To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**31 July 2014**
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 June 2014 was 91.2% compared to 85.4% in June 2013 and 83.4% in May 2014.
- July 2014, month to date, is 91.98%.
- Emergency admissions were slightly up in June; 206 per day compared to 203 per day in May and are slightly further up in July 211 per day.
- Delayed transfers of care remain continually above the agreed performance level at 4.7%.
- Admissions remain high compare to this time last year.
- Little progress on the delayed transfer of care (DTOC) rate
- UHL agreed action plan is attached.
- Performance is improving but the current level of performance remains unacceptable.

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

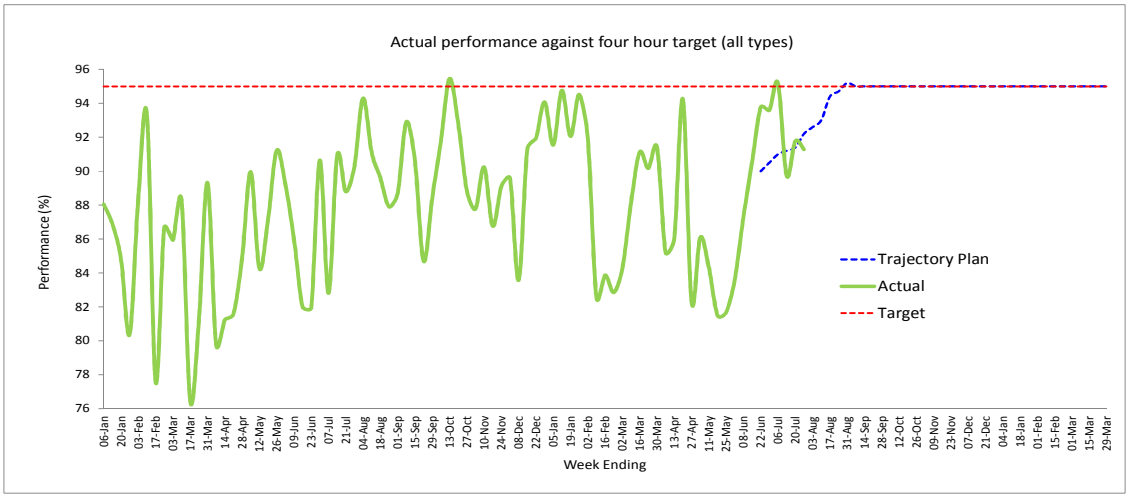
REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**31 July 2014**

Introduction

- Performance in June 2014 was 91.2% compared to 85.4% in June 2013 and 83.4% in May 2014.
- July 2014, month to date, is 91.98%.
- Emergency admissions were slightly up in June; 206 per day compared to 203 per day in May and are slightly further up in July 211 per day.
- Delayed transfers of care remain continually above the agreed performance level at 4.7%.

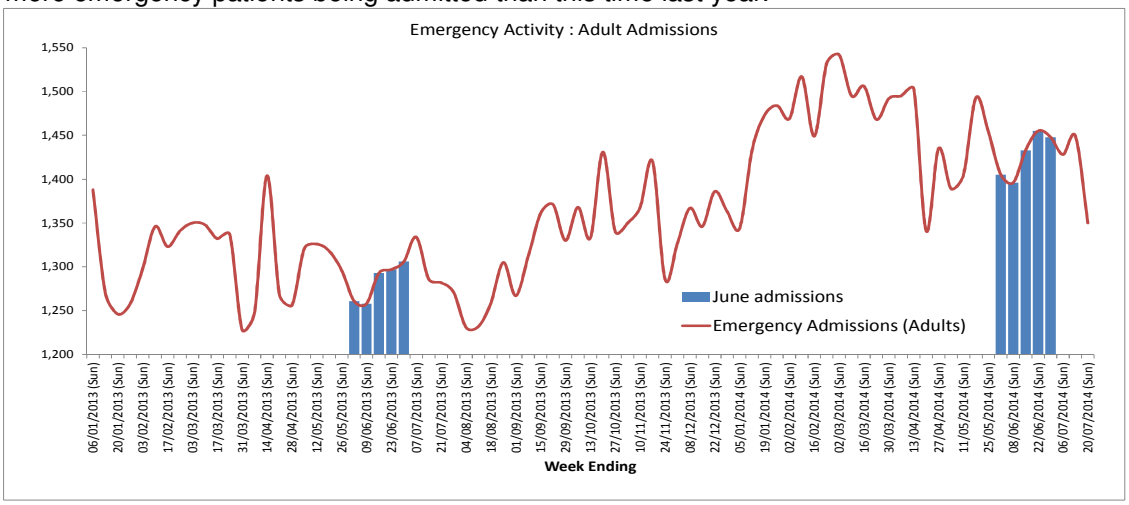
Performance overview

Weekly performance is detailed in graph one below. There has been one week of compliant performance so far in July. An improvement trajectory has been agreed with the TDA and is shown as the dotted blue line below. The expectation is UHL becomes sustainably compliant by the last week in August 2014.



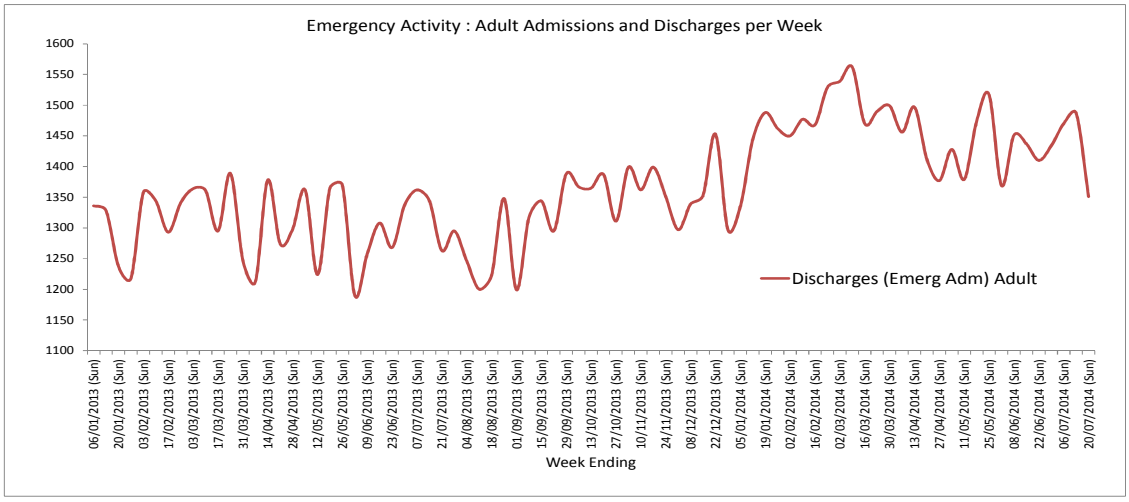
(graph one)

Weekly admissions and discharges are shown below in graphs two and three. It is apparent from graph two that despite admissions reducing from the high in the winter, there are still substantially more emergency patients being admitted than this time last year.



(graph two)

Discharges remain constant and continue to be predominantly driven by the admissions rate.



(graph three)

Key actions since the last report:

- Chief Executive and Chief Operating Officer attended an emergency care escalation meeting with the CCGs, NTDA and NHSE on 1 July. The following was written in the feedback 'we note your comments that the Urgent Care Working Group is working together well and that you have recruited Dr Ian Sturgess to work across the system for 6 months. Your presentation and analysis of system issues were good and the system is showing some signs of improvement in recent weeks. You identified issues with variable in-flow, variation in internal processes and outflow (including delayed transfers of care) that drive underperformance. The focus on sub-optimal clinical processes is important alongside work on care plans, discharge and the modular ward (due to open in November). The Area Team is confident that the Urgent Care Working Group is now focussing on the key issues but all parties acknowledge that there are risks around clinical push back, both at acute and general practice level. The next iteration of the recovery plan will include details on work plans and metrics.'
- ECAT has been reworked as the emergency quality steering group (EQSG) with a detailed action plan (attached as appendix one).
- Dr Ian Sturgess provided a report to the consultant body and senior nursing and management teams detailing his findings and areas for improvement after the first six weeks at UHL. The actions from this report have been fully included in the EQSG plan. A report on community hospitals and GP practice will follow later in the year.
- A series of rapid cycle testing initiatives have begun in ED, MAU, base wards and CDU with early promising signs of improvement.
- A gold, silver and bronze command management structure has been put in place to provide greater governance and grip to UHL.
- A reworked dashboard of metrics is in place.
- Emergency care intensive support team have been working in UHL in particular looking at variable practice on the base wards.

Recommendations
The Board is asked to:

- Note the contents of the report and action plan, and
- Support the actions being taken to improve performance.

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Jeff Worrall
Cardinal Square
10 Nottingham Road
Derby
DE1 3QT

Dear Jeff,

RE IMPROVEMENT PLAN FOR UNIVERSITY HOSPITALS OF LEICESTER EMERGENCY CARE PATHWAY

University Hospitals Leicester has the largest (volume) single site Emergency Department in the NHS and has consistently failed to meet the four hour performance measure. Over the last 18 months we have worked with our three Clinical Commissioning Groups, LPT, NHSE, NTDA and other partners to identify the root causes of the poor performance across the LLR health economy.

What we are doing to address the issue
Working with Dr Ian Sturgess, we have developed a detailed action plan, underpinned by a robust governance process to repair the critical parts of the internal emergency care pathway. This will reduce mortality and improve patient safety and the net effect of this work will aid our performance against the four hour wait target as well.

Appendices

1. Emergency Care Improvement Action Plan. The plan has been co-developed with clinicians and focuses on clinical leadership and clinical accountability in its delivery. The plan addresses the key internal emergency pathway issues that we have jointly identified with Dr Sturgess, the Emergency Care Intensive Support team, CCGs and NTDA.

2. Emergency Care Improvement Charter. This details the governance arrangements we have put in place to ensure we track, monitor and manage progress against the improvement plan across all levels in the Trust, from ward to board. The governance arrangements mirror that of the plan, in that it is has clinical leadership and clinical accountability at its centre. The key areas of delivery will be patient facing areas where clinicians are encouraged to undertake rapid cycle testing in order to see what works well and what doesn't work so well. This will be followed through at ward level with a rapid spread and adoption approach to spread good practice.

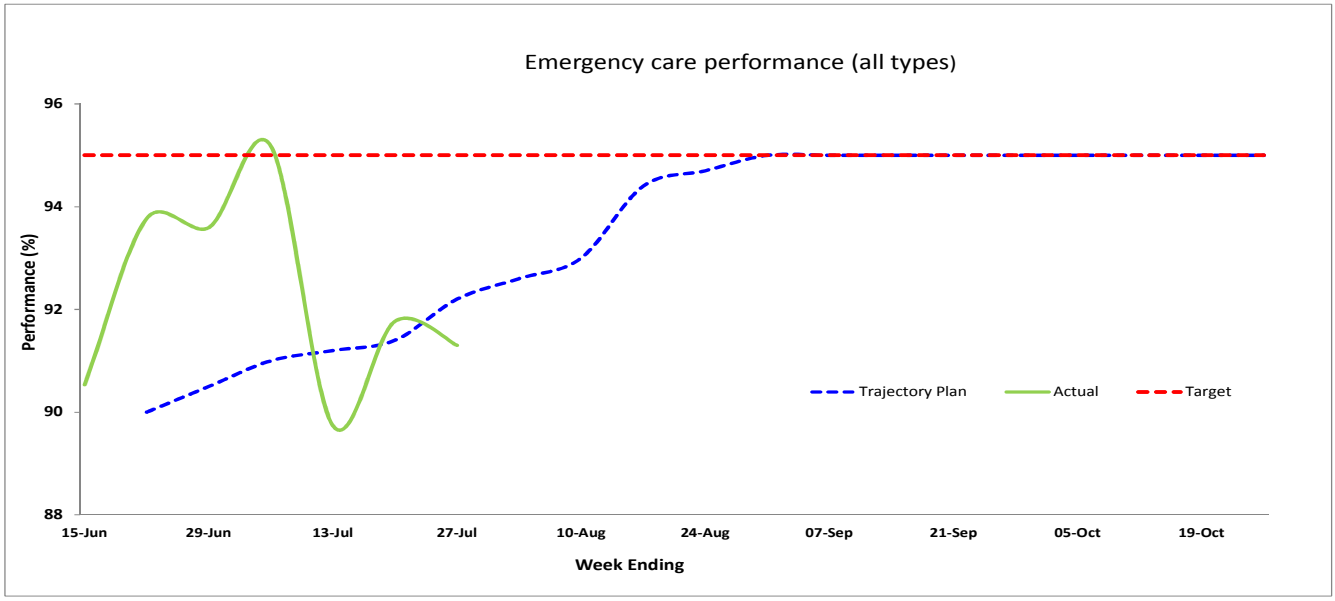
3. Emergency Care Dashboard. As we progress with the improvement plan we will use the dashboard, which will be monitored weekly, (at some levels daily), in order to ensure the improvement activities and actions we undertake are having the desired effect on key outcome, flow and process metrics.

I have attached at the bottom of the page our agreed improvement trajectory which takes us to compliant performance by the last week in August 2014.

Please confirm if you require anything else.

Yours sincerely,

Richard Mitchell
Chief Operating Officer



UHL ED Flow Project Plan

Task Name	Start	Finish	Resource Names	Status
1. Organisation			Rachel Overfield	
1.1 Governance				
Create Operational Grip	Mon 28/07/14	Fri 05/09/14		Closed
Set up Gold Command Group - Medical Director, Chief Nurse, COO	Mon 28/07/14	Fri 08/08/14	Rachel Overfield/Andrew Furlong/Richard Mitchell	
Set up Silver Command Group - CMGs CD's, Head of Nursing & Gen. Mgrs.	Mon 28/07/14	Fri 08/08/14	Julie Dixon	
Set Bronze Command Group - Heads of Service, Matrons & Business Mgrs.	Mon 28/07/14	Fri 08/08/14	Julie Dixon	
Organisational Working Group Set Up	Mon 21/07/14	Mon 18/08/14	Rachel Overfield	Closed
Draft Terms of Reference for Organisational Working Group	Mon 21/07/14	Fri 25/07/14	Rachel Overfield	
Identify metrics for Organisational Group	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Obtain Steering Group Sign-Off on Working Group ToRs and Metrics	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Working Groups to Meet on Weekly Basis	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Re-Fresh of Daily Bed Meeting/Ops Centre/capacity staff roles	Mon 28/07/14	Fri 08/08/14	Julie Dixon	On Track
Identify and establish data set to enable 'real time' and predictive performance management	Mon 04/08/14	Fri 15/08/14	Julie Dixon/Simon Sutherland	
EPMA/ICE roll out	Mon 11/08/14	TBC	Rachel Overfield	
Feedback to junior doctors re TTOs - invite to group and set up focus group	TBC	TBC	Rachel Overfield	
Staffing gaps issue - 7 day snapshot/data capture	TBC	TBC	Julie Dixon	
1.2 Stakeholder and Communications				On Track
Develop Draft Communications Strategy	Mon 4/08/14	Fri 14/08/14	Nick Walkland	
Circulate Communications Strategy for Comment to Steering Group.	Mon 18/08/14	Fri 29/08/14	Nick Walkland	
2. Front Door			Mark Ardron	
2.1 ED & Assessment Unit Operating Model				
Map Consultant Presence to Demand Profile	Mon 04/08/14	Fri 29/08/14	Mark Ardron	On Track
Receiving GP Bed Bureau Calls	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Process for Receipt of GP Bed Bureau Calls	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Process for Receipt of GP Bed Bureau Calls	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
Early Senior Assessment in ED and Assessment Units	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Process for Early Senior Assessment	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Process for Early Senior Assessment	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
Clinical Criteria for Discharge, (CCD) & Expected Date of Discharge, (EDD)	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Process for CCD & EDD	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Process for CCD & EDD	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
Review of Patients by Admitting Consultant	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create Policy for Review of Patients by Admitting Consultant	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test Policy for Review of Patients by Admitting Consultant	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Assessment Unit Roving Review Process	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create Process for AU Roving Review and Ward Round	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test Process for AU Roving Review and Ward Round	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Twice Daily Review of New Admissions on MAUs	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create Process for Twice Daily Review of New Admissions on MAUs	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test Process for Twice Daily Review of New Admissions on MAUs	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
ED In-Reach Process	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create ED In-Reach Process	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test ED In-Reach Process	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Daily Review of Six Week Rolling Average Data Set	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create Process for Daily Review of Six Week Rolling Average Data Set	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test Process for Daily Review of Six Week Rolling Average Data Set	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Creation of Early Senior Assessment, ESA, Process	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create ESA Process, (Mapped to Demand Profile)	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test ESA Process	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Pathway to ACB	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create Process for Patients Being Sent to ACB	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test Process for Patients Being Sent to ACB	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Primary Care Co-Ordinator	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
Create Primary Care Co-Ordinator Process Across All MAUs	Mon 01/09/14	Fri 12/09/14	Mark Ardron	
Test Primary Care Co-Ordinator Process Across All MAUs	Mon 15/09/14	Fri 10/10/14	Mark Ardron	
Surgical Assessment Unit	Mon 04/08/14	Fri 31/10/14	Chris Sutton	On Track
Create Pathway for Co-Management & Transfer of ED Surgical Referrals				
Test Pathway for Co-Management & Transfer of ED Surgical Referrals				
Obstructive Jaundice/Pancreatitis Pathway	Mon 04/08/14	Fri 10/10/14	Chris Sutton	On Track
Revise Jaundice/Pancreatitis Pathway	Mon 04/08/14	Fri 15/08/14	Chris Sutton	
Test Revised Jaundice/Pancreatitis Pathway	Mon 18/08/14	Fri 12/09/14	Chris Sutton	
Access to Ultrasound at Weekends	Mon 04/08/14	Fri 10/10/14	Chris Sutton	On Track
Improve Process for Accessing Ultrasound at Weekends	Mon 04/08/14	Fri 15/08/14	Mark Ardron	
Test Improved Process for Accessing Ultrasound at Weekends	Mon 18/08/14	Fri 12/09/14	Mark Ardron	
Co-Management of Surgical Referrals in ED	Mon 04/08/14	Fri 10/10/14	Chris Sutton	On Track
Create Co-Managed Pathway for Surgical Referrals in ED	Mon 04/08/14	Fri 15/08/14	Chris Sutton	
Test Co-Managed Pathway for Surgical Referrals in ED	Mon 18/08/14	Fri 12/09/14	Chris Sutton	
NCEPOD Theatre Utilisation	Mon 04/08/14	Fri 31/10/14	Chris Sutton	On Track
Review NCEPOD Theatre Utilisation	Mon 04/08/14	Fri 08/08/14	Chris Sutton	
Identify Different Models Care for Improving Theatre Utilisation	Mon 11/08/14	Fri 29/08/14	Chris Sutton	
Test Different Models of Care for Improving Theatre Utilisation	Mon 01/09/14	Fri 19/09/14	Chris Sutton	
Select New Model for Improving Theatre Utilisation	Mon 22/09/14	Fri 03/10/14	Chris Sutton	
Roll Out New Theatre Model	Mon 06/10/14	Fri 31/10/14	Chris Sutton	
2.2 Implementation of AEC				
2.3 Operational Standards				
Time to Initial Assessment	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Policy for Time to Initial Assessment	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Policy for Time to Initial Assessment	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
Time to Treatment	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Policy for Time to Treatment	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Policy for Time to Treatment	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
Time to Senior Clinical Decision	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Policy for Time to Senior Clinical Decision	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Policy for Time to Senior Clinical Decision	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
30 Minute Response Time to ED and Assessment Units, (AU), Referral	Mon 04/08/14	Fri 24/10/14	Mark Ardron	On Track
Create Policy for 30 Minute Response Time to ED & AU Referrals	Tue 05/08/14	Mon 18/08/14	Mark Ardron	
Test Policy for 30 Minute Response time to ED & AU Referrals	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
Create Balanced Score Card Template for Consultants	Mon 01/09/14	Fri 21/11/14	Mark Ardron	On Track
Determine What Data Should be on Balanced Score Card	Mon 01/09/14	Fri 12/09/14	Mark Ardron	

UHL ED Flow Project Plan

Task Name	Start	Finish	Resource Names	Status
Create Process for Sharing Balanced Score Card Data	Mon 15/09/14	Fri 26/09/14	Mark Ardron	
Test Process for Sharing Balance Score Card Data	Mon 29/09/14	Fri 24/10/14	Mark Ardron	
Roll Out Balance Score Card Process	Mon 27/10/14	Fri 21/11/14	Mark Ardron	
2.4 Glenfield Site				
Use of CCD and EED	Tue 05/08/14	Mon 13/10/14	Jon Bennett	On Track
Create Process for Use of CCD/EDD as Part of Consultant Case Management	Tue 05/08/14	Mon 18/08/14	Jon Bennett	
Test Process for Use of CCD/EDD as Part of Consultant Case Management	Tue 19/08/14	Mon 15/09/14	Jon Bennett	
Create Second Cardiology Consultant to Cover CDU	Mon 04/08/14	Fri 24/10/14	Jon Bennett	On Track
Create Protocol for Second Cardiology Consultant Cover at CDU	Tue 05/08/14	Mon 18/08/14	Jon Bennett	
Test Protocol for Second Cardiology Consultant Cover at CDU	Tue 19/08/14	Mon 15/09/14	Jon Bennett	
In Day Resolution of Internal Delays in ED & MAUs	Mon 04/08/14	Fri 10/10/14	Jon Bennett	On Track
Create Escalation Process for In-Day Resolution of Delays	Mon 04/08/14	Fri 15/08/14	Jon Bennett	
Test Escalation Process for In-Day Resolution of Delays	Mon 18/08/14	Fri 12/09/14	Jon Bennett	
2.5 Upper GI Bleed Pathway				
Revise Upper GI Bleed Pathway	Mon 04/08/14	Fri 15/08/14	Mark Ardron	
Test Revised Upper GI Bleed Pathway	Mon 18/08/14	Fri 12/09/14	Mark Ardron	
3. Base Wards			Ian Lawrence	
3.1 Ward Round Processes				
Assertive Board Rounding	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Assertive Board Rounding Process	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Assertive Board Rounding Process	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
One Stop Ward Round	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create One Stop Ward Round Process	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test One Stop Ward Round Process	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
3.2 Base Ward Operating Model				
In Day Resolution of Internal Delays	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Escalation Process for In-Day Resolution of Delays	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Escalation Process for In-Day Resolution of Delays	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Roll Out Escalation Process for In-Day Resolution of Delays	Mon 15/09/14	Fri 10/10/14	Ian Lawrence	
"Ticket Home" Questions Patients Should Know the Answer To	Mon 04/08/14	Fri 22/08/14	Ian Lawrence	On Track
Create Briefing on "Ticket Home" Questions	Mon 04/08/14	Fri 08/08/14	Ian Lawrence	
Disseminate "Ticket Home" Questions Along with Briefing Pack	Mon 11/08/14	Fri 22/08/14	Ian Lawrence	
Long Length of Stay Review Process	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Long Length of Stay Review Process	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Long Length of Stay Review Process	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Attending Consultant Input for Specialties Not on Acute Medicine Rota	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Policy for Attending Consultant Input	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Policy for Attending Consultant Input	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Roll Out Policy for Attending Consultant Input	Mon 15/09/14	Fri 10/10/14	Ian Lawrence	
Discharge Lounge	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process of Identifying Patients for Next Day Discharge	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process of Identifying Patients for Next Day Discharge	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Two by 1000 and Two by 1220 Process	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Roll Out Process	Mon 15/09/14	Fri 10/10/14	Ian Lawrence	
3.3 Oncology & Haematology Base Wards				
Oncology Assessment Unit	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process Enabling Twice Daily Ward Rounds	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process Enabling Twice Daily Ward Rounds	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
MASCC Risk Assessments	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create MASCC Risk Assessment Process	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test MASCC Risk Assessment Process	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Utilisation of GCSF Across Oncology	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process for Utilising GCSF Across Oncology	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process for Utilising GCSF Across Oncology	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Community Based Chemotherapy Service	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Protocols for Community Based Chemotherapy Service	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Protocols for Community Based Chemotherapy Service	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Community Chemotherapy Teams	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Delivery Model for Community Chemotherapy Teams	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Delivery Model for Community Chemotherapy Teams	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Haematology Base Wards	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Community Based Transfusion Service	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	
Create Protocols for Transfusion Service	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Protocols for Transfusion Service	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
BMT on an Ambulatory Basis	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process for Delivering BMT on an Ambulatory Basis	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process for Delivering BMT on an Ambulatory Basis	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
3.4 Surgical Base Wards				
Physician Assistant	TBC	TBC	Ian Lawrence	On Track
Create Role of Physician Assistant	TBC	TBC	Ian Lawrence	
Test Role of Physician Assistant	TBC	TBC	Ian Lawrence	
Vascular Ward Outliers	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Review Protocols for Vascular Ward Outliers	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Updated Protocols for Vascular Ward Outliers	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Turnaround of Contaminated Beds	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process for Turning Around Contaminated Beds within 30 Mins	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process for Turning Around Contaminated Beds within 30 Mins	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
3.5 Glenfield Site				
Assertive Board Rounding	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Assertive Board Rounding Process	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Assertive Board Rounding Process	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
One Stop Ward Round	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create One Stop Ward Round Process	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test One Stop Ward Round Process	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Roll Out One Stop Ward Round Process	Mon 15/09/14	Fri 10/10/14	Ian Lawrence	
Discharge Lounge	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process of Identifying Patients for Next Day Discharge	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process of Identifying Patients for Next Day Discharge	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	

UHL ED Flow Project Plan

Task Name	Start	Finish	Resource Names	Status
Roll Out Process of Identifying Patients for Next Day Discharge	Mon 15/09/14	Fri 10/10/14	Ian Lawrence	
Two by 1000 and Two by 1220 Process	Mon 04/08/14	Fri 10/10/14	Ian Lawrence	On Track
Create Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 04/08/14	Fri 15/08/14	Ian Lawrence	
Test Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 18/08/14	Fri 12/09/14	Ian Lawrence	
Roll Out Process	Mon 15/09/14	Fri 10/10/14	Ian Lawrence	
4. Frailty Wards			Simon Conroy	
Comprehensive Geriatric Assessment	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Comprehensive Geriatric Assessment Process	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Comprehensive Geriatric Assessment Process	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Board Round Referral to AHP, (Abolisihing Written Referral)	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Process Enabling Verbal Board Round Referral to AHP	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Process Enabling Verbal Board Round Referral to AHP	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Reduce Dependancy on Home Visits	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Process to Reduce Dependancy on Home Visits	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Process to Reduce Dependancy on Home Visits	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Early Supported Discharge	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Upate Processes to Deliver Better Early Supported Discharge	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Processes to Deliver Better Early Supported Discharge	Mon 18/08/14	Fri 12/09/14	Simon Conroy	

Key
= Working Group Name
= High - Level Task/Activity
= Detailed Task to be Delivered
= The Detail of What Needs to be Delivered at Ward Level

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

UHL Emergency Care Quality Improvement Charter

One team shared values

July 2014 vo.9

Contents

Background & Purpose

Background

The University Hospitals of Leicester Trust, UHL, has faced significant challenges over a number years in the delivery of an effective emergency care pathway.

The Leicester, Leicestershire and Rutland, LLR, system as well as UHL has had significant input from the Emergency Care Intensive Support Team, ECIST and Right Place Consulting. They have both identified the key processes that need to be improved to deliver an effective emergency care pathway.

However, there has not been universal ownership of the recommendations and not all those that were accepted have been embedded in a consistent manner.

Purpose

The main purpose of this Charter is to articulate how UHL will set out a clear vision and embark on a programme of change, driven by clinical leadership on the shop floor in order to deliver:

1.Reduced Mortality

2.Reduced Harm

3.Reduction in Long Term Care Placements from Hospital

4.Reduced Re-Admissions

5.Reduction in Complaints – Increase in Compliments

6.Reduced Cancellations of Electives

Scope

Emergency Care Pathway

The scope of this is limited to the Emergency Care Pathway within the hospital, from front to back, excluding:

- The elective care pathway
- Emergency outpatient pathway, (except hot clinics, which are included)

There are four principal areas or working groups that will drive the necessary changes on a day to day basis.

The Working Groups terms of reference are detailed in Appendix B, however, the high level roles are captured opposite.

Working Groups

1.Organisation - this covers the communication strategy, organisational development, customer service processes and Trust-wide systems/processes that impact on the emergency care pathway

2.Front Door – this deals with assessment, initial investigation, decision making, referral and short stay

3.Base Wards – will cover base wards and mono-organ Specialties looking specifically at effective case management for non-short stays

4.Frailty – this group will look at optimising the inputs and flow for all frail older patients admitted to the emergency pathway

Working Groups

Membership of Working Groups

The Working Groups will be Consultant led and will be made up of a multi-disciplinary team of clinicians (Organisation will be differently configured).

The broad remit of the Working Groups is to develop and implement known, effective ways of working in order to address the poor performing areas along the emergency care pathway.

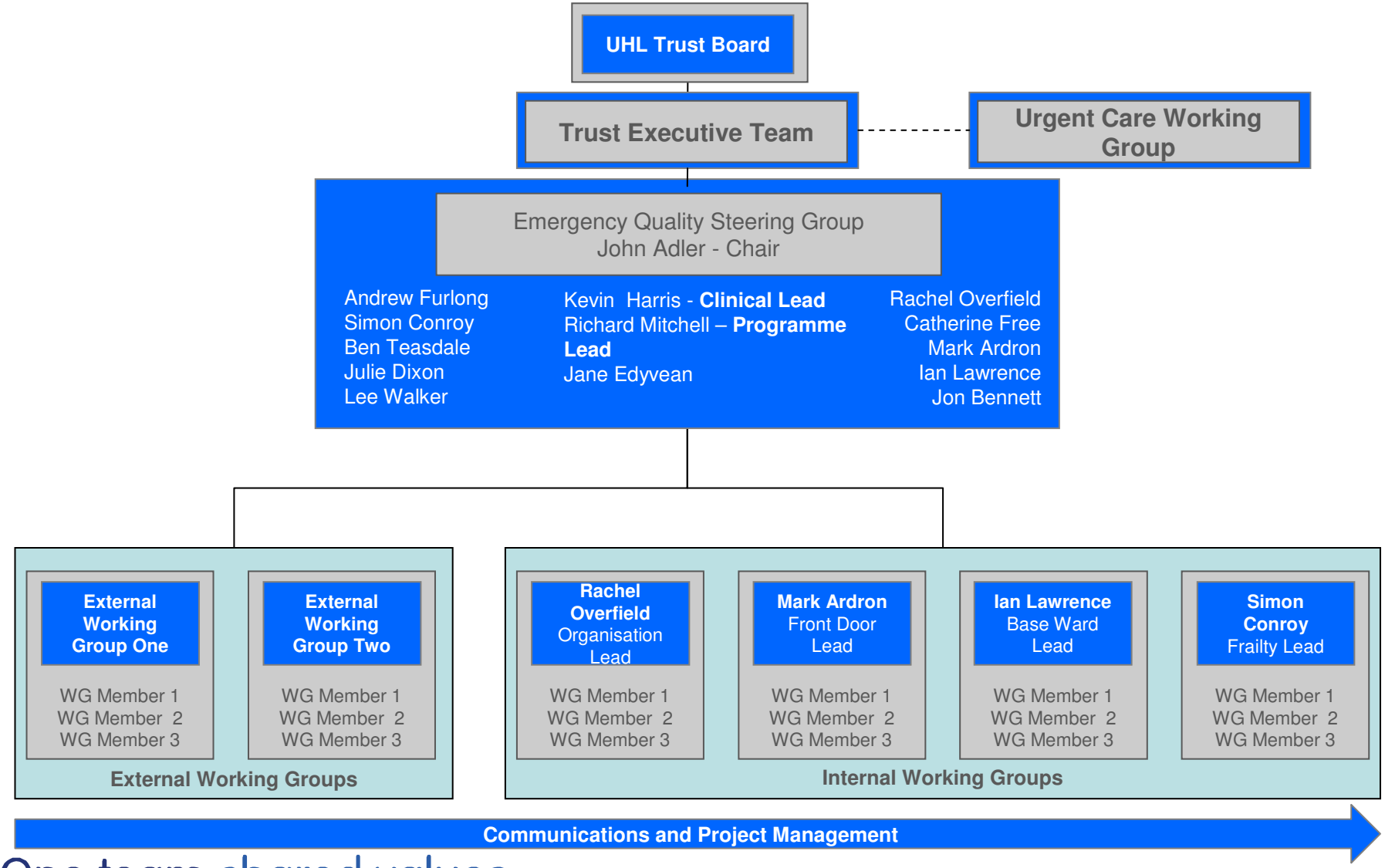
The work of the Working Groups needs to be action focused, whereby:

- New ideas or processes can be deployed/tested quickly
- Feedback on new ideas or processes tested on wards can be received quickly
- Processes can be refined quickly, to achieve further improvement
- Good practice can be easily replicated and rapidly disseminated amongst the wider team
- Tracking of specific KPIs will provide “live feedback” on how well interventions are doing

Governance

University Hospitals of Leicester NHS
NHS Trust

Caring at its best



One team shared values

Roles and Responsibilities

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Role	Responsibilities
UHL Trust Board	• The highest internal escalation point within the programme • Provides consent for any expenditure over £1m
Executive Team	• Holds collective responsibility for delivery of the improved emergency care pathway • Acts as escalation point for the Emergency Care Steering Group • Acts as link between the Trust and Local Health Economy, (via the Urgent Care Working Group) • Engaging external agencies in improving the quality of the Emergency Care Pathway • Approve any expenditure up to £1m
Urgent Care Working Group	• Membership made up of representatives from National Trust Development Agency, NHS England, East Midlands Ambulance Service, LLR CCGs • No formal role, however will receive regular updates from Executive Team on quality improvements in Emergency Care
Emergency Care Quality Steering Group	• Oversees internal and external activities to improve the quality of the Emergency Care Pathway • Acts as escalation point when issues can't be resolved at Working Group Level • Acts as senior decision making body, giving guidance where appropriate to the Working Groups
Clinical Lead	• Responsible for providing overall clinical leadership, unblocking issues in a timely manner • Acts as arbiter on conflicting priorities across Working Groups
Programme Lead	• Provides link across Working Groups • Acts as escalation point to Steering Group and Executive Team
Working Group Leads	• Leads and chairs Working Groups • Provides inspiration to Working Group members in idea generation and issue resolution
Working Group Members	• Act as champions of the Change, sharing and communicating best practice amongst clinical fraternity • Contributing regularly to Working Group Meetings and fostering engagement and input from the shop floor

Meetings

Working Group Meetings

Working Group meetings need to be action based meetings, focusing on the identification of what is working well and what needs changing.

It needs to take place on a weekly basis and to be chaired by the Working Group Lead.

The key items to be discussed are:

1. Performance against KPIs
2. Confirmation of interventions that are working well and how to spread them
3. Ideas for interventions not performing well
4. Key messages or escalations for Steering Group

Steering Group Meetings

The Steering Group has its own terms of reference, (see Appendix B), and will have oversight of both internal and external activities required to improve the emergency care pathway across the whole of the Local Health Economy.

The Steering Board will meet initially on a fortnightly basis, dropping to once a month once more grip and control is achieved across the whole emergency care pathway and performance indicators are above an agreed baseline and on a consistent upward trajectory.

Reporting and Feedback

Creation of KPI Measures

Each working group will create their own set of KPIs that will be signed off by the Steering Group. These KPIs will relate specifically to the outcome.

The main purpose of the KPIs is for the working groups to measure the efficacy of their actions taken in improving the Emergency Care Pathway.

The monitoring and reporting of the KPIs will occur at all levels from Ward to Board enabling:

1. *Clinicians*

-To receive live feedback on interventions

-To make quick improvements to processes

-To identify what works well, quickly

-Share good practice rapidly

2. *Working Groups*

- To review performance at weekly meetings
- To have clear oversight of what is working well
- To be responsive to what is working well and areas for improvement
- Provide updates on progress to Steering Group

3. *Clinical Lead*

- To have oversight of performance across all Working Groups
- Identify unintended consequences on one Working Group caused by actions in another
- Report on overall progress to the Steering Group

4. *Steering Group*

- See improvement right across the emergency pathway
- Provide evidence to the Urgent Care Working Group and other external stakeholders on improvements across the emergency pathway

Appendices

Appendix A – Working Groups ToRs (1/6)

Outcome Metrics for Front Door Working Group:

1.100% (excluding physiologically unstable patients needing resus as deemed by paramedics) of GP referred patients to assessment units by 31st July 2014

2.10% reduction in ED (non GP referred) emergency admissions by 31st August 2014

3.20% reduction in GP referrals translating in to an admission by 30th November 2014

4.5% reduction in deaths in first 48 hours by 30th November 2014

5.20% reduction in harm events by 30th November 2014

6.20% reduction in complaints re ED + Assessment Units by 30th November 2014

7.95% 4 hour emergency standard for total UCC/ED attendances by 31st August 2014

8.95% admitted patients to an in-patient bed in < 4 hours – reported by specialty by 31st October 2014

9.100% not admitted patients discharged home in 4 hours or less < by 31st October 2014

Front Door ToRs

The key a activities for this workstream are:

Optimisation of the following front of house processes that take place in A&E, Medical/Surgical Assessment and any other acute/emergency assessment areas, short stay including EDU:

- Assessment
- Initial Investigation
- Decision Making
- Referral
- Short Stay

The product of this working group will be an “assess once, investigate once and decide once” model.

Flow Metrics for Front Door Working Group:

1.Total and split admitted and not admitted 4 hour standard performance.

2.% admitted patients discharged in 12hours or less from transfer from ED/arrival from GP referral – aiming to achieve 30% of all admissions

3.% admitted patients discharged with LOS 2 days or less - aiming to achieve 70% of all admissions

4.% delivery of the Directory of Ambulatory Emergency Care for Adults (HRG Groups)

Appendix A – Working Groups ToRs (2/6)

Base Wards ToRs

This work-stream will be responsible for designing and delivering effective case management delivery for non-short stay admissions, minimising the impact of handover between the assessing team and the base ward team, and ensuring that all internal 'waits' are abolished.

The two key processes to optimise within this group will be the effective delivery of the 'board round' and the 'one stop ward round'.

Outcome Metrics for Base Ward Working Group

1.5% reduction in deaths in non-elective inpatients aged <75 with LOS > 2days by 30th November 2014

2.20% reduction in harm events in non-elective inpatients with LOS > 2days by 30th November 2014

3.20% reduction in complaints re Base Wards by 30th November 2014

Flow Metrics for Base Ward Working Group

1.Beds occupied on Base Wards reduced by >50 beds below seasonal baseline by end August 2014 and by >75 by end September 2014 and >100 by end October 2014

2.Discharges per week by ward.

Frailty ToRs

There is an overlap between this group and the assessment and base ward groups but this group will be tasked with optimising inputs and flow for all frail older patients admitted to any specialty in the emergency pathway.

The main purpose of this group will be to reduce the 'deconditioning' impact of hospitalisation by early and assertive management of patients with frailty.

Outcome Metrics for Frailty Working Group

1.5% reduction in deaths in non-elective inpatients aged >75 by 30th November 2014

2.20% reduction in harm events in non-elective inpatients aged >75 by 30th November 2014

3.20% reduction in complaints from patients/relatives aged >75 by 30th November 2014

4.10% reduction in Long Term Care Placements from Hospital by 30th November 2014

Flow Metrics for Frailty Working Group

1.Beds occupied by patients aged 75 and over with LOS 10 days or more – 25% reduction by end August 2014, 50% reduction by end October 2014.

2.Discharges per week by Older Peoples Wards to include Community Hospitals

Appendix A – Working Groups ToRs (3/6)

Organisation ToRs

The key a activities for this workstream are:

-Development of communication strategy
-Development of high-level metrics
-Organisational development
-Development of internal and external customer processes
-Act as arbiter across working groups
-Escalate inter-Working Group issues not resolved to Steering Group
-Develop knowledge management strategy for identifying and promulgating goo practice

Front Door ToRs

The key a activities for this workstream are:

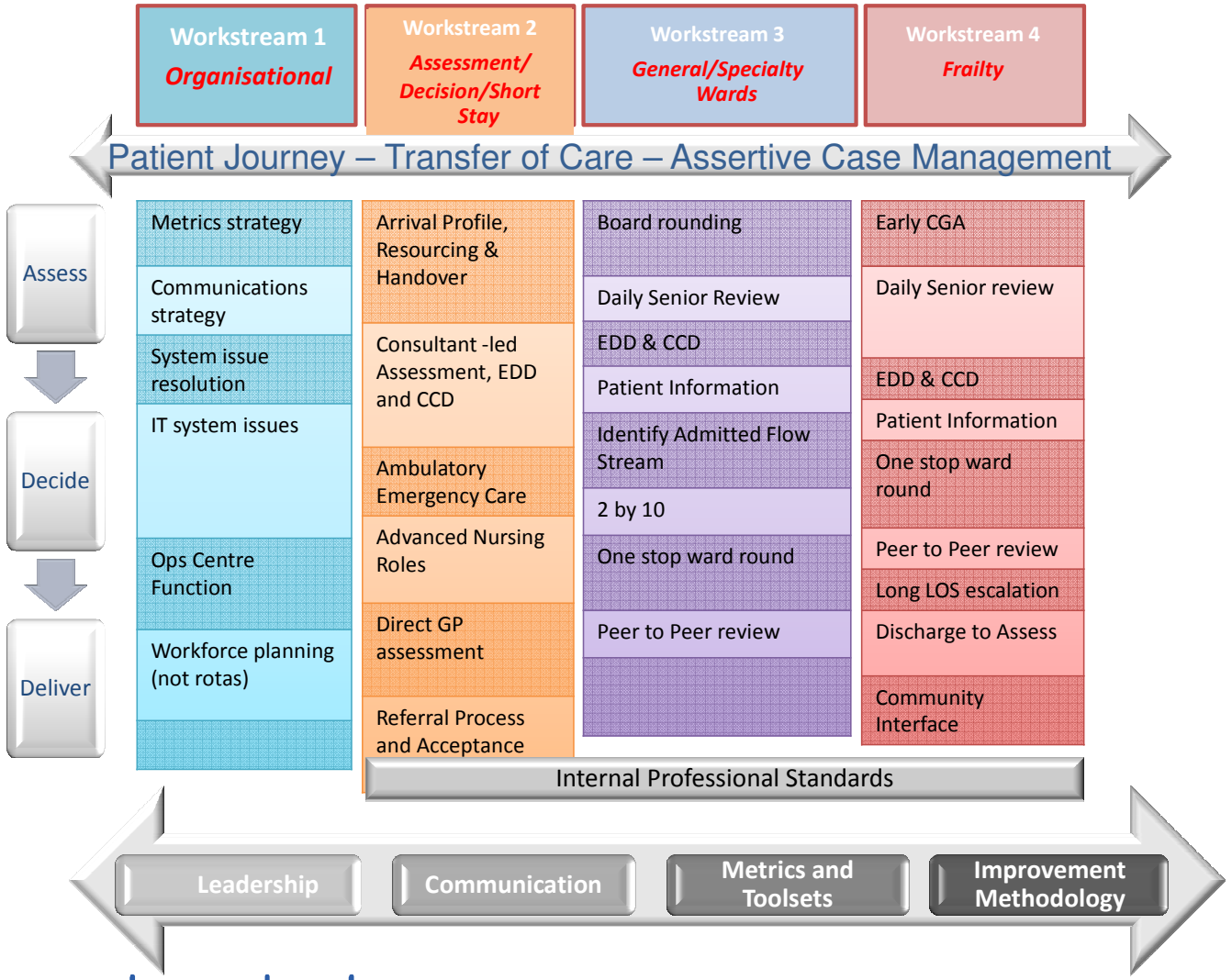
Optimisation of the following front of house processes that take place in A&E, Medical/Surgical Assessment and any other acute/emergency assessment areas, short stay including EDU:

- Assessment
- Initial Investigation
- Decision Making
- Referral
- Short Stay

The product of this working group will be an “assess once, investigate once and decide once” model.

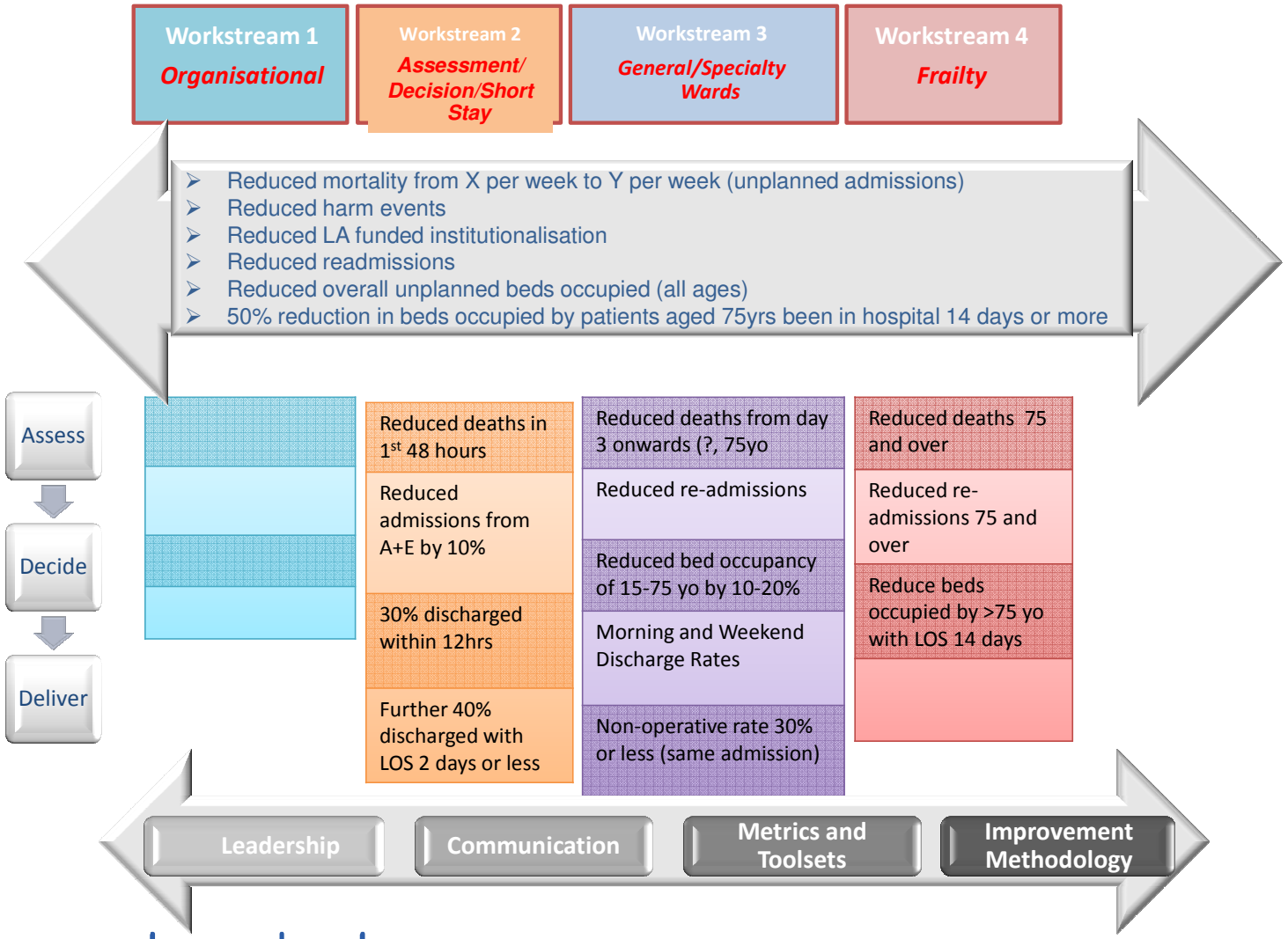
Appendix A – Working Groups ToRs (4/6)

Emergency Care Programme – Work-stream Overview



Appendix A – Working Groups ToRs (5/6)

Emergency Care Programme – Outcome Metrics Overview

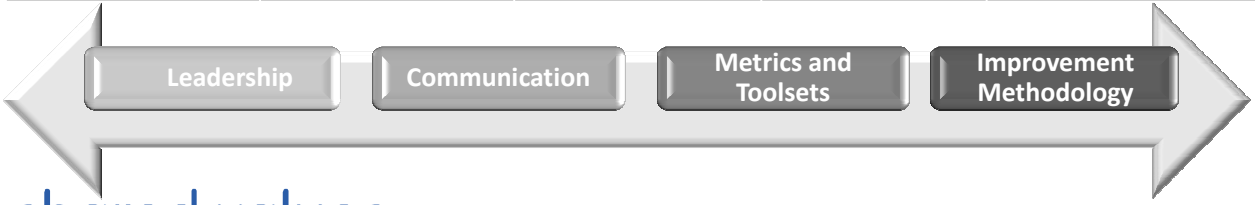


Appendix A – Working Groups ToRs (6/6)

Emergency Care Programme – Working Group Overview

Workstream 1 *Organisational*	Workstream 2 *Assessment/ Decision/Short Stay*	Workstream 3 *General/Specialty Wards*	Workstream 4 *Frailty*	Workstream 5 *Glenfield*

Membership:				
Rachel Overfield	Mark Ardron	Ian Lawrence	Simon Conroy	John Bennet
Julie Dixon	Ben Teasdale	Consultants x 2 – Med and Surg	Consultants x 2	Consultants x 2
	Lee Walker	Nursing Leads x 3	Nursing Leads x 3	Nursing Lead x 3
	Surgical Lead	AHP Lead	AHP Lead	AHP Lead
	Diagnostic Lead	Junior Doctors x 2	Junior Doctors x 2	Junior Doctors x 2
	Nursing Lead x 3	Managerial Lead	Managerial Lead	
	AHP Lead			
	Junior Doctor x 3			
	Managerial Lead			



Appendix B – Steering Group ToRs (1/3)

Purpose

To ensure the delivery of the Emergency Care Quality Programme, by monitoring and taking actions to address any potential failures to deliver.

To review performance against the expected benefits, receiving regular updates from each Working Group on progress against delivery.

To ensure all actions are completed within timescales set.

To gain assurance from individual Working Group Leads on the progress of quality improvement across the emergency care pathway.

To provide assurance to the Executive Team on the delivery of the Emergency Care Quality programme. To escalate as necessary to the executive team any issues for decision / discussion / assurance / endorsement.

To provide a forum of support for Working Group Leads in delivering enhanced quality performance across the emergency care pathway, enabling escalation of concerns, joint resolution of problems.

Appendix B – Steering Group ToRs (2/3)

Scope

The Emergency Care Steering Group will have oversight of all the Trust led Working Groups tasked to deliver quality improvements across the whole emergency care pathway, both within the Trust and with key partners outside of the Trust such as East Midlands Ambulance Service, Leicester, Leicestershire and Rutland CCGs, NHS England.

The Emergency Care Steering Group will meet on a fortnightly basis initially and will drop to monthly once performance levels have reached a pre-agreed level across the emergency care pathway.

Membership

The following are the substantive members:

Post / Remit	Post Holder(s)	Post / Remit	Post Holder(s)
Chief Executive Officer, CEO (Chair)	John Adler (chair)	Chief Operating Officer, (COO)	Richard Mitchell
		Chief Technical Advisor	Ian Sturgess
Clinical Lead	Kevin Harris	Organisation Working Group Lead	Julie Dixon
Deputy Medical Director	Andrew Furlong		
Deputy Medical Director	Peter Rabey	Front Door Lead	Mark Ardron
Clinical Director, Emergency Medicine	Catherine Free	Base Ward Lead	Ian Lawrence
		Frailty Lead	Simon Conroy
Director of Nursing	Rachel Overfield	Glenfield Lead	TBC
		Project Manager	Themba Moyo

Appendix B – Steering Group ToRs (2/3)

Constitutional Arrangements

1. A quorum shall be four members, one of these members must be the Chair or Clinical Lead and one must be either the COO or Deputy Medical Director.

2. The Emergency Care Quality Steering Group will meet fortnightly and run for two hours.

3. Minutes of this meeting will be provided to the Working Groups and Executive Team.

4. The Emergency Care Quality Steering Group is responsible and accountable to the Executive Team. The Chair will report on a fortnightly basis to the Executive Team and provide updates on progress.

5. Actions arising from the Emergency Care Steering Group will be captured and circulated to the membership, Working Groups and Executive Team post-meeting. Actions will further be captured in the Emergency Care Quality Action, Risk & Issue, (ARI), log, to be updated and circulated to all members post-meeting.

6. Attendance at the meeting is a mandatory requirement; where attendance is not possible due to annual leave, members must ensure a nominated deputy attends. The deputy should be fully conversant with all the key issues in their area.

7. All apologies are to be given to the Chair five days prior to the meeting along with the name of the nominated deputy.

8. Any associated papers must be forwarded electronically to the Chair three working days prior to the meeting, to enable review / consideration.

9. Co-option of key stakeholders will occur at the discretion of the Chair. Any individuals attending for ad-hoc agenda items are to be confirmed / agreed by the Chair prior to the meeting. The Chair will invite individuals to update the meeting as necessary.

10. In the interests of time management, meeting members must ensure timely attendance due to the information required to be reviewed at each meeting.

Appendix C – Project Management (1/4)

Defining and Capturing Risks

A risk in project terms is defined as "an uncertain event or set of events that, should it/they occur, will have an effect on the achievement of objectives". A risk is measured by a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impact on objectives.

Project risks will be logged centrally in the Actions, Risk and Issues, (ARI), Log and capture the following:

1. A description of the risk
2. It's potential impact
3. Mitigating actions, (to reduce the chances of the risk occurring or to reduce the impact if it does occur)
4. The probability of the risk occurring
5. The potential impact of the risk occurring on the project
6. The overall risk score
7. A risk owner, (who is part of the project organisation), to lead on the mitigating actions

The risk owner is to provide an initial description and resolution plan for the risk to the Project Manager who is the "custodian" of the ARI log.

Appendix C - Project Management (2/4)

Probability Scoring Matrix

Probability		
What is the Likelihood that the Risk will Occur		
Level	Approach and Processes	
1	Not Likely	0 - 20% Probability of Occurrence
2	Low Likelihood	20 - 40% Probability of Occurrence
3	Likely	40 - 60% Probability of Occurrence
4	High Likely	60-80% Probability of Occurrence
5	Near Certainty	80 - 100% Probability of Occurrence

In order to arrive at an overall risk score, the probability of the risk occurring and the impact are multiplied, resulting in a risk score. The table below provides the combination of scores and corresponding RAG status that can occur using the matrices opposite.

Impact Scoring Matrix

Potential Impact			
Given the Risk is Realized, what would be the magnitude of the impact?			
Level	Technical	Schedule	Cost
1	Minimal OR No Impact	Minimal OR No Impact	Minimal or No Impact
2	Minor OR < 2%	Slight delay < 1 month	Budget Increase of (< £1M)
3	Moderate performance	Minor Schedule Slip	Budget Increase of (£1 - 2M)
4	High Performance	Major Schedule Slip	Budget Increase of (£2 - 5M)
5	Unacceptable; Over 10%	Unacceptable Schedule	Budget Increase of (> £5M)

Risk Score Matrix

Probability					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	*2*	*3*	*4*	*5*

Potential Impact

Appendix C - Project Management (3/4)

Defining and Capturing Issues

An issue in project terms is defined as "a relevant event that has happened, was not planned, and requires management action".

Project issues will be logged centrally in the ARI log and will capture the following:

1. A description of the issue
2. Its impact
3. A resolution plan
4. When the issue should be resolved by
5. The issue owner, (who is part of the project organisation), to lead on the mitigating actions
6. Status, (i.e. whether it is open or not)

As with risks, the issue owner is to provide an initial description and resolution plan for the issue to the Project Manager who is the "custodian" of the ARI log.

Appendix C - Project Management (4/4)

Purpose of the Action Log

The purpose of the action log is to capture important things that need to be done in a timely fashion but aren't large enough to warrant integrating into the project plan.

The action log should capture:

1. The action description
2. The owner
3. A deadline for completion of action
4. Any comments
5. Status, (i.e. whether the action is open or closed
6. Date of closure

Review of Action, Risk and Issue Logs

The action, risk and issue logs will be reviewed on a regular basis by the project manager.

As a minimum, the action and issue log should be reviewed and updated at every team meeting.

As a minimum the risk log will be reviewed in depth on a fortnightly basis ahead of each Steering Group meeting in order to ensure the risks are being proactively managed.

As with risks, the action owner is to provide an initial description of the action and progress update on the action to the Project Manager who is the "custodian" of the ARI log.

Key
IA Improvement Aim
LY Last Years Figure
IF Improvement Figure
AF Actual Figure

Key
IA Improvement Aim
LY Last Years Figure
IF Improvement Figure
AF Actual Figure

Front Door		July 2014																	August 2014															
		W/E Sun 6 Jul				W/E Sun 13 Jul				W/E Sun 20 Jul				W/E Sun 27 Jul					W/E Sun 3 Aug				W/E Sun 10 Aug				W/E Sun 17 Aug				W/E Sun 24 Aug				W/E Sun 31 Aug				
		IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF		IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	
Outcome Metrics	1. Percentage of GP Referred Patients to Assessment Units	100%				100%				100%				100%				July 2014	100%				100%				100%				100%				100%				August 2014
	2. Numbers of Emergency Admissions, (Non-GP)	**JR**	**1031**		**1081**	**-**	**1010**		**1102**	**-**	**983**		**1053**	-	960				-	882			-	893			-	918			-	962			-	909			
	3. Number of GP Refeerrals Translating in to an Admission	**JR**																																				
	4. Number of Deaths in First 48 Hours	**JR**	**8**		**13**		**9**		**12**		**11**		**14**		11					13				13				9				9				12			
	5. Number of Harm Events	**JR**																																				
	6. Number of ED and Assessment Unit Complaints	**JR**																																				
	7. Percentage of Patients Being Treated iaw 4 Hour	95%	76%	N/A	92%	95%	87%	N/A	84%	95%	83%	N/A	87%	95%	84%	N/A			95%	90%	N/A		95%	85%	N/A		95%	82%	N/A		95%	80%	N/A		95%	81%	N/A		
	8. Pecentage of Admitted Patients in an In-Patient Bed < 4hrs	95%	48%	N/A	79%	95%	64%	N/A	66%	95%	57%	N/A	68%	95%	59%	N/A			95%	77%	N/A		95%	63%	N/A		95%	56%	N/A		95%	49%	N/A		95%	51%	N/A		
	9. Percentage of Non-Admitted Patients Discharged Home < 4 Hrs	95%	85%	N/A	97%	95%	95%	N/A	91%	95%	94%	N/A	94%	95%	93%	N/A			95%	96%	N/A		95%	94%	N/A		95%	92%	N/A		95%	92%	N/A		95%	91%	N/A		
Flow Metrics	1.a) Proportion of admitted patients treated wihtin 4 Hrs	-		N/A		-		N/A		-		N/A	Yes	-		N/A	Yes		95%		N/A	Yes	95%		N/A	Yes	95%		N/A	Yes	95%		N/A	Yes	95%		N/A	Yes	
	1.b) Proportion of non-admitted patietns treated within 4 Hrs	98%		N/A		98%		N/A		98%		N/A	No	98%		N/A	No		99%		N/A	No	99%		N/A	No	99%		N/A	No	99%		N/A	No	99%		N/A	No	
	2. Percentage of Admitted Patients Discharged < 12 Hrs	30%	17%	N/A	18%	30%	18%	N/A	14%	30%	15%	N/A	20%	30%	16%	N/A			30%	19%	N/A		30%	17%	N/A		30%	16%	N/A		30%	14%	N/A		30%	12%	N/A		
	3. Percentage of Admitted Patients Discharged with LoS < 2 Days	70%	43%	N/A	46%	70%	47%	N/A	43%	70%	43%	N/A	46%	70%	44%	N/A			70%	45%	N/A		70%	42%	N/A		70%	42%	N/A		70%	38%	N/A		70%	40%	N/A		
	4. Percentage of Patients on Ambulatory Emergency Care Pathway with a Zero Length of Stay	TBC		N/A		TBC		N/A		TBC		N/A		TBC		N/A			TBC		N/A		TBC		N/A		TBC		N/A		TBC		N/A		TBC		N/A		
Process Metrics	1. Percentage of Patients with Time to Initial Assessment < 15 mins	TBC	54%	N/A	38%	TBC	57%	N/A	37%	TBC	54%	N/A	42%	TBC	55%	N/A			TBC	58%	N/A		TBC	59%	N/A		TBC	54%	N/A		TBC	55%	52%		TBC	55%	52%		
	2. Percentage of Patients with Time to Doctor < 30 mins	TBC	31%	N/A	44%	TBC	35%	N/A	43%	TBC	41%	N/A	43%	TBC	46%	N/A			TBC	50%	N/A		TBC	53%	N/A		TBC	46%	N/A		TBC	48%	43%		TBC	48%	43%		
	3. Time to Consultant Review < 4 Hrs	80%	N/A	N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No		80%	N/A	N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No	
	4. Patients Leaving Assessment Unit for Base Ward with EDD and Clinical Criteria for Discharge	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes		TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	
Base Wards		W/E Sun 6 Jul				W/E Sun 13 Jul				W/E Sun 20 Jul				W/E Sun 27 Jul					W/E Sun 3 Aug				W/E Sun 10 Aug				W/E Sun 17 Aug				W/E Sun 24 Aug				W/E Sun 31 Aug				
Outcome Metrics	1. Number of Deaths in non-Elective Inpatients Aged < 75 with LoS > 2 days	**JR**	**9**		**14**		**15**		**11**		**14**		**9**		17					11				11				16				8				18			
	2. Number of Harm Events in Non-Elective Inpatients with LoS > 2 Days	**JR**																																				
	3. Number of Complaints About Base Wards	**JR**																																				
Flow Metrics	1. Beds Occupied by Non-Elective Patients Aged < 75	**JR**	**163**		**164**		**155**		**164**		**146**		**167**		139					150				147				148				152				168			
	2. Beds Occupied on Base Wards Reduced > 50 Beds Below Seasonal Baseline; (> 75 by Sep & > 100 by Oct)	-50 Beds				-50 Beds				-50 Beds				-50 Beds					-50 Beds				-50 Beds				-50 Beds				-50 Beds				-50 Beds			
	3. Discharges per Week	TBC	**1103**		**1167**	TBC	**1044**		**1157**	TBC	**992**		**1073**	TBC	1019				TBC	977	974	984	TBC	974	974	984	TBC	984	974	984	TBC	1093			TBC	942			
Process Metrics	1. Each Base Ward to Pull Patients from Assesment Units at Rate of Two by 1000 and Two by 1200 Midday	**TBC**																																				
	2. Percentage of TTOs Completed by Evening Before Discharge	-	N/A	N/A	Yes	-	N/A	N/A	Yes	-	N/A	N/A	Yes	-	N/A	N/A	Yes		40%	N/A	N/A	Yes	40%	N/A	N/A	Yes	40%	N/A	N/A	Yes	40%	N/A	N/A	Yes	40%	N/A	N/A	Yes	
	3. Discharge Lounge Use by Ward by 1000																																					
Frailty		W/E Sun 6 Jul				W/E Sun 13 Jul				W/E Sun 20 Jul				W/E Sun 27 Jul					W/E Sun 3 Aug				W/E Sun 10 Aug				W/E Sun 17 Aug				W/E Sun 24 Aug				W/E Sun 31 Aug				
Outcome Metrics	1. Number of Deaths in Non-Elective Inpatients Aged >75	**JR**	**22**		**27**		**23**		**35**		**46**		**25**		27					39				26				37				36				22			
	2. Number of Harm Events in Non-Elective Inpatients Aged > 75	**JR**																																				
	3. Number of Complaints from Patients/Relatives Aged > 75	**JR**																																				
	4. Number of Long Term Care Placements from Hospital	**JR**																																				
Flow Metrics	1. Beds Occupied by Patients Aged 75 ad Over with LoS 10 Days or More	**JR**																																				
	2. Discharges per Week by Older Peoples Ward to Include Community Hospitals	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes		TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	
Process Metrics	1. Percentage of Compprehensive Geriatric Assessment, CGA, Complete in < 2 Hrs	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes		TBC	N/A	N/A	No	TBC	N/A	N/A	No	TBC	N/A	N/A	No	TBC	N/A	N/A	No	TBC	N/A	N/A	No	
	2. Percentage Return to Original Home	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes		TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	
Steering Group		W/E Sun 6 Jul				W/E Sun 13 Jul				W/E Sun 20 Jul				W/E Sun 27 Jul					W/E Sun 3 Aug				W/E Sun 10 Aug				W/E Sun 17 Aug				W/E Sun 24 Aug				W/E Sun 31 Aug				
Outcome Metrics	1. Non-Elective Mortality in Hospital	**JR**																																				
	2. Reduce Non-Elective Harm Events in Hospital	**JR**																																				
	3. Reduce Complaints from the Non-Elective Pathway	**JR**																																				
	4. Increase in Compliments from the Non-Elective Pathway	**JR**																																				
Process Metrics	1. Total Number of Non-Elective Beds Occupied (Adult) (Daily Ave)	**JR**	**1137**		**1141**		**1088**		**1118**		**1042**		**1097**		**1051**					1041				1040				1081				1084				1115			
	2. Percentage of Midday Discharges Accounting for 40% of Discharges	**JR**	**13%**		**15%**		**13%**		**13%**		**14%**		**15%**		**13%**					16%				10%				13%				14%				14%			
4 Hour A&E Performance		W/E Sun 6 Jul				W/E Sun 13 Jul				W/E Sun 20 Jul				W/E Sun 27 Jul					W/E Sun 3 Aug				W/E Sun 10 Aug				W/E Sun 17 Aug				W/E Sun 24 Aug				W/E Sun 31 Aug				
	Achievement of A&E 4Hr Wait (Whole Campus)	95%	**83%**	N/A	**95%**	95%	**91%**	N/A	**90%**	95%	89%	N/A		95%	90%	N/A			95%	94%	N/A		95%	91%	N/A		95%	90%	N/A		95%	88%	N/A		95%	89%	N/A		