To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**29 August 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:

- Performance in July was above the agreed trajectory, although the national performance target was not met. Since July performance has been inconsistent with the difference between actual performance and target narrowing.
- July saw variable performance from 63.43% (Type 1 and 2 activity) to 95.61%, in-month. When combined with the Urgent Care Centre (UCC) performance improved from 85.27% to 88.34%.
- Performance year to date stands at 82.11% (type 1 and 2 activity) and 86.05% (campus performance) respectively.
- There has been an overall reduction in activity of 6.7% (1,002 attendances).
- The 'Single Front Door' pilot started on 17 July 2013. All adult walk-in patients are now directed through the UCC. Regular progress reports and conference calls remain in place to monitor performance.
- Three out of the five quality indicators have been achieved.
- Performance continues to 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 Yes	**Performance KPIs year to date** Please see report

Resource Implications (eg Financial, HR)
Yes

Assurance Implications
The 95% (4hr) target and ED quality indicators.

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO: **TRUST BOARD**

REPORT FROM: **RICHARD MITCHELL, CHIEF OPERATING OFFICER**

REPORT BY: **JANE EDYVEAN, EMERGENCY CBU MANAGER**

REPORT SUBJECT: **ED PERFORMANCE REPORT – SUSTAINING AND IMPROVING ED PERFORMANCE**

REPORT DATE: **29 AUGUST 2013**

1. Introduction

UHL continues to perform poorly against the four hour emergency care target, with better performance against the quality indicators. Plans for performance improvement including the ECAT action Plan and the wider NHS England (NHSE) action plan are in place and continue to be refined. Performance against a revised trajectory is monitored on a daily basis and the Trust has agreed to achieve 95% performance on a sustainable basis from the end of September 2013.

This report provides an overview of performance for July 2013. Included is an overview of factors contributing to poor performance and the internal and external actions taken to remedy this.

2. Performance overview

In July 2013, UHL had a wide variation in daily performance, ranging from 63.43% to 95.61% against the 95% standard for type 1 and 2 activities. In terms of overall performance, UHL achieved a performance of 84.49% for type 1 and 2 attendances. When the Urgent Care Centre figure is included, overall performance moves to 88.34%.

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	13,516	2,096	84.49%
Urgent Care Centre	Type 3	4,555	11	99.76%
UHL + UCC Total	All	18,071	2,107	88.34%

The full year to date position is 82.11% for type 1 and 2 activity and 86.05% overall for the campus.

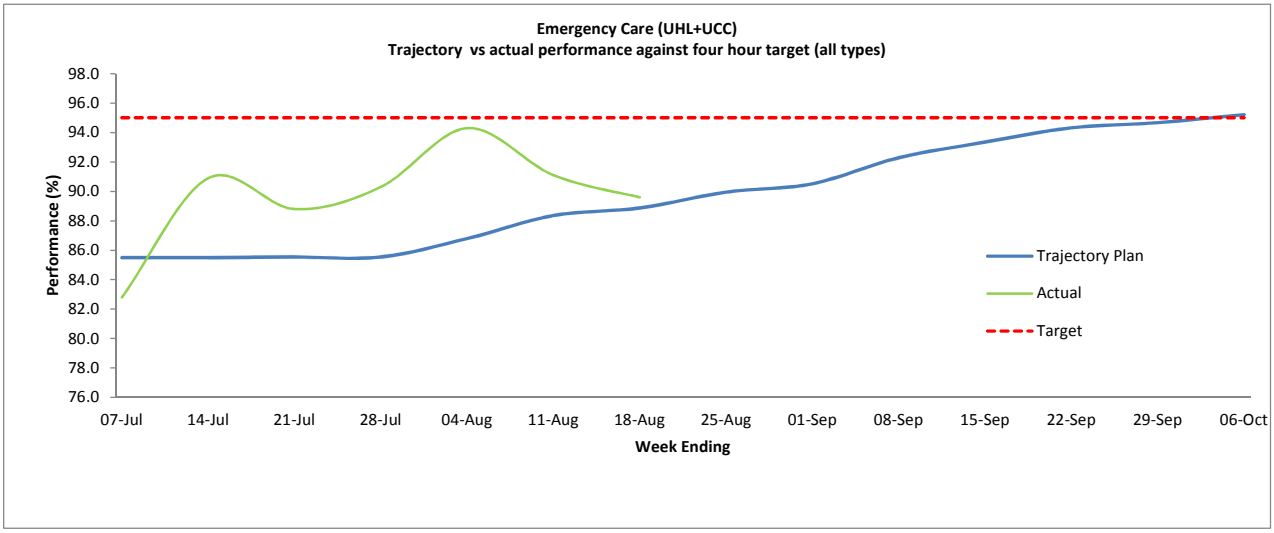
Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	56,752	10,153	82.11%
Urgent Care Centre	Type 3	16,197	20	99.88%
UHL + UCC Total	All	72,949	10,173	86.05%

Performance overall for the past 6 months has again showed variation, however, there has been an improvement in July:

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	YTD
ED 4 Hour Waits UHL + UCC	96.3%	98.0%	96.8%	94.2%	92.0%	92.0%	84.9%	86.1%	84.7%	82.0%	88.7%	85.3%	88.3%	86.1%
ED 4 Hour Waits - UHL (Type 1 and 2)	95.4%	97.5%	96.0%	92.6%	90.0%	89.8%	80.9%	82.2%	80.4%	77.0%	85.5%	81.6%	84.5%	82.1%

3. Performance against the revised trajectory and improvement plan

As detailed above, a trajectory for achieving 95% performance has been developed. This has now been signed off by NHS England. There will be variation on a week to week basis against the weekly targets for performance improvement, but the plan is predicated on achieving 95% by the end of September 2013. Actual performance against the revised trajectory is detailed below:



Performance remained above trajectory for the majority of July with sustained weekly performance improvement into early August. This was a better position than the June position. Since this period however performance has deteriorated and daily actions are being taken to rectify this. Detailed analysis has also been undertaken to examine the time of day and therefore the profile of breaches and by day of the week. This has shown some variation with the Trust remaining vulnerable particularly overnight.

Based on current activity levels, and the latest weekly information, UHL can have no more than **27 breaches per day** or 190 breaches per week to achieve 95% on a weekly basis.

4. **Breach Analysis**

The number of breaches varies widely on a day to day basis, but there are some clear trends when reasons for breaches are examined. Access to beds is the primary cause of breaches, followed by ED capacity and ED process. It is also clear that when there is not timely access to beds, all other reasons for breaches begin to deteriorate. The actions being taken focus on resolving the key reasons for breaches.

Delay Reason	May-13	Jun-13	Jul-13	Total	Cumulative %
Bed Breach	468	655	575	1723	**30%**
ED Capacity (Cubicle Space)	544	612	417	1574	**27%**
ED Process	336	477	354	1185	**20%**
Clinical Reasons	181	214	240	663	**11%**
Investigation (Imaging and Pathology)	66	68	61	205	**4%**
Transport	41	54	74	176	**3%**
Specialist Assessment	60	43	61	170	**3%**
Treatment	18	34	38	93	**2%**
Specialist Decision	15	9	11	40	**1%**
Sum:	**1729**	**2166**	**1831**	**5829**	**100%**

Allocation	May-13	Jun-13	Jul-13	Total	Cumulative %
MAJORS	1181	1491	1215	3950	**68%**
RESUS	305	374	370	1080	**19%**
MINORS	200	215	188	609	**10%**
CHILDREN	43	86	58	190	**3%**
Sum:	**1729**	**2166**	**1831**	**5829**	**100%**

A significant number of breaches were previously classified as reason ‘unknown’. Work to remove the use of the ‘unknown’ classification was presented to ECAT on 23 August 2013.

A letter is circulated weekly updating all staff on performance and key actions being taken. Daily meetings are in place to resolve key issues from the previous day or which may be impacting on today's performance.

5. **ED Quality Indicators**

Three of the five quality indicators were met in July with results more positive than reported in the previous month. Unplanned re-attendances have remained the same and are marginally better than the 5% threshold, and the % patients who left before being seen is the lowest since December 2012. Overall time in the department has increased whilst the time to initial assessment shows a slight deterioration.

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	TARGET
Left without being seen %	2.5%	2.8%	2.9%	3.3%	3.4%	2.7%	3.0%	2.4%	<=5%
Unplanned Re-attendance %	5.2%	5.5%	5.4%	5.3%	4.8%	5.1%	5.1%	4.6%	< 5%

TIMELINESS

	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	TARGET
Time in Dept (95th centile)	344	457	432	483	504	398	421	400	< 240 Minutes
Time to initial assessment (95th)	24	25	33	45	37	31	31	37	<= 15 Minutes
Time to treatment (Median)	68	79	60	47	55	45	43	41	<= 60 Minutes

A dedicated task and finish group has been 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 are being progressed in collaboration with EMAS set to address the issues at the point of handover from ambulance personnel. 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 assist in driving up performance.

6. **Governance arrangements**

Internal assurance against plan and delivery of actions continue to be measured through the arrangements described above. Wider assurance is provided through ECAT with external assurance provided principally through the LLR Urgent Care Board which continues to receive all action plan updates and performance dashboards. It has been agreed that a joint clinical group of primary and emergency care physicians will meet to establish how pathways can be improved to lessen the burden on the ED.

7. **Winter plan**

The process for winter planning has begun and is being led by the Deputy Director of Operations. UHL is using the NTAD template as a basis for the plan and has arranged an information sharing meeting with other Trusts in the East Midlands. The bed modelling part of the winter plan will be complete by the end of August 2013.

8. **Recommendations**

The Trust Board is asked to:

- Note the contents of this report
- Acknowledge the continuing focus on further and continued sustained performance improvement
- Note the on-going support from the CCGs and healthcare partners to deliver the required step changes across the Health Economy
- Note the weekly performance improvements against the revised trajectory for improvement
- Note progress against the detailed actions to turn performance around over the forthcoming weeks.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING: **TRUST BOARD REPORT**

FROM: **RICHARD MITCHELL, CHIEF OPERATING OFFICER**

DATE: **AUGUST 2013**

SUBJECT: **EMERGENCY DEPARTMENT MEDICAL AND NURSING WORKFORCE PLAN**

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1. INTRODUCTION

1.1 This report provides an update on the paper presented to the Trust Board in July 2013 concerning the workforce in the Emergency Department, which described the current risks to the supply and current initiatives being undertaken.

1.2 This report focuses specifically on the medical and qualified nursing workforce plan for the Emergency Department (ED and EDU) demonstrating the most likely impact of current initiatives being undertaken.

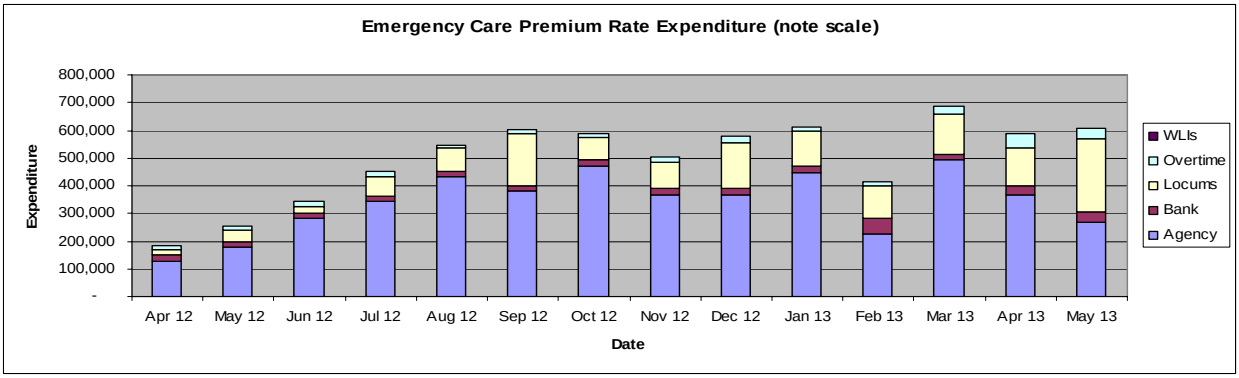
1.3 The workforce plan covers the next 18 months to January 2015 on the assumption that over the next few months a more detailed piece of work will be undertaken as part of the workforce modelling that will form an integral part of the full business case being prepared as part of the emergency floor development.

1.4 The driver for the workforce plan was not only to quantify the likely benefits of the initiatives but also to ensure cost containment and an improved pay expenditure position.

2. HEADCOUNT AND PAYBILL

2.1 The pay bill spend for the Emergency Department in 2012/3 was £19.34m. However, the total pay budget was £16.85m, representing an overspend of £2.49m (15%). For the year to date, staffing expenditure stands at £7.7m at month 4, with a YTD overspend of £1.187m.

2.2 A similar trend to the previous financial year is seen in 2013/14 owing to the increased reliance on agency and locum staff and the enhanced rates used to provide the incentive for staff to cover shifts. Further to this, for many months there has been a continuation of shifts routinely covered from 6pm until 12 midnight for which premium rates continue to apply.



2.3 Fifty percent (£9.65m) of the total pay bill in the Emergency Department was spent on Medical staff in 2012/13. This represented an overspend of £2.19m against the Medical staff budget which was £7.46m. Of the £9.65m total medical pay spend, £6.31m (65%) was spent on substantive staff, with premium pay (agency and locum pay) accounting for the other 35%.

2.4 The total nursing pay spend in 2012/13 was £7.2m. This represented an overspend of £380k against a budget of £6.82m. Of the £7.2m total qualified nursing pay spend, £5.61m (78%) was spent on substantive staff, with premium pay (agency and bank) accounting for the other 22%.

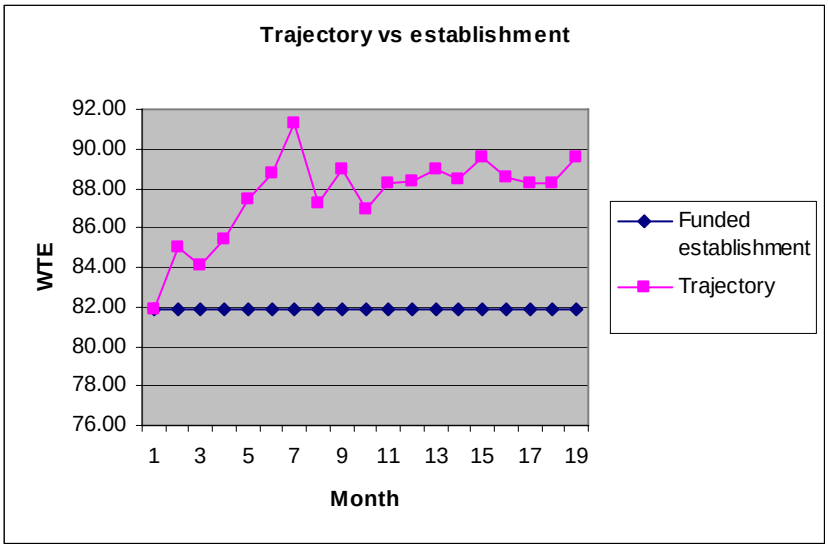
2.5 The current position year to date is summarised in the table below:

	YTD Actual
Total Medical Pay bill	4,232
	40.09%
Agency	70
Locum	613
Substantive	3,550
% substantive	83.88%
% Premium	16.12%
Total Nursing Pay bill	5,675
Agency	1,342
Bank	440
Substantive	3,893
% substantive	68.59%
% Premium	31.41%

2.6 A workforce plan is required not only to inform targeted recruitment initiatives but also to provide a more stable workforce that is not reliant on high levels of agency and locum staff. Further to this, an effective workforce plan will deliver more effective management of the pay bill and the essential contribution to the in year financial recovery plan.

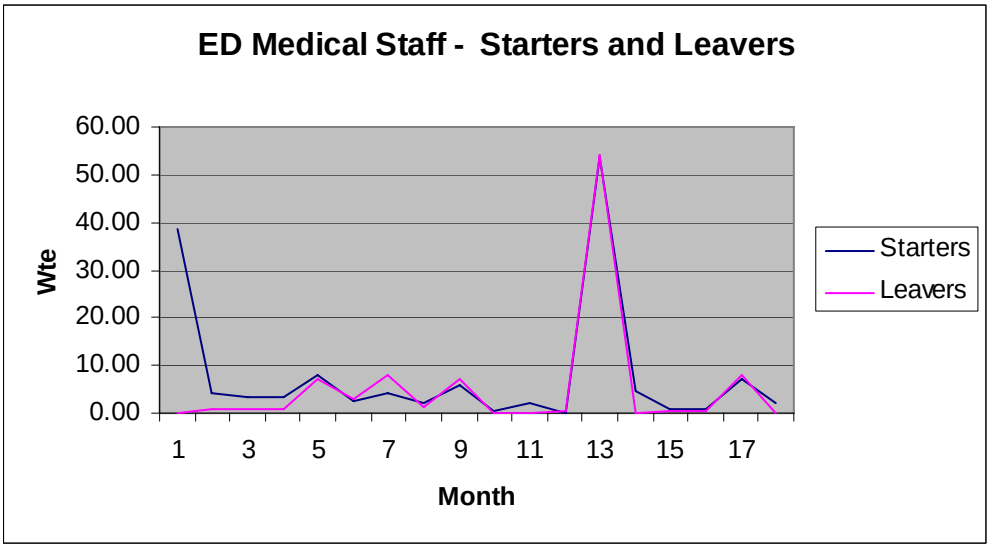
3. MEDICAL WORKFORCE PLAN

3.1 A trajectory for recruitment into more substantive posts is shown in the chart below:



Whilst it appears that the projected in post establishment is higher than funded posts, it should be noted that the current staffing levels, when locum and agency staff are taken into consideration, are in excess of the plan shown above. Further to this, a fill rebasing exercise is required in order that the staffing levels are aligned to service need. This will also include a rebasing of the budget and where different groups are allocated on the ledger this will deliver a robust model that reflects the assumptions within the financial recovery plan. It should be taken therefore that the current trajectory presents the upside scenario.

An analysis of starters and leavers has been undertaken and is based on the outcome of current recruitment activities. This analysis shows that if recruitment activity is managed proactively then the number of starters and leavers follow similar profiles.



3.2 The traditional training route for Emergency Department Consultants is through the Acute Common Core Stem (ACCS) training programme. Although it has been suggested that "Many ACCS trainees migrate to another specialty rather than progressing to ST4 in Emergency Medicine" (National "Emergency Medicine Taskforce Interim Report" published November 2012.), the department has recruited to 4 posts. Two vacancies are expected from February but it is projected that fill rate will return to 4 from August 2014.

3.3 Despite concerns that the development of Major Trauma Centres (MTCs) across the country (22 in total) would have a detrimental effect on the recruitment to Emergency Consultant posts, the Trust has recently achieved Trauma Unit status. As part of UHL's role in the Trauma network, the Trust has been designated as the Regional Centre of the coordination of Pre Hospital Care. As a consequence it is felt that this will help the Trust in attracting consultant staff.

3.4 To further aid the recruitment to consultant posts a strategic approach to improving recruitment is being implemented based on "Five Pillars" of future development:

Paediatric Emergency Medicine
Academic Emergency Medicine
Geriatric Emergency Medicine
Medical Education as a special area of interest
Pre-Hospital Care

3.5 The “Five Pillars” strategy aims to crystallise our reputation in these five areas. Such areas of excellence are also likely to attract senior trainees. It is essential that UHL is regarded as having areas of excellence and unique selling positions to attract doctors at all levels which are a scarce resource. The principles are being used in informal discussions with potential candidates and candidates appointed with a potential interest in specific areas. It is hoped that the approval of a specific relocation package and scope for individualised remuneration packages including recruitment and retention premia will further assist in the department delivering the consultant element of the workforce plan.

3.6 Given that the number of trainees available does not meet our demands, we have gaps in the trainee doctor rotas. UHL has been successful in the last couple of years in attracting this grade of doctor and will continue to build on this. However given the national picture, vacancies are likely to remain. The success of international recruitment is providing the necessary flexibility in order to backfill vacant positions. Contained within the workforce plan are assumptions around the phased implementation of international doctors to ensure there is backfill from early in 2014 where there are known vacancies. This initiative will be a continuous feature of ED medical staff recruitment for the foreseeable future.

3.7 The department will benefit from the release of educator time amongst junior doctors from August 2014. Currently these post holders are only available for 50% of the time, however from August 2014 they will be available on a full time basis. To further strengthen the junior staffing compliment the department has just received confirmation from the East Midlands LETB that the F2 bid has been successful. This will incorporate 18 F2 posts within Adult and Paediatric Emergency and Geriatric Medicine with effect from August 2015. These will replace the existing academic educator posts.

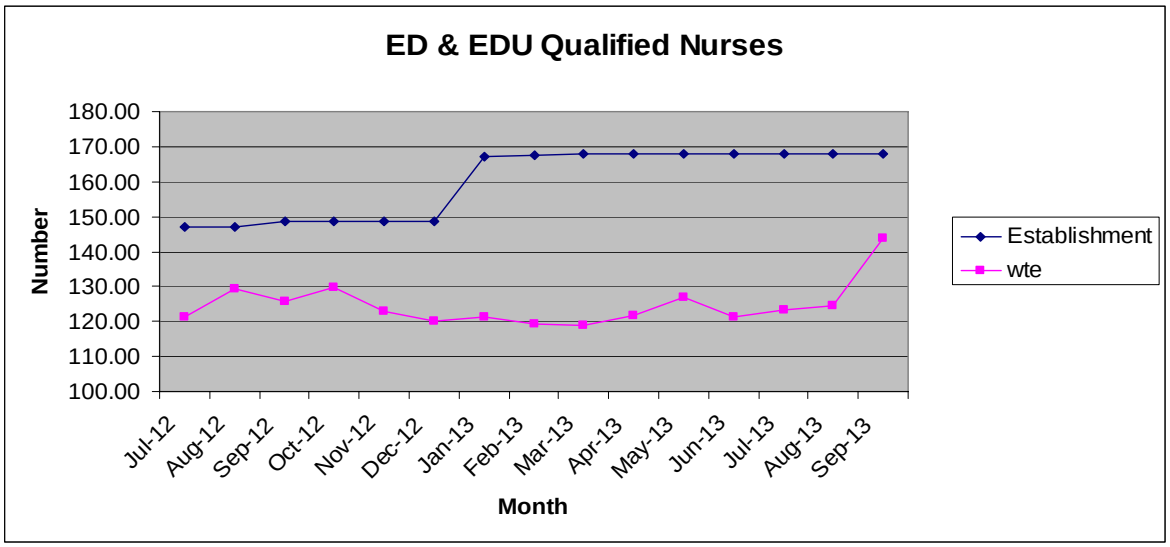
3.8 The department has a high degree of confidence in securing more GP’s to work on a sessional basis. The role has proved very successful since its inception in 2008 and many of the original GPs still work with us and have requested to increase their hours. There are currently 8 ED GPwSi’s, soon to be 11, and more applicants for posts which we are advertising shortly. It is anticipated that by December 2013 there will be 15 GPwSi‘s working a variety of hours within the department. Of the new recruits there is usually an attrition rate of 25%–30%, therefore over the year it would be expected that 3-4GP’s would leave but be directly replaced.

4. NURSING WORKFORCE PLAN

4.1 Turnover for the last twelve months has been around 11%. This is higher than the Divisional average over the same period of 8.97%.

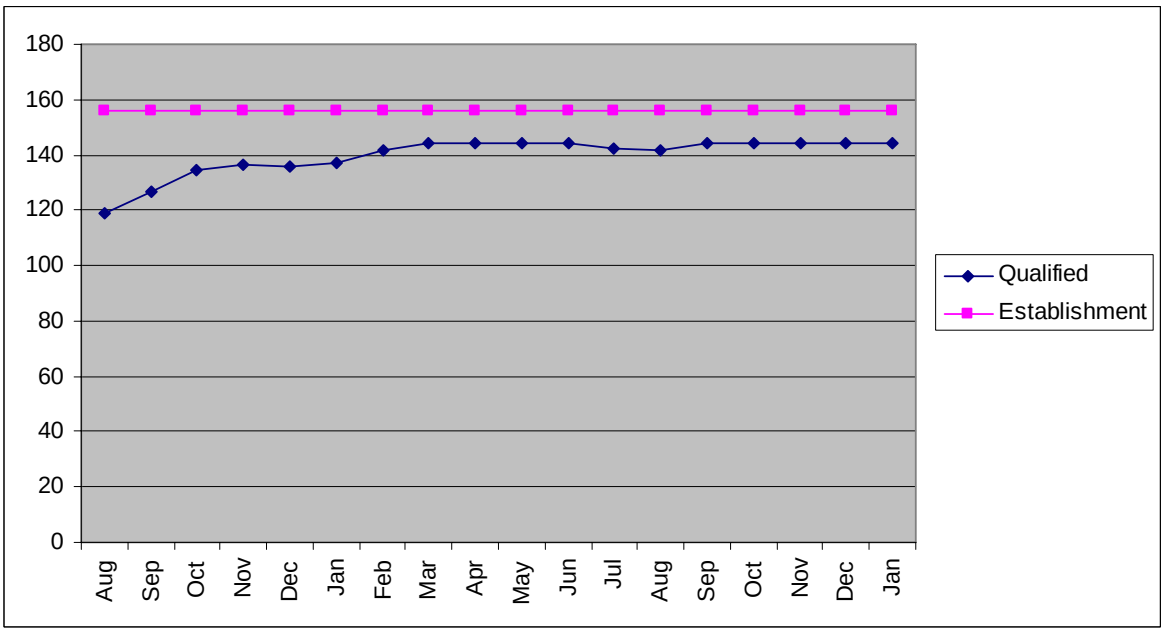
4.2 Work has been ongoing for some time to improve the vacancy position for qualified nurses in ED. A number of nurses have been appointed, however promotions to Band 6 and 7 are nearly always internal and when coupled with turnover has meant that vacancies have continued. The challenge to recruit to qualified posts, against the national picture of a shortage of ED nurses, has been increased with the introduction of the assessment bay in January 2013. This resulted in an additional requirement to recruit a further 18.45wte posts, taking the total vacancies to 45wte.

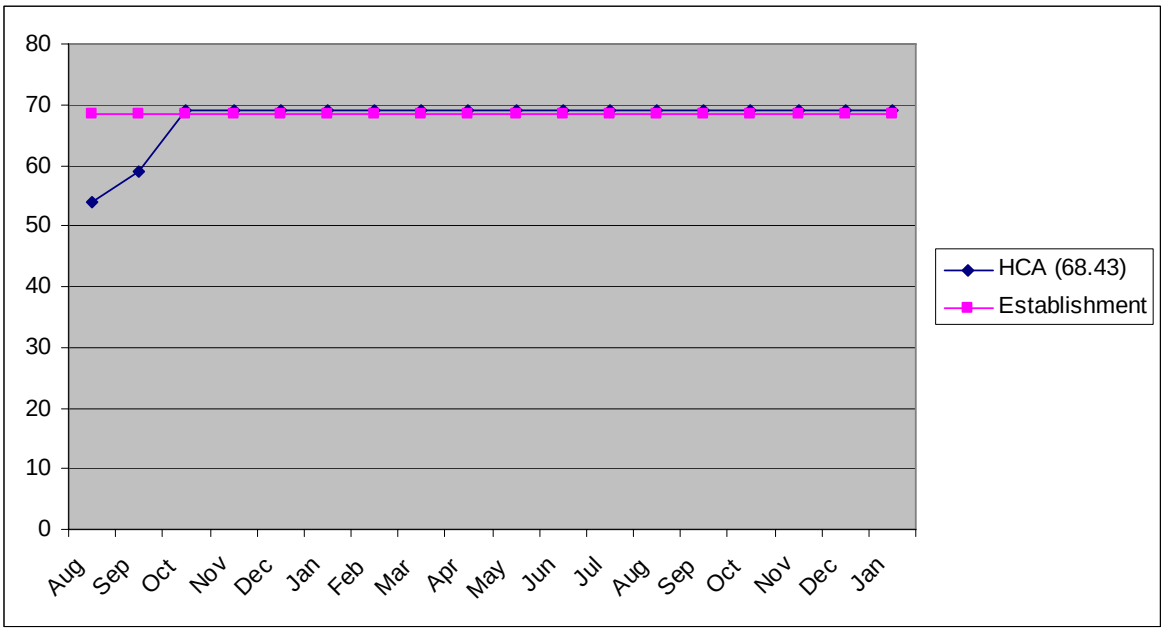
This is demonstrated in the chart below:



NB figures for August and September are projections.

4.3 A review of nursing establishments has taken place leading to the development of a trajectory for fill rates based on recruitment activities reported to the Trust Board in July. The trajectory for in post establishment going forward is shown in the tables and graphs below. A further breakdown of monthly numbers is provided in appendix 1.





4.4 To boost the in post establishment, and to respond to the changes in activity as a consequence of the introduction of the single front door, staffing for Triage (5.6wte) will be offset against existing vacancy factor going forward.

4.5 The potential to recruit either dual trained or mental health nurses into existing Band 7 vacancies is being explored as it is thought that this would further yield a greater in post establishment with the benefit of greater expertise afforded for patients with mental health problems.

4.6 There has been a review and reduction of the existing nursing numbers per shift, to reflect the reduction of ED attendances and the change in process with the single front door and expansion of the assessment day. This has been factored into the workforce plan and is likely to minimally reduce the current vacancy factor. One ENP post that has become vacant on account of a retirement remains vacant. As from October 2013 new shift patterns will come into effect, which will match staffing levels to activity. Again this has been factored into the workforce plan.

4.7 The range of recruitment and retention initiatives that have been previously described will continue at pace to ensure optimal fill rates against the recruitment trajectory are maintained.

5. THE IMPACT OF THE WORKFORCE PLAN

5.1 The most significant impact of the medical workforce plan will be to provide a more stable senior workforce. This will enable more senior decision makers for the department, which has an impact on the efficiency of the patient pathway. Additionally medical education for both nursing and medical staff will be enhanced.

5.2 The successful implementation of the workforce plan, as previously highlighted, will reduce reliance on locum and agency shifts which have been used to fill gaps on the various levels of medical and nursing rotas. This will provide greater continuity for staff, which will have a positive impact on the quality of care the department can provide.

5.3 The department undertook a stress audit in the early part of 2013. One of the driving factors highlighted within the findings was poor staff morale created by a continuous feeling that the department was understaffed. Opportunities to address this will be sought through the execution of the workforce plan underpinned by extensive recruitment strategies and other supporting activities.

6. RISK

6.1 A strong recruitment and retention strategy will be required in order to deliver the proposed workforce plan and minimise the need for locum and agency staff. The service will remain vulnerable to external market factors and the national shortfall in ED nursing and medical personnel.

6.2 Whilst the service has become an attractive area for international recruitment, the service may become vulnerable should recruits decide to leave unexpectedly. Similarly, the length of time for some candidates from appointment to starting in post can be lengthy and unpredictable.

6.3 There has been concerted effort to recruit to consultant posts. It is assumed within the plan that those who have recently been offered posts (substantive and locum) or who are making a choice to stay at UHL will take up post. There is therefore a degree of risk that all consultant posts may not be filled substantively. Against the national picture, this may leave the service with gaps in senior provision.

6.4 Changes are proposed for the next phase of the plan. This requires buy-in from the workforce in order that the service is not vulnerable to cost. An effective communications strategy will therefore need to underpin the next stage of development.

7. NEXT STEPS

7.1 In terms of nursing, over the last couple of months, the Lead Nurses and Matrons have undertaken a detailed piece of work to confirm the nursing establishment across the new CBU. This has now been combined with up-to-date vacancy information and information on the progress of recruitment so that an accurate picture is maintained going forward.

7.2 There are plans to review the medical and nursing workforce using benchmarking against comparable ED's. It is suggested that there is the potential to reduce Band 5 nursing establishment due to decreased ED attendance, however, this is dependent on maintaining patient outflow. The effect of this is shown in the workforce plan from April 2014 to ensure staffing levels are maintained during the winter pressures**.**

7.3 An initial review has taken place of the medical staffing requirements based on patient flows and the existing shift patterns within the current daily schedule. The direction of travel points to a shift from the current shift patterns for medical staff to a rota where staff are recruited to a pattern of working. In moving to this position the use of international recruits and the flexibility that this workforce offers could support implementation. This requires further attention to ensure the optimum use of staff and skill mix across the department. It will also drive the reduction in cost having established the correct baseline for the service.

7.4 The Trust has been looking to adopt an Integrated Workforce Planning Tool and this will be used in the development of the detailed workforce model for the new emergency floor. The tool is designed to facilitate a review of both the medical and non-medical workforce and determine a future costed configuration. This work commenced on 20th August 2013. It is estimated that this will be concluded by November 2013. This will inform future iterations of the workforce plan.

8. RECOMMENDATIONS

8.1 The Board is requested to note the contents of this report comment on and support the initiatives being undertaken.

ED Workforce Plan Appendix 1

Nursing Staffing Trajectory – In post versus establishment August 2013 – January 2015

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Band 7 (13.74)	11.34	11.34	10.34	12.34	12.34	12.34	13.34	13.34	13.34	13.34	13.43	13.34	13.34	13.34	13.34	13.34	13.34	13.34
ENP (17.17)	17.17	17.17	17.17	17.17	16.57	16.57	16.57	16.57	16	16	16	16	16	16	16	16	16	16
Band 6 (24.09)	18.67	22.47	22.47	20.47	20.47	21.47	21.47	23.47	23.47	23.47	23.47	23.47	22.47	22.47	22.47	23.47	23.47	23.47
Band 5 (101.14)	71.6	75.6	84.6	86.6	86.6	86.6	90.6	90.6	91.6	91.6	91.6	89.6	89.6	92.6	92.6	91.6	91.6	91.6
Establishment	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14	156.14
Planned	118.78	126.58	134.58	136.58	135.98	136.98	141.98	143.98	144.41	144.41	144.5	142.41	141.41	144.41	144.41	144.41	144.41	144.41

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
HCA (68.43)	53.95	58.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95	68.95
Establishment	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43	68.43

ED Workforce Plan Appendix 1

Medical Staff

GRADE	Funded Establishment	Aug	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Total consultants	**19.80**	**15.80**	**16.80**	**17.80**	**18.80**	**20.80**	**20.80**	**20.80**	**20.80**	**20.80**	**20.80**	**20.80**	**20.80**	**20.80**	**21.60**	**20.60**	**20.60**	**20.60**	**21.6**
Associate specialist	**1.00**	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0*	0.00	0.00	0.00	0.00	0.00
Staff grade	**1.00**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0
GP	**2.64 plus 0.5 staff grade funding**	2.45	2.55	2.85	3.15	3.15	3.65	3.65	3.35	3.35	3.65	3.65	3.35	3.35	3.65	3.65	3.35	3.35	3.65
ST 6	**6.00**	4.00	4.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
ST 4	**6.00**	7.60	8.60	9.60	9.60	9.60	10.60	9.60	9.60	8.60	9.60	9.60	10.60	10.60	10.60	9.60	9.60	9.60	9.60
CT 3	**6.40**	7.40	8.40	8.40	8.40	8.40	9.40	9.40	9.40	9.40	9.40	9.40	9.40	7.40	8.40	8.40	8.40	8.40	8.40
Paediatric ED	**2.00**	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30	3.30
GPVTS	**7.00**	7.00	7.00	7.00	7.00	6.00	7.00	7.00	7.00	6.00	6.00	6.00	6.00	7.00	7.00	7.00	7.00	7.00	7.00
ACCS	**4.00**	4.00	4.00	4.00	4.00	4.00	4.00	2.00	2.00	2.00	2.00	2.00	2.00	4.00	4.00	4.00	4.00	4.00	4.00
CT1/2 (Trust grade)	**6.00**	6.50	7.50	7.50	7.50	7.50	7.50	5.50 ****	7.50	7.50	7.50	7.50	7.50	7.00	7.00	7.00	7.00	7.00	7.00
SHO (EDU with EFU)	**2.00**	8.00	7.00	7.00	8.00	8.00	7.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	7.00	8.00	8.00	8.00	8.00
FY 2	**18.00**	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00
TOTAL	**81.84**	**85.05**	**84.15**	**85.45**	**87.45**	**88.75**	**91.25**	**91.25**	**88.95**	**86.95**	**88.25**	**88.35**	**88.95**	**88.45**	**89.55**	**88.55**	**88.25**	**88.25**	**89.55**

* Convert associate specialist post into consultant funding

** 3 OOPE's only do partial on call, weekends and nights only

*** 1.3 wte funded by paediatrics

**** Offset with International recruitment

Additional ST4 posts compensate for OOPEs

International trainees work on a PA system of 40 hours per week not 48

ED Workforce Plan Appendix 1

ED Medical Staff - Starters and leavers

Month	Aug-13	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Starters	38.80	4.10	3.30	3.30	8.00	2.50	4.00	2.00	6.00	0.30	2.00	0.00	53.70	4.60	1.00	1.00	7.00	2.30
Leavers	0.00	1.00	1.00	1.00	7.00	3.00	8.00	1.30	7.00	0.00	0.00	0.30	54.20	0.00	0.30	0.30	8.00	0.00

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:	**20-8-13 pre ECAT update 23-8-13**

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~~ 23/08/13	Different options available for execution. JA has escalated to EMAS CEO. EMAS and PW to meet. Meeting on 9th. Action plan to ECAT 23/08/13 Action plan drafted out and with commissioners/divisions for comment	4
3	ED PROCESS					
Minors	Introduce Minors co-ordinator	PR	RW	23/08/13	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 cover and not completely filled New coordinator starting wc 29/07/13	4
	Focus on zero breaches in minors	RM	BT	1/9/13	New action	4
ED Rapid Assessment Bay	Publish clear escalation plans in place for all areas and roles	BT	JE	~~19/07/13~~ 23/08/13	Work progressing. Need to focus on full staff awareness and compliance once completed. ED to define contingency plan in order to prevent minor breaches – BT/JE by 16/08/13	4
	Install real time dashboard in place for all area and an overview	JC/CF	TC/AC	23/08/13	CF to escalate delays to John Clarke Director of IM&T – meeting arranged for w/c 1/7/13	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
					12/07/13 Mockup of dashboard presented at ECAT. Need confirmation of screens to view – JE 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 26/07/13. Need live data to be displayed. RM 09/08/13 CF to update	
MAJORS	Ensure that Orthopaedic and ENT referrals are direct to wards where appropriate.	PR	CF	~~12/07/13~~ 23/08/13	In case of Orthopaedics, this could also be #clinic CF has sent KH info regarding attending ED within 30 minutes of request which KH to circulate to HoS this week. 26/07/13. JE to meet NK re T&O 31st July. Most areas v. supportive. KH to contact any area struggling to aid in delivery. Need update on any new issues from JE and KH. If no further issues then this is complete	4
	Re-review medical and nursing staff scheduling to match peak demand	RM	BT	01/09/13	New action	4
ASSESSMENT BAY	Increase Cannulation capacity in ED	JE	AC	~~01/08/13~~ 31/09/13	Need update from LL/KM All HCAs to be trained and signed off by 31/09/13	4
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. Case of need requested. Agreed area with Mark Williams. Meeting to update CQC being organised with Sharron Hotson and Michael Clayton 26/07/13. JE Case of need to go to Division this week. Funding has also been requested as part of the RIP/RAP submissions.	4
	LC CCG to talk to LPT in order to improve access	SF	RV	~~05.07.13~~	Meeting Due To Occur On 4th July.	4

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
	to Psychiatric Liaison.			30/08/13	PW Speaking To Sarah Smith JA To Talk To Sue Noyes Re Mental Health Provision To UHL. Geraldine Burdett (GB) and LPT medical lead agreed as links to agree SLA for LPT response times – JE to let GB know. UHL to see the LPT SLA re access times. Update on weekly meetings needed – JE/GB	
4	STAFFING & ENGAGEMENT					
	Develop comprehensive workforce plan for all disciplines with timed action plan and recruitment milestones	JA	JE	~~31/07/13~~ 16/08/13	New action to bring together existing approaches more systematically Need current vacancy position and recruitment strategy by clinical group and grade. Draft paper to come to ECAT on 12.7.13 Still work in progress but going well. Nursing paper tabled. The revised paper to go to the TB would be discussed in advance of the paper being submitted at ECAT on 16th August. JE. Paper not available on 16th. To come to ECAT on 23rd	3
	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~~ 23/08/13	£50,000 funded already. Further £50k requested Non-recurrent. Currently struggling to recruit to posts. PW to discuss with Chrissi Grace about how to progress this. Awaiting confirmation of further £50,000 from bid Awaiting ci formation of further £50,000 from RIP bid – 23/08/13	4
	Appoint 2 locum ED consultants (Resp and Cardiology)	PR	CF	30/09/13	Discussions with potential candidates and specialties on-going. (respiratory candidate pulled out) Meeting with cardiology early July to agree way forward Acting up arrangements to be considered - current cardiology proposal would offer limited coverage so needs further discussion CF and JK 26/07/13. I Loake and BT/MW to agree process for medium risk chest pain patients in ED by 23/8/13 Proposal from general surgery and T&O to PR, to come to	3

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
					ECAT. No longer needed due to reduction in minors breaches Update on new cardiologist as an option. CF	
	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	GPs to be able to admit directly to AMU more consistently	PR	LW	30/08/13	Ambulances asked to check 5 minutes away from LRI with BB re GP patients going straight to AMU ED asked to direct GP patients straight to AMU if beds available	4
	Use of AMC beds and senior doctor review of all GP referrals	CF	LW/PW	19/8/13	Trial to start of consultant review of all GP referrals for and use of 3 AMC beds for GP admissions. LW Possible use of GPs as part of review process – discuss with N Pullman – CF Bed Bureau support for consultant. PW	4
	To agree way forwards on what a 24/7 admission service at GGH would require	JB	PW/LB	30/08/13	JB/PW. JB/PW to meet 18/07. Feedback to ECAT	4
Assessment Units - Consultant - delivered dedicated 12 hour	Stream cardio-respiratory admissions direct to Glenfield	PR	PW/CF	30/08/13	Recognition that cardio respiratory streaming pathway is required – with cardiologists for input Cardiology pathways being discussed between cardiology and ED. PR to take forward	4

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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 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. Associate Specialist cover in CDU agreed, 8-8 Monday to Friday & 8-4 weekends with consultant evening ward round. Move from ward based to team based ward model with post take ward round. Action within 4 weeks.	4
	Address issue of discharge sister ability to discharge to community hospitals/LA	PW	CF /SC	~~26/07/13~~ 30/08/13	PCC bid gone to CCG for additional support to ED and CDU PW to formalise agreement with LA. S Latham setting up training programme re community facilities. LA agreed process for SS access – communicated to matron and discharge team. S. Latham to come back with training dates in 2/52	4
	Implement Minimum standards in Respiratory	PR	NM/ JB	~~31/07/13~~ 30/08/13	In place except 52 week cover is still outstanding. Consider fee for service to enable cross cover 52 weeks. New appointments in place by November. Service job plan review currently being undertaken by HOS.	4
	Implement Minimum standards in Diabetes	PR	TP/ I Lawrence	~~31/07/13~~ 30/08/13	Meeting next week to agree job plans Shift to daily ward rounds Need agreement on whether diabetologists will manage 2.5 wards or 2 MH to update Agree that it is to be 2.5 wards but staffing needs addressing – PR to agree and bring back resolution to ECAT	4

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
	Implement Minimum standards in Cardiology	PR	NM/ J Kovac	30/08/13	Ward round rota agreed. Associate specialist to be appointed Meeting with Cardiologists 19/07/13 2 Ass Spec to be appointed to provide senior cover on CDU. LB to update re dates MH to send update	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	Review bed co-ordinator and matron roles in capacity management	RM	PW	31/08/13	New action. To be addressed in bed management LiA	4
Discharge	Increase ICS rehabilitation capacity	JA	CCGs	City 01/10/13 East TBC by LPT	Work in progress via CCGs/LPT. City ICS to start 1/10/13 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.** MH to present update on TTO work to ECAT on 16/08/13	4
	Reassess acute capacity requirement including by time of day to rectify outflow-inflow mismatch	RM	RM	30/08/13	RM to update	4
	Undertake review of discharge planning and timing (incl use of discharge lounges)	RM	TBC	30/08/13	RM to update	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	30/08/13	RM to update	4
	Investigate 'unknown reasons' for breaches and remove	RM	JE	23/08/13	RM to update	4
	Implement daily pace setting meetings at 8am and daily reviews at midday	RM	JE	16/08/13	RM to update	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	JB	Jay Banerjee
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
JE	To get daily information on board rounds on assessment units to SS	30th Aug		
CF	To talk to S Conroy regarding has AFU between told about the need to document reviews	30th Aug		
YD/JE	To address need for AFU staff to have EDIS training	23rd Aug		
BT/RW	Feedback to GPs on end of Life patients presenting inappropriately to ED – currently collecting data	28th Aug		
YD/JE	YD to check if it is possible to tell whether patients who attend ED have been told to go elsewhere first	9th Aug		
JE	To draft out paper on possible use of old fracture clinic to bring to ECAT	30th Aug		
JE	Workforce plan to come to ECAT	16th Aug		
KH	To agree how delivery of consistent, rapid specialist opinion on RAU is taken forward	16th Aug		
JB	To take forward safety audit.	16th Aug		
RM	All areas to use discharge lounge for patients being discharged that day unless agreed otherwise	16th Aug		
PW	To look at the number of re-beds to assess what impact this currently has	16th Aug		
SS/S Adams	To agree the quality metric thresholds for dashboard	16th Aug		

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Completed

PW	Write to RV re impact of ICS on rehab delays	16th Aug	Complete	
SS/PW	To agree how to present the EMAS handover data	16th Aug	Complete	

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