To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**28 November 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 October was 91.80%
- Performance year to date is 87.90%
- Emergency admissions continue to increase creating significant capacity problems
- Sixteen additional admissions beds opened at the LRI on 4 November 2013
- A resilience checklist has been implemented
- The discharge rate has begun to improve
- There is an increased focus on non-admitted breaches
- Continuing the selective elective work outsourcing
- 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	**Performance KPIs year to date**
Yes	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

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**28 November 2013**

Introduction
UHL's performance continues to vary against the four hour emergency care measure.Plans for performance improvementincluding the 'Hub' integrated plan have developed over the last eight weeks. This report provides an overview of performance for October and November 2013.

Performance overview
In October 2013,91.80% of patients were treated, admitted or discharged within four hours. Thiswas the strongest monthly performance since September 2012.November 2013 performance, month to date, (up to and including 21November 2013) has dropped to 87.9%.Year to date performance is 87.89%.

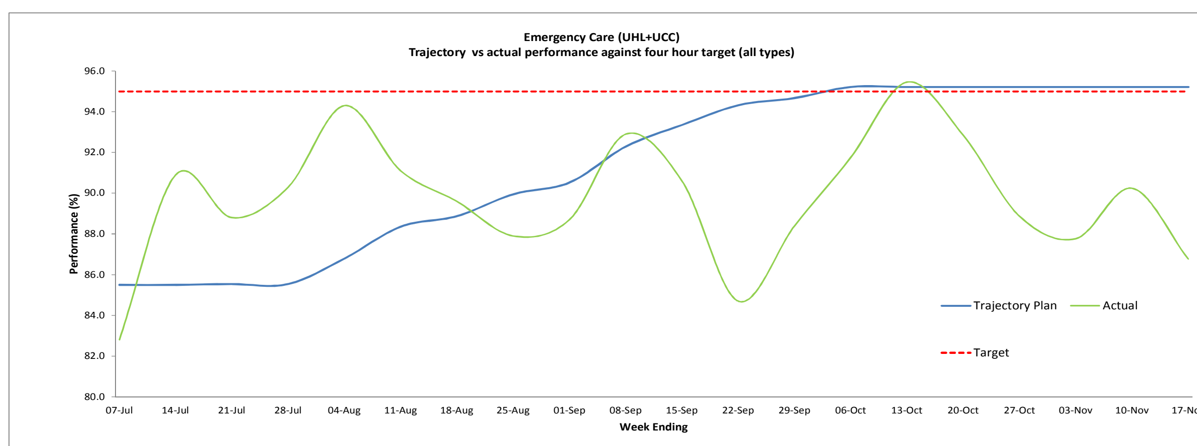

Table one

Root cause of poor performance
As detailed previously, an in-depth diagnosis of causative factors for poor performance was conducted in July and early August and actions were put in place to negate the factors. Some success occurred with the range of factors at play reducing but the primary reason for poor performance is access to beds.

The key contextual issues at UHL remain:

- UHL is the biggest single site A&E in the country. Many other single site EDs such as Heart of England NHS FT (85.0%) and Nottingham University Hospitals NHS Trust (86.6%) are experiencing problems
- UHL has the second highest number of elective and non-elective admissions in the NHS. The highest, Barts Health Trust has 300 more beds than UHL
- Admissions are increasing (table two).Two of the last five weeks have had more admissions than at any stage last winter. This is a national problem but is particularly pronounced in our health economy. Adult emergency admissions are 3.89% higher than this time last year (table three)
- This is particularly challenging in the over 65 year old patients whose admissions rate has doubled since 2012.
- Our non-elective medicine length of stay is significantly below peer average with only one Trust of our complexity with a lower length of stay
- UHL treats 160,000 in a A&E built for 100,000

The consequence is flow out of A&E is often poor which means too many patients back up in the department and breach. Unlike many peer organisations, UHL cannot open significant numbers of additional beds this winter because of staffing and estates constraints.

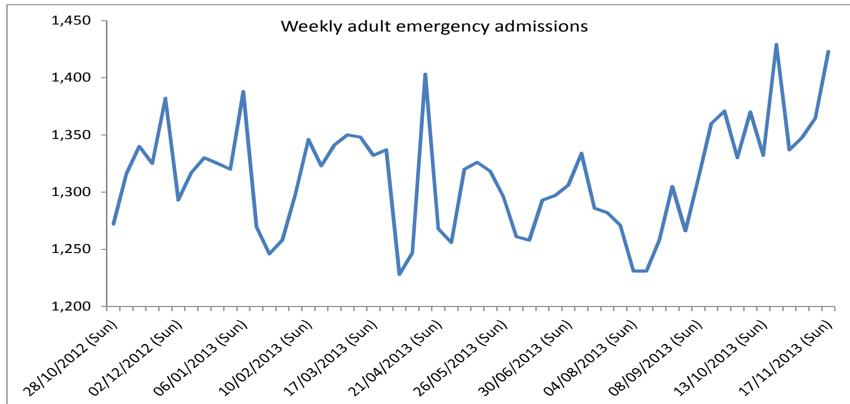

Table two

Week Ending	Emergency Admissions	Emergency Admissions (Adults)	Discharges (Emerg Adm)	Discharges (Emerg Adm) Adult
04/11/2012 (Sun)	1,426	1,316	1,394	1,279
11/11/2012 (Sun)	1,472	1,340	1,507	1,385
18/11/2012 (Sun)	1,456	1,325	1,459	1,321
Total	**4,354**	**3,981**	**4,360**	**3,985**
03/11/2013 (Sun)	1,476	1,348	1,521	1,400
10/11/2013 (Sun)	1,501	1,365	1,503	1,358
17/11/2013 (Sun)	1,598	1,423	1,547	1,393
Total	**4,575**	**4,136**	**4,571**	**4,151**

Change	**221**	**155**	**211**	**166**
% Change	**5.08%**	**3.89%**	**4.84%**	**4.17%**

Table three

Key actions since last month

- Resilience checklist implemented (attached)
- Improved discharge process (attached) and tables four and five
- Improved focus on non-admitted breaches
- Sixteen additional assessment beds opened on 4 November 2013
- Continuing the spend of winter monies
- Continuing the selective elective work outsourcing

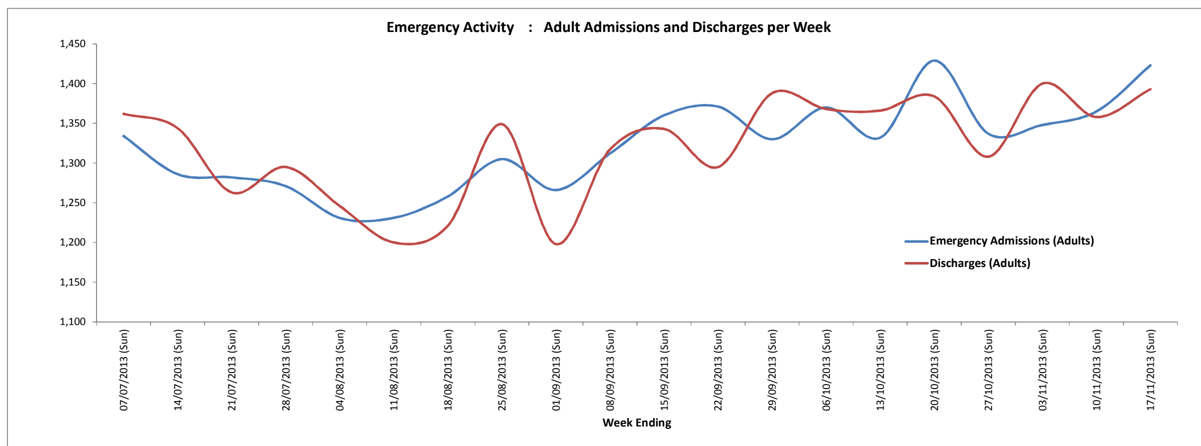

Table four

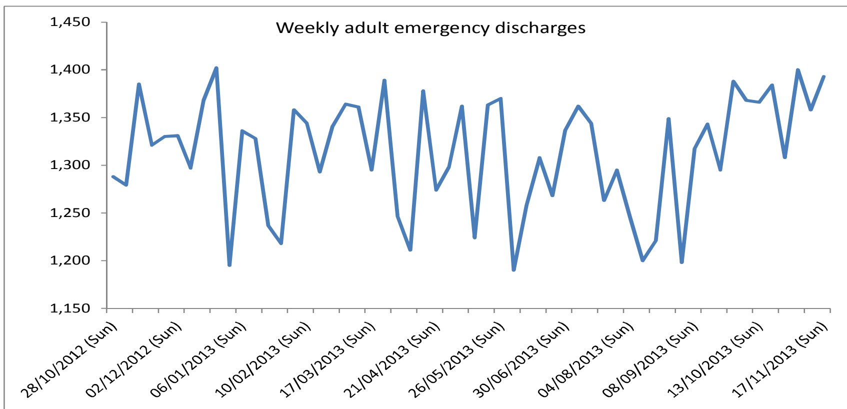

Table five

Recommendations

The board are asked to:

- Note the contents of the report
- Acknowledge the continuing focus on further and continued sustained performance improvement

Briefing Note – Urgent Care Working Group

November 2013

Rachel Overfield Chief Nurse UHL

The Patient Census – Pathway Monitoring and Escalation

1. Introduction

Part of the Emergency Care Hub action plan, the need to work to a single list of patient information that's updated at least daily was identified as a key action.

Responsibility for delivery of this action has been shared between operational and nursing leadership.

Originally described as 'developing a single discharge list' this action has been further refined to what we believe the organisation and wider system actually need – a patient census (updated at least daily) that details every patient by where they are in their individual pathway. There is no system ability to do this currently. The census will then be monitored for delays and actions escalated where necessary. This process to be done via conference calls.

2. The Problem – what are we trying to resolve?

When we first identified the need to work towards a single discharge list UHL (and others) were working from various paper lists of patients with varying degrees of information. The information was entirely focused on 'today's discharges' and was gathered by both bed management staff walking the wards and also ward staff attending 2 – 3 discharge/bed meetings daily. In other words a fairly traditional bed management model.

In addition specialist teams were working to other lists eg Delayed transfer of care. The daily discharge lists were not rolled over from one day to the next and so there was no audit trail of actions undertaken or required.

Problems with this model :

- Huge amount of nursing time reporting into meetings
- Meetings not about challenge, learning or action – just data collection
- No forward planning
- No audit trail or collection of information to learn from
- No holding anyone to account

- Entirely focused on delays in discharge today and not delays in pathway progress.

Inevitably this model leads to very limited ability to resolve pathway delays in a timely way, forces discharges in a chaotic way, wastes staff time duplicating 'counting' and does not support effective, well planned discharges.

3. **The New Model**

For the past 3 weeks we have been working with ward tams across the medical wards at the LRI to introduce a more proactive approach to pathway management and discharge planning.

Key features of the New Model

Before 8.30am – Ward Produces Patient Census

Before 9.30am – All wards have a MD Board Round

Between 11am – 12 noon – wards phone in to call centre to update patient census (5 – 10 min conversation maximum)

- Pathway position known for all patients including
  - Delays in pathway
  - Medically fit status
  - Discharge status
  - Discharge plan status
- Wards challenged and coached to act and learn
- Other key staff involved in call centre
  - Transport
  - Pharmacy
  - Therapies
- Actions for other staff clearly identified and assigned.

3pm – Repeat conference call to update progress and escalate actions.

Lists are rolled over to the next day and kept for audit/accountability purposes.

Conference call needs to be led by a

senior, credible operational/nursing professional (preferably both) with admin/ tracker support.

4. **Issues so Far**

- Paper system
- Ward leadership not owning the process/accountable
- Unfamiliarity conference call process – intimidating
- Some calls led by staff too junior and/or too entrenched in old bed management model
- Opportunity to support/coach ward staff not valued/done every day
- Shifting location and frequent changes (minor) to process – confusion
- Weekends and scaling up – not yet resolved.
- However every day the system is improving.

5. **Benefits New Model**

- Ability to track pathway progress of every patient
- Clear accountability for actions
- Ability to learn and therefore deliver sustainable approach
- Nurses not wasting time in meetings – remain in clinical area
- Rapidly engages/escalates to others
- Provides rolling census and rolling actions
- Provides audit trail of delays/themes/actions
- Identifies areas that need particular help/support
- Provides single list for others to work from.

6. **Further actions this week**

- Move to electronic list by next week (appendix 1)
- Re-issue clear process, timings, location and roles
- Identify wider team of credible senior staff to run call centre
- Daily involvement CN/COO
- Mandatory 'attendance' at calls from wider teams – phone in
- Concluded snap shot detailed patient census – see high level early results (appendix 2)
- Redefine 'language' eg census not discharge list

7. **Conclusion**

We believe that this change is fundamental to the effective flow of patients through the system and is innovative in its approach. However it must be recognised that this will only embed into practice if ward staff understand and relate to its value ; are supported and developed to use the system with confidence and without fear of criticism; that it recognises the need for safe and caring discharge and duplication of information collection is eradicated. In other words this is about culture and leadership development and not just

about system application and data collection. It will therefore take some time to fully introduce and embed.

We will continue to focus on medical wards at the LRI initially whilst resolving scaling up across the Trust ; involvement of other organisations and weekend processes.

Appendix 2

Initial results of patient snapshot census undertaken 18-20th November 2013 across LRI Medical Wards

Purpose

To capture current delays in actual discharge from Acute hospital care.

Auditors

Corporate Nursing Team and Senior Operational Staff

Findings/Delays (NB just LRI Medical Wards)

Fast track/CHC terminal care	X 3
Rapid discharge terminal care	X 1
CHC packages of care	X 9
Waiting Nursing Home Assessment	X10
Waiting patient choice of destination	X 2
Waiting mental health location	X 6
Waiting family choosing nursing home	X 5
Waiting brain injury/YDU/stroke rehab	X 6
Waiting social situation issue e.g. boiler repair	X 3

In addition, team picked up several internal delays in pathway progression

- **Therapy**
- **Medical review**
- **CNS review**
- **Outlier delays**

Team also noted ward staff reluctance to start discharge arrangements until medical fit status declared.

Action Area Number	Action Area	Lead	Action Reference	Action	Lead Organisation	Lead Individual	Project Support	Completion Date & RAG	Update	Planned Progress Next Week
1	Inflow	Sue Lock	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	30.11.13	KW has shared the data from the pilot and avoidable data for September. This will be shared with practices individually and via the Nov localities for LC CCG. Oct/Nov data is now being reviewed by UCC GP on 13.11,13. and will be fed back to GPs during the December localities as opposed to November localities. Audit of GP inappropriate referrals expected on 27/11/13	
			1.2	Implementing a 15 min handover times between UCC and ED	UHL / GEH	Jane Edyvean Kim Wilding	Catherine Free Kim Wilding	30.11.13	Nursing proceses have been agreed by KW and JE. There is also now a dedicated porter in the Assessment Bay area. The new nursing process is making a big difference to handover process. As an ongoing measure, a process has been implemented whereby KW contacts JE in the event of a significant delay for handover.	
			1.3	Patients referred by GPs in to ED to be triaged through UCC	GEH	Julie Whittikar	Kim Wilding	30.11.13	Pilot went live on 28.10.13 for one week using additional resource and 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 onwards to triage GP referrals through the ED Front Door without any additional resources. If successful, the process will remain in place.	
			1.4	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 informed immmediately as and when this happens - this process has been implemented. Richard Mitchell is confirming with UHL Information Team whether they have the >20minute triage to ED data. An audit tool will also be added to this process for 1 week. No information has yet been received by KW. MK to discuss with UHL the feasability of sharing with GEH (UCC) which of these patients breach. No breach information has been received from UHL.	
			1.5	Results management out of hours - pathology reporting	UHL / OOH	Angus McGregor Roy Aston	Michael Kaiser	30.11.13	Generic use of ICE would assist with this. ICE requesting rates in primary care are a little over 85% at the moment. We believe that the telephone number is a part of that requesting process; that the GPs will have more up to date records of patient information (address and phone number) than the Trust; and that increasing the usage of ICE requesting will improve the quality of the data and in particular ensure that all patients have the right telephone number linked to the pathology request. Access to the patients phone number is the key issue and creating a mandatory field in ICE will resolve this. Pathology are investigating this. A significant proportion of cases will have a phone number in iLab (the laboratory computer) already and staff who are phoning out results will provide that number with immediate effect. Pathology have investigated the above by auditing ICE requests and iLab to find that the proportion of patients for whom the telephone number is known is 99.1%, however the accuracy of these phone numbers is questionable. Pathology are also reviewing how ICE links to PAS and iLab Access to ICE for OOH would allow them to view previous results easily. If GPs are expecting the results to be high GPs will be asked to complete a OOH will provide numbers of Pathology patients flowing through their se UHL will look at numbers of Pathology patients attending ED.	

			Ref	Issue	Organisation	Lead	Support	Date	Update	
			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	30.11.13	Rapid review Clinic 1 OOH and UCC functions will be organised to ensure that any duplication is removed and the two services align. An initial meeting to be set up by 18.11.13. Despite contacting CNCS several times, we are still awaiting a response from them re: arranging a meeting.	
			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 the effectiveness of this at the Inflow Group meetings. A report of October data is in progress.	
			1.8	Streamlining of cardiology and respiratory admissions via the clinical decisions unit at GGH.	UHL	Catherine Free Tim Sacks	N/A	01.11.13	Pathway now written and agreed with UHL. Pathway now signed off by 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 Sourt	30.11.13	A review of the '20 minute triage window' for these patients will commence at the Inflow meeting on 04.11.13. Completed. In addition, a pilot of the original Bounce Back pathway will occur. A date for this is still to be decided. A proposed pilot process will be discussed with the UCC CD on 20.11.13.	
			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	02.12.13	CCG COO's provided a review of ED referrals and Bounce Back levels as well as issues to understand issues. The Merlyn Vaz contract due for renewal next year and this will align with the UCC SOP.	
			1.11	Lack of consistency in implementing EOL Pathway across CCGs.	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	18.11.13	CCGs and GEH met on 18.11.13 to compare current EoL pathways and relative levels of uptake, to test and confirm that each CCG is doing all they can to prevent EOL patients getting into ED. WL CCG is in the 2nd year of a QIPP programme including EoL resulting in a higher number of patients on EoL registers. WL will use winter funding to set up a GP telephone triage for those at the end of life. ELR CCG will use winter funding to increase care planning. LC CCG plan to fund a mix of both. Learning from the GP triage system will be shared with ELR CCG. The meeting will also review those EOL patients that arrive at the ED Front Door or ED itself to ensure that the patients are following the most appropriate pathways. CCGs do not have robust data on EoL patients arriving at ED. JE and GEM requested to review the number of EoL patients (last 12 months of life) and the number of dying patients attending A&E. Additionally, all inpatient EOL issues and what is being undertaken to ensure that all EOL patients already in UHL are being treated in the right place will be discussed. AB to contact TY and JT to discuss potential for in	
			1.12	Frequent Flyers	UHL	Jane Edyvean	TBC	31.12.13		
			1.13	Batching of calls - EMAS.	EMAS	TBC	TBC	TBC	This has been investigated and confirmed with EMAS that this does not 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	30.11.13	The three CCG COOs will meet on 25.11.13 to satisfy each other that each CCG is doing all it can within Primary Care to keep patients out of ED. COOs have discussed this issue. CCGs are focusing on highlighting appropriate pathways to GPs. We do not have information to support this action and require further evidence that we can take to GPs for discussion.	
			1.15	GP - admits earlier in the day.	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	30.11.13	The three CCG COOs will meet on 25.11.13 to satisfy each other that each CCG is doing all it can to ensure that GPs admit patients earlier in the day.	
			2.1	Streamline and speed up TTO process	UHL	Suzanne Khalid	Claire Ellwood David Kearney Kevin Harris Nick Pulman	30.11.13	Proof of concept studies with Pharmacist on ward round coordinating discharge medication and ensuring appropriate medication and using Pharmacist to update ICE letter successfully completed. This has been very positive and pharmacist input is well received by medical staff. Two locums will start 25.11.13 to provide pharmacists on ward rounds. Roll out aligned with where other discharge improvement work to maximize impact. Advertisements for further 2 to 3 locums placed with recruitment by 2.12.13 to allow full implementation at LRI through December. Testing of IT fix is ongoing. Estimated date for this to be used in medicine is beginning of December at which time the EPMA discharge tab will be rolled out across all medical wards at LRI.	

			2.2	**Locum inductions**	UHL	Pete Rabey	Rachel Williams	15.11.13.	Handbook developed as well as the process flash cards to help them. Any new locum is left an envelope in the pocket near majors desk and a note for the doctor in charge on the daily sheet to induct them and give this envelope to the doctor. They are allocated a locum EDIS account. Also developing a folder with CV's and feedback on all locums working or worked in the department and this is then taken to the consultant meetings for feedback on competency of the doctors. A final review of this process to ensure completeness will occur by 15.11.13.	
			2.3	**Timely Specialty engagement (workshop with specialties to understand the blocks)**	UHL	Andrew Furlong	Sarah Morley	14.11.13	Successful Specialty/ED engagement workshop held on 8.11.2013 (with Hub support). Initial resulting plans for MSK, Surgey, Critical Care and ENT reveiwed on 15/11/13. COMPLETE	
			2.4	**Progress CMG/Specialty project plans - output from workshop 8/11/13 - gain agreement to progress**	UHL	Andrew Furlong	Sarah Morley	~~15.11.13~~ 29.11.13	x4 specialty plans (Gen Surgery, MSK, ITU, ENT) submitted to ECAT by Andrew Furlong/specialty representatives on 15/11/13. ECAT 15.11.13 decision that an amalgamated paper for all 4 plans to be compiled (using the Urgent Care template). ITU to return business plans by 29.11.13 to AF, remaining 3 services by 21/11/13 for presentation at ECAT.	
			2.5	**Setup Task & Finish Group to monitor, track, measure and report on agreed outputs from 2.3.1**	UHL	Andrew Furlong	Sarah Morley	~~29.11.13~~ 04.12.13	AF to communicate w/e 22/11/13 to lead clinicians with a view to the initial meeting taking place 1st week fo December.	
			2.6	**Quick wins identified from workshop 8/11/13 to be prioritised for action _ track via Task & Finish Group2.3.1.1**	UHL	Andrew Furlong	Sarah Morley	22.11.13	IBM IPWC project tool to be used for tracking/reporting subject to receiving go ahead for 2.4/2.5.	
			2.7	**EDIS to be put into place for identified areas**	UHL	Andrew Furlong	Sarah Morley	6.12.13	? Specialties to confirm requirements and specialty leads for implementation to be identified	
			2.8	**Walk through ED from ITU Consultant**	UHL	Andrew Furlong	John Parker	22.11.13	Agreed at the workshop by ITU - completed action - requires monitoring through related action. AF to check with Ben Teasdale w/e 22.11.13 that this is in practice and working as required.	
			2.9	**Reconvene daily operational meetings between ED & Specialties to enforce communication and change culture**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	29.11.13	Requires further expansion on quick wins to agree on outline for daily 5 minute meeting prior to 8am capacity planning meeting. To be revisited through task/finish group.	
			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	~~22.11.13~~ 29.11.13	Being arranged - delayed by 1 week.	
			2.11	**Review existing SOPs for accuracy, effectiveness and adherence.**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	06.12.13	List compiled. To be led by the individual specialties/CMGs - to implement "no-brainer" processes, eg Fractured NOF. ED/Specialty leads will review and revise where appropriate once regular meetings (2.10) are setup. Action will be monitored through the task/finish group (2.5).	
			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	Radiology/ED working group already exists and update 19.11.13 shows good progress is being made with many actions estimated to be complete by mid December 2013. Aim to bring Imaging into the task/finish group for engagement and to track progress against current action plan with Radiology and to pick up any identified issues as a result of other workstreams.	
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	3 have been written but need to be amended to account for new structures. External comparisions being undertaken. To be signed off 22 11-13	
			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 less able to cope with high levels of pressure. A SOP is being written that includes a checklist of measurable actions on behalf of the doctor in charge and based on the SBAR concept to maintain safety in the department and address the escalation plan to reduce variation under these extreme conditions. This will go to ECAT for sign off by end of November. Coaching plan for specific individuals has been developed with HR and will commence in December. Although the deadline	
			~~2.15~~	~~**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 04.11.13. Task and Finish group to meet Monday 18th Novemeber. Meetings with matrons and sisters in medical CMG to take plavce with RO & JB Thursday/Friday next week~~	This Action will be moved to Action Area 3 (Ward Practice) moving forward and is identified as Action 3.14 on this sheet.

~~2.16~~	~~Communication to patients - setting expectations at point of admission~~	~~UHL~~	~~Pete Rabey~~	~~Ann Hall~~	~~15.11.13~~	~~Rachel Overfield has had several meetings with nursing staff to ensure that their communication to patients is accurate.~~ ~~There is a new ward round standard being written which will be reviewed to account for this.~~ ~~There will be a need to target specific areas where messages communicated to patients are not accurate and can create more complex patients than necessary.~~	This Action will be moved to Action Area 3 (Ward Practice) moving forward and is identified as Action 3.15 on this sheet.
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	15.11.13	Gen surgery have produced a short business case for SAU triage model along similar lines to LRI MAU. Now ro be linked to action following speciality workshop. T&O have also produced plan for increased senior decision maker pull through from ED to # clinic assessment area. **19.11.13 UPDATE** - Suggest that this is removed as covered by earlier action points. In addition, timeframe for rapid improvement plan suggests ability to have a reasonable impact as a separate workstream is limited. Business plans to be submitted from the specialties all aim to improve capacity issues within the specialties in order to support improved flow and process with ED.	
2.18	Robust ED medical staffing	UHL	Catherine Free/Ben Teasdale	Rachel Williams	~~15.11.13~~ 06.12.13	Plan revised to include fundamental demand and capacity review, re-basing of establishment and ongoing recruitment plan. New reporting template developed to highlight gaps and relationship to breached - to be reported weekly. Recruitment of international doctors is on going with inductions of the NHS and clinical skills set up . Regular junior staff adverts are placed and then interviewed into vacancies . Fixed term contracts are negogiated for Agency locum staff to ensure consistency for the deaprtment .	
2.19	Specialty referrals being routed through ED + adherence to SOP's	UHL	Andrew Furlong	Sarah Morley	30.11.13	KW and PW met and initiated new process. Any declines of speciality referrals will be raised with duty manager. Any referrals to ED from UCC will be marked as such on S1. In relation to the SOPs being adhered to, AF is reviewing and Inflow believe these need to be looked at from GP, UCC and other agency referrals. A.Furlong reviewed SOPs prior to the meeting on 08.11.13 Inflow group to set up monitoring process/data set to monitor. UCC have report for their referrals and KW to speak to Simon Court at Loughborough UCC to ensure they can utilise the same report. Complete as per the above detail - outstanding SOP review/engagement now detailed elsewhere. **AF UPDATE 19.11.13** - Suggest this is now merged with similar workstream in action 2.11 above.	
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 effectiveness. Complete Ward Managers/Matrons returned to wards full time from early October	
3.2	Establish Ward round – baselines - rapid improvement (using exemplar wards)	UHL	Andrew Furlong Julia Ball	Julia Ball	~~15.11.13~~ 01/12/13	Review group to agree operational standards for surgical and medical ward rounds. Audit tool to be produced for matrons to audit week commencing 04.11.13. task and finish group planned for 21.11.13.matron audit completed and audit information from completed by medics throughout October being collated to inform on 21st November. (Purpose of task and finish is to drive forward standards with emphais on communication /responsibility /accountability) Consultant and junior medical leads identified.	
3.3	Prevent computers hibernating – action now	UHL	John Clarke	Jane Edyvean	Completed	Completed	

3	**Ward Practice**	Rachel Overfield	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	Meeting with Jude Smith 23/10/13 Link in with work stream led by Paul Hunt on minimum data set. Meeting this week. Meeting with Paul on 11.11.13. paul taking forward discussions with leicestershire HISS team . JB to discuss with John Clarke re tool required /nterface etc this week. Work will continue through task and finish group which PH will attend. JB to contact Paula Dunnan to link in with work on patient discharge tracker tool currently under development. Discussed at task and finish group 18.11.13 and work ing to look for interim solution to take place next week (JB/PH)	
			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 expected. 100 overseas nurses offered posts to start in January, more overseas recruitment planned. Over recruiting to HCA posts. week commencing 11 November 538 nursing posts vacant.	
			3.7	**Discharge / transfer checklist**	UHL	Rachel Overfield	Julia Ball	17.10.13	Transfer checklist reviwed. Meeting with Mandy Gillespie for final sign off. Roll out via matrons next week (11.11.13) District nurse /practice nuse referral letters /drug authorisation letter now all available on ICE and this will replace where possible all paper versions by end of November. Ann Hall supporting access to ICE /ICM and training for all medical ward sisters and matrons . Will be completed by 28.11.13	
			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. £50K funding agreed. Details of equipment to be agreed this week. 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 agreed. Detail to be confirmed re posts later this week. Aim to have in post end of November.	
			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 planned from 6 November 2013 onwards. KPIs improving. Issue with meal time deliveries. May need contractual changes. 1st LiA meeting has taken place at LRI and had excellent engagement from both UHL nursing and interserve teams. Further meetings booked for LGH and GGH sites.	
			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	Information from matrons to be collated next week Funding agreed. RT2C team to give detailed plan by 18.11.13. majority of areas have space designated and signage will be put up to clearly identify areas. Where minor works needed to provide space costings being requested this week.	
			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 standards. Complete audit along side 1.2 This workstream to be combined with 3.2 going 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 long to get therough contract variation process therefore Bank HCAs to be used for first two months. 8:00 am - 8:00 pm cover at LRI/LGH - in place 1 December 2013.	
			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 04.11.13. Task and Finish group to meet Monday 18th Novemeber. Meetings with matrons and sisters in medical CMG to take plavce with RO & JB Thursday/Friday next week	This Action has been moved from Action Area 2 (ED/Specialty Working) moving forward and was previously identified as Action 2.15 on this sheet.
			3.15	**Communication to patients - setting expectations at point of admission**	UHL	Pete Rabey	Ann Hall	15.11.13	Rachel Overfield has had several meetings with nursing staff to ensure that their communication to patients is accurate. There is a new ward round standard being written which will be reviewed to account for this. There will be a need to target specific areas where messages communicated to patients are not accurate and can create more complex patients than necessary.	This Action has been moved from Action Area 2 (ED/Specialty Working) moving forward and was previously identified as Action 2.16 on this sheet.
			3.16	**Implementation of a functional patient census used consistently, twice every day**	UHL	Rachel Overfield	Julia Ball	30.11.13	Rachel Overfield has had several meetings with nursing staff to ensure that their communication to patients is accurate. There is a new ward round standard being written which will be reviewed to account for this. There will be a need to target specific areas where messages communicated to patients are not accurate and can create more complex patients than necessary.	This Action has been moved from Action Area 4 (Operational) moving forward and was previously identified as Action 4.1 on this sheet.
			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		
			3.18	**Protocols and procedures for the patient census to be written.**	UHL	Julia Ball	N/A	30.11.13		

4	**Operational**	Richard Mitchell	~~4.1~~	~~**Implementation of a functional single discharge list used consistently every day**~~	~~UHL~~	~~Richard Mitchell~~	~~Phil Walmsley~~	~~30.11.13~~	~~List in place since 29/10/13. Ongoing work to fine tune the effectiveness. UHL execs now dial into the meeting and further change to the process will be implemented on Thursday.~~	This Action will be moved to Action Area 3 (Ward Practice) moving forward and is identified as Action 3.16 on this sheet.
			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	~~15.11.13~~ 12.12.13	Some changes implemented but date extended to incorporate more extensive process improvements	
			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 action. Assessment centre next week. We are confident some staff can start immediately. **Nb- this is not a significant delay but is a mission critical action**	
			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 action. Advert for vacancies has been placed. Currently covered through bank and agency.	
			4.6	**Review protocols for discharge lounge - re - trollies**	UHL	Richard Mitchell	Phil Walmsley	Complete	Protocol written. Appropriate patients transferred to the discharge lounge.	
			4.7	**Minor estates work discharge lounge**	UHL	Richard Mitchell	Phil Walmsley	13.12.13	Minor estates work required to increase scope of patient mix in 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	Meeting held. More up to date information circulated. Discussion at ECAT last week and CMG are exploring ways to increase EFU/ EDU function	
			4.10	**Meeting to agree the subcontracting of elective activity**	UHL	Richard Mitchell	Sarah Taylor	Complete	Agreement made to outsource work whilst plan to increase core capacity and reduce backlog agreed.	
			4.11	**Opening of additional assessment unit capacity and benefits fully realised**	UHL	Catherine Free	Jane Edyvean	30.11.13	Beds opened. Date change to note change of detail in action	
			4.12	**Additional Decanting space via Vanguard converting daycase unit into an inpatient unit.**	UHL	Richard Mitchell	Sarah Taylor	30.11.13	Estates work begun- will be complete by 30.11.13.	
			4.13	**Completion of capacity modelling**	UHL	Richard Mitchell	John Roberts	Complete	Complete and shared with Emergency Care Hub, UCWG. Response paper received and meeting being organised to discuss modelling assumptions with Dave Briggs	
			4.14	**Ensure consistent use of the outlier list**	UHL	Richard Mitchell	Helen Mather	Monthly	Outlier list is shared at 1400 and reviewed at 1700 each day	
			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 each site meeting	
			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 at ECAT	
			4.17	**Review of internal escalation process**	UHL	Richard Mitchell	Phil Walmsley	30.11.13	Meeting with HM 7/11/13. Escalation plan being reviewed	
			4.18	**Appoint to senior site manager post**	UHL	Richard Mitchell	Richard Mitchell	31.01.14	JD writtten, candidates contacted. Interviews planned for end of wc 2/12/12 **Nb- this is not a significant delay but is a mission critical action**	
			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 delay but is a 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 held and decision paper to ECAT on 29-11-13	
			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 warning has been shared	
			4.23	**Refocus on minimal non-admitted breaches**	UHL	Richard Mitchell	Jane Edyvean	Monthly	This is checked at every site meeting and disciplinary warning has been 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.	

5	**Multi-agency Integration**	Jane Taylor	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	Funding has been approved. This has also been reviewed for accuracy given the progress now made in relation to recruitment processes and required agency staff. Staffing structure has been reviewed with LPT and is now complete. Of 10 vacancies identified across the SPA and CRT teams, 10 have now been recruited to. KPIs have been written as well as a formal delivery plan for this sub-section. Intention is to Go Live with a pilot on 02.12.13 until the end of March. All parties agreed to a structured <2 hour assessment time across UCC and ED. 2 additional staff are required to support the CDR through the night. The banding is now confirmed but appointments are expected to have older people background. EMAS are sharing data on the number MH patients that are medically stable that are taken to ED that this service would redirect. GEH sharing peak time data for MH patients arriving at the UCC. Recruitment will immediatley followin gthe meeting on 14.11.13.	
				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	
			Use of Community Hospital Capacity	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	17.10.13	The process was set up by the initial date, the ability to identify 4 patients every day and then have them transfer before 9 has been a challenge. Data collection process refined to capture activity on an on going basis. The corrolation between patients identified and those been transferred before 9 is being sought to ensure bed use is maximised. 4 patients are not being tansfered before 9 every day but the process to maximise bed use through the day is being driven.	
				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	No further progress on previous weeks update: - All City beds are planned to be open by the 1st December - The additional 24 Loughborough beds are opening on a phased basis as staff are recruited - 12 open currently - In addition the ICS service will be at full capacity prior to Christmas at present activiity is being phased in. - City are working towards 24 beds, EAst have 12 open and are working towards 48 and West have 48 already open.	
			Integrated Discharge	5.5	**Single integrated discharge team ***	CCGs	Jane Taylor	Tracy Yole	30.11.13	CHC team member comenced this week. Additional admin support to support care home placement / D2A due to start within the next 2 weeks Office accomodationis due to be available next week and will further support integration.	
				5.6	**Directory of Services – knowing what's available**	CCGs	Jane Taylor	Tracy Yole	31.12.13	Further work is being undertaken to ensure appropriate referral for EOL care which is provided by LPT and palliative care which is provided thorugh CHC fast track. At the moment the role of these services are being confused.	
			CHC and Care Homes	5.7	**Expediting CHC decisions***	LA	Jackie Wright Helen Manning	Alison Cain	30.11.13	CHC - 1 WTE has been allocated to the integrated discharge team and started this week. The remit is expidite health funding desisions, review and agree fast track referrals, provide quality checks on DST sumissions to avoid bounce back. Support for D2A DST assessments has now been schedulled and the first 10 assessments agreed and further 10 is being reviewed with a view to completing by the end of next week. No pannel delays as of 19th Nov.	
				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	Following meeting with Clarendon Mews and partner organisations - the option of pursing a block booking with the home for the purpose of D2A is not an appropriate option. The facilities for dementia patients are well worth persuing and this will be picked up by the discharge team at UHL. There is not quick solution to cohort D2A in the right environment / model of care. This needs taking forward with strategy leads to commission approprite environments for what will be an increasing need.	

				5.9	**Care homes and protocol for falls management**	LA / CCGs / GEM	Jackie Wright Helen Manning Caroline Trevethick	Jane Taylor	30.11.13	An initial meeting has been set up with care homes and wider partners for the 3rd December.	
			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	15.12.13	Meeting set up for 21st November. Links with 5.6	
			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**	UCB / UHL	Kevin Harris Richard Mitchell Azhar Farooqi Nick Pulman Hamant Mistry	Julia Ball	30.11.13	Awaiting information from UHL on proposed patient information.	

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 delivery date will be marked Amber if on track for the revised delivery date.
2	Significant Risk or Issue or Deadline already missed – unlikely to be completed as planned.
1	Not yet commenced.

		Monday				Tuesday				Wednesday				Thursday				Friday				Saturday				Sunday			
Activity checklist	Lead	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700
Site meeting started on time and all bed numbers inputted before the start of the meeting	DM																												
Representation from all specialities at site meeting	DM																												
Confirm current performance (%)	DM																												
Note any IPC issues and key actions	IPC																												
Review of actions from previous meeting	DM	X				X				X				X				X				X				X			
All preventable non-admitted breaches escalated since the previous meeting	ED rep	X				X				X				X				X				X				X			
Confirm patient level plans for all patients in dept over 180 minutes	ED rep																												
ED staffing numbers checked- plans in place to resolve any problems	ED rep																												
Confirm capacity and staffing at the Glenfield	DM																												
Confirm capacity and staffing at the General	DM																												
Confirm next two patients to move out of AMU and AFU	AMU rep																												
Confirm priority discharges for the day	Med rep		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X
Confirm how many patients are in the discharge lounge	Med rep	X				X				X				X				X				X				X			
Confirm number of empty beds on ward two	DM																												
Confirm there are no patients suitable for the discharge lounge not already in the discharge lounge	Med rep																												
Discharge list completed by all wards- clear single discharge plan in place	Med rep	X				X				X				X				X				X				X			
Confirm how many discharges will take place before the next site meeting-medicine	Med rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting-surgery	Surg rep				X				X				X				X				X				X				X
Confirm how many, if any surgical patients will be cancelled today and tomorrow	Surg rep	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
Confirm how many discharges will take place before the next site meeting-orthopaedics	Ortho rep				X				X				X				X				X				X				X
Confirm how many, if any ortho patients will be cancelled today and tomorrow	Ortho rep	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
Confirm how many discharges will take place before the next site meeting-cancer	Ca rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting-gynaecology	Gynae rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting-paediatrics	Paeds rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting-ITU	ITU rep				X				X				X				X				X				X				X
Confirm outcome from 1pm single discharge meeting	Med rep	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
Afternoon outliers identified and list shared	DM	X	X			X	X			X	X			X	X			X	X			X	X			X	X		
Plan to move outliers before 8pm shared	Med rep	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Confirm Acute Medical Clinic will stay open	Med rep																												
AMU staffing numbers checked-plans in place to resolve any problems	Med rep																												
Any other staffing shortages confirmed with bank team	DM																												
Confirm of DTOC state- all problems escalated	PW TBC																												
Confirm community bed state- all problems escalated	DM																												
Confirm portering situation - all problems escalated	Speci-alities																												
Confirm TTO situation- all problems escalated	Speci-alities																												
Two duty managers on duty, with one in ED	DM																												
Two bed coordinators on	DM																												
Confirm site state (RAG) for all sites	DM																												
Confirm any other issues for escalation	DM	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Confirm plan for the evening for all sites, signed off by SMOC and exec oncall informed	SMOC	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Site meeting actions for all sites confirmed and circulated immediately	DM																												