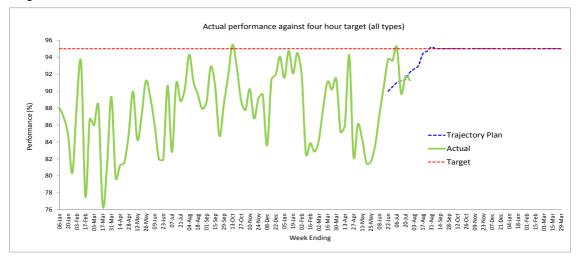
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From:					ell, Chief Operati	na (Officer	
Date:			luly 20		,	5		
CQC regulat	ion:		applica					
Title:	Emer				nt Performance Rep	ort		
Author: Rid	chard I	Mitch	ell, Chie	ef Op	erating Officer			
Purpose o To provide a		-		perfo	rmance.			
The Repor	t is pr	ovid	led to	the E	Board for:			
Decision					Discussion			
Assuranc	e		\checkmark		Endorsement			
Summary /	Key P	oints	:					
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-		-			in July 211 per da			
	transt	ers c	of care	rema	in continually abov	e th	e agree	ed performance level at
4.7%.								
			•	•	e to this time last ye			
	-		-		ansfer of care (DTO	C) ra	ate	
UHL agr						,		
• Performa	ance is	s impi	roving c	out th	e current level of pe	ertorr	nance	remains unacceptable.
Recomme	ndatio	ons:						
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Monthly								

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%.

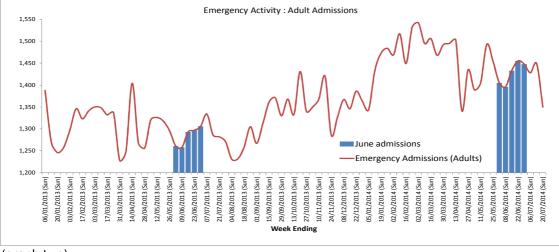
Performance overview

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.



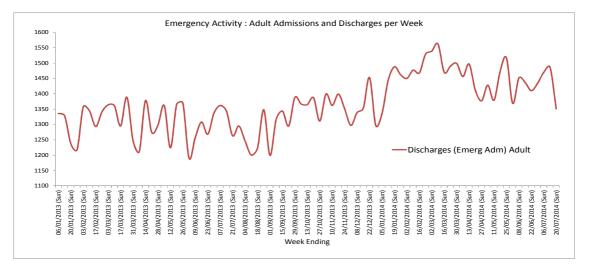
(graph one)

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.

Caring at its best

Leicester Royal Infirmary

Level 3 – Chief Executive's Corridor Balmoral Building Infirmary Square Leicester LE1 5WW

Chief Operating Officer Tel: 0116 258 6311 Fax: 0116 258 6868 E-mail: richard.mitchell@uhl-tr.nhs.uk

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.

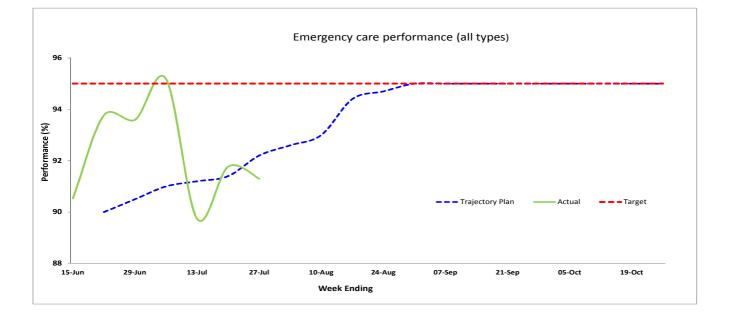
3. Emergency Care Dashboard. As we progress with the improvement plan we will use the dashboard, which will be monitored weekly, (at some levels daily), in order to ensure the improvement activities and actions we undertake are having the desired effect on key outcome, flow and process metrics.

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



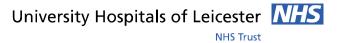
ask Name Organisation	Start	Finish	Resource Names Rachel Overfield	Status
1.1 Governance				
Treate Operational Grip	Mon 28/07/14	Fri 05/09/14		Closed
iet up Gold Command Group - Medical Director, Chief Nurse, COO	Mon 28/07/14	Fri 08/08/14	Rachel Overfield/Andrew Furlong/Richard Mitchell	
et up Silver Command Group - CMGs CD's, Head of Nursing & Gen. Mgrs.	Mon 28/07/14	Fri 08/08/14	Julie Dixon	
et 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
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Detain Steering Group Sign-Off on Working Group ToRs and Metrics	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Vorking Groups to Meet on Weekly Basis	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
te-Fresh of Daily Bed Meeting/Ops Centre/capacity staff roles	Mon 28/07/14	Fri 08/08/14	Julie Dixon	On Track
dentify and establish data set to enable 'real time' and predictive performance management	Mon 04/08/14	Fri 15/08/14	Julie Dixon/Simon Sutherland	
PMA/ICE roll out	Mon 11/08/14	TBC	Rachel Overfield	
eedback to junior doctors re TTOs - invite to group and set up focus group	TBC	TBC	Rachel Overfield	
:taffing gaps issue - 7 day snapshot/data capture2 Stakeholder and Communications	TBC	TBC	Julie Dixon	On Track
Develop Draft Communications Strategy	Mon 4/08/14	Fri 14/08/14	Nick Walkland	On Huck
Circulate Communications Strategy for Comment to Steering Group.	Mon 18/08/14	Fri 29/08/14	Nick Walkland	
. Front Door			Mark Ardron	
.1 ED & Assessment Unit Operating Model				
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est Process for CCD & EDD	Tue 19/08/14	Mon 15/09/14	Mark Ardron	
eview of Patients by Admitting Consultant	Mon 01/09/14	Fri 07/11/14	Mark Ardron	On Track
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elect New Model for Improving Theatre Utilisation	Mon 22/09/14	Fri 03/10/14	Chris Sutton	
oll Out New Theatre Model	Mon 06/10/14	Fri 31/10/14	Chris Sutton	
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ask Name	Start F	Finish	Resource Names	Status
oll Out Process of Identifying Patients for Next Day Discharge	Mon 15/09/14	Fri 10/10/14	lan Lawrence	
wo by 1000 and Two by 1220 Process	Mon 04/08/14	Fri 10/10/14	lan Lawrence	On Track
reate Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 04/08/14	Fri 15/08/14	lan Lawrence	
est Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 18/08/14	Fri 12/09/14	lan Lawrence	
oll Out Process	Mon 15/09/14	Fri 10/10/14	lan Lawrence	
. Frailty Wards			Simon Conroy	
omprehensive Geriatric Assessment	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
reate Comprehensive Geriatric Assessment Process	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
est Comprehensive Geriatric Assessment Process	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
oard Round Referral to AHP, (Abolisihing Written Referral)	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
reate Process Enabling Verbal Board Round Referral to AHP	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
est Process Enabling Verbal Board Round Referral to AHP	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
educe Dependancy on Home Visits	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
reate Process to Reduce Dependancy on Home Visits	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
est Process to Reduce Dependancy on Home Visits	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
arly Supported Discharge	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
pate Processes to Deliver Better Early Supported Discharge	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
est Processes to Deliver Better Early Supported Discharge	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
est Process to Reduce Dependancy on Home Visits arly Supported Discharge ipate Processes to Deliver Better Early Supported Discharge	Mon 18/08/14 F Mon 04/08/14 F Mon 04/08/14 F	Fri 12/09/14 Fri 10/10/14 Fri 15/08/14	Simon Conroy Simon Conroy Simon Conroy	On

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

Key



Caring at its best

UHL Emergency Care Quality Improvement Charter

One team shared values

July 2014 vo.9

Contents

University Hospitals of Leicester NHS Trust

Caring at its best

- 1. Background and Purpose
- 2. Scope
- 3. Working Groups
- 4. Governance
- 5. Roles and Responsibilities
- 6. Meetings

- 8. Reporting and Feedback
- 9. Appendices
 - a) Working Group Actions
 - b) Working Group ToRs
 - c) Emergency Care Quality Steering Group ToRs
 - d) Project Management

Background & Purpose



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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

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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 pathwayEmergency 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

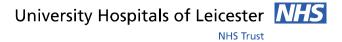
1.Organisation - this covers the communication strategy, organisational development, customer service processes and Trust-wide systems/processes that impact on the emergency care pathway

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

3.Base Wards – will cover base wards and monoorgan 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



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Membership of Working Groups

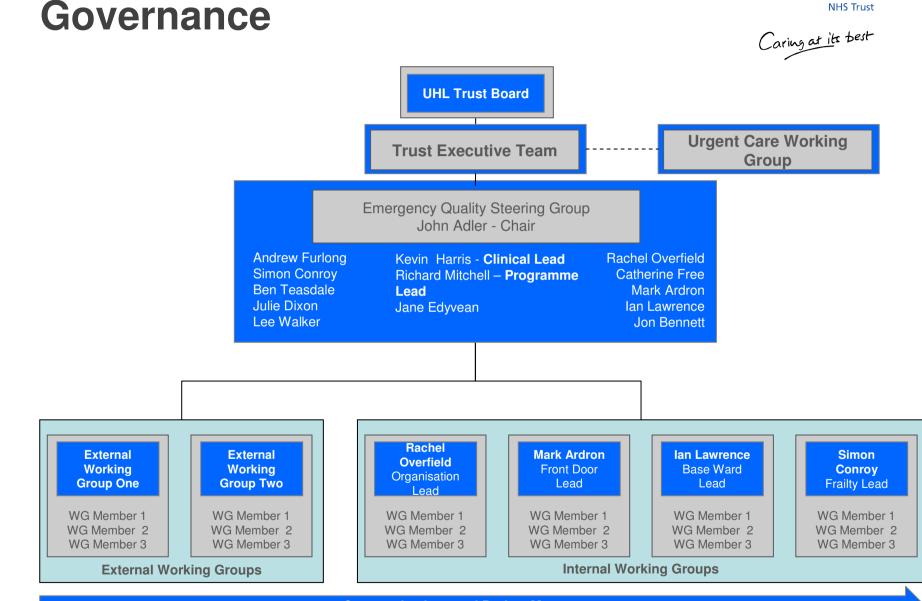
The Working Groups will be Consultant led and will be made up of a multi-disciplinary team of clinicians (Organisation will be differently configured).

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

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Communications and Project Management

Roles and Responsibilities



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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

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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:

 Performance against KPIs
 Confirmation of interventions that are working well and how to spread them
 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

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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

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- 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

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Appendix A — Working Groups ToRs (1/6)

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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 31^{st} August 2014

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

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

5.20% reduction in harm events by 30^{th} November 2014

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

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

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

9.100% not admitted patients discharged home in 4 hours or less < by 31^{st} 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 Referral
- Initial Investigation Short Stay
- Decision Making

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)

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Base Wards ToRs

This work-stream will be responsible for designing and delivering effective case management delivery for nonshort 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.

One team shared values

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)



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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

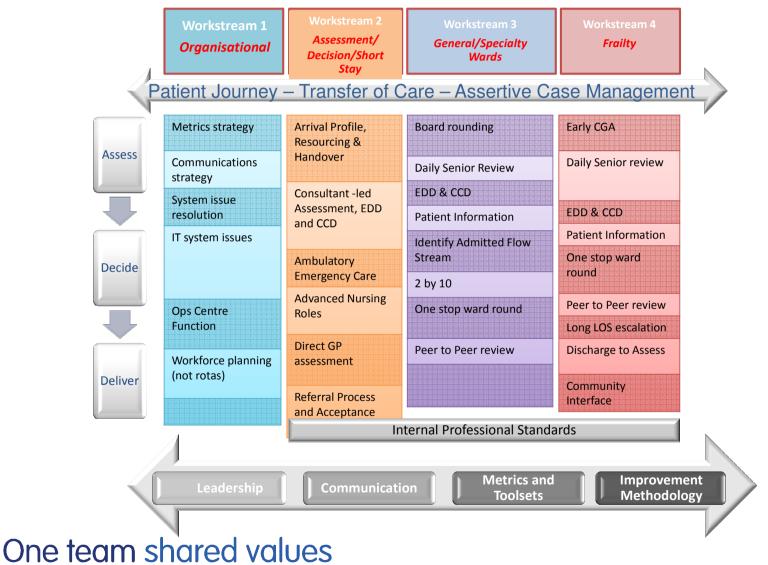
The product of this working group will be an "assess once, investigate once and decide once" model.

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Appendix A – Working Groups ToRs (4/6)



Emergency Care Programme – Work-stream Overview

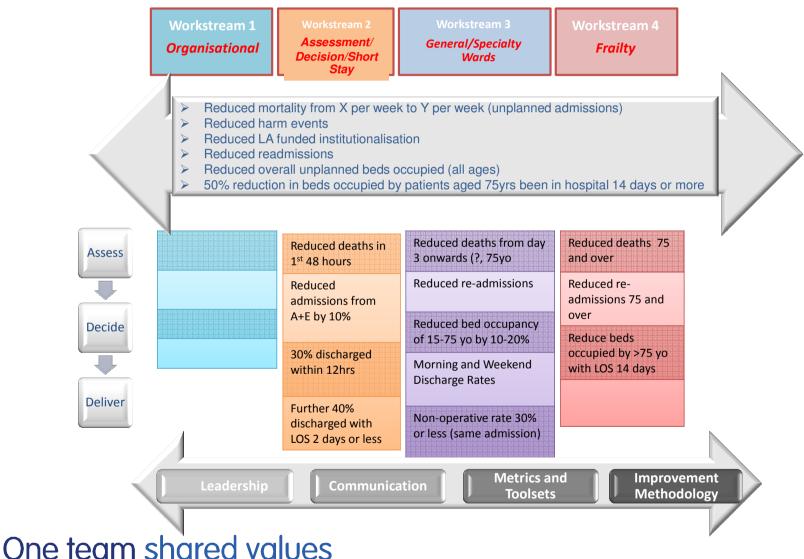


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Appendix A — Working Groups ToRs (5/6)

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Emergency Care Programme – Outcome Metrics Overview



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Appendix A — Working Groups ToRs (6/6)

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Workstream 1 Organisational	Workstream 2 Assessment/ Decision/Short Stay	Workstream 3 General/Specialty Wards	Workstream 4 <i>Frailty</i>	Workstream 5 <i>Glenfield</i>					
1embership:									
achel Overfield	Mark Ardron	lan Lawrence	Simon Conroy	John Bennet					
ulie 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								
Leader	ship Comm			mprovement Methodology					

Emergency Care Programme – Working Group Overview

Appendix B — Steering Group ToRs (1/3)

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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)

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

Appendix B — Steering Group ToRs (2/3)

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Constitutional Arrangements

1. A guorum 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 adhoc 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)

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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)

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Probability Scoring Matrix

Probabil	ity	
	What is the Likeliho	ood that the Risk will Occur
Level	App	proach 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

Impact Scoring Matrix

Potentia	l Impact							
Giver	the Risk is Realized, what	would be the magnitu	de 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)					

One team shared values

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.

	Ri	isk Sco	ore Mat	trix		
Probabilit	y					
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	•
			Potenti	al Impa	ct	

Appendix C - Project Management (3/4)

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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)

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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.

		IF	Last Y	ement A ears Figu ement F Figure	ure				l. l. e										IF	Last Ye	ement Aim ears Figure ement Figur Figure	re								014								
	Front Door		W/E S	un 6 Jul		W/E Sun 13		n 13 Jul	July 2		W/E Sur	20 Jul		W/E Sun 27 Jul				W/E Sun 3 A		n 3 Aug		W/E Sun 10 Aug		g	W/E		Augus I/E Sun 17 Aug			W/E Su	Sun 24 Aug			W/E Su	n 31 Aug			
		IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF		IA	LY	IF A	AF IA	LY	(IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	IA	LY	IF	AF	
	1. Percentage of GP Referred Patients to Assessment Units	100%				100%				100%				100%				2014	100%			100	%			100%				100%				100%				2014
	2. Numbers of Emergency Admissions, (Non-GP)	JR	1031		1081	-	1010		1102	-	983		1053	-	960			July	-	882		-	89	3		-	918			-	962			-	909			August
	3. Number of GP Refeerrals Translating in to an Admission	JR																																				Au
Metrics	4. Number of Deaths in First 48 Hours	JR	8		13		9		12		11		14		11					13			13	3			9				9				12			
ne M	5. Number of Harm Events	JR																																				
utcol	6. Number of ED and Assessment Unit Complaints	JR																																				
0	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%	859	% 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%	639	% N/A		95%	56%	N/A		95%	49%	N/A		95%	51%	N/A		
	 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%	5 949	% N/A		95%	92%	N/A		95%	92%	N/A		95%	91%	N/A		
	1.a) Proportion of admitted patients treated wihtin 4 Hrs	-		N/A		-		N/A				N/A	Yes	-		N/A	Yes		95%		N/A Y	es 95%	, b	N/A	Yes	95%		N/A	Yes	95%		N/A	Yes	95%		N/A	Yes	
ics	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	lo 99%	, D	N/A	No	99%		N/A	No	99%		N/A	No	99%		N/A	No	
v Metrics	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%	5 179	% N/A		30%	16%	N/A		30%	14%	N/A		30%	12%	N/A		
Flow	 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%	6 42°	% N/A		70%	42%	N/A		70%	38%	N/A		70%	40%	N/A		
1	 Percentage of Patients on Ambulatory Emergency Care Pathway with a Zero Length of Stay 	твс		N/A		TBC		N/A		твс		N/A		TBC		N/A			твс		N/A	тво	;	N/A		TBC		N/A		TBC		N/A		TBC		N/A		
s	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	тво	599	% N/A		TBC	54%	N/A		TBC	55%	52%	,	TBC	55%	52%		
Metrics	2. Percentage of Patients with Time to Doctor < 30 mins	твс	31%	N/A	44%	твс	35%	N/A	43%	твс	41%	N/A	43%	TBC	46%	N/A			твс	50%	N/A	тво	539	% N/A		TBC	46%	N/A		TBC	48%	43%	,	TBC	48%	43%		
cess	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	lo 80%	6 N//	A N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No	80%	N/A	N/A	No	
Pro	 Patients Leaving Assessment Unit for Base Ward with EDD and Clinical Criteria for Discharge 	твс	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes		твс	N/A	N/A Y	es TBO	C 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 Su	n 27 Jul			W/E Sun 3 Aug W/E Sun 10 Aug					g	W/E Sun 17 Aug					W/E Sun 24 Aug				W/E Su	n 31 Aug									
s	 Number of Deaths in non-Elective Inpatients Aged < 75 with LoS > 2 days 	JR	9		14		15		11		14		9		17					11			11	I			16				8				18			
Outcome Metrics	2. Number of Harm Events in Non-Elective Inpatients with LoS $>$ 2 Days	JR																																				
ō²	3. Number of Complaints About Base Wards	JR																																				
etrics	1. Beds Occupied by Non-Elective Patients Aged < 75	JR	163		164		155		164		146		167		139					150			14	7			148				152				168			
w Met	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 Bed				-50 Beds				-50 Beds				-50 Beds				
Flor	3. Discharges per Week	твс	1103		1167	TBC	1044		1157	TBC	992		1073	TBC	1019				твс	977	974 9	84 ТВС	97	4 974	984	TBC	984	974	984	TBC	1093			TBC	942			
s s	1. Each Base Ward to Pull Patients from Assesment Units at Rate of Two by 1000 and Two by 1200 Midday	твс																																				
Proce: Metric	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 Y	es 40%	6 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 S	un 6 Jul			W/E Sur	n 13 Jul			W/E Sur	n 20 Jul		W/E Sun 27 Jul				W/E Sun 3 Aug			ug W/E Sun 10 Aug				W/E Sun 17 Aug					W/E Su	ın 24 Au	ıg		W/E Sur	n 31 Aug			
Metrics	1. Number of Deaths in Non-Elective Inpatients Aged >75	JR	22		27		23		35		46		25		27					39			26	3			37				36				22			
	2. Number of Harm Events in Non-Elective Inpatients Aged > 75	JR																						_											<u> </u>			
Outcome	3. Number of Complaints from Patients/Relatives Aged > 75	JR																						_											\vdash		\square	
	4. Number of Long Term Care Placements from Hospital	JR																	<u> </u>											<u> </u>					<u> </u>	<u> </u>	\square	
Flow Metrics	Beds Occupied by Patients Aged 75 ad Over with LoS 10 Days or More Dispherence per Week by Older Papeles Word to Include	JR																									<u> </u>	<u> </u>							<u> </u>	ļ!		
-	2. Discharges per Week by Older Peoples Ward to Include Community Hospitals			N/A	Yes			N/A	Yes	TBC			Yes	TBC		N/A	Yes			N/A			C N//	_			N/A			TBC	-			TBC	-		Yes	
Process Metrics	1. Percentage of Compprehensive Geriatric Assessment, CGA, Complete in < 2 Hrs		N/A	N/A	Yes		N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC		N/A	Yes			N/A	N/A			_		TBC		N/A	No	TBC	-			TBC		N/A	No	
Pre Mé	2. Percentage Return to Original Home	TBC		N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes	TBC	N/A	N/A	Yes		TBC		N/A Y	es TBO	C N//			TBC		N/A	Yes	TBC				TBC		N/A	Yes	
	Steering Group		W/E S	un 6 Jul			W/E Sur	n 13 Jul			W/E Sur	i 20 Jul			W/E Sur	n 27 Jul			<u> </u>	W/E Su	n 3 Aug		W/E	Sun 10 Au	g		W/E Su	n 17 Aug	9		W/E Su	ın 24 Au	ıg		W/E Sur	n 31 Aug		
Metrics	1. Non-Elective Mortality in Hospital	JR																	<u> </u>				_	_	<u> </u>				<u> </u>						<u> </u>	<u> </u>	\square	
	2. Reduce Non-Elective Harm Events in Hospital	JR																	┣──				_	_						-		-				'	$\mid = \mid$	
Outcome	3. Reduce Complaints from the Non-Elective Pathway	JR																	⊢				_	_								-				'	\mid	
-	 Increase in Compliments from the Non-Elective Pathway Total Number of Non-Elective Beds Occupied (Adult) (Daily 	JR																	<u> </u>			_								-					—	<u> </u>	\square	
Process Metrics	Ave) 2. Percentage of Midday Discharges Accounting for 40% of	JR	1137		1141		1088		1118		1042		1097		1051				<u> </u>	1041			104	_	<u> </u>		1081		<u> </u>		1084				1115	<u> </u>	\square	
Ţ,	Discharges	JR	13%		15%		13%		13%		14%		15%		13%				_	16%			109				13%				14%				14%			
	4 Hour A&E Performance		1	un 6 Jul			W/E Sur	1		1	W/E Sur	1			W/E Su				-		n 3 Aug		1	Sun 10 Au	-			n 17 Aug	9		1	ın 24 Au	-		1	n 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%	919	% N/A		95%	90%	N/A		95%	88%	N/A		95%	89%	N/A		