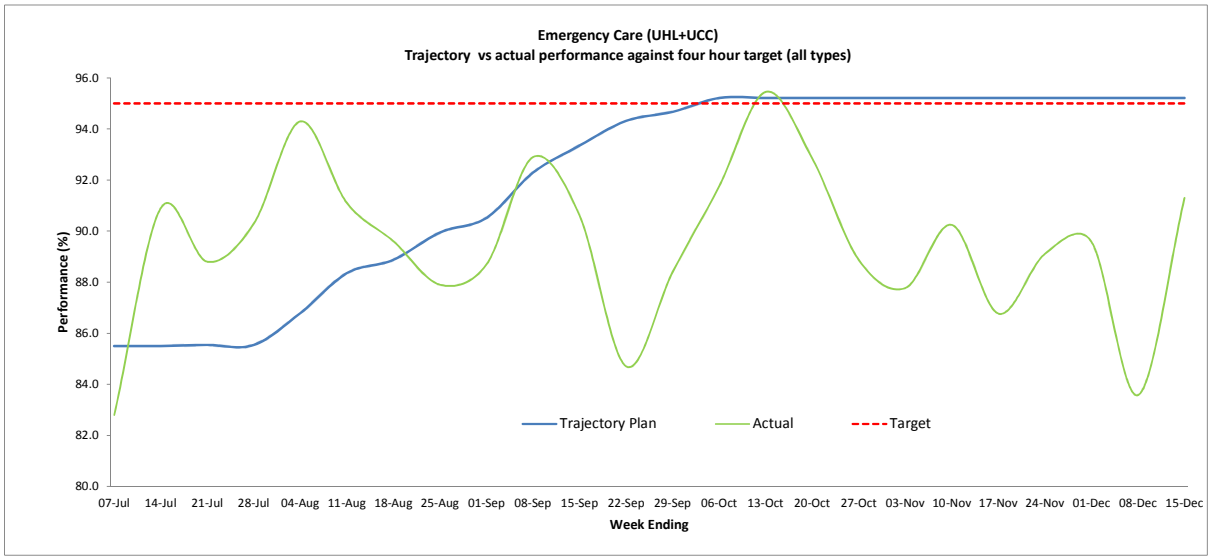

Table one

Key actions

Key actions continue to be taken and are recorded on the 'Hub' action plan attached as appendix one. Particular success is evident in reducing the number and % of non-admitted breaches (table two below). UHL has set a target of no more than five non-admitted breaches per day.

A group of UHL staff visited University Hospitals of Coventry and Warwickshire NHS Trust on 10 December 2013 because UHCW are a trust which has dramatically improved their emergency performance over the last three months. The findings from the visit are attached as appendix two and were discussed with 30 of the most senior clinical leaders at UHL on 16 December. An agreement was made to revisit UHCW the week commencing 23 December with a group of clinical representatives from A&E, the assessment units and medical wards and then UHL will implement trial bronze command cells on 6 January 2014. In addition, plans are being agreed for providing increased staffing numbers on the weekend of 4 and 5 January and elective surgery will reduce across January to increase the number of emergency lists and to reduce the number of on the day cancellations.

		AB	NAB	NAB %
	Q2	3748	1818	33
w/e	03-Nov	326	150	32
	10-Nov	262	126	32
	17-Nov	366	167	31
	24-Nov	293	132	31
	01-Dec	314	107	25
	08-Dec	523	133	20
Days	28-Nov	35	12	26
	29-Nov	34	14	29
	30-Nov	16	2	11
	01-Dec	50	19	28
	02-Dec	88	28	24
	03-Dec	81	14	15
	04-Dec	79	20	20
	05-Dec	70	8	10
	06-Dec	83	28	25
	07-Dec	69	25	27
	08-Dec	53	10	16
	09-Dec	98	23	19
	10-Dec	51	18	26
	11-Dec	26	3	10

Table two

Recommendations

The board are asked to:

- Note the contents of the report
- Acknowledge the continuing focus on sustainably improving emergency care performance.

Action Area Number	Action Area	Lead	Action Reference	Action	Lead Organisation	Lead Individual	Project Support	Completion Date & RAG	Update
			1.1	**Analysis of exclamation orders and rapid feedback to referrers + links to UCC audit of inappropriate attenders**	UHL/GEH/CCGs	Kim Wilding	N/A	Complete	KW has shared the data from the pilot and avoidable data September. This will be shared with practices individually Nov localities for LC CCG. Oct/Nov data is now being reviewed by UCC GP on 13.11. fed back to GPs during the December localities as opposed localities. Audit of GP inappropriate referrals expected on Audit findings being reviewed by KW for feedback to Infl 2/12 Oct/Nov GP-referred majors data reviewed. 35 cases had by ED as possibly inappropriate but the review shows tha were inappropriate. The others were not inappropriate r UHL campus, but were inappropriately in ED. In 16 cases because the GPs were told to send patients to ED due to in capacity elsewhere e.g. Assessment clinic / ward. in 14 ca clear if the GP had spoken to a clinician first. 3 patients w appropriate for ED. This is the second audit that has shown very small numbe inappropriate GP referrals in ED majors and is therefore n to be an issue. However it does identify when there are is
			1.2	**Implementing a 15 min handover times between UCC and ED**	UHL / GEH	Jane Edyvean Kim Wilding	Catherine Free Kim Wilding	Complete	Nursing processes have been agreed by KW and JE. There dedicated porter in the Assessment Bay area. The new nursing process is making a big difference to har As an ongoing measure, a process has been implemented contacts JE in the event of a significant delay for handover Exception reporting process is now in place. No further a required. Exception report relating to Sun 01/12.
			1.3	**Patients referred by GPs in to ED to be triaged through UCC**	GEH	Julie Whittikar	Kim Wilding	Complete	Pilot went live on 28.10.13 for one week using additiona is now completed. A detailed review of data was undertaken on 11/11/13. The second phase pilot will be undertaken from 18.11.13 triage GP referrals through the ED Front Door without an resources. If successful, the process will remain in place. During the second pilot, 72 patients attended with a GP le now being reviewed for discussion at meeting on 2/12. Findings of the reveiw discussed on 2/12. Only 4 patients for self-care. Others were appropriate for UHL campus al there as instructed by other UHL specialty e.g. ENT. There issue of inappropriate GP referrals.
			1.4	**Understand what can be done to improve the issue of patients transferring from UCC following assessment late into the 4 hour pathway**	GEH	Jane Edyvean Kim Wilding	N/A	18.11.13	UCC to ensure that duty manager at UHL called and infor immmediately as and when this happens - this process ha implemented. KW has only ever received one >20minute triage data rep First report received for 1/12/13. Shows 27 x20 min bre 331 transfers to ED. Review shows only 5 were over the target. The remaining 22 were either delayed at transfer to ED o completed the traige in time but needed further consultat assessment. Of the 9 that breached 4 hours on 1/12, the UCC accept th to them. No further information has been shared by UHL with GEH

1	Inflow	Sue Lock	1.5	**Results management out of hours - pathology reporting**	UHL / OOH	Angus McGregor Roy Aston	N/A	30.11.13	Generic use of ICE would assist with this. ICE requesting r primary care are a little over 85% at the moment. We bel telephone number is a part of that requesting process; th have more up to date records of patient information (add number) than the Trust; and that increasing the usage of will improve the quality of the data and in particular ensu patients have the right telephone number linked to the pa request. Access to the patients phone number is the key issue and mandatory field in ICE will resolve this. Pathology are inv A significant proportion of cases will have a phone numbe laboratory computer) already and staff who are phoning provide that number with immediate effect. Pathology have investigated the above by auditing ICE re to find that the proportion of patients for whom the telep known is 99.1%, however the accuracy of these phone nu questionable. Pathology are also reviewing how ICE links Access to ICE for OOH would allow them to view previous If GPs are expecting the results to be high GPs will be aske OOH will provide numbers of Pathology patients flowing UHL will look at numbers of Pathology patients attending Information received from Pathology shows that 85% of Roy to report back to Tim Sacks whether or not the phone S1 access in OOH to be given.
			1.6	**Potential duplication of Clinic 1 and ED front door/UCC or not complimenting as best it could.**	CCGs	Tim Sacks	Roy Aston Kim Wilding	Complete	A meeting occurred on 04.12.13 to discuss how these ser allign. An agreement has been made that mutual aid will be give escalation. This has the potential to benefit 20-25 patient
			1.7	**Consultant triage of GP referrals for medical admission via Bed Bureau.**	UHL	Lee Walker	Sue Harris	Monthly	Lee Walker will continue to provide a monthly update of effectiveness of this at the Inflow Group meetings. A repo data is in progress. Report received from Lee Walker re analysis of figures / i Resultst will be fed back to November localities
			1.8	**Streamlining of cardiology and respiratory admissions via the clinical decisions unit at GGH.**	UHL	Catherine Free Tim Sacks	N/A	Complete	Pathway now written and agreed with UHL. Pathway no EMAS clinical governance forum. Pathway became live on 18.11.13
			1.9	**GP Bounce Back levels are poor from both UCCs.**	GEH	Kim Wilding Angela Bright	Kim Wilding Simon Court	Complete	A review of the '20 minute triage window' for these patie commence at the Inflow meeting on 04.11.13. Completed. In addition, a pilot of the original Bounce Back pathway w date for this is still to be decided. A proposed pilot proces discussed with the UCC CD on 20.11.13. The Bounceback process has been reinstated at the front to be provided at 2/12
			1.10	**There is inconsistency of criteria used WiC/MIU/UCCs to refer into ED.**	CCGs	Angela Bright Sue Lock Tim Sacks	Kim Wilding Simon Court	Complete	CCG COO's provided a review of ED referrals and Bounce well as issues to understand issues. The Merlyn Vaz contract due for renewal next year and th with the UCC SOP.

1.11	**Lack of consistency in implementing EOL Pathway across CCGs.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	Complete	Discussion had at Inlfow Group meeting. UHL feel that nc is required here in order to turn a patient around from wi Primary care work is continuing however. These scheme developed and are being implemented. The impact of the being progressed by the LLR EoL group. The group will n more robustly and share the results at the end of Februar Therefore it is suggested that this is closed.
1.12	**Frequent Flyers**	UHL	Jane Edyvean	TBC	Complete	COOs have confirmed that practices already receive frequ reports via HERA and undertake action where appropriat
1.13	**Batching of calls – EMAS.**	EMAS	TBC	TBC	Complete	This has been investigated and confirmed with EMAS that occur. It is proposed that this is removed.
1.14	**Low % of patients seen by GP prior to presentation at hospital.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	Complete	The three CCG COOs will meet on 25.11.13 to satisfy each CCG is doing all it can within Primary Care to keep patien COOs have discussed this issue. CCGs are focusing on high appropriate pathways to GPs. We do not have informatio this action and require further evidence that we can take discussion. COOs have confirmed that care plans are a priority for ea will reduce the number of patients who are admitted with contact with a primary care clinician.
1.15	**GP – admits earlier in the day.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	~~30.11.13~~ 16.01.13	The three CCG COOs will meet on 25.11.13 to satisfy each CCG is doing all it can to ensure that GPs admit patients e day. COOs have shared details of schemes. City - Emergency R undertaking urgent home visits in the mornings. County Community Paramedics undertaking urgent home visits d working day. CCGs will share referral criteria / learning p impact. For update in Jan 2014. Given that this action has been completed and it is follow needs completing, it is proposed that the date is changed
1.16	**Explore possibility of creating electronic templates in GP clinical systems to support consistent referral information.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	16.12.13	
1.17	**Explore feasibility of x-ray requests via ICE from GP practices.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	16.12.13	
1.18	**Special Patient Notes to be visable by ED, EMAS and OOH**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	31.12.13	

2.1	**Streamline and speed up TTO process**	UHL	Suzanne Khalid	Claire Ellwood David Kearney Kevin Harris Nick Pulman	~~30.11.13~~ 16.12.13	Proof of concept studies with Pharmacist on ward round discharge medication and ensuring appropriate medicati Pharmacist to update ICE letter successfully completed. T rollout of the use of discharge tab on ePMA. This has been very positive and pharmacist input is well r medical staff. Four locums now in place and supporting roll out of disch ePMA. Retraining completed on wards 38, 37, FJ and 19 fo rotation of Junior Doctors. Plan to roll out to 36, IDU, 23, 2 16th Dec, then 29, 30,25, 26 the following week. Plan to c out of discharge tab to base wards by end Dec. Demo to cl IT fix now planned for 12.12.13 with plan to pilot on ward Dec if viable. Progressing recruitment to fixed term posts.
2.2	**Locum inductions**	UHL	Pete Rabey	Rachel Williams	Complete	Handbook developed as well as the process flash cards to Any new locum is left an envelope in the pocket near majo note for the doctor in charge on the daily sheet to induct t this envelope to the doctor. They are allocated a locum EDIS account. Also developed a folder with CV's and feedback on all locu worked in the department and this is then taken to the co meetings for feedback on competency of the doctors. A final review of this process to ensure completeness has This is now complete.
2.3	**Timely Specialty engagement (workshop with specialties to understand the blocks)**	UHL	Andrew Furlong	Sarah Morley	Complete	Successful Specialty/ED engagement workshop held on 8 Hub support). Initial resulting plans for MSK, Surgey, Crit ENT reveiwed on 15/11/13. COMPLETE
2.4	**Progress CMG/Specialty project plans - output from workshop 08.11.13 - gain agreement to progress**	UHL	Andrew Furlong	Sarah Morley	~~15.11.13~~ ~~29.11.13~~ 06.12.13	The HUB did not support the plans going forward due to c further discussed at ECAT 6.12.13. MSK & ENT did not fe take these plans further forward without investment but away to review whether they might be able to introduce a of surgical triage during the working week M-F.
2.5	**Setup Task & Finish Group to monitor, track, measure and report on agreed outputs from workshop.**	UHL	Andrew Furlong	Sarah Morley	Complete	ECAT decision 22.11.13 that ECAT should be the forum fo progress instead of a separate task/finish group.
2.6	**Re-establish communication lines between ED & specialties through a monthly/bi-weekly meeting between ED & HOS to include:** **1. quick wins identified from workshop 8/11/13** **2. review of existing SOPs for accuracy, effectiveness and adherence.**	UHL	Andrew Furlong	Sarah Morley	~~22.11.13~~ ~~06.12.13~~ 03.01.14	Some meetings have been setup but further confirmation outstanding areas required.
2.7	**EDIS to be put into place for identified areas**	UHL	Andrew Furlong	Sarah Morley	Complete	In light of failure of the HUB to support the plans as per 2 longer clear whether EDIS is required. However, will look in the estates work for the surgical triage unit which is no commence until 20.1.14 with a 6 week work period.
2.8	**Walk through ED from ITU Consultant**	UHL	Andrew Furlong	John Parker	~~22.11.13~~ ~~6.12.13~~ 16.12.13	Plan for this to commence w/c 16.12.13 - now confirmed Parker. JP is on call this week and will test the process fo
2.9	**Reconvene daily operational meetings between ED & Specialties to enforce communication and change culture**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	Complete	In view of the feedback from the HUB, we suggest this is r due to lack of resources to take forward
2.10	**Re-establish communication lines between ED & specialties through a month/bi-weekly meeting between ED & HOS**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	Complete	See action 2.6 - merged action point
2.11	**Review existing SOPs for accuracy, effectiveness and adherence.**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	Complete	See action 2.6 - merged action point
2.12	**Radiology availability and rapid access to investigations by ED consultants (avoiding specialty sanction)(Radiologists in ED)**	UHL	Andrew Furlong	Sarah Morley	~~30.11.13~~ 16.12.13	Existing action plan from Radiology still expected to deliv

2	**ED/ Specialty Working**	Kevin Harris	2.13	**Clear ED SOP's and implementation**	UHL	Catherine Free Ben Teasdale		~~15.11.13~~ 22.11.13	All SOPs have been written and reviewed to account for n External comparisons have also been undertaken. 3 SOPs were signed off at ECAT on 22.11.13 fore: - Minors - Assessment - AMU A further SOP was signed off at ECAT on 06.12.13 for: - Majors
			2.14	**Ensure consistent shift by shift ED leadership**	UHL	Ben Teasdale	Jay Banerjee	~~15.11.13~~ 13.12.13	Rotas have been re-organised to reduce exposure of those cope with high levels of pressure. Date has been extended to reflect development of actions sustainability. A SOP is being written that includes a chec measurable actions on behalf of the doctor in charge and SBAR concept to maintain safety in the department and a escalation plan to reduce variation under these extreme c will go to ECAT for sign off by end of November. Coaching plan for specific individuals has been developed will commence in December. MD to review first draft of SOP with Ass Director of QI. Meeting with consultant to agree objectives for coaching.
			2.17	**Engagement with services that have wider capacity issues – Critical care, theatre capacity for emergency surgery, out of hours capacity etc. –(link to specialty discussions)**	UHL / CCGs	Andrew Furlong	Sarah Morley	Complete	Gen surgery have produced a short business case for SAU along similar lines to LRI MAU. Now ro be linked to action following speciality workshop. T&O have also produced plan for increased senior decisio through from ED to # clinic assessment area. **19.11.13 UPDATE** - Suggest that this is removed as cove action points. In addition, timeframe for rapid improvem suggests ability to have a reasonable impact as a separate limited. Business plans to be submitted from the specialt improve capacity issues within the specialties in order to improved flow and process with ED.
			2.18	~~**Robust ED medical staffing**~~ **Undertake fundamental review of ED activity and capacity and medical processing power**	UHL	John Adler/Catherine Free/Ben Teasdale	Tim CoatsRachel Williams	~~15.11.13~~ ~~06.12.13~~ 15.01.14	Plan revised to include fundamental demand and capacity basing of establishment and ongoing recruitment plan. N template developed to highlight gaps and relationship to prospective and retrospective versions reported weekly a address issues in real time. Initial KM&T work based oin Leeeds model indicates sign proceccing gapa at junior trainee level. in house model n populated against CEM and UHL productiviity standards t 80th percentile demamd. Initial results will be avalable b Christmas.
			2.19	**Specialty referrals being routed through ED + adherence to SOP's**	UHL	Andrew Furlong	Sarah Morley	Complete	KW and PW met and initiated new process. Any declines referrals will be raised with duty manager. Any referrals to ED from UCC will be marked as such on S In relation to the SOPs being adhered to, AF is reviewing believe these need to be looked at from GP, UCC and othe referrals. A.Furlong reviewed SOPs prior to the meeting on 08.11.1 Inflow group to set up monitoring process/data set to mo have report for their referrals and KW to speak to Simon Loughborugh UCC to ensure they can utilise the same rep Complete as per the above detail - outstanding SOP revie now detailed elsewhere. **AF UPDATE 19.11.13** - Suggest this is now merged with workstream in action 2.11 above.

			2.20	**Implement new discharge focussed approach to rounds**	UHL	Catherine Free	Lee Walker	31.12.13	New approach to weekend discharge rounds at LR impler improve flow rate.
3	**Ward Practice**	Rachel Overfield	3.1	**Liberating nursing time - Keeping senior nurses in clinical areas for the next month (no meetings)**	UHL	Rachel Overfield	Julia Ball	Completed	This is now operational and will be monitored for effectiv Complete Ward Managers/Matrons returned to wards full time fror
			3.2	**Establish Ward round – baselines - rapid improvement (using exemplar wards)**	UHL	Andrew Furlong Julia Ball	Julia Ball	Complete	Audit completed. Mixed picture. New standards drafted a out for comment (8/12). A further action has been developed as per 3.19.
			3.3	**Prevent computers hibernating – action now**	UHL	John Clarke	Jane Edyvean	Complete	Completed
			3.4	**Management plan for all patients transferring to community hospitals (and GP letters)**	LPT	Jude Smith	Julia Ball	~~15.11.13~~ 01/12/13	agreed can link medical/nursing handover IT solution to tracker.
			3.5	**Minimum data set for transfer information / avoidance of re-clerking**	LPT	Jude Smith	Julia Ball	~~15.11.13~~ 01/12/13	As above
			3.6	**Expedited recruitment – increase of HR expertise to increase pace (recent significant increase in nursing establishment following workforce and skill mix review)**	UHL	Kate Bradley	Elenour Meldrum (Nurse) TBC (HR)	31.12.13	Recruitment action plan in place and progressing as expe 100 overseas nurses offered posts to start in January, mo recruitment planned. Over recruiting to HCA posts. week commencing 11 November 538 nursing posts vacar
			3.7	**Discharge / transfer checklist**	UHL	Rachel Overfield	Julia Ball	Complete	Transfer checklist reviwed. Meeting with Mandy Gillespie off. Roll out via matrons next week (11.11.13) District nu nuse referral letters /drug authorisation letter now all av and this will replace where possible all paper versions by November. Ann Hall supporting access to ICE /ICM and tr medical ward sisters and matrons . Will be completed by
			3.8	**Access to equipment**	UHL	Rachel Overfield	Releasing Time To Care Team	~~15.11.13~~ 01.12.13	Equipment list now available, pending funding approval. agreed. Details of equipment to be agreed this week. Agre computers on wheels will have biggest impact. Order plac Equipment purchase agreed and being purchased.
			3.9	**Ward clerk resources**	UHL	Rachel Overfield	Rachel Overfield	~~15.11.13~~ 01/12/13	Induction/training programme being finalised Funding a be confirmed re posts later this week. Aim to have in post November. Recruitment slipped - in post mid december.

			3.10	**Facilities engagement in roles and responsibilities over meal times**	UHL	Rachel Overfield	Releasing Time To Care Team	~~15.11.13~~ 31/12/13	LiA events taken place on all three sites. Clear plans for in Will not be a quick solution. Action should come off this p
			3.11	**Environment for Medical teams to work at ward level (including IT)**	UHL	Rachel Overfield	Releasing Time To Care Team	~~15.11.13~~ 01/12/13	link to action 3.8 . CMG are working thorugh plans for eac wards have identified quiet space for doctors but signage improved. Not considered a big issue now.
			3.12	**Consistency of practice and protocols across wards**	UHL	Rachel Overfield Andrew Furlong	Julia Ball	15.11.13	Audit current practice against internal professional stand audit along side 1.2 This workstream to be combined wit foward.
			3.13	**Recruit discharge cleaning team - releasing 40 minutes of nusing time for every discharge bed space cleaned.**	UHL	Rachel Overfield	Julia Ball	01.12.13	Interserve asked to provide source. Weekly to take too lo therough contract variation process therefore Bank HCAs first two months. 8:00 am - 8:00 pm cover at LRI/LGH - i December 2013. rapidly recuyiting but likley to be mid de
			3.14	**Review of roles and responsibilities of who can discharge (including confidence and competence)**	UHL	Pete Rabey Nursing Lead (TBC)	Julia Ball	15.11.13	All discharge work in UHL reviewed at a meeting w/c 04. and Finish group to meet Monday 18th Novemeber. Meet matrons and sisters in medical CMG to take plavce with R Thursday/Friday next week . Discussed with nursing exe has now commenced.
			3.15	**Communication to patients - setting expectations at point of admission**	UHL	Pete Rabey	Ann Hall	Complete	Letter A approved for issue to all in patient s on admissio stating discharge expectations. Thjis is available on all w included in nursing metrics. Also checked on daily census
			3.16	**Implementation of a functional patient census used consistently, twice every day**	UHL	Rachel Overfield	Julia Ball	30.11.13	Twice daily census meetings now working well Daily repo produced for all Daily feedback to ward teams to raise st
			3.17	**External agencies to feed into the patient census and use the information to pull any patients out of UHL on a daily basis.**	UHL	Rachel Overfield	Julia Ball	30.11.13	Daily census feedback to teams and all teams communica
			3.18	**Protocols and procedures for the patient census to be written.**	UHL	Julia Ball	N/A	30.11.13	Procedures and policies in draft
			3.19	**Agree action plan to improve ward round processes.**	UHL	Julia Ball	N/A	20.12.13	Standards drafted for circulation for comment. Coaching continues to improve communication through Nursing , Andy Jones and team.
			4.2	**Review and improvement to bed bureau process Ensure one process is in place for allocating beds at UHL**	UHL	Phil Walmsley	Helen Mather	Complete	Some changes implemented but date extended to incorpo extensive process improvements- screens now in place
			4.3	**ED process - lots of just do it issues : telecoms, IT (including IT passwords), equipment**	UHL	Jane Edyvean	Ann Hall	Complete	Complete.
			4.4	**Fully staffed site management team and bed coordinators team**	UHL	Phil Walmsley	Helen Mather	~~30.11.13~~ 02.01.14	Date changed to note staff in post/ change of detail in acti Assessment centre next week. We are confident some sta immediately. **Nb- this is not a significant delay but is a critical action.** All interviews complete and all roles appo
			4.5	**Non clinical vacancies recruited to with staff in post**	UHL	Jane Edyvean	Rachel Williams	~~30.11.13~~ 02.01.14	Date changed to note staff in post/ change of detail in acti vacancies has been placed. Currently covered through ba
			4.6	**Review protocols for discharge lounge - re – trollies**	UHL	Richard Mitchell	Phil Walmsley	Complete	Protocal written. Appropriate patients transferred to the lounge.
			4.7	**Minor estates work discharge lounge**	UHL	Richard Mitchell	Phil Walmsley	Complete	Minor estates work required to increase scope of patient discharge lounge
			4.8	**Investigate the feasibility for UHL to open an additional 24 beds at LGH.**	UHL	Richard Mitchell	Phil Walmsley	Complete	Completed. Not Feasible.
			4.9	**Meeting to review impact of FOPAL changes on admission rates**	UHL / CCGs	Simon Conroy Spencer Gay	Catherine Free	30.11.13	There is now a service on EFU and AFU providing more el assessment facility than was available previously. There h LPT/UHL geriatrician appointments recently but recruitn additional posts is not possible at present.
			4.10	**Meeting to agree the subcontracting of elective activity**	UHL	Richard Mitchell	Sarah Taylor	Complete	Agreement made to outsource work whilst plan to increa capacity and reduce backlog agreed.
			4.11	**Opening of additional assessment unit capacity and benefits fully realised**	UHL	Catherine Free	Jane Edyvean	Complete	16 Beds opened.
			4.12	**Additional Decanting space via converting daycase unit into an inpatient unit.**	UHL	Richard Mitchell	Sarah Taylor	Complete	Major estates work complete
			4.13	**Completion of capacity modelling**	UHL	Richard Mitchell	John Roberts	Complete	Complete and shared with Emergency Care Hub, UCWG. F received and meeting being organised to discuss modellir with Dave Briggs
			4.14	**Ensure consistent use of the outlier list**	UHL	Richard Mitchell	Helen Mather	Complete	Outlier list is compiled as part of the discharge conferenc medical wards and via the CMG is for all other wards. Thi at 1400 and 1700 site meetings.

4	**Operational**	Richard Mitchell		4.15	**Increased use of discharge lounge for patients who do not need to be on a ward- learning from LTH**	UHL	Richard Mitchell	Jane Edyvean	Monthly	Patient suitable for the discharge list are discussed at eac
				4.16	**Improve patient signage in ED- learning from LTH**	UHL	Jane Edyvean	Gill Staton	02.01.14	Estates and ED team are now working on plans. Agreed a
				4.17	**Review of internal escalation process**	UHL	Richard Mitchell	Phil Walmsley	30.11.13	Meeting with HM 7/11/13. Escalation plan being reviewe
				4.18	**Appoint to senior site manager post**	UHL	Richard Mitchell	Richard Mitchell	31.01.14	JD writtten, candidates contacted. Interviews planned for 2/12/12 **Nb- this is not a significant delay but is a miss action** Candidate appointed
				4.19	**Appoint to substantive SMOC posts**	UHL	Richard Mitchell	Richard Mitchell	31.01.14	JD written. Now advertising. **Nb- this is not a significant mission critical action**
				4.20	**Review best clinical and physical location for patients awaiting beds**	UHL	John Adler	Richard Mitchell/ Rachel Overfield	30.11.13	Discussed at ECAT 15-11-13. Further discussions to be h decision paper to ECAT on 29-11-13. Discussion at the ECAT identified that there are no safe al locating patients away from ED whilst they await medical
				4.21	**Explore ways for greater exec leadership in site meetings and out of hours**	UHL	Richard Mitchell	Richard Mitchell	Monthly	COO or CN attend, when possible, every site meeting.
				4.22	**Refocus on zero minors breaches**	UHL	Richard Mitchell	Jane Edyvean	Monthly	This is checked at every site meeting and disciplinary wai shared
				4.23	**Refocus on minimal non-admitted breaches**	UHL	Richard Mitchell	Jane Edyvean	Monthly	This is checked at every site meeting and disciplinary wai shared. New escalation process is in place
				4.24	**Ensure set agenda in site meetings is adhered to and new resileince checklist being implemented.**	UHL	Richard Mitchell	Helen Mather	Monthly	COO or CN attend, when possible, every site meeting.
				4.25	**Introduce 24/7 escalation process for threatened, non-admitted breaches.**	UHL	John Adler	Richard Mitchell	Monthly	Revised policy sent out on 28 November ensuring that all non-admitted breaches are escalated through to the CEO 24/7.
				4.26	**JA to chair meeting with all heads of speciality/ service and CMG directors to reconfim expectations for speciality involvement in the emergency pathway**	UHL	John Adler	Richard Mitchell	Complete	Meeting chaired
				4.27	**Implement a bronze level of consultant command with four cells; ED, assessment units, medical base wards, all other specialities**	UHL	Richard Mitchell	Richard Mitchell	~~18.12.13~~ 6.1.14	Each cell nominates a named consultant to work between 0 week day to be a point of contact for decision making, expe discharges, keeping flow going etc. The day may be split int consultant does not necessarily need to be supernumerary b to be the focal point for their cell's activity without other du them- Learning from UHCW
				4.28	**The four bronze commanders above, senior medical colleague eg KH, AF etc and RM meet daily at 0800 to review position and agree on plans to get patient flow going.**	UHL	Richard Mitchell	Richard Mitchell	~~18.12.13~~ 6.1.14	Learning from visit to UHCW
				4.29	**If GP bed referrals come to ED because of bed pressures, the patients remain the responsibility of medicine, and medicine provide support for them.**	UHL	Richard Mitchell	Catherine Free	~~18.12.13~~ 6.1.14	Learning from visit to UHCW
				4.3	**When a specific trigger point is met eg 150% of maximum patients in ED, on call consultant comes in to assist irrespective of clinical commitments tomorrow.**	UHL	Richard Mitchell	Catherine Free	23.12.13	The incentive is to resolve issues in hours other than out Learning from visit to UHCW
				4.31	**Trial Super Saturday and Sunday first weekend in January**	UHL	Richard Mitchell	Andrew Furlong	05.01.14	Paper going to ET and ECAT this week
				4.32	**Amend site report to show capacity gap more clearly and to state the number of discharges required per area**	UHL	Richard Mitchell	Phil Walmsley	Complete	Learning from visit to UHCW
			Mental Health	5.1	**Mental health assessment and crisis response - matching of capacity and demand – immediate actions**	LPT	Jim Bosworth Debi O'Donovan	N/A	30.11.13	Pathway now written and agreed between LPT and and G
				5.2	**Community hospital and Mental Health inflow (talk to consultant in ED first)**	LPT	Jim Bosworth Debi O'Donovan	N/A	30.11.13	As 5.1
				5.3	**Set number of CH transfers at 9am daily – pre book Arriva for immediate transfer ***	UHL / LPT	Phil Walmsley Rachel Bilsborough	Rachel Bilsborough Nikki Beacher Hospital Matron tbc	Complete	Whilst the process was deliverable - 4 patients per day w acheivable and on review was agreed that resources wou used from 11am. But patients ready for transfer should b discharge lounged to enable propt transfer from 11 am

5	**Multi-agency Integration**	Jane Taylor	Use of Community Hospital Capacity	5.4	**24 additional rehab / step down beds at LPT 12 at Loughborough and 12 at LGH.**	LPT	Rachel Bilsborough	Rachel Bilsborough	15.11.13	All City beds are open, all additional Loughborough beds ; ICS have 48 in West, 24 in East with another 24 being op week, City have 16 with two being opened every week un 24.
			Integrated Discharge	5.5	**Single integrated discharge team ***	CCGs	Jane Taylor	Tracy Yole	Complete	
				5.16	**Define operating protocols for the Integrated Discharge Team**	CCGs	Jane Taylor	Tracy Yole	20.12.13	
				5.6	**Directory of Services – knowing what's available**	CCGs	Jane Taylor	Tracy Yole	31.12.13	EOL update - see 5.12 and 5.15
			CHC and Care Homes	5.7	**Expediting CHC decisions***	LA	Jackie Wright Helen Manning	Alison Cain	Complete	
				5.8	**Expediting discharge whilst waiting dispute resolution and facilitation of discharge to assess continuing health needs**	LA / CCGs / GEM	Jackie Wright Helen Manning	Alison Cain	~~30.11.13~~ 31.03.14	Strategy meeting arranged for the 18th December to revi D2A provision. CCG DM have met with GEM - the out come is for GEM to p proposal for provision of an end to end CHC service, D2A site, provision of fast track.
				5.9	**Care homes and protocol for falls management**	LA / CCGs / GEM	Jackie Wright Helen Manning Caroline Trevethick	Jane Taylor	30.11.13 25.12.13	Follow up meeting on 9th Dec re falls decision tree and cl Draft to be circulated and further meeting with stakehold for the 17th Dec.
			EOL	5.10	**Expansion of capacity of existing EOL service to result in 3 EOL patients per day to be discharged.**	CCGs	Tracey Yole	N/A	Complete	Links with 5.6 New pathway proposed and being refined this week. Wo receiving 1-2 EOL patients per day within exisiting resou
			Choice	5.11	**Withdrawn choice for Rehab location – agree protocol to avoid expectation of choice for next step care. UCWG to sign off next week**	UCWG / UHL	Kevin Harris Richard Mitchell Azhar Farooqi Nick Pulman Hamant Mistry	Julia Ball	Complete	
				5.17	**Monitor issuing of letters via patient census**	UCWG	Azhar Farooqi Nick Pulman Hamant Mistry	N/A	20.12.13	No choice letters issued this week
			EOL	5.12	**Review of end of life pathway**	CCGs	Jane Taylor	Tracy Yole	31.12.13	Developed from 5.6 pathway has been updated to define EOL and paliative ca Access to the EOL team now 7/7 and available to all ward single contact phone number. New pathway to be circula and the cheif nurse bulletin. The patient census t/c are also supporting coaching of wa of process application.
			Reducing discharge delays out of UHL and LPT	5.13	**Establish external partner discharge group**		Jane Taylor		Complete	Group established further meeting on the 12th Dec - actio other points
				5.14	**Utilisation of the daily patient census report to focus partner actions**		Jane Taylor	Julia Ball	31.12.13	Informaiton being received- quality is improving daily wh increasing the ability to focus on those over 48 hours of b fit. Data is being collected to enable review of impact of a
				5.15	**Same day provision of community equipment for UHL discharges**		Jane Taylor	Julie Morley	31.12.13	Negotiation for same day delivery and 7/7 working arran been agreed and started - the weekend cover will comme weekend. Additional staff to undertake ording has been ic training sue to be undertaken this week to support weeke

RAG Status Key:	
5	Complete.
4	On Track / Delivered with continuing monitoring.
3	Slight delay to delivery but within a reasonable tolerance level and a risk of not being completed as planned. Any action with a delayed
2	Significant Risk or Issue or Deadline already missed – unlikely to be comp
1	Not yet commenced.

Top ten learning from University Hospitals Coventry and Warwickshire NHS Trust/ Reflection on UHL

1. Partnership working between senior clinicians in different specialities is insufficient. We need a 'call to arms' noting the importance of closer working. **Action- JA to chair meeting at 1730 on Monday 16 December for all heads of speciality/ service and CMG directors to attend with quick drink afterwards.**
2. Operational decisions to support emergency flow are too dependent on junior administrators, managers and nurses. Clinicians rarely attend site meetings. **Action- RM implement a bronze level of command with four cells; ED, assessment units, medical base wards, all other specialities.** Each cell nominates a named consultant to work between 0730- 1800 each week day to be a point of contact for decision making, expediting discharges, keeping flow going etc. The day may be split into two. The consultant does not necessarily need to be supernumerary but must be able to be the focal point for their cell's activity without other duties distracting them. **This is the biggest change that UHCW made with immediate benefits.**
3. There is insufficient pace to decision making early in the morning. Action- **The four bronze commanders above, senior medical colleague eg KH, AF etc and RM meet daily at 0800 to review position and agree on plans to get patient flow going.**
4. When the wards cannot directly take GP bed referrals they are routed to ED but there is no further support for the ED team. **Action- if GP bed referrals come to ED because of bed pressures, the patients remain the responsibility of medicine and medicine provide support for them.**
5. At times of difficulty out of hours, ED are left too much to get on with it. **Action- when a specific trigger point is met eg 150% of maximum patients in ED, on call consultant comes in to assist irrespective of clinical commitments tomorrow. The incentive is to resolve issues in hours other than out of hours.**
6. Duty management team is not strong enough with too much variability between individuals. **Action- senior site manager recruited, deputy site managers being recruited and team will be overhauled.**
7. Processes at weekends are weak compared to midweek with too few discharges. **Action- super Saturday and Sunday planned for first weekend in January. AF leading on this.**
8. Site report doesn't clearly articulate the number of beds required each day. **Action- RM to amend site report to show capacity gap more clearly and to state the number of discharges required per area**
9. Function of site meetings remains inconsistent linked into # 5. **Action- RM to send an email to UHL bed state group reminding them of expectations.**
10. Still unclear about the functionality of ward rounds. UHCW have a 'Mr Ben' ward round in which a senior member of staff will visit a specific ward to spot check on the actions from the ward round. Information is shared. **Action- discuss at ECAT.**
11. Non-admitted breach escalation is too dependent on the SMOC. **Action- JA and RM to review process.**