To:	Acute Care Divisional Board
From:	Monica Harris Divisional Manager
Date:	May 2013
CQC regulation:	All applicable

Title:	Emergency Department Performance Report

Author:
Monica Harris, Jane Edyvean

Purpose of the Report:
To provide an overview and update on the Emergency Care Delivery for UHL.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

- Significant pressures continue throughout the LLR emergency care system resulting in a continued deterioration in performance during April. UHL achieved a performance of 76.9% against the Emergency 4 hour target for type 1 and 2 activity and when combined with the UCC the month 1 position stands at 81.96%.
- ED attendance rates show an increase of 6.7% and the UCC diversion rates continue to reduce falling below those recorded for the previous 2 months
- As of the 5th May 2013 UHL was ranked 139 out of 146 Acute Trusts for its weekly 4 hour performance, and 141 out of 146 over the last 4 weeks, with a performance of 83.8%.
- The Acute flow is further impaired by poor staffing levels in both ED and Medicine, limiting available capacity. Action plans are in place to improve fill rate of bank and agency shifts with some positive results.
- The top three reasons for breaches are consistent, being ED process, bed breaches and clinical exceptions.
- Performance against the clinical quality indicators improved in April with 3 of the standards being met:
- The Acute pathway continues to be supported by the RPC team, and ECAT
- The CCG collaborative continue to support the internal steps taken by UHL to improve performance through the programme of work to be facilitated by Right Place Consulting.

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)
Additional winter capacity beds remain open
Resource implications of implementing ED action plans including capital schemes.

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: **ACUTE CARE DIVISIONAL BOARD**

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

REPORT SUBJECT: **ED PERFORMANCE REPORT**

REPORT DATE: **17 MAY 2013**

1. Introduction

Significant pressures continue throughout the LLR emergency care system resulting in continued deterioration in performance during April. UHL achieved a performance of 76.9% against the Emergency 4hour target for type 1 and 2 activity and when combined with the UCC the month 1 position stands at 81.96%.

Following the recently Emergency Summit concerted efforts have been made in conjunction with Commissioners to manage demand and support new ways of working including additional resources to stream patients and manage flow. A revised trajectory for achieving the 95% performance has been agreed with CCGs and the NDTA for the forthcoming year.

The demand for bank and agency nurses, in response to staffing requirements for the new processes in ED, the opening of additional capacity and an increase in sickness absence rates continues to provide daily challenges in medical and nurse staffing. April has seen the sustained use of extra capacity beds in response to unremitting demand coupled with a lack of consistent flow across the emergency pathway. These factors have significantly impacted on our ability to achieve the four hour target and thus performance has remained below the standard despite a slight improvement more or less in line with trajectory.

This report provides details for the current level of performance for April 2013, an overview of the issues and describes the actions which have been taken to mitigate the impact both in the short and longer term.

2. Current Activity and Performance

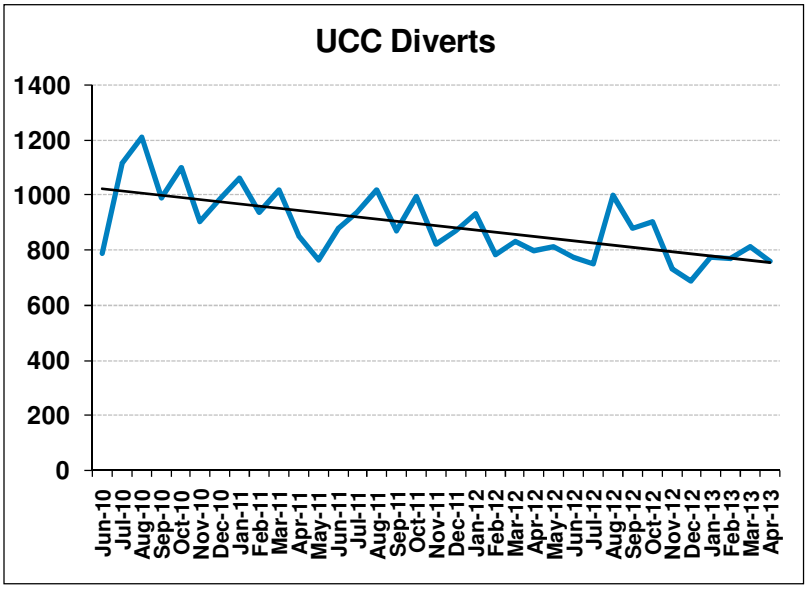
2.1 Attendances rates and Diversion rates.

At the start of the financial year ED attendance rates show an increase of 6.7% which is a reverse trend from the previous month in which a downward trend showed a further overall percentage change in activity of –2.8% .

EMERGENCY DEPARTMENT TYPE 1 and 2 PLUS URGENT CARE CENTRE									
	UHL 2010/2011 (Post Diversion)	UHL 2010/2011 (Pre Diversion)	UHL 2011/2012 (Post Diversion)	UHL 2011/2012 (Pre Diversion)	UHL 2012/2013 (Post Diversion)	UHL 2012/2013 (Pre Diversion)	UHL 2013/2014 (Post Diversion)	UHL 2013/2014 (Pre Diversion)	Overall % Change 13/14 vs 12/13
Apr	14,117	14,117	13,507	14,358	13,532	14,332	14,527	15,287	6.7%
May	14,574	14,574	13,871	14,636	14,819	15,633			
Jun	13,509	14,298	13,318	14,197	14,248	15,022			
Jul	12,983	14,100	13,075	14,014	14,107	14,860			
Aug	12,544	13,757	13,086	14,109	13,815	14,817			
Sep	12,726	13,720	13,270	14,142	13,839	14,719			
Oct	12,918	14,022	14,002	15,000	14,051	14,955			
Nov	13,057	13,963	13,226	14,051	14,201	14,933			
Dec	13,500	14,488	13,291	14,162	14,150	14,839			
Jan	12,830	13,893	13,260	14,196	13,751	14,528			
Feb	12,263	13,202	12,978	13,762	12,985	13,754			
Mar	14,100	15,119	14,884	15,719	14,458	15,273			
Sum:	159,121	169,253	161,768	172,346	167,956	177,665	14,527	15,287	

Focussed efforts between ED assessment teams and UCC staff continue in order to maximise the numbers of patients diverted to the UCC. The number of patients diverted in

April unfortunately fell below those recorded for the previous 2 months and totalled 760 (815 in March and 769 in February).



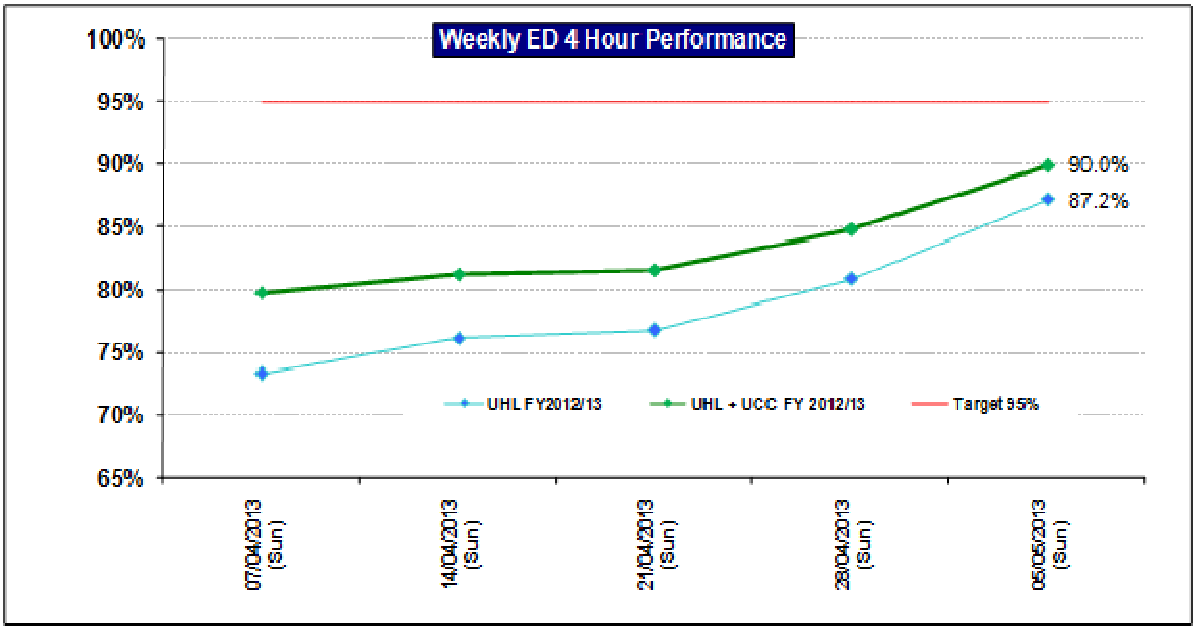
When diversion rates in month are compared year on year there has been a steady decline in the numbers deflected. In April 2011/12 851 patents were deflected. This reduced to 800 in 2021/13 and to 760 in April this year.

The Emergency Department continues to work in collaboration with the City CCG and partners from the George Elliott Hospital who are responsible for the implementation and delivery of a single front door for all ambulatory patients. This service was due to go live in May however to ensure that all the necessary governance arrangements are in place this has been delayed to 1st July. The CCG's and George Elliott Hospital anticipate that approximately 24.8% of walk in patients will be diverted away from ED through this new triage service. Currently the known number diverted is 13.11%, a predicted rise from 9,700,per annum to 18,383 (figures shared with UHL by the Project Manager).

In addition to this work stream CCGs continue with their sustained efforts to review all ambulance requests by a GP, to prevent attendance and ensure GP review of patients referred from nursing and residential care.

2.2 4-Hour Performance target

Throughout April there was a daily variance in performance against the 4 hour ED target resulting in a performance of 76.99% or UHL type 1 & 2 attendances, an improvement against the previous months performance of 73.3%. An overall performance of 81.96% was delivered when UHL and UCC figures are combined which is a 2.16% improvement against the previous month.



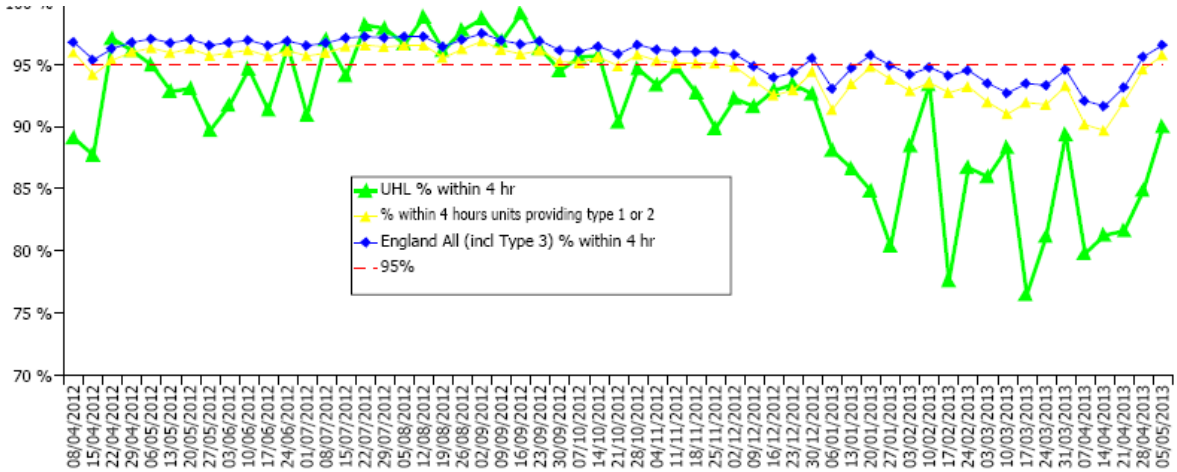
ED and UCC to Week Ending Sunday 5th May 2013

Emergency Department 4hr Wait 2013/14

Apr 13

Site	Type	Atts	Breaches	% < 4 hr
UHL	Type 1 + 2	14,527	3,343	76.99%
Urgent Care Centre	Type 3	4,020	2	99.95%
UHL + UCC Total	All	18,547	3,345	81.96%

As of the 5th May 2013 UHL was ranked 139 out of 146 Acute Trust for its weekly 4 hour performance and 141 out of 146 over the last 4 weeks, with a performance of 83.8%.Our trend in performance compared to other Acute Trusts, for ED type 1, 2 and 3 attendance is shown below:



Out of the top 20 largest Trusts UHL is ranked as the 11th busiest department for its average daily attendances of 780 but the poorest performing trust for the number of patients seen within 4 hours. Across the East Midlands the Trust is the 3rd busiest for type 1 attendances and again is one of the lowest performing Trusts:

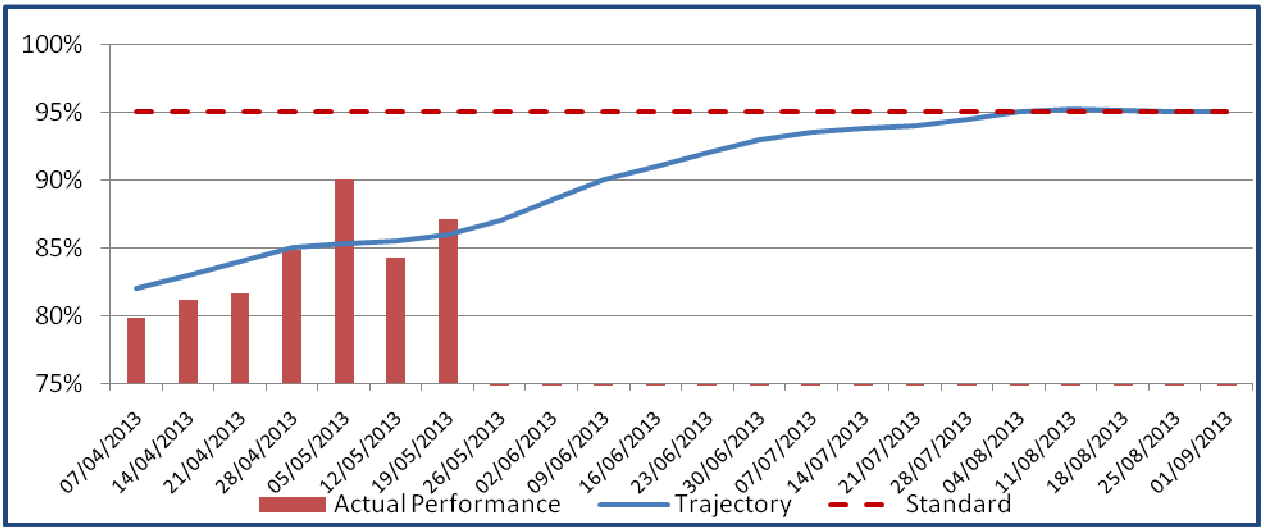
A&E recent weekly Throughput and Performance: East Midlands Acute Trusts

Week Ending: 05/05/2013

Org Code	Org Name	Type 1 Atts	Type 2 Atts	Type 3 Atts	Average Daily Atts	% within 4 hours
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	1,841	0	803	378	98.98 %
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	1,340	0	0	191	97.39 %
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	3,243	373	40	522	97.18 %
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	3,179	0	0	454	97.07 %
RTG	DERBY HOSPITALS NHS FOUNDATION TRUST	2,386	0	0	341	94.89 %
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1,876	234	16	304	94.03 %
RWE	**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**	**3,016**	**348**	**910**	**611**	**89.96 %**
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	1,463	0	0	209	89.82 %

2.3 Performance Trajectory

Our actual performance against the agreed trajectory is shown below:



The expectation from CCGs remains that UHL's position will continue to improve through an number of initiatives:

- CCG's implementing a number of actions agreed at the Emergency Summit in April as shared with the Trust Board last month;
- Embedding phase 1 and 2 of the Emergency Care Programme and implementation of Phase 2 associated with ward processes and discharge arrangements, supported by Right Place Consulting. Embedding the new processes continues to provide a real challenge to the Trust particularly at times of such high demand and lack of continuous patient flow across our emergency processes;
- Implementation of the Emergency Care Action Team (ECAT) recommendations (Appendix 2) including the development of the Emergency Floor.

In April an average of 24.25% patients were admitted from the ED which remains consistent with previous months (range 23.1 – 26.2). Similarly length of stay across medical specialities has ranged from 6.1 to 7.3 during April. The Acute Division achieved 13 – 16% against a 30% discharge before 1pm target out of the hospital during April which has added pressures into the emergency system as described elsewhere within this report.

Staffing has provide a challenge for both medicine and ED, agency and bank requests have continued at high levels in both Medical and nursing in response to increasing sickness rates, additional capacity and vacancies. To manage the acute flow, and to provide outflow for ED and the assessment units, a decision was made to keep all additional capacity beds open. Even with these arrangements being in place there continue to be difficulties with flow across the system . Contributing factors are the numbers of patients remaining in an acute hospital bed who no longer require acute intervention. This has been escalated to relevant parties across the Health Community for resolution.

2.5 Delay Reasons

The top cause this month for breaches is the ED process which remains consistent with those reported in previous months. The top three reasons for breaches are summarized as

- ED Process – 24%
- Bed Breaches – 27%%
- ED Capacity – 29%

The increase in % reasons attributed to ED capacity is associated with the continued high numbers of patients in the department associated with ED processing time and bed breaches. Reflected in this picture is the fact that the department has consistently had several patients awaiting admission at any one time during a 24 hour period and this impacts on the team's ability to focus on preventing breaches amongst the significant numbers of patients who are ED non admitted patients. Further to this the acuity and numbers of patients attending the resus area of the department continues to increase having a dual impact of resources being drawn from the majors area of the department as well as increasing numbers of sick patients in the majors area of the department requiring additional input.

The distribution of breaches by area is shown in the table below which demonstrates that 70% of breaches continue to occur not surprisingly within the majors area. Work is on-going to address the increase in minors breaches through sustained coordination in this area which will release ENP resource to reduce these potentially avoidable breaches. It should be noted that numbers of resus breaches in resus continue to climb. Discussions are underway to try to mitigate this:

Allocation	Feb-13	Mar-13	Apr-13	1st - 7th May-13	Total	Cumulative %
CHILDREN	73	47	84	10	214	**3%**
MAJORS	1402	1633	1766	235	5036	**70%**
MINORS	225	235	260	29	749	**10%**
RESUS	356	389	407	71	1223	**17%**
Sum:	**2056**	**2304**	**2517**	**345**	**7222**	**100%**

The table below provides more detail, and specifies more reasons attributed for breaches. It is worth noting that there has been an increase in the number of breaches attributable to ED process in March linked in part to ED overcrowding as a result of no outflow. The number of bed breaches is reflective of the significant pressures on beds whilst those reported for clinical reasons have declined against numbers reported for the previous 2 months again.

Emergency Department Type 1
Delay Reasons (Excluding "Unknown")

Delay Reason	Feb-13	Mar-13	Apr-13	1st - 7th May-13	Total	Cumulative %
Bed Breach	506	616	692	107	1921	**27%**
ED Process	519	760	390	73	1742	**24%**
ED Capacity (Cubicle Space)	479	563	989	67	2098	**29%**
ED Capacity (Inflow)	51				51	**1%**
ED Capacity (Workforce)	54				54	**1%**
Clinical Reasons	189	183	224	35	631	**9%**
Specialist Assessment	40	41	39	17	137	**2%**
Specialist Decision	8	15	19	6	48	**1%**
Investigation (Imaging and Pathology)	64	46	82	17	209	**3%**
Transport	108	64	46	18	236	**3%**
Treatment	38	16	36	5	95	**1%**
	2056	**2304**	**2517**	**345**	**7222**	**100%**

For another month ED has to cope with very high numbers of patients in the department at times for a number of reasons as reported previously. At times this is due to internal delays in patients awaiting medical review (see section 2.6 below) whilst at other times this can be due to the availability of beds on the rapid assessment and Short Stay units and access to speciality beds, which is impacted by timeliness of discharge throughout the day.

The early availability of beds on base wards to allow flow from the Rapid Assessment and Short Stay units has impacted on the availability of beds at the time of request. This coupled with the ability of the emergency department to transfer a patient from the department without delay once a bed is available results in lengthy waits for patients, particularly when the department is at full capacity. In the previous month's report it was suggested that there were an increasing numbers of acute frailty patients being admitted to the RAU and SSU resulting in an increased length of stay and lower discharge rates from these areas. A piece of work has been undertaken to look at this and a decision taken to create a dedicated environment for the Acute Frailty Service (AFS), relocate the Elderly Frailty Unit (EFU) back to the Emergency Decisions Unit (EDU) and to focus Rapid Assessment and Short Stay Medical Unit patients on wards 15 and 16 at the LRI. Detailed plans are in place to deliver this solution for early June.

Further analysis of timeliness of discharge in the department shows that 26 of bed requests are made after 4 hours. Conversion rates remain high with the number of bed requests in April, 4,489 the second highest since December 2012:

	Dec-12	%	Jan-13	%	Feb-13	%	Mar-13	%	Apr-13	%	1st-7th May-13	%
0-1 Hours	189	4%	194	5%	231	6%	265	6%	312	8%	80	8%
1-2 Hours	865	19%	686	16%	673	17%	718	17%	651	16%	170	18%
2-3 Hours	1510	34%	1214	29%	1095	28%	1102	26%	906	23%	285	30%
3-4 Hours	1459	33%	1452	34%	1181	30%	1243	29%	1062	27%	302	32%
4-5 Hours	270	6%	448	11%	416	11%	453	11%	482	12%	61	6%
5-6 Hours	104	2%	157	4%	193	5%	221	5%	255	6%	34	4%
6 Hours+	71	2%	112	3%	177	5%	299	7%	329	8%	18	2%

2.6 ED Quality Indicators

Performance against the clinical quality indicators has improved in April with 3 of the standards being met:

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

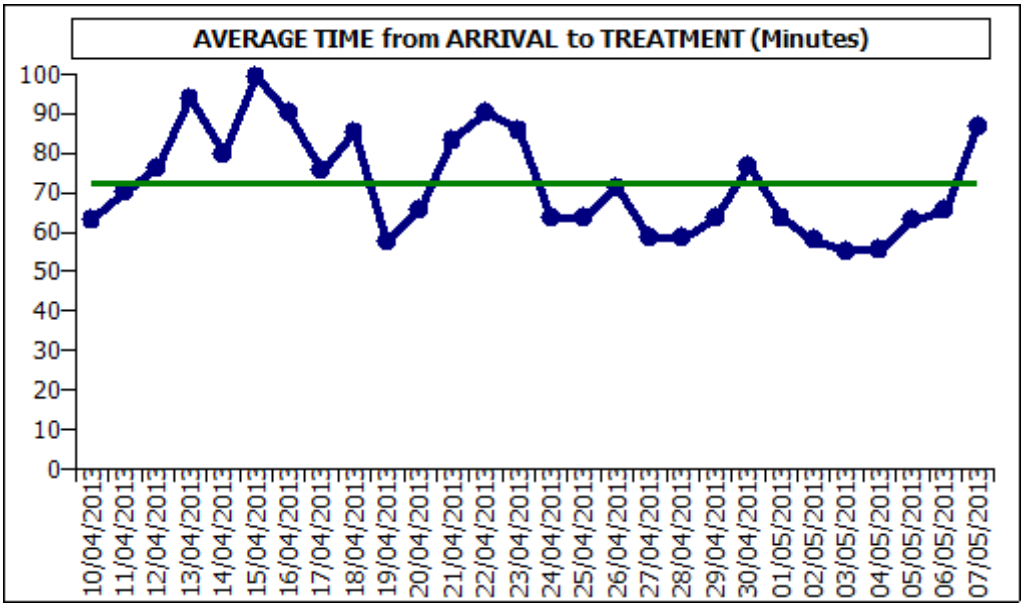
	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	TARGET
Left without being seen %	2.2%	2.7%	2.5%	2.5%	2.8%	2.9%	3.3%	3.4%	<=5%
Unplanned Re-attendance %	5.3%	5.0%	5.2%	5.2%	5.5%	5.4%	5.3%	4.8%	< 5%

TIMELINESS

	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	TARGET
Time in Dept (95th centile)	240	298	326	344	457	432	483	504	< 240 Minutes
Time to initial assessment (95th)	16	23	24	24	25	33	45	37	<= 15 Minutes
Time to treatment (Median)	58	64	69	68	79	60	47	55	<= 60 Minutes

The time in the department has continued to rise to 504 minutes against a 240 minute target. Waiting times to be seen by a doctor and for a treatment plan to be in place is recognised as an issue overnight particularly when the numbers in the department at the time of handover are high. The 'time to initial assessment' standard remains under scrutiny. The data is not routinely entered in all areas. This causes a higher than actual figure to be reported. When the subset of majors is taken the average time for initial assessment is 8 minutes which reflects the new initial assessment process implemented. This data entry is a major focus moving forward.

Average Time to Treatment (Minutes)



It continues to be recognised that as the new emergency processes become embedded and improved outflow is created across the system that performance will improve. This will be addressed through the second phase of the work undertaken with Right Place Consulting. Previously reported data capture accuracy in the assessment bays continues to be worked on to ensure that the data within the clinical quality indicators is reflective of the success of the new assessment bay processes and the actual time to initial assessment. It should be noted that this is imperative owing to the contractual penalties to be introduced in 2013/14 where handover is not completed within the requisite time.

3 CCG Support

As noted above there remains continued from the CCGs through a variety of activities to support the Trust in reducing attendance rates, improve diversion, provide improved access to primary care placements as a means to reducing delayed transfers, and the enablement of improved access to health and social care to prevent admission. The CCGs continue to fully support the work undertaken by Right Place Consulting and recognise the challenges faced by the Trust in embedding the new processes whilst allowing working practices to transform.

Through the weekly ECAT meeting the direction of travel proposed by Emergency Care Intensive Support Team (ECIST) has been reaffirmed and outstanding actions addressed (appendix 1 refers).

CCGs continue to pursue innovative work to help support the Trust reducing attendance to ED. The project with GPs allocated to 999 calls is being expanded and it is anticipated that further impact on attendance will be seen. As previously reported the CCGs continue to support and monitor the implementation of the single front door initiative is being closely aligned and linked with the new assessment processes within ED.

4. RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report
- Acknowledge the continuing pressures in the emergency system resulting in a further continued pressures on sustained performance improvement:
- Note the on-going support from the CCGs to alleviate pressures across the Health Economy;
- Note the weekly performance against the revised trajectory for improvement for 2013/14;
- Note the actions taken by ECAT (appendix 1)

University Hospitals of Leicester NHS
NHS Trust

Emergency Care Action Team

Appendix 1

Monitoring body (Internal and/or External):	ECAT
Reason for action plan:	Current emergency pathway performance
Date of action plan approval:	
Executive Sponsor:	Chief Executive
Operational Lead:	Jez Tozer
Frequency of review:	Weekly
Date of last review:	10th May 2013
Expected completion of action plan:	

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	EMERGENCY DEPARTMENT						
	Need high level matching of activity to staffing	JT	MH/ PW	17/05/13		Updating the detailed analysis from last year. Proposal from Simul8 regarding simulation model to come to ECAT 31st May A weekly sheet is available with all staff issues identified Weekly sign off for all weekly staffing by JE	3
	Management of medical patients in the ED by medical team	PR	CF CF/JB/ BT/TP	24th May 28th June	Lack of time from ACB reg Lack of ability to agree on model to support ED		
	Standardise equipment in majors cubicles	PR	JE/BT	31/05/13		No update	3
	Agree placement of new CT scanner. (Need paper on imaging requirements for new ED & CT activity in the meantime).	JT	MH/ PW	31/05/13		After discussion with CT the scanner cannot be moved in to ED. The future replacement of a simpler CT scanner will be used to build an ED CT scanner	5
	To assess the need for more therapists in ED from 08:00-18:00	PR	MH	17/05/13		Paper regarding front door therapy support already written	5

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
	Project group to refine model of single front door and move to implementation asap.	JT	MH	June 2013	Change in process may delay implementation	Regular meeting to address governance issues	4
	Need to ensure that the single front door does not suffer from any internal delays. Need CEO to CEO contact	JA		31/05/13		Discussion over SOPs and staffing model with George Eliot CEO.	
	End of Life patients presenting inappropriately to ED and feedback to GP	PR	BT	24/05/13		No update	3
J Worral	Ensure patients in AED are seen in a timely manner. All patients to have treatment plan at 180mins.	PR	CF/JE			Escalation plans for AED performance are being re-drafted to address this. Ultimate escalation in hours to COO, and out of hours to Director on call.	
2	**INCREASING CAPACITY**						
	Agree how haematology ward can be renovated without using ward 19	JT	NK/ PW	24/05/13	Currently no clear plan identified	Meeting on the 14th May to identify ways forward	3
	2 side paper on options re vascular move to GGH	JT	PW/ NK	24/05/13		Draft paper written and with planned care	4
	Paper on all accommodation moves to come to ECAT	JT	PW	24/05/13	Timescales may not fit in with current pressures		
3	**MEDICAL WARDS PROCESS**						
	To set up a separate Frail Elderly Unit with increased capacity than previously-option appraisal on best location and number of beds	PR	CF/TP	03/06/13		Need to include PCCs in process of move To start early June	4
	Enhance porter capacity throughout day	PR	JE	17/05/13	Problems recruiting porters	Need report on any portering issues brought to ECAT	4
	To ensure that med reg on 15+16 continues to process patients overnight.	PR	CF	10/05/13			3
	Report from emergency pathway process audit to come to ECAT weekly	PR	JE	17/05/13			3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
J Worral	Improve accuracy of live EDIS information.	MH	JE	31/06/13	Lack of budget Inability to recruit	Possible need to recruit additional trackers in to AED whose only job is to manage and watch EDIS	
	Diabetologists to get changed ward rounds in place by 21st June. Request for this timescale to be brought forward	PR	CF	31/05/13	Resistance to early implementation from diabetologists		
4	**RECRUITMENT**						
	Need a list of each grade of post / post and whether the posts are filled.	PR	BT/LL	10/05/13			3
	Revised model of consultant cover for ED for evening and night cover	PR	BT/TP/ CF	24/05/13	Lack of agreement on ED & acute medical model		
J Worral	High use of Locums, and the need to ensure all shifts have equal mix of locums and permanent medical staff.	PR	JE	31st May		Recruitment programme for all grades of staff including middle grades. Weekly sign off for all weekly staffing by AED manager. Need to ensure that there is a max number of bank/agency per shift and where exceeded actions taken to balance staffing.	
	To try international recruitment for nursing staff.	CR	ES	26th July 2013		CR to send ES list of possible countries to try	
5	**AMBULANCE DELAYS**						
	Costs for HAS screens	JT		17/05/13			4
	Need electronic clocking off for EMAS staff in ED	JT		31/05/13			4
6	**DELAYED TRANSFER OF CARE**						
	Paper to ECAT regarding update on increasing community discharge	JT	PW	17/5/13	Progress on getting additional capacity is too slow	Paper presented on 17/05/13	4
J Worral	Set up a control room with a senior manager 8-midnight on a rota	JT	PW/ MH	01/06/13		Control room already in place, senior manager on call on site until needed each week day.	

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
	supported by a Duty Manager, near ED					Discuss with AED the placement of the control room near AED	
J Worral	Review agenda for bed meetings and ensure each meeting is appropriately attended and led.	PW	Done			There is already a fixed agenda for each of the bed meetings. The bed meetings will be changed to reflect feedback received from Emergency Process changes	5
J Worral	Review timings of bed meeting, in particular the 8.30am meeting.	PW	May 21st			The new emergency process is changing the bed meetings to 1 meeting a day at 11:00 with live information to work from The changes in process will move the first bed meeting to 11:00 to ensure that a better set of information is available. A live bed state is part of this change	5
J Worral	Transfers between sites cause breaches and blocks capacity.	JT	31st May	.		All patients who can move out to EDU to wait are moved there. An additional An AED ambulance is available from 12-midnight every day. Ambulance was made available throughout winter but no improvement in breaches and funding stopped on April 1st	
7	EMERGENCY FLOOR						
	To agree the board to develop and deliver new emergency floor	JA	NT			Newcastle model being requested – PW Comments on NTDA paper to NT by 21st May Present to ECAT 7th June - NT	
	To discuss with WRVS, the need to move from current position	JT	JE	24th May 2013	Threat to good WRVS relationship		

Key to initials of leads

BT	Ben Teasdale
CF	Catherine Free
JA	John Adler

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

JB	Jon Bennet
JE	Jane Edyvean
JT	Jez Tozer
KH	Kevin Harris
LL	Lisa lane
MF	Miriam Farr
MH	Monica Harris
PR	Pete Rabey
PW	Phil Walmsley
SM	Sue Mason
TP	Tim Petterson

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised