| | |
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| **To:** | **Trust Board** |
| **From:** | **Richard Mitchell, Chief Operating Officer** |
| **Date:** | **25 July 2013** |
| **CQC regulation:** | **As applicable** |

**Title:** Emergency Department Performance Report

**Author:** Jane Edyvean, Emergency CBU Manager

**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:**

- June saw deterioration in performance from 85.5% (Type 1 and 2 activity) to 81.59%, in-month. When combined with the Urgent Care Centre (UCC) performance fell from 88.7% to 85.27%.
- Performance year to date stands at 81.4% (0.1% difference) and 85.3% (unchanged from previous month) respectively
- UCC diversion rates fell in June totalled 659, the lowest over the last 4 months.
- The Single Front Door' pilot has started, 17 July 2012.. All adult walk-in patients are now directed through the UCC. Regular progress reports and conference calls are in place to monitor performance
- ED saw 532 more breaches in June than in May despite a reduction in attendances of 221. When compared to other East Midlands Acute Trusts UHL saw the second highest number of average attendances and dropped to become the worst performer against the 4hrly target.
- Early June saw performance above the agreed trajectory however since then performance has fallen below expected levels with only a degree of recovery in the last week of the month.
- 2 out of the 5 quality indicators have been achieved.
- ED attendance rates shows an overall percentage change in activity of -0.8%
- Performance has come under considerable external scrutiny over recent weeks. The NTDA require daily reports on performance and hold weekly conference calls to offer advice and support

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

**Previously considered at another UHL corporate Committee N/A**

| | |
|---|---|
| **Strategic Risk Register**<br>Yes | **Performance KPIs year to date**<br>Please see report |

**Resource Implications (eg Financial, HR)**
Additional staffing has been required throughout the acute pathway to support improved flows

**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

**REPORT TO:** **TRUST BOARD**

**REPORT FROM:** **RICHARD MITCHELL – CHIEF OPERATING OFFICER**
**JANE EDYVEAN – EMERGENCY CBU MANAGER**

**REPORT SUBJECT:** **ED PERFORMANCE REPORT**

**REPORT DATE:** **19 JULY 2013**

## 1.Introduction

UHL continues to struggle to achieve the 4-hour emergency care target and other quality indicators. Internally we continue to work on implementing new processes to improve waiting times and the experience of our patients. To date however performance has shown variable degrees of improvement against the 4 hour target . In June 2013 The Urgent Care Board for Leicester, Leicestershire and Rutland, chaired by NHS England's David Sharpe, agreed a plan of further radical actions to help the Trust move beyond the current poor level of performance. The plan was endorsed by NHS partner agencies as a way to rapidly improve the 4-hour wait target, reduce waiting times and improve the patient experience.

In June 2013, UHL saw a variable performance from day to day and saw deterioration in performance in-month to from 85.5% (Type 1 and 2 activity) to 81.59%. When combined with the Urgent Care Centre (UCC) performance fell from 88.7% to 85.27%. Performance year to date stands at 81.4% (0.1% difference) and 85.3% (unchanged from previous month) respectively.

The factors previously reported as impacting on performance continue to be addressed through targeted actions overseen by the weekly Emergency Care Action Team (ECAT). As previously reported, the demand for bank and agency staff continues to ensure adequate staffing levels to deliver the revised emergency care processes. The requirement for additional capacity beds to remain open remains unchanged.

This report provides details for the current level of performance for June 2013. It also provides an overview and update on actions being taken to respond to ongoing concerns and external scrutiny of performance.

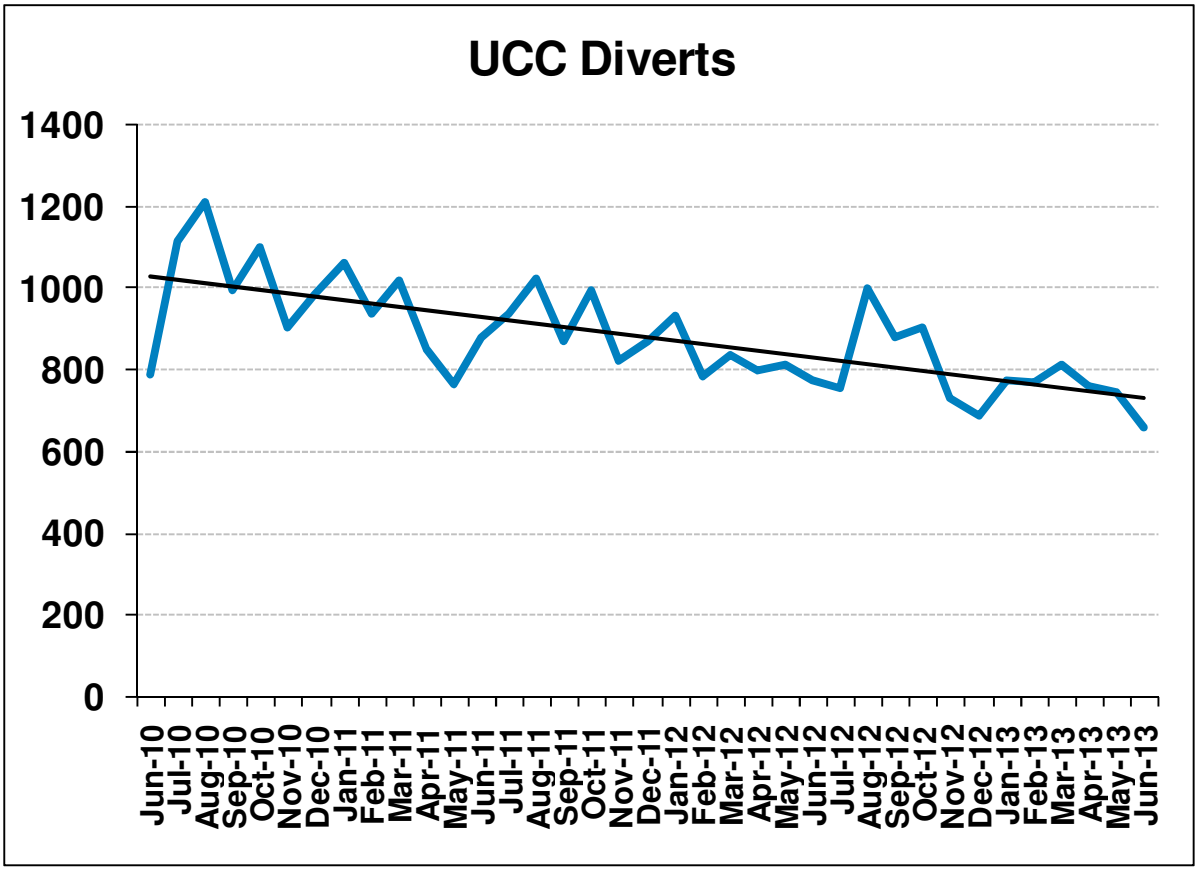
## 2. Current Activity and Performance

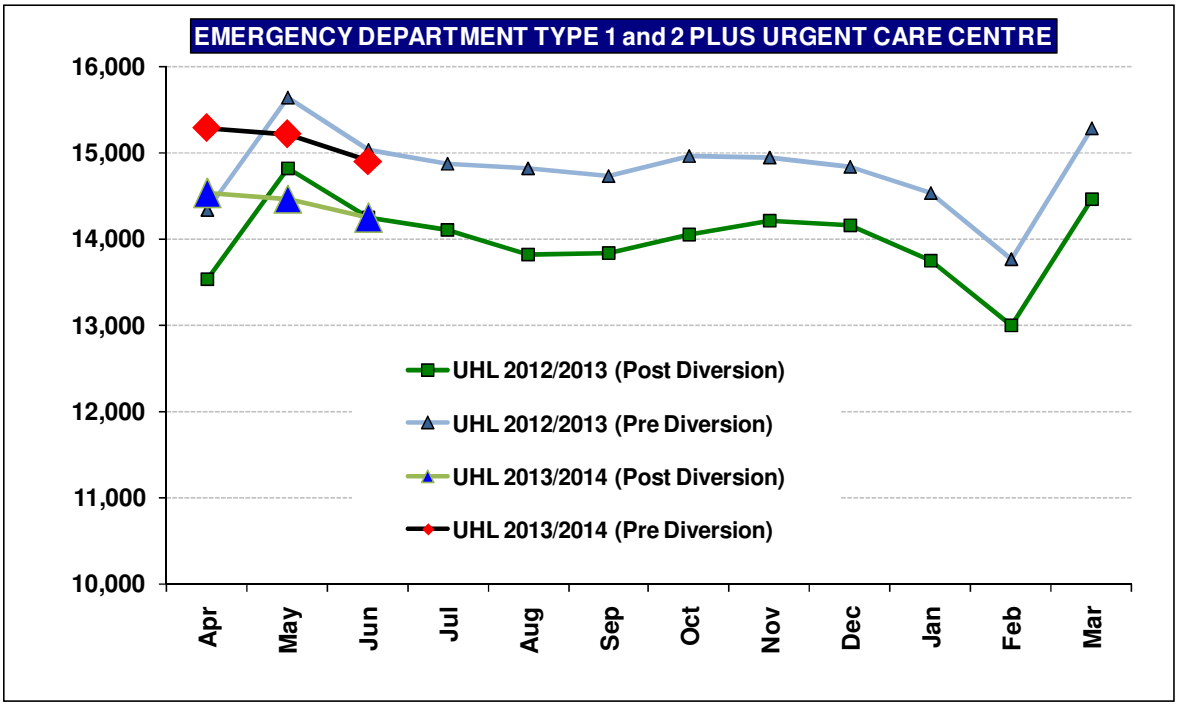
### 2.1 Attendances rates and Diversion rates.

In the previous month, May 2013 it was reported that the overall activity trend had reverted back to a reduction in overall activity against the same period for 2012/13. In June this trend continued although the reduction was less than seen in May and had reduced from a 2.7% to 0.8% decline in activity. The number of patients diverted to the UCC during June totalled 659, falling below the numbers diverted in the previous 4 months. In percentage terms the percentage change is minimal (0.48%). Further details are provided below:

| 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) | UHL 2013/2014 (Post Diversion) | UHL 2013/2014 (Pre Diversion) | Overall % Change 13/14 vs 12/13 |
| Apr | 14,117 | 14,117 | 13,507 | 14,358 | 13,532 | 14,332 | 14,527 | 15,287 | 6.7% |
| May | 14,574 | 14,574 | 13,871 | 14,636 | 14,819 | 15,633 | 14,465 | 15,211 | -2.7% |
| Jun | 13,509 | 14,298 | 13,318 | 14,197 | 14,248 | 15,022 | 14,244 | 14,903 | -0.8% |
| Jul | 12,983 | 14,100 | 13,075 | 14,014 | 14,107 | 14,860 | | | |
| Aug | 12,544 | 13,757 | 13,086 | 14,109 | 13,815 | 14,817 | | | |
| Sep | 12,726 | 13,720 | 13,270 | 14,142 | 13,839 | 14,719 | | | |
| Oct | 12,918 | 14,022 | 14,002 | 15,000 | 14,051 | 14,955 | | | |
| Nov | 13,057 | 13,963 | 13,226 | 14,051 | 14,201 | 14,933 | | | |
| Dec | 13,500 | 14,488 | 13,291 | 14,162 | 14,150 | 14,839 | | | |
| Jan | 12,830 | 13,893 | 13,260 | 14,196 | 13,751 | 14,528 | | | |
| Feb | 12,263 | 13,202 | 12,978 | 13,762 | 12,985 | 13,754 | | | |
| Mar | 14,100 | 15,119 | 14,884 | 15,719 | 14,458 | 15,273 | | | |
| Sum: | 159,121 | 169,253 | 161,768 | 172,346 | 167,956 | 177,665 | 43,236 | 45,401 | |

In June, 87 fewer patients were diverted to the UCC against 14 fewer in the previous month continuing the steady downward, declining trend:



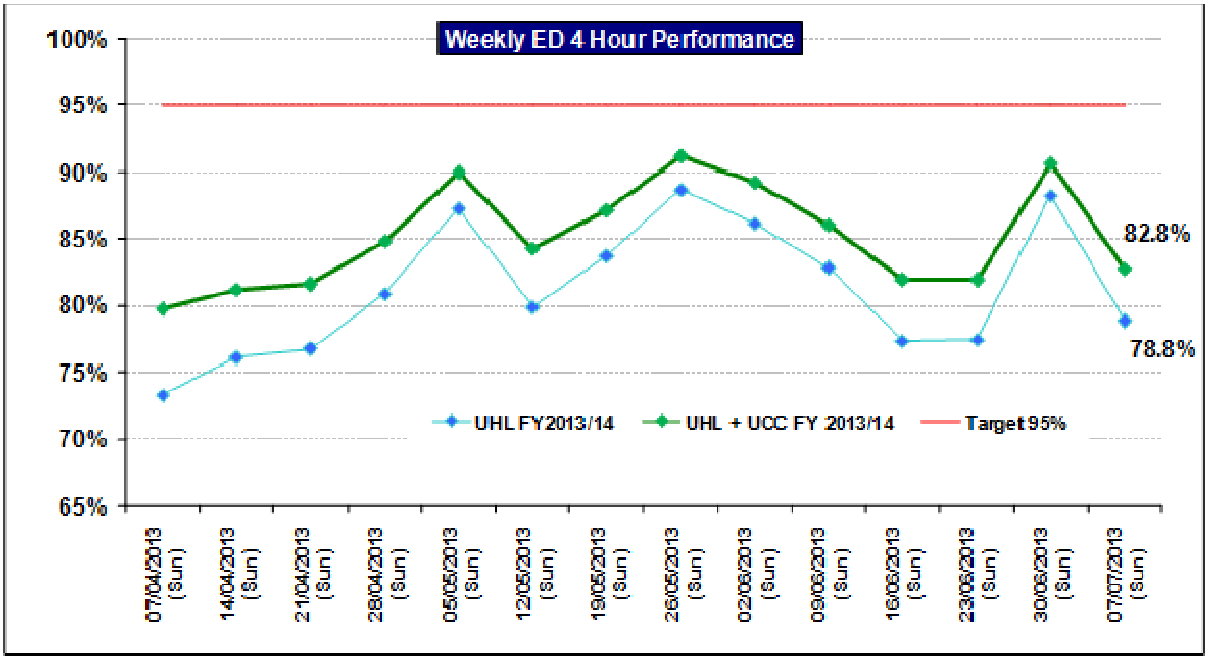

In response to this situation and as one of the radical actions agreed by the Emergency Care Board we have been working with our partners in the CCG's to redirect all adult walk-in patients through one new 'Single Front Door' located in the Urgent Care Centre (UCC). Not only is this aimed at improving deflection rates it is also anticipated that it will have benefits in reducing overall demand, mitigating risks associated with overcrowding and most importantly enhancing patient experience. The new process went live on 17th July 2013 . It

is intended that this new model will operate 24 hours a day, 7 days a week. The model accelerates implementation of the proposals described in earlier reports to develop a Single Front Door. Evaluation will be undertaken throughout the trial period.

### 2.2 4-Hour Performance target

Daily performance against the emergency 4 hour target remains variable with the Trust in month falling short of the trajectory for improvement. Overall performance is stated as 81.6% for UHL and 85.27% when figures for UHL and UCC are combined.

**ED and UCC to Week Ending Sunday 7th July 2013**




**Jun 12**

| Site | Type | Atts | Breaches | % < 4 hr |
|---|---|---|---|---|
| UHL | Type 1 + 2 | 14,244 | 2,623 | 81.59% |
| Urgent Care Centre | Type 3 | 3,593 | 5 | 99.86% |
| UHL + UCC Total | All | 17,837 | 2,628 | 85.27% |

**Quarter 1**

| Site | Type | Atts | Breaches | % < 4 hr |
|---|---|---|---|---|
| UHL | Type 1 + 2 | 43,236 | 8,056 | 81.37% |
| Urgent Care Centre | Type 3 | 11,642 | 9 | 99.92% |
| UHL + UCC Total | All | 54,878 | 8,065 | 85.30% |

For the month of June 2013, ED saw an increase in the number of breaches to 2,623 (type 1 and 2) which is 532 more than in the previous month, despite a reduction in attendances of 221 presentations to ED. Part of this can be explained by the lack of outflow on a number of occasions into the medical bed base.

As of 7th July 2013, UHL had the second highest number of average daily attendances when compared with East Midlands Acute Trusts but had dropped to become the worst performer against the 4 hour target. When ranked against other large Acute Trusts, UHL is consistently one of the poorest performers and is the lowest when ranked against all other Trusts (143 out of 145 Trusts).

**A&E recent weekly Throughput and Performance: East Midlands Acute Trusts**

Week Ending: 07/07/2013

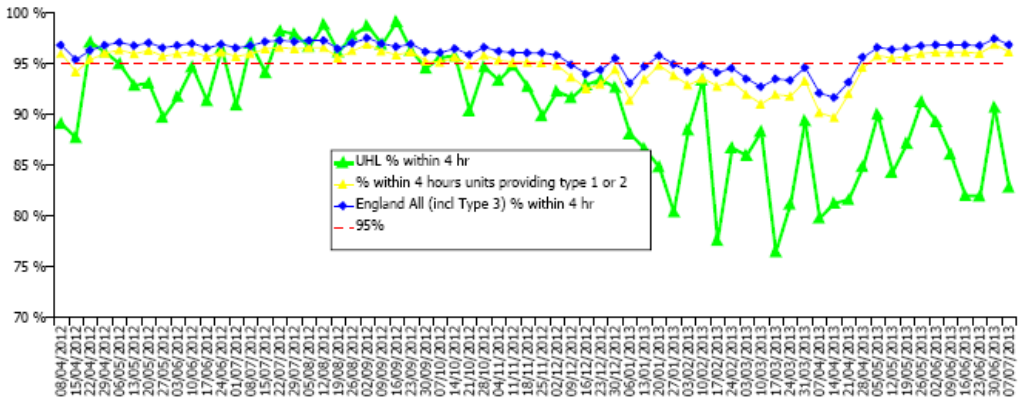
| Org Code | Org Name | Type 1 Attn | Type 2 Attn | Type 3 Attn | Average Daily Attn | % within 4 hours |
|---|---|---|---|---|---|---|
| RFS | CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST | 1,396 | 0 | 0 | 199 | 98.57 % |
| RNS | NORTHAMPTON GENERAL HOSPITAL NHS TRUST | 1,949 | 207 | 14 | 310 | 98.02 % |
| RX1 | NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST | 3,181 | 379 | 59 | 514 | 97.92 % |
| RTG | DERBY HOSPITALS NHS FOUNDATION TRUST | 2,329 | 0 | 848 | 454 | 97.73 % |
| RK5 | SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST | 1,902 | 0 | 813 | 388 | 97.72 % |
| RNQ | KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST | 1,422 | 0 | 0 | 203 | 96.69 % |
| RWD | UNITED LINCOLNSHIRE HOSPITALS NHS TRUST | 3,266 | 0 | 0 | 467 | 93.17 % |
| RWE | UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST | 3,178 | 373 | 954 | 629 | 92.78 % |

**A&E Throughput and Performance last 4 weeks: East Midlands Acute Trusts**

Period: 10/06/2013 to 07/07/2013

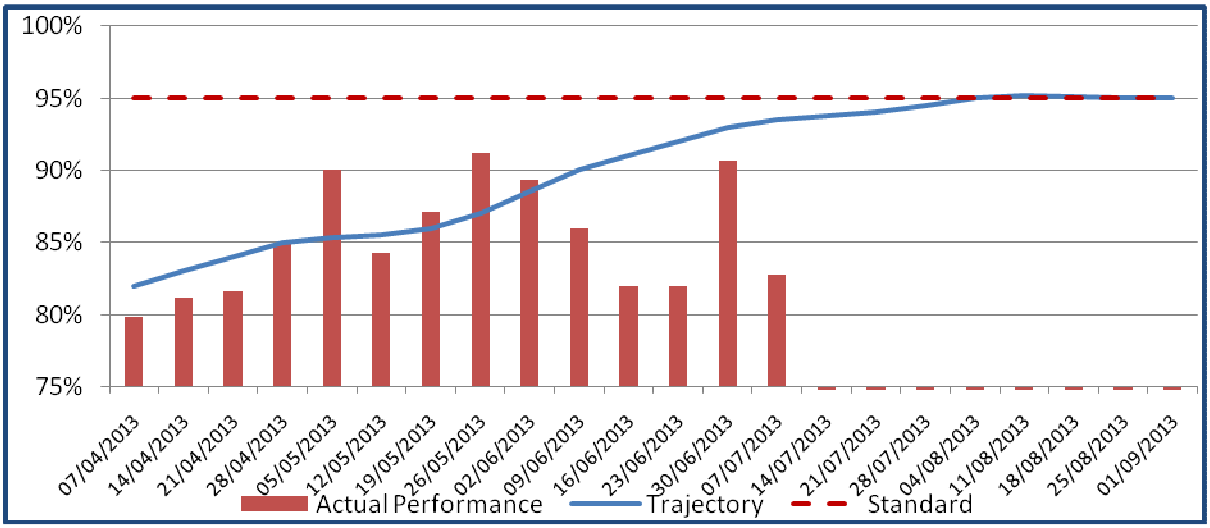
| Org Code | Org Name | Type 1 Attn | Type 2 Attn | Type 3 Attn | Average Daily Attn | % within 4 hours |
|---|---|---|---|---|---|---|
| RK5 | SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST | 7,289 | 0 | 3,139 | 372 | 98.33 % |
| RFS | CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST | 5,462 | 0 | 0 | 195 | 97.71 % |
| RX1 | NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST | 12,714 | 1,548 | 235 | 517 | 97.61 % |
| RTG | DERBY HOSPITALS NHS FOUNDATION TRUST | 9,343 | 0 | 3,423 | 455 | 95.81 % |
| RWD | UNITED LINCOLNSHIRE HOSPITALS NHS TRUST | 12,580 | 0 | 0 | 449 | 94.64 % |
| RNQ | KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST | 5,704 | 0 | 0 | 204 | 94.09 % |
| RNS | NORTHAMPTON GENERAL HOSPITAL NHS TRUST | 7,737 | 886 | 80 | 310 | 93.79 % |
| RWE | UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST | 12,210 | 1,380 | 3,407 | 607 | 84.39 % |

Our trend in performance compared to other Acute Trusts for ED type 1, 2 and 3 attendances is shown below:-




## 2.3 Performance Trajectory

Our actual performance against the revised trajectory is shown below:




At the beginning of June 2013 the Trust performed above the trajectory for improvement however since then performance has fallen below expected levels with only a degree of recovery in the last week of the month.

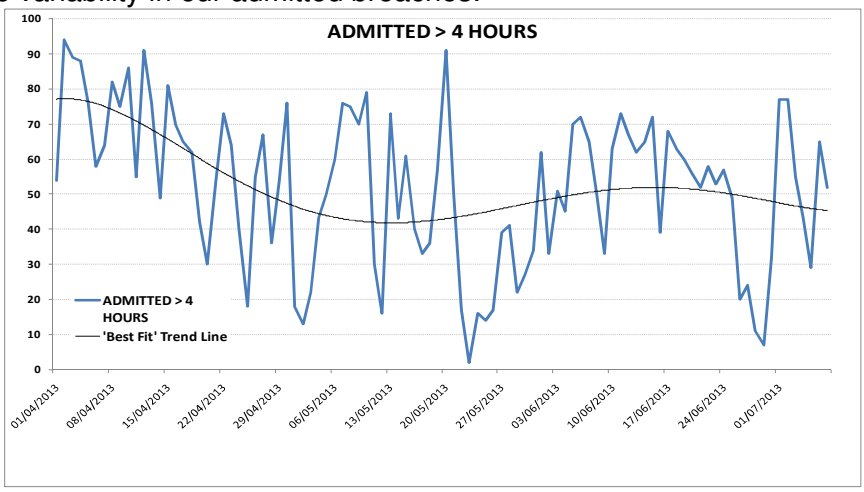
Performance has come under considerable external scrutiny over recent weeks. The NTDA require daily reports on performance and hold weekly conference calls to offer advice and support. Further to this the Trust is being held to account through the Emergency Care Board, CCG's and NHS England for its variable performance. A revised plan has been agreed and resubmitted to NHS England on behalf of the Health Community proposing further plans to create a step change in performance.

**2.5 Delay Reasons**

Analysis of admitted and non-admitted breaches reveals significant variances in performance on a daily basis. The top 3 reasons for breaches remain as reported for several months as follows:

- ED Process – 19% (477)
- Bed Breaches – 27% (655)
- ED Capacity – 34% (612)

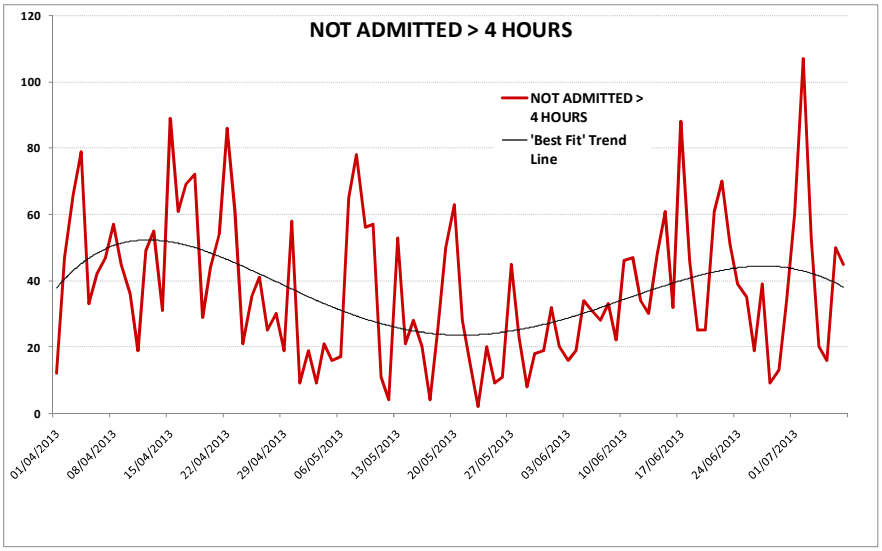
There is huge variability in our admitted breaches:




The availability of cubicle space remains as a direct result of delays in getting patients out of the department as a consequence of poor outflow and poor availability of beds early in the day. Consistently the Trust has struggled with bed availability, particularly in the medical base wards. The implementation of the new configuration of the assessment units coupled with improved streaming of elderly patients to AFU and more respiratory patients to the Glenfield site has undoubtedly improved outflow and early bed availability . On days when outflow has been available performance has improved considerably for admitted breaches.

As part of the revised NHS England Plan a series of improvement actions have been implemented to address "the back door". This includes further investment in therapy services and the proactive in reach to facilitate discharge of some of our more complex patients and those with a delayed transfer of care. Improved ward processes, the removal of hidden waits are also programmes set to deliver the flow from our base wards.

Non admitted breached continue to be a challenge. In part this is associated with the lack of cubicle space to review patients when outflow to base wards is poor. The other apparent reason is long waiting times to be seen by a doctor and the corresponding delays in obtaining a confirmed discharge destination. Medical staffing skill mix is a known causative factor. The department continues to be reliant upon a high number of agency and locum doctors whilst recruitment is undertaken to recruit to substantive posts. A workforce plan is being developed for the service, underpinned by ongoing recruitment initiatives, to enable a more stable, permanent workforce. A similar challenge appears in the nursing workforce however efforts are being sustained to ensure fill rates are good on each shift. Recruitment initiatives have seen vacancy numbers reduce. An overview of the patterns of non admitted breaches is as follows:




The distribution of breaches by area is shown in the table below. As previously reported the major's area of the department continues to have the highest number of breaches with the cumulative position reducing marginally from 70% to 69% in month. The number of breaches in the children's department doubled in June, whilst the minors breaches cumulatively equate to 11% of breaches. Resus breaches are noted to have risen significantly in June.

| Allocation | Apr-13 | May-13 | Jun-13 | 1st - 7th Jul-13 | Total | Cumulative % |
|---|---|---|---|---|---|---|
| CHILDREN | 84 | 43 | 86 | 34 | 247 | **3%** |
| MAJORS | 1766 | 1181 | 1491 | 480 | 4918 | **69%** |
| MINORS | 260 | 200 | 215 | 80 | 755 | **11%** |
| RESUS | 407 | 305 | 374 | 99 | 1185 | **17%** |
| **Sum:** | **2517** | **1729** | **2166** | **693** | **7105** | **100%** |

As agreed through ECAT it remains the aim that there should be zero breaches in the minors area. This will be achieved through the introduction of a new coordinator role who will be responsible for managing the flow and waiting times. This should in time release nursing resource which will be redirected into patient care to help expedite patient processing time. Further to this the ability to protect the nursing resource in this area remains under discussion. An operational group to oversee this area of work has been established with a clinical lead and Matron supporting the delivery of agreed actions. Flow metrics form part of this work in order that the department is better able to understand constraints and bottlenecks to flow.

### 2.6 ED Quality Indicators

Two of the five quality indicators were met in June with results remaining similar to the previous month and minimal improvement. Unplanned re-attendances have remained the same and are marginally above the 5% threshold. Overall time in the department has increased whilst the time to initial assessment shows no improvement. The department however is still struggling to meet the required standards.

**CLINICAL QUALITY INDICATORS**

**PATIENT IMPACT**

| | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | TARGET |
|---|---|---|---|---|---|---|---|---|---|
| **Left without being seen %** | 2.5% | 2.5% | 2.8% | 2.9% | 3.3% | 3.4% | 2.7% | 3.0% | <=5% |
| **Unplanned Re-attendance %** | 5.2% | 5.2% | 5.5% | 5.4% | 5.3% | 4.8% | 5.1% | 5.1% | < 5% |

**TIMELINESS**

| | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | TARGET |
|---|---|---|---|---|---|---|---|---|---|
| **Time in Dept** (95th centile) | 326 | 344 | 457 | 432 | 483 | 504 | 398 | 421 | < 240 Minutes |
| **Time to initial assessment** (95th) | 24 | 24 | 25 | 33 | 45 | 37 | 31 | 31 | <= 15 Minutes |
| **Time to treatment** (Median) | 69 | 68 | 79 | 60 | 47 | 55 | 45 | 43 | <= 60 Minutes |

A dedicated task and finish group is being established to examine ways in which lean processes and better data capture can improve delivery against some of the quality indicators. Further to this a number of actions being overseen by ECAT are set to address the issues at the point of handover from ambulance personnel. In particular the provision of dashboards in key areas of the department to support flow and the use of escalation triggered though information displayed on the dashboards should drive up performance.

Ambulance handover times and the achievement of the 30 minute handover will increasingly come to bear. The dedicated task and finish group will incorporate actions to address compliance with the required standards.

## 3. ECAT UPDATE

Weekly ECAT project team meetings continue in order to manage and monitor progress against the action plan and to agree remedial actions where necessary. A number of actions have been closed or are in the auditing on monitoring implementation phase. An achievement of note is the reconfiguration of the assessment units (wards 15,16 & 33 LRI) to which now provide a 28 bedded RAU, 9 ACB beds, a 19 bedded Short Stay ward for acute medical patients and a 24 bedded Acute Frailty Unit. Early results derived from this model are promising and feedback from medical and nursing teams is positive.

The wider health community has had to resubmit radical action plans to remedy our emergency performance. The latest ECAT Action Plan forms an integral part of the plan.

## 4. RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report
- Acknowledge the continuing pressures in the emergency system resulting in a further continued pressures on sustained performance improvement:
- Note the on-going support from the CCGs and healthcare partners to alleviate pressures across the Health Economy;
- Note the weekly performance against the revised trajectory for improvement for 2013/14;
- Note the actions taken by ECAT, and
- Note and support the radical actions to turn performance around over the forthcoming weeks.

University Hospitals of Leicester NHS
NHS Trust

# Emergency Care Action Team

| | |
|---|---|
| **Monitoring body (Internal and/or External):** | ECAT |
| **Executive Sponsor:** | Chief Executive |
| **Operational Lead:** | Phil Walmsley |
| **Frequency of review:** | Weekly |
| **Date of last review:** | **19-7-13 pre ECAT review** |

| REF | ACTION | SENIOR LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| 1 | AMBULANCE INTERFACE | | | | | |
| **Ambulance Delays** | Install electronic handover recording in ED | PW | Karlie Thompson | 31/07/13 | Different options available for execution. JA has escalated to EMAS CEO. | 3 |
| 2 | REDUCE ED ATTENDANCES | | | | | |
| **Reduce Attends** | Introduce "Single Front Door" | JA | CF/MH | 01/08/13 | Model of initial diversion of ambulatory patients to UCC has been agreed by UCB and ECAT. Incremental launch likely from 17/7<br>Launch date 17/7/13 dependant on UCC filling their staffing rota. Most other enablers likely to be completed on time. Escalation strategy if longer than expected delays in UCC needs strengthening.<br>SOP commented on today. Escalation plan now sorted<br>Commenced 17/7/13. UCC doing triage allowed See and Treat process in minors. Few issues to resolve re: better signage and intercom on minors entry door. Positive engagement from clinical staff. Rag=5 | 5 |
| 3 | ED PROCESS | | | | | |
| **Minors** | Introduce Minors co-ordinator | PR | RW | 19/08/13 | Starting to be filled using overtime and extra hours. Excellent response to bank shifts – fill started wef 30/6/13. Recruitment underway. Improved Co-ordinator fill rate now. Interviews completed. 3 appointments made. 1 start date 22nd July and the other 2, 26th Aug. All shifts out to bank for | 4 |

| Status key: | 5 | Complete | 4 | On track | 3 | Some delay – expect to completed as planned OR implemented but not fully embedded | 2 | Significant delay – unlikely to be completed as planned | 1 | Not yet commenced | 0 | Objective Revised |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

| REF | ACTION | SENIOR LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| | | | | | cover and not completely filled | |
| **Flow Principles in Minors** | Staff with ENPs (2 off peak/3 peak), HCA and registered nurse with a clerical coordinator during peak periods and therapies input 7 days | PR | AC/BT | 24/06/13- ENP's 22/07/13- HCA's | ENP recruited and start date confirmed<br>Awaiting outcome of transformation bids, as the therapy bid now sits within this overall bid.<br>Monitor frequency of availability of HCA's<br>ENPs now going through training programme | 4 |
| **ED Rapid Assessment Bay** | Publish clear escalation plans in place for all areas and roles | BT | JE | 19/07/13 | Work progressing. Need to focus on full staff awareness and compliance once completed. | 4 |
| | Install real time dashboard in place for all area and an overview | JC/CF | TC/AC | 31/07/13 | CF to escalate delays to John Clarke Director of IM&T – meeting arranged for w/c 1/7/13<br>Mock up of dashboard presented at ECAT. Need confirmation of screens to view – JE<br>Needs to include SAU's. PW to talk to AC.<br>Screens purchased and due to be installed Friday by Interserve. Dashboard data for CDU complete. RAU has changed way of recording senior review times so time to senior review can be captured and displayed. RAU/AFU and ED data model expected to be ready for Friday 19/7/13 | 3 |
| **Resus** | Identify major issues causing delay due to external teams and agree a cross divisional approach (This applies to all areas of ED) | PR | BT/PR | 31/07/13 | Action modified in order to focus on hot spot areas as not a generalised problem. | 3 |
| **MAJORS** | Ensure that Orthopaedic and ENT referrals are direct to wards where appropriate. | PR | CF | 12/07/13 | In case of orthos this could also be #clinic<br>CF has sent Kevin Harris text regarding this and attending ED within 30 minutes of request which KH was going to circulate to HoS this week. | 4 |
| **Majors** | Identify potential to increase majors cubicles in short term to reduce blockages | JA | BT | ~~05/07/13~~ 12/07/13 | ECAT confirms only possible area is old Fracture Clinic (currently occupied by Discharge Lounge). Priority to decide best use of this separate area | 4 |
| **ASSESSMENT BAY** | Increase Cannulation capacity in ED | LL | JE | 01/08/13 | | 4 |



| Status key: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
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| REF | ACTION | SENIOR LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| **EDU** | Enhance Mental Health Assessment space | PW | BT/JE | 30/09/13 | Local plans agreed by the department and proposals being costed. Plans can be accommodated within current bed capacity.<br>Case of need requested. Agreed area with Mark Williams. Martin Watts project managing. Case of need will need to go to Division for discretionary capital. Meeting to update CQC being organised with Sharron Hotson and Michael Clayton | 4 |
| | LC CCG to talk to LPT in order to improve access to Psychiatric Liaison. | SF | RV | 05.07.13 | Meeting due to occur on 4th July.<br>PW to chase RV or Sarah Smith | 3 |
| **Document new ways of working** | Finalise SOP for all ED areas | PR | BT/ LL | 31/07/13 | Rolling audit of Minors, Resus and Majors SOP to be implemented | 3 |
| **4** | STAFFING & ENGAGEMENT | | | | | |
| | Continue to recruit to medical and nursing vacancies | PR | BT/KM/LL | 31/07/13 | Nursing R&R premium agreed, medical staff equivalent being designed. | 3 |
| | Develop comprehensive workforce plan for all disciplines with timed action plan and recruitment milestones | JA | JE | 31/07/13 | New action to bring together existing approaches more systematically<br>Need current vacancy position and recruitment strategy by clinical group and grade. Draft paper to come to ECAT on 12.7.13<br>Still work in progress but going well. Nursing paper tabled. | 4 |
| | To enhance Therapy support for ED, AMU, and EDU. A new interim therapy support team will be established and implemented | PW | Lynne Cook | 10/07/13 | £50,000 funded already. Further £50k requested Non-recurrent.<br>Currently unable to recruit to posts. PW to discuss with Chrissi Grace about how to progress this. | 3 |
| | Appoint 2 locum ED consultants (Resp and Cardiology) | PR | CF | 30/09/13 | Discussions with potential candidates and specialties ongoing<br>CCT date for respiratory candidate not available until December 13 (respiratory candidate pulled out)<br>Meeting with cardiology early July to agree way forward<br>Acting up arrangements to be considered – proposed cardiology candidate not an option – current cardiology proposal would offer limited coverage so needs further discussion CF and JK | 2 |



| Status key: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 5 | Complete | 4 | On track | 3 | Some delay – expect to completed as planned OR implemented but not fully embedded | 2 | Significant delay – unlikely to be completed as planned | 1 | Not yet commenced | 0 | Objective Revised |

| REF | ACTION | SENIOR LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| | | | | | Proposal from general surgery and T&O to PR. | |
| | Explore potential for recruitment of overseas ED Consultants or alter mix of disciplines | PR | CF | 30/08/13 | Discussed at ECAT 5/7. Requires further discussion re approaches most likely to deliver results | 4 |
| | Review operational medical staff scheduling to reduce short notice gaps | JA | CF/MH/PW | 20/07/13 | MH to identify additional support for JDAs by 12.7.13. ECAT debate indicates sub-optimal functioning. | 3 |
| | Undertake Listening into Action Programme in ED (Pioneering Team) | JA | AC/LM | 31/12/13 | Sponsor Group Formed. Pulse Check underway. Listening Event to be held on 30/07/13 | 4 |
| 5 | INCREASE DOWNSTREAM CAPACITY AND IMPROVE FLOW | | | | | |
| **Assessment Units – LRI and Glenfield Sites** | Implement revised Assessment and Elderly care Model:<br>Wd 15 – Medial admissions (AMU)<br>Wd33 – Elderly admissions (AFU)<br>Wd 16 – Short Stay and High Dep (SSU+ACB) | PR | LW | ~~02/07/13~~ 19/07/13 (to monitor impact) | Launched as planned. ECAT review 5/7 indicates positive impact and good clinical support. Teething issues to be addressed by actions outside ECAT plan . To be further evaluated and adapted as necessary | 5 |
| | GPs need to be able to admit directly to AMU more consistently | PR | LW | 30/08/13 | | 1 |
| **Assessment Units - Consultant - delivered dedicated 12 hour** | Stream cardio-respiratory admissions direct to Glenfield | PR | PW/CF | 05/07/13 1st stage 12/07/13 – further review | New respiratory protocols are in place and well thought of by GPs. Potential for further development of diversion protocols with EMAS. Approach to be agreed at ECAT 12/7. Clear respiratory pathways. Need clear cardiology pathways. PR/JK<br>To agree way forwards on what a 24/7 service at GGH would require. JB/PW. JB/PW to meet 18/07. Feedback to ECAT | 3 |



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| REF | ACTION | SENIOR LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| | Develop clear rota to cover 12 hour consultant input in Respiratory and Cardiology Glenfield 7 days per week | PR | LI | 30/09/13 | Currently agreed 5 days per week. Cardiology remains unresolved. Requires escalation<br>JB and CF met with Luci Blackwell and Jan Kovac who have agreed to discuss preferred model, staffing requirement, and timeline for implementation for 12hr CDU cover, consultant ward cover to achieve minimum standards, a solution for chest pain/cardiology patients attending ED and a way of formalising the cardio respiratory divert at their cardiology away day on 19/7/13. Luci Blackwell to attend ECAT on 24/7/13 with proposals on all these issues | 3 |
| | Audit Rapid Assessment model (6-14hours) and Short Stay (48 hours)<br>• LRI Ward rounds at 8am, and 3.30pm<br>• LRI Board rounds at 12/1pm and 6pm and 8pm<br>• LRI Ward round (16 consultant – ACB at 8am-9am/2-3pm)<br>CDU Ward round 8am, Board rounds 2pm and 5pm | PR | JE/ LJ | 30/08/13 | Daily Audits through manager of the day role to monitor adherence to standards. JE to investigate IT solution to produce automated reports<br>Ward and Board round timings altered 02/07/13 aligned to new processes | 4 |
| | Senior review within 30 minutes of admission | PR | JE/LJ | 02/07/13 Ongoing for review | In place via NIC/Registrar and above wef 2/07/13 – will require audit via metrics<br>JE setting up audit of compliance | 4 |
| **Frailty Units and Integration with the** | Dedicated Emergency Frailty unit (EFU)for patients meeting defined frailty markers | PR | CF/ SC | 02/07/13 | EFU model implemented<br>Junior doctor cover on EFU remains problem-Additional doctors would be needed to cover 24/7. Proposals developed post August 2013 but funding would cause a cost pressure<br>Ward Clerks sorted.<br>Phlebotomy – JE to speak to UniTemps.<br>Therapists – to be maintained at level of last week. Complete | 4 |
| | Manage Ambulatory Frailty patients with clear criteria and MDT input in EDU | PR | CF /SC | 02/07/13 Ongoing for review | In place – will require on-going audit via metrics | 4 |
| **Assessment** | Address issue of discharge sister ability to | PW | CF /SC | | PCC bid gone to CCG for additional support to ED and CDU | 3 |



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| **Units** | discharge to community hospitals/LA | | | 26/07/13 | Jo Blackwell identified as leading changes to rights for discharge sisters for AMU/CDU.<br>JB moving from current post. New lead is Sarah Latham. | |
| **and In Reach** | Implement Minimum standards in Respiratory | PR | NM/ JB | 31/07/13 | In place except 52 week cover is still outstanding. Consider fee for service to enable cross cover 52 weeks | 3 |
| | Implement Minimum standards in Diabetes | PR | TP/ I Lawrence | 31/07/13 | Meeting next week to agree job plans<br>Shift to daily ward rounds<br>Need agreement on whether diabetologists will manage 2.5 wards or 2 | 3 |
| | Implement Minimum standards in Cardiology | PR | NM/ J Kovac | 04/08/13 | Ward round rota agreed. Associate specialist to be appointed<br>Meeting with Cardiologists 19/07/13 | 3 |
| | Explore feasibility of 5 day specialist delivered ward rounds (Monday to Friday) with weekend cover arrangements | PR | TP | 04/11/13 | Plans to be developed | 4 |
| **Corporate Capacity** | Design revised Trust wide escalation processes and roles/responsibilities action cards (for when demand exceeds predicted capacity) | PW | PW | 12/7/13 | Progress reviewed at ECAT 5/7. To be finalised next week.<br>Only outstanding area is new AFU. Otherwise complete | 4 |
| | Table top exercise for escalation plan | PW | PW | 17/7/13 | | 4 |
| | Full rollout of Escalation Plan | PW | PW | 26/07/13 | On track | 4 |
| **Flow metrics** | Review bed co-ordinator and matron roles in capacity management | RM | PW | 31/08/13 | New action.<br>To be addressed in bed management LiA | 4 |
| | Design and implement new dashboard on INsite | PW | PW | 24/06/13 1st phase<br>31/07/13 2nd phase | Completed but needs to be aligned with ED indicators<br>Meeting with TC 12/07/13. Agreed that the Uni of Leic would use maths dept to see if our current information indicates any key areas | 4 |
| | Develop comprehensive metrics (inputs and outputs) plus dashboard for all key aspects of the emergency care pathway | JA | SS | 31/07/13 | Initial metrics identified and reviewed at ECAT. Technical development to be completed w/c 8/7.<br>3rd draft on ECAT agenda 12/7. Also presented to UCB 11/7 | 4 |



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|---|---|---|---|---|---|---|
| | Increase ICS rehabilitation capacity | JA | CCGs | City 01/10/13<br>East TBC by LPT | Work in progress via CCGs/LPT.<br>City ICS to start 1/10/13<br>East ICS service going through board w/c 1st July. Awaiting start date | 4 |
| | Improve TTO timeliness to expedite discharge | JA | SK | 30/09/13 | **See separate detailed action plan.** | 4 |
| | Reassess acute capacity requirement including by time of day to rectify outflow-inflow mismatch | RM | RM | 07/08/13 | New action | 4 |
| | Undertake review of discharge planning and timing (incl use of discharge lounges) | RM | TBC | 31/08/13 | New action | 4 |
| | Undertake further detailed review of key published checklists (NHS England, King's Fund/NHSSoE/ECIST) to identify any points not yet actioned/in plan | RM | RM | 31/08/13 | New action | 4 |



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**Key to initials of leads**

| | | | | | |
|---|---|---|---|---|---|
| BT | Ben Teasdale | NT | Nicky Topham | NM | Nick Moore |
| CF | Catherine Free | ES | Emma Stevens | CL | Cathy Lea |
| JA | John Adler | AC | Andy Coser | RM | Richard Mitchell |
| JB | Jon Bennet | TC | Tim Coats | JC | John Clarke |
| JE | Jane Edyvean | JM | John Mortimer | RW | Rachel Williams |
| KH | Kevin Harris | KM | Kerry Morgan | SS | Simon Sutherland |
| LL | Lisa lane | JBu | Julie Burdett | SK | Suzanne Khalid |
| MH | Monica Harris | EL | Emily Laithwaite | IL | Ian Lawrence |
| PR | Pete Rabey | LW | Lee Walker | KT | Karlie Thompson |
| PW | Phil Walmsley | LJ | Lisa Jeffs | | |
| SM | Sue Mason | SC | Simon Conroy | | |
| TP | Tim Petterson | KT | Kerry Tebbut | | |

## Short term actions from ECAT meetings

| Resp | Action | Date to be completed | Date completed | Completed |
|---|---|---|---|---|
| PW | To find out from EMAS if they can pre-phone to Bed Bureau to be aware of where to bring GP patient | 19th July | 18th June | Yes |
| BT/RW | Feedback to GPs on end of Life patients presenting inappropriately to ED | 8th Aug | | |
| PR | PR to bring up the issue of HDU commissioning at the CPM next week | 21st June | | |
| JB | To talk to Jan K re purpose of the meeting on the 19th | 19th June | | Yes |
| CF | To draft letter to come from KH re speciality admissions to ED and 30 minute speciality support to ED | 19th June | | Yes |
| C O'B | To provide UHL with a list of quality metrics for quality assurance | 19th June | | Yes |
| RM | To invite Toby Sanders to ED to look at cubicle options in majors. Link to Nicky Topham/Interserve | 19th June | 18th June | Yes |
| JE | To draft out paper on possible use of fracture clinic to bring to ECAT | 19th June | | |
| PW/TP | To pick up issues over Arriva discharge times | 19th June | 17th June | Yes |
| SS | Send out updated metrics sheet to ECAT for comments | 15h June | | |
| BT | Send email to JA re issue over CRIS | 15h June | | |



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| 6 | ARCHIVED COMPLETED ACTIONS | | | | | |
|---|---|---|---|---|---|---|
| 2 | New Pathways developed and operational | JT | MW/BT | 31/03/13 | Complete | 5 |
| | Agree Clinical lead for Minors | BT | | 30/06/13 | Lead identified | 5 |
| **3** | Handover from ED doctor to Assessment Units Floor coordinator to facilitate safe clinical handover of all patients | JT | JBu | 31/03/13 | Revised role with support from bed coordinators working well | 5 |
| 4 | Budgets signed off for additional resources | JT | CF/JE | 31/5/13 | In progress | 5 |
| 4 | Rotas implemented for the ED/EDU | JT | BT | 31/03/13 | Extensive recruitment plan | 5 |
| **4** | Launch Listening into Action within ED | JA | SM/ ES | 01/06/13 | LiA launched 1 June. | 5 |
| **5** | | | | | | |
| 6 | Radiology pathways and ICE systems in place | JT | CL | 30/04/13 | Pathways in place | 5 |
| 6 | Pathology pathways and ICE systems in place | JT | JM/ BT | 30/04/13 | Pathways in place | 5 |
| 6 | Develop demand and capacity predictor tool | JT | PW | 29/05/13 | On track | 5 |
| 6 | Redefine roles and responsibilities of bed coordinators and those staff involved in capacity management | JT | PW | 17/05/13 | Complete | 5 |
| 6 | Existing Ambulatory care services moved to the fracture clinic located near ED (TIA and DVT) | JT | H O'Connel l | 31/03/13 | Complete | 5 |
| 6 | Frail friendly ED plan defined and implemented | JT | EL | 06/06/13 | Plan documented | 5 |
| | | | | | | |
| 6 | SLAs have been developed for pathology and imaging outlining request and order expectations, urgency criteria and expected turnaround times and KPIs | JT | CL | 18/02/13 | Complete | 5 |
| 6 | A clear rota is developed to cover 12 hour acute/general physical (LRI) consultant input 7 days per week | PR | LW | 06/0/13 | Complete | 5 |
| 6 | Physical space to manage up to 20 ambulance arrivals per hour | | BT | 30/05/13 | Complete | 5 |
| | Directory of services written and publicised | PR | Helen | 31/07/13 | | 5 |

**9**

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| | | | O'Connell; | | | |
| | Gastroenterology In Reach into Assessment Units – Monday to Friday consultant delivered | PR | A Grant | 17/06/13 | | 5 |
| | Standardised ward round documentation, including EDD and reasons why EDD not met. | PR | R Denton-Beaumont | 03/06/13 | On track for respiratory and geriatrics | 5 |
| | SOP complete for new bed meeting function, agenda, times, frequency and membership | JT | PW | 04/06/13 | On track | 5 |
| | Implement new capacity management processes including new meeting times, agenda and attendees | JT | PW | 04/06/13 | On track | 5 |
| | Review SMOC roles and responsibilities to be by a Duty Manager | JT | PW | 04/06/13 | On track | 5 |
| | Haematology ward to be renovated without removing acute medicine from ward 19 | JT | SM | 08/06/13 | Ward 1 and 2 to accommodate 17 additional patients and Odames to move early June | 5 |
| | See and Treat process implemented in Minors | PR | AC/BT | 18/02/13 | Implemented, but KPI's not at 100%<br>Out to ortho reg locums from monday. If costs go beyond current spend then this needs to be seen as a cost pressure. | 5 |
| | Direct referrals to UCC, Medicine, clinics or GP to bypass Majors | PR | BT | 18/02/13 | In place bt depends on bed capacity (see below) | 5 |
| | Initial clinical assessment within 15 minutes | PR | BT | 18/02/13 | Monitor flow and compliance | 5 |
| | Sort out initial data recording issue to accurately record 15 minute review in RATT process | PR | CF | 30/06/13 | Improved to 17 minutes | 5 |
| | Reinforce protocols for management of majors processes and monitor via KPIs | PR | BT | 06/06/13 | Need to ensure 100% compliance | 5 |
| | Investigate Newcastle escalation response process | PR | AC | 14/06/13 | Discussions held with Newcastle – CF to follow up | 5 |
| | Full staffing model developed for ED/EDU | JT | BT/KM | 30/06/13 | Medical staffing review and Nursing review completed. | 5 |
| | Produce a list of each post / grade of post and whether the posts are filled. | PR | RW | 14/07/13 | Completed. | 5 |
| | Turnaround time for urgent CT tests at the Glenfield site to be monitored | JT | MH | 14/06/13 | Information on performance presented at meeting by MH and distributed to ECAT members. To continue and in future to include ED and AMU. | 5 |
| | RW to provide an overview of what staffing is needed and what it is in place. | RW | CF | 12/7/13 | Complete | 5 |



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| **Ambulance Delays** | Install HAS screens | PW | Phil Milligan | 30/06/13 | Costs still awaited. Escalated for action by PW. Revised date to be identified.<br>Installed in ED on the 5th July. | 5 |
| | Develop flow metrics for minors | PR | TC/JE | 5/07/13 | Flow principles shared with ECAT | 5 |
| **ED Rapid Assessment Bay** | Provide Senior clinical decision maker covering 8am-10pm | PR | BT | 30/05/13 | In place although variations occur in cover due to staff shortages<br>Senior decision makers will be ED Consultants, ED ST4-6, ED GPSI's, Fully qualified ANP's after a period of induction. RW to record levels of senior decision maker presence in assessment bay. | 5 |
| | Refine NIC, Tracker and DIC roles with a clear single leadership role | PR | LL/KM | 30/06/13 | Role cards developed for NIC and Tracker | 5 |
| **Assessment Units – LRI and Glenfield Sites** | Clearly define Assessment area processes for LRI and GH ; document within SOP | PR | LW | 02/07/13 | Documented and circulated to all clinicians | 5 |
| Establish Acute Neurology ambulatory care service in Fracture Clinic – First fits and acute headache | | PR | H O'Connell | 01/07/13 | Will start as 2 days per week pilot<br>5.7.13. Started at GGH. Will move to LRI, old fracture clinic, 19th July | 5 |
| Make Acute Medical clinic and CDU green chaired area available for direct referral from ED 7 days per week with acute physician/respiratory physician cover | | PR | CF | 30/06/13 | Introduced 02/07/13 - will need review | 5 |
| Implement 7/7 consultant reviews and daily MDT in Stroke | | PR | TP/M. Fotherby | 01/07/13 | In place – to be audited via metrics | 5 |
| Implement Minimum standards in Geriatrics | | PR | TP/SC | 07/06/13 | In place – to be audited via metrics | 5 |
| Implement Minimum standards Renal, ID and Neurology | | PR | TP/Heads of Service | 01/07/13 | In place – to be audited via metrics | 5 |
| Implement necessary e-bed state changes to support new plan/process to provide real time bed state information | | PW | PW | 24/06/13 | Complete | 5 |
| Investigate Modular build at GGH to accommodate surgical specialities | | PW | RG/NT | 06/06/13 | Already being managed as part of Vascular Project Team. PW to link to vascular surgery move | 5 |



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