Trust Board Paper S3

To:	**Trust Board**
From:	**Chief Executive**
Date:	**27 June 2013**
CQC regulation:	**As applicable**

Title:	**Emergency Care Performance Update**

Author/Responsible Director: John Adler, Chief Executive

Purpose of the Report: To update the Board on recent performance and action planning.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	x	Endorsement	

Summary / Key Points: This report summarises recent performance and national developments.

Recommendations:

The Board is recommended to note the contents of the report.

Previously considered at another corporate UHL Committee? No.

Board Assurance Framework: **Emergency care risk**	**Performance KPIs year to date:** **Provided in separate report (paper W1)**

Resource Implications (eg Financial, HR):
Under continual review by Emergency Care Action Team (ECAT)

Assurance Implications:
The 95% (4 hour) target and ED quality indicators

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

Stakeholder Engagement Implications:
Under continual review by Emergency Care Action Team (ECAT)

Equality Impact:
N/A

Information exempt from Disclosure:
N/A

Requirement for further review?
Monthly

REPORT TO: **TRUST BOARD**

REPORT FROM: **JANE EDYVEAN – EMERGENCY CBU MANAGER**

REPORT SUBJECT: **ED PERFORMANCE REPORT**

REPORT DATE: **19 JUNE 2013**

1.Introduction

Programmes of work continue in order to improve performance across the Emergency Care system. Internally within UHL this is specifically aimed at delivering performance against the trajectory for improvement as agreed with CCGs and the NHS Trust Development Authority (NDTA). In May 2013, UHL saw an improvement in performance and achieved 85.5% (Type 1 and 2 activity) and when combined with the Urgent Care Centre (UCC) this was 88.7%. Performance year to date stands at 81.3% and 85.3% respectively.

There are a number of factors that continue to impact on performance against which a range of actions are being undertaken overseen by the weekly Emergency Care Action Team (ECAT). As previously reported, the demand for bank and agency staff continues in order to support new processes introduced in February of this year. Similarly, the requirement for additional capacity beds to stay open remains unchanged.

This report provides details for the current level of performance for May 2013. It also provides an overview and update on progress against actions identified in previous reports.

2. Current Activity and Performance

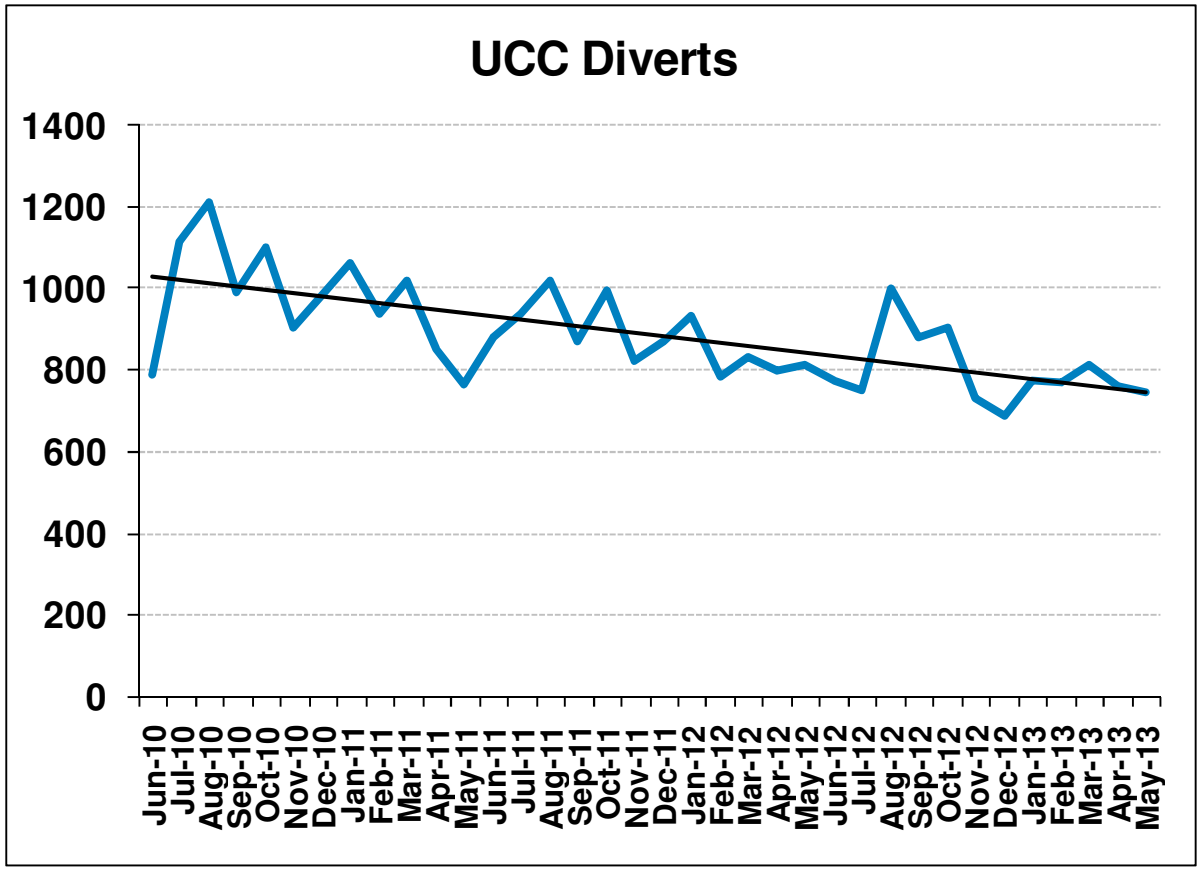
2.1 Attendances rates and Diversion rates.

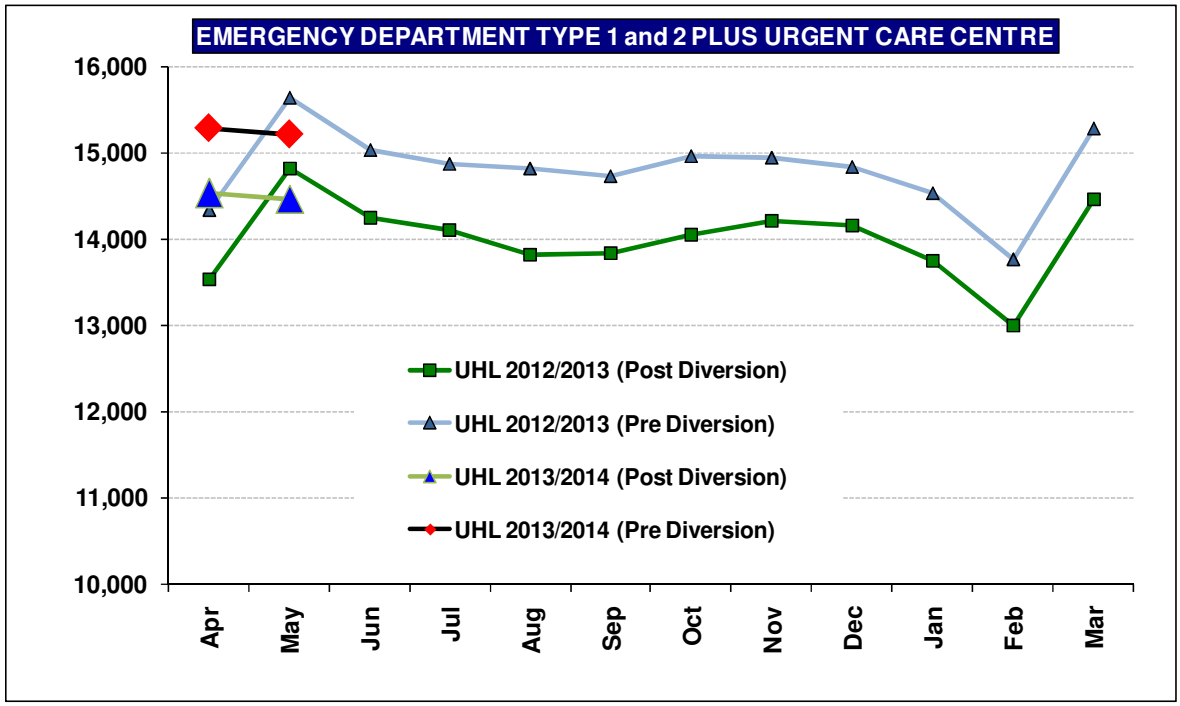
In the previous month, April 2013 it was reported that the trend of a decline in activity had changed. In May 2013 this reverted back to a reduction in overall activity of 2.7% against the same period for 2012/13.

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			
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	28,992	30,498	

The number of patients diverted to the UCC during May totalled 746, falling below the numbers diverted in the previous 3 successive months. In percentage terms however, there is no change.

In May, 14 fewer patients were diverted to the UCC, resulting in a continued downward trend.





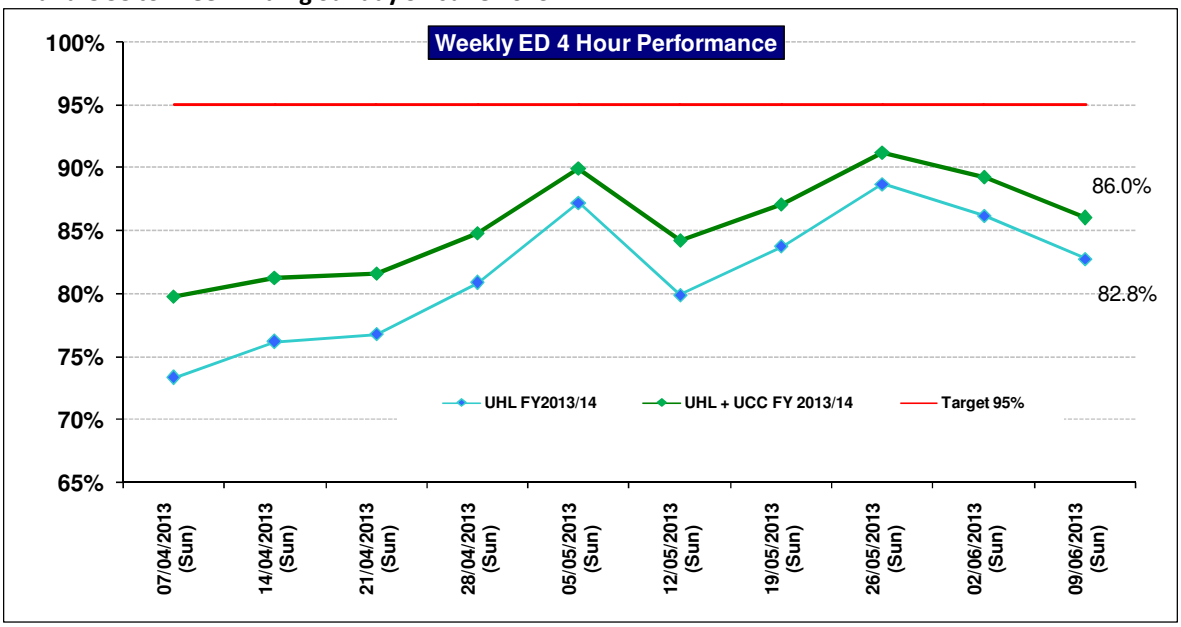
Work continues in preparation for the implementation of the Single Front Door provided by the GeorgeElliottHospital. There is a particular focus on developing the requisite governance arrangements between the UCC and ED, agreeing the clinical pathways and recruiting staff for the new service. The governance arrangements will encompass both the clinical handover of patents between services as well as the robustness of patient tracking on different IT systems. A revised date for August has been proposed as the go live date.

Initiatives to review all ambulance requests made by a GP remain in place to appropriately deflect patients away from the ED with positive results.

2.2 4-Hour Performance target

Daily performance against the emergency 4 hour target has continued to vary on a daily basis giving an overall performance of 82.8% for UHL and 86% when figures for UHL and UCC are combined.

ED and UCC to Week Ending Sunday 9th June 2013



Emergency Department 4hr Wait 2013/14

May 12

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	14,465	2,091	85.54%
Urgent Care Centre	Type 3	4,029	2	99.95%
UHL + UCC Total	All	18,494	2,093	88.68%

Full Year to Date
May 12

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	28,992	5,433	81.26%
Urgent Care Centre	Type 3	8,057	4	99.95%
UHL + UCC Total	All	37,049	5,437	85.32%

For the month of May 2013, ED saw some improvement through a reduction in the number of breaches to 2091 (type 1 and 2) which is 1252 less than in the previous month. By contrast, the department only saw 62 less patients.

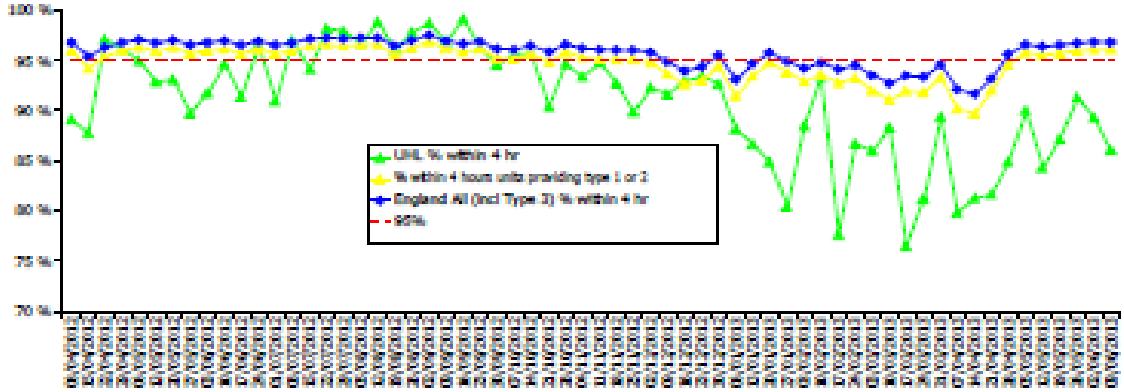
As of 2nd June 2013, UHL had the highest number of average daily attendances when compared with East Midlands Acute Trusts but the second worst performance against the 4 hour target. When ranked against other large Acute Trusts, UHL is one of the poorest performers and is the third poorest when ranked against all other Trusts (143 out of 145 Trusts).

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

Period: 13/05/2013 to 09/06/2013

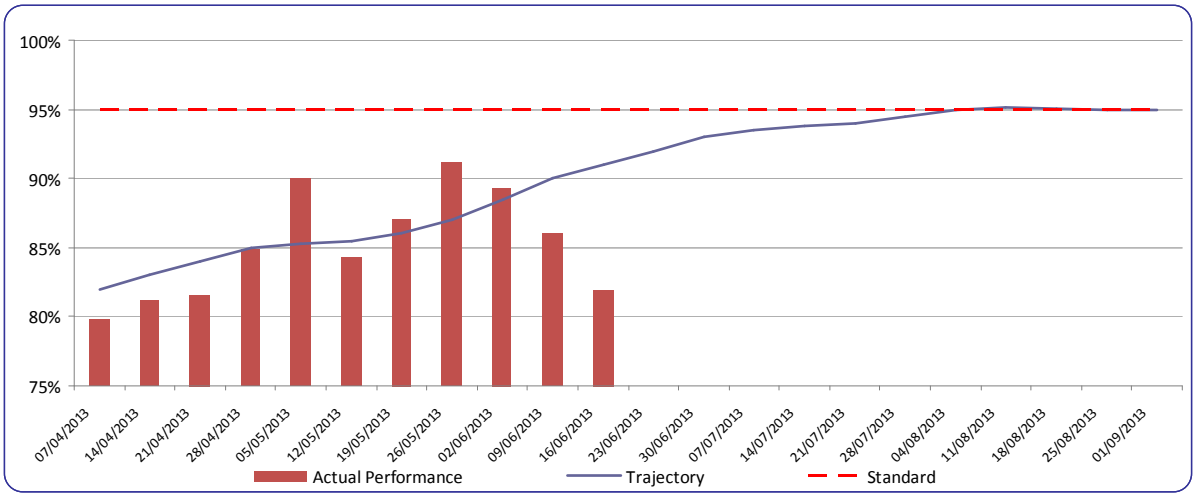
Org Code(Unify)	Org Name(Unify Data)	Type 1 Atts	Type 2 Atts	Type 3 Atts	Average Daily Atts	% within 4 hours
RX5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	6,965	0	2,978	355	98.20 %
RF5	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	5,417	0	0	193	97.12 %
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	12,316	1,346	213	495	97.07 %
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	7,121	732	88	283	96.74 %
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	11,637	0	0	415	96.40 %
RT3	DERBY HOSPITALS NHS FOUNDATION TRUST	9,042	0	3,343	442	94.28 %
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	11,446	1,320	3,446	693	88.58 %
RNO	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	5,539	0	0	197	87.37 %

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:



During the period from 29th April 2013 until 2nd June 2013 the Trust achieved above the trajectory for improvement on four weeks out of the five week period.

There is a clear expectation that UHL will achieve the trajectory for improvement or indeed exceed this. The Trust still remains vulnerable to achieving and sustaining performance improvements. As previously described a number of areas of work are being progressed in order to achieve this. Particular focus remains on delivering actions from the weekly ECAT meetings (Appendix 1).

Members of the Trust recently attended a day hosted by the NTDA to reaffirm the direction of travel and ensure that significant areas for improvement were not being overlooked. The day provided assurance to attendees that the actions being undertaken by the Trust replicated those taken by other Trusts who had succeeded in turning their performance around.

2.5 Delay Reasons

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

- ED Process – 23%
- Bed Breaches – 28%
- ED Capacity – 31%

The availability of cubicle space as a reason for breach is as a direct result of delays in getting patients out of the department as a consequence of poor outflow. Consistently the Trust has struggled with bed availability, particularly in the medical base wards. Easing of pressures on the bed base and flow onto the base wards late on in the day has been a consistent theme. On days when outflow has been available performance has improved considerably.

In response to the continued challenges associated with achieving continuous outflow, revisions to the configuration of the assessment units at the LRI have been proposed. This will provide a separation of the Acute Frailty Service from the acute medical flow which it is believed will improve the rapid turnaround from both the Rapid Assessment Unit (RAU) and reduced length of stay for medical short stay patients and frailty patients. A final date for implementation is to be confirmed.

The distribution of breaches by area is shown in the table below. The major's area of the department continues to have the highest number of breaches with the cumulative position continuing to stand at 70%. The number of breaches in the childrens department has halved in the month, whilst the minors breaches cumulatively equate to 10% of breaches.

Allocation	Mar-13	Apr-13	May-13	1st - 10th Jun-13	Total	Cumulative %
CHILDREN	47	84	43	20	194	**3%**
MAJORS	1633	1766	1181	486	5066	**70%**
MINORS	235	260	200	54	749	**10%**
RESUS	389	407	305	147	1248	**17%**
Sum:	**2304**	**2517**	**1729**	**707**	**7257**	**100%**

Through ECAT it has been agreed that the department should aim to achieve 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 is under discussion.

2.6 ED Quality Indicators

Two of the five quality indicators were met in May. Performance against the quality indicators shows improvement in the time to treatment and the percentage of patients being seen. Both of these targets are consistently being met. Unplanned re-attendances have increased and are marginally above the 5% threshold. Overall time in the department has reduced considerably and continued improvements are seen in the time to initial assessment. The department however is still failing to meet the required standards.

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	TARGET
Left without being seen %	2.7%	2.5%	2.5%	2.8%	2.9%	3.3%	3.4%	2.7%	<=5%
Unplanned Re-attendance %	5.0%	5.2%	5.2%	5.5%	5.4%	5.3%	4.8%	5.1%	< 5%

TIMELINESS

	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	TARGET
Time in Dept (95th centile)	298	326	344	457	432	483	504	398	< 240 Minutes
Time to initial assessment (95th)	23	24	24	25	33	45	37	31	<= 15 Minutes
Time to treatment (Median)	64	69	68	79	60	47	55	45	<= 60 Minutes

3. ECAT UPDATE

Weekly ECAT project team meetingscontinued in May in order to manage and monitor progress against the action plan and to agree remedial actions where necessary. Particular attention has been on providing assurance against plans for the implementation of the new AMU/ACB/AFU model , an update from the CCG's on the plans for the single front door ,an update on the development of the emergency floor and ensuring an adequate response following the visit from the NDTA.. Further to this the action plan was reviewed in response to the NHS England letter and cross referenced to the NHS Checklist.

4. RECOMMENDATIONS

The board are 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 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

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:	14th June 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	REDUCE ED ATTENDANCES						
Reduce Attends	Introduce "Single Front Door"	JT	MH	1/08/13		SOPs being agreed (CCG/GEHT/UHL) Start date linked to appointment of staff. Concern expressed over ability of UCC to recruit the calibre of nurse they want. IT remains a significant problem due to system one and EDIS interface. UHL needs to provide governance and to agree contractual process if service is not delivering as expressed.	3
2	ED PROCESS						
Minors	Minors coordinator in place	PR	RW	14/06/13		Rota set up. Starting to be filled using overtime & extra hours. WCF signed off and with HR. Minimal fill rate on rota at present. Should improve once recruitment is underway . Will be a cost pressure.	3
	See and Treat processes implemented in Minors	PR	AC/BT	18/02/13		Implemented, but KPI's not at 100% Out to ortho reg locums from monday. If costs go beyond current spend then this needs to be seen as a cost pressure.	3
Stream	Staffed 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 awaiting start date Helen Seth needs to update on progress around transformation bids, as the therapy bid now sits within this overall bid.	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	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
ED Rapid Assessment Bay	Senior clinical decision maker covering 24/7	PR	BT	30/05/13		In place although variations occur in cover due to staff shortages The level of cover needs to be agreed. This could be provided by an ENP, GP, or senior ED doctor. JE/BT to provide a basline and trajectory for improvement for next friday.	3
	Direct referrals to UCC, Medicine, clinics or GP to bypass Majors	PR	BT	18/02/13		In place but depends on bed capacity (see below) BT to provide information on how many could leave directly and how many actually do for next friday	3
	Initial clinical assessment within 15 minutes	PR	BT	18/02/13		See above	3
Coordination of the Unit	Clear escalation plans in place for all areas and roles	JT	PW	01/07/13		Further work being undertaken to embed	4
	A real time dashboard in place for each area and an overview	JT	TC/AC	31/7/13			4
	Sort out initial data recording issue to accurately record 15 minute review in RATT process	PR	CF	30/06/13		Improved to 17 minutes	4
	Refined NIC, Tracker and DIC roles with a clear single leadership role	PR	LL/KM	30/06/13		NIC role being revisited to have overall authority of the department	4
Majors	Reinforce protocols for management of majors processes and monitor via KPIs	PR	BT	06/06/13		Need to ensure 100% compliance Audit paper to be completed by 14/6/13 RW	3
Resus	To be used only for patients meeting Resus criteria. Criteria to be defined and disseminated	PR	BT	30/06/13		Lead identified for SOP revision. Criteria to be agreed	4
	Investigate Newcastle escalation response process	PR	AC	14/06/13		Awaiting call back from Newcastle.	4
	Rapid access to external teams where required e.g. ICU, GI etc. Timely transfer of patients with written plan and verbal handover out of the unit	PR	PR	31/03/13		Variable speciality team response Need to be monitoring against Newcastle standards by 21/6/13. BT/RW.	3

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
Diagnostic & Therapy Support	Therapies support implemented	JT	CS	30/07/13		Recruitment underway	4
EDU	Mental Health Assessment space enhanced	JT	BT/JE	30/06/13		Impact of new EFU moving to EDU to be assessed in terms of space allocation for Mental Health CF to check with S Hotson if 2 year delay on provision of area is ok	4
Document new ways of working	Finalised SOP for all ED areas	PR	BT/ LL	30/06/13		Majority of components complete – revisions needed for Minors, Resus and Majors	4
3	**SPEED UP INITIAL ED ASSESSMENT**						
Speed up initial ED assessment	Embed Rapid Assessment Model	PR	CF/BT	30/06/13		Continue audit and reinforcement	4
	Improve consistency of senior medical staff performance	PR	CF/BT	14/06/13		Further discussions with medical staff and practice/productivity audit. Linked to productivity dashboard. BT to link with PW re any concerns.	4
	Report from emergency pathway process audit to come to ECAT weekly	PR	JE	14/06/13		MH to ensure that this happens	4
	Management of medical patients in the ED by medical team	PR	CF CF/JB/BT /TP	28/06/13	Lack of time from ACB reg Lack of ability to agree on model to support ED	If it is Mon-Fri, 9-5, then AMU staff will go to ED to support process	4
	Develop Productivity Dashboard	JT	PW	14/06/13			4
4	**ENHANCE ED RESILIENCE AND MORALE**						
Enhance ED resilience and morale	Full staffing model developed for ED/EDU	JT	BT/ KM	30/06/13		Medical staffing review being undertaken. Nursing review completed.	4
	Recruit to medical and nursing vacancies	PR		31/07/13		Nursing R&R premium agreed, medical staff equivalent being designed.	4

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	Produce a list of each post / grade of post and whether the posts are filled.	PR	RW	14/07/13			4
	2 locum ED consultants (Resp and Cardiology) to be appointed	PR	CF	15/07/13-Resp 15/08/13-Card			4
	Launch Listening into Action Programme in ED	JA	AC/LM	15/06/13		?complete	4
5	**AMBULANCE DELAYS**						
Ambulance Delays	Installation of HAS screens	JT	Phil Milligan	30/06/13		EMAS have been asked but have not got quote back	3
	Install electronic handover recording in ED	JT	Phil Milligan	31/07/13			4
6	**INCREASE DOWNSTREAM CAPACITY AND IMPROVE FLOW**						
Assessment Units – LRI and Glenfield Sites	Creation of a Rapid Assessment Function (6-14 hours) and Dedicated Short Stay area (48-72 hours) on both sites	JT	LW	30/06/13		Re-launch of standards on 30/06/13	4
	Clearly define Assessment area processes for LRI and GH ; document within SOP	JT	LW	30/06/13		On track	4
Consultant - delivered dedicated 12 hour cover on assessment and short stay areas	Develop clear rota to cover 12 hour consultant input in Respiratory and Cardiology Glenfield 7 days per week	PR	LJ	30/09/13	Respiratory is late Sept completion for 5 days per week service	Funding source to be agreed for 7 days per week Currently agreed 5 days per week	4
	Rapid Assessment model (6-14hours) and Short Stay (48 hours) • LRI Ward rounds at 8am, and 3.30pm • LRI Board rounds at 12/1pm and 6pm and 8pm • LRI Ward round (16 consultant – ACB at 8am-9am/2-3pm) • CDU Ward round 8am, Board rounds 2pm	PR	JE/ LJ	30/06/13		Daily Audits through manager of the day role to monitor adherence to standards	4

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	and 5pm						
	Senior review within 30 minutes of admission	PR	JE/LJ	30/06/13			4
Frailty Units and	Dedicated Acute Frailty unit for patients meeting defined frailty markers	PR	CF/ SC	30/06/13		Go live date for new model is w/c 1st July. LL and JE to agree nursing model by 19th June. Needs ACB moving. Confirmed date for moving needs confirming as soon as possible to communicate out to staff. Junior doctor cover on EFU remains a problem. CF to to see if they can be brought back to EDU. Additional doctors would be needed to cover 24/7.	4
Integration with the Assessment Units	Ambulatory Frailty patients to be managed with clear criteria and MDT input in EDU	JT	CF /SC	30/06/13			4
	Clear mechanisms for geriatric and MDT In Reach into assessment unit on both sites where required based on frailty markers	JT	CF /SC	30/06/13		Clear model to be defined in detail	4
Diagnostic Response to Assessment Units	Provide visible performance data	JT	MH	30/06/13			4
	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. To be circulated afterwards. To continue and in future to include ED and AMU.	4
Ambulatory Care Pathways	Acute Neurology ambulatory care services are documented, staffed and housed in the fracture clinic – First fits and acute headache		H O'Connell	01/07/13		Will start as 2 days per week pilot	4
	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		Re-launch standards 30/06/13	4
Ward Rounds in Acute	Implemented 7/7 consultant reviews and daily MDT in Stroke	PR	TP/M. Fotherby	01/07/13		On track	4

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Division and In Reach	Minimum standards implemented in Geriatrics	PR	TP/SC	07/06/13		On track 52 week cover is still outstanding	3
	Minimum standards implemented in Respiratory	PR	NM/ JB	03/06/13		On track 52 week cover is still outstanding	3
	Minimum standards implemented in Diabetes	PR	TP/ R Gregory	01/07/13		Plans in development Meeting next week to agree job plans and cover for additional beds	4
	Minimum standards implemented in Cardiology	PR	NM/ J Kovac	04/08/13		Plan still to be devised by Cardiology	3
	Minimum standards implemented in Renal, ID and Neurology	PR	TP/Heads of Service	01/07/13		Plans in development	4
	Implementation across Acute Division stretch target – 5 day consultant delivered ward rounds (Monday to Friday) with weekend cover arrangements	PR	TP	04/11/13		Plans to be developed	
Corporate Capacity Management and Escalation							5
							5
							5
	Design revised Trust wide escalation processes and roles/responsibilities action cards (for when demand exceeds predicted capacity)	JT	PW	14/06/13		On track	4
	Implement necessary e-bed state changes to support new plan/process to provide real time bed state information	JT	PW	24/06/13	IT Support	On track	4
	Design and implement new dashboard on INsite	JT	PW	24/06/13	IT Support	Design confirmed, onto roll out phase	4

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	Full rollout of Escalation Plan	JT	PW	01/07/13			4
Increase Capacity							
	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	4
	Increase ICS rehabilitation capacity	JA	CCGs	TBC by LPT		Work in progress via CCGs/LPT.	4
Medical HDU	**PR to bring up the issue of HDU commissioning at the CPM next week**	PR	PR	21/06/13			
ED STaffing	RW to provide an overview of what staffing is needed and what is in place	RW	CF	12/7/13			1
	Nursing premia relates to the person not the band so career progression of staff will mean that they keep their premia.	LL					1
ED Flow	TC and PW to work on a set of indicators from ED and imaging, set by the service, that would indicate any slowing down of the system.	TC	PW	TBC		Tim Coats presented a paper on flow in ED.	1

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Short Actions to be completed

Resp	Action	Date to be completed	Date completed	Completed
PW	John Roberts to do a running graph of admitted and non-admitted patients	7th June		
PW	John Roberts to circulate KPI report to ECAT members.	7th June		
CF/TW	To have conversation re. changing "majors" sections into actions based on KPIs.	14th June		
JT	To send out the name of the person who was the GP / ED consultant who acted as the controller	7th June		
BT	Feedback to GPs on end of Life patients presenting inappropriately to ED	7th June		
MH	Chase up ED Therapies issue	7th June		

Key to initials of leads

BT	Ben Teasdale	SM	Sue Mason	SC	Simon Conroy
CF	Catherine Free	TP	Tim Petterson	KT	Kerry Tebbut
JA	John Adler	NT	Nicky Topham	NM	Nick Moore
JB	Jon Bennet	ES	Emma Stevens	CL	Cathy Lea
JE	Jane Edyvean	AC	Andy Coser		
JT	Jez Tozer	TC	Tim Coats		
KH	Kevin Harris	JM	John Mortimer		
LL	Lisa lane	KM	Kerry Morgan		
MF	Miriam Farr	JBu	Julie Burdett		
MH	Monica Harris	EL	Emily Laithwaite		
PR	Pete Rabey	LW	Lee Walker		
PW	Phil Walmsley	LJ	Lisa Jeffs		

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

7	COMPLETED ACTIONS						
2	New Pathways developed and operational	JT	MW/BT	31/03/13		Complete	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
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 O'Connel l;	31/07/13			5
Gastroenterology In Reach into Assessment Units – Monday to Friday consultant delivered		PR	A Grant	17/06/13			5

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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

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Completed Short Actions

~~JT~~	~~Tues & Wed next week needs notifying to the CCG & TDA regarding reduced consultant availability in ED during the day.~~	~~3rd June~~	~~31st June~~	~~Yes~~
~~CF~~	~~List of outstanding IT actions to John Adler~~	~~7th June~~	~~31st June~~	~~Yes~~
~~JT~~	~~Paper to ET 28/05/13 re using Odames ward for haem/onc patients.~~	~~28th May~~	~~28th May~~	~~Yes~~
~~PW~~	~~Review timings of bed meeting, in particular the 8.30am meeting.~~	~~21st May~~	~~21st May~~	~~Yes~~
~~PW~~	~~Review agenda for bed meetings and ensure each meeting is appropriately attended and led.~~	~~21st May~~	~~21st May~~	~~Yes~~
~~PW~~	~~Identify resources for transfers between sites.~~	~~21st May~~	~~21st May~~	~~Yes~~
~~MH~~	~~Agree placement of new CT scanner in relation to ED~~	~~24th May~~	~~24th May~~	~~Yes~~
~~MH~~	~~To assess the need for more therapists in ED from 08:00-18:00 – CCG informed~~	~~24th May~~	~~24th May~~	~~Yes~~
~~JA~~	~~Need to ensure that the single front door does not suffer from any internal delays.~~	~~24th May~~	~~24th May~~	~~Yes~~
~~MH/PW~~	~~Need high level matching of activity to staffing~~	~~17th May~~	~~17th May~~	~~Yes~~
~~JE~~	~~Enhance porter capacity throughout day~~	~~10th May~~	~~10th May~~	~~Yes~~
~~CF~~	~~To ensure that med reg on 15+16 continues to process patients overnight.~~	~~24th May~~	~~24th may~~	~~Yes~~
~~JA~~	~~ICE and system one to be high priority for IT to sort~~	~~31st May~~	~~31st May~~	~~Yes~~
~~MH~~	~~To discuss with WRVS, the need to move from current position~~	~~7th June~~	~~6th June~~	~~Yes~~
~~PW/MH~~	~~To agree the value of having control room near ED with a senior manager rota, supported by a Duty Manager.~~	~~7th June~~	~~6th June~~	~~Yes~~
~~JT/PW~~	~~Review Other Support for Tues & Wed for lack of ED consultant~~		~~7th June~~	~~Yes~~

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