UHL Emergency Performance

Author: [Richard Mitchell] Date: [Thursday 4 June 2015]

Executive Summary Paper S

Context

Although non-compliant, emergency performance has improved from last year but UHL remains under pressure because of the continuing and unseasonably high levels of attendance and admissions. We (UHL) need to work more effectively with Leicester, Leicestershire and Rutland partners (LLR) to resolve this key problem.

Questions

1. What more can UHL do to resolve this problem?
2. What more can our partners do to resolve this problem?
3. Besides trying to resolve the high levels of attendance and admissions what else does UHL need to focus on?

Conclusion

1. We need to work more effectively on gaining greater control of the front door function. This may involve working with partners outside of LLR who have previous experience of resolving a similar problem.
2. CCG partners need to work more effectively on identifying the attendance/ admission avoidance schemes that are working in parts of the health economy and then need to develop an urgent plan to roll them out across the health system.
3. Out of hours ED performance remains to variable and is a key part of our UHL improvement plan.

Input Sought

We would welcome the board's input regarding the pace and scale of change in the attendance and admission avoidance schemes.

For Reference

Edit as appropriate:

1.The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /No /Not applicable]
Effective, integrated emergency care	[Yes /No /Not applicable]
Consistently meeting national access standards	[Yes /No /Not applicable]
Integrated care in partnership with others	[Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes /No /Not applicable]
A caring, professional, engaged workforce	[Yes /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /Not applicable]
Financially sustainable NHS organisation	[Yes /No /Not applicable]
Enabled by excellent IM&T	[Yes /No /Not applicable]

2.This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes /No /Not applicable]
Board Assurance Framework	[Yes /No /Not applicable]

3.Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4.Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5.Scheduled date for the next paper on this topic: 2 July 2015

6.Executive Summaries should not exceed 1 page. [My paper does comply]

7.Papers should not exceed 7 pages. [My paper does comply]

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**4 June 2015**

The emergency care performance report will now take a more consistent approach to reviewing emergency performance from one trust board to another. The suggested key points which will be covered are:

- High level performance review
- Update on UHL plan
- LLR KPIs
- Key risks

High level performance review

- 91.8% year to date (+6.7% on last year)
- Attendance +2.6%
- Admissions +7.3%
- 2990 more patients cared for within four hours
- April 2015 92.4% vs 86.9% April 2014
- May 2015 91.6% vs 83.4% May 2015
- **Performance remains consistently below 95%.**

UHL has a key role to work with partners to improve performance and there is now a clear view that inflow remains the single biggest problem. Internal flow and process within UHL have improved dramatically over the last 12 months and progress has been made with partners including Leicester Partnership Trust to discharge more patients in a timely and high quality manner. However, as previously stated at Trust Board, to achieve sustainable improvement requires all parts of the health economy to improve.

Update on UHL plan

We continue to make progress on our internal flow plan. The plan is monitored through the weekly Emergency Quality Steering Group and of the 62 actions identified most are on track or complete, details below.

Row Labels	Count of Actions
1. Not yet commenced	24
2. Significant delay – unlikely to be completed as planned	2
3. Some delay – expected to be completed as planned	2
4. On track	32
5. Complete	1
6. Complete and regular review	1
Grand Total	**62**

The detailed plan that went to EQSG on 27/5 is attached. A point of particular focus is out of hours ED resilience as performance at that time of day often deteriorates. Also attached is a more detailed update on out of hours ED resilience. We have 17 key actions within this plan that form part of the 62 actions and they are broadly on track.

LLR KPIs

LLR KPIs are attached and are tracked through the fortnightly Urgent Care Board.

Key risks

The key risks identified in the last Trust Board report remain:

1. Communications- **Attendances and admissions remain high.** LLR needs an effective communications message directly to GPs, care homes, nursing home and carers of patients restating the importance of choosing wisely and acknowledging where the risks currently are.
2. There remains an **urgent requirement to spot purchase nursing home and care home beds** to alleviate some of the pressure within UHL and LPT.
3. Surge capacity – we continue to see increasing rates of admissions and **we have no surge capacity**.
4. Progress has been made with short notice cancellations but **risks remain** around; EMAS capacity, overcrowding in ED/ CDU, handover delays in ED and overstretched nursing and medical capacity.
5. We need to **unite the deliverability of the urgent care agenda and Better Care Together**

Conclusion

The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy stops overall improvement. We must set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are met. Current progress is insufficient to provide a higher quality of care to our patients in winter 2015-16.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the UHL update against the delivery of the new operational plan
- Seek **assurance** on UHL and LLR progress

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

ED Reliable Performance Progress Update

19/05/15

One team shared values

ED Reliable Performance – Context

The list below represents the 18 key factors affecting reliable ED performance.
The following slides detail (where applicable) the actions being taken to address the issue and the estimated impact of these actions

#	Description	#	Description
1	Occupancy is not low before spike in demand	10	Medical and nursing staffing capacity
2	Patients waiting for beds before spike in demand	11	Portering
3	We have an unusual pattern of attendance	12	Flow to CDU
4	Limitations imposed by the size of the department	13	Dependency on NIC & DIC
5	Period of handover slows decisions down	14	Transfer ambulances
6	UCC send patients up late	15	Paeds flow
7	Whole hospital response	16	Skill Mix
8	Minors closes during the night	17	Resus (excessive activity)
9	Outflow does not keep up with the rate that patients are added to the bed list	18	Lack of strong and clear capacity plan at 4pm

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

ED Reliable Performance – Context

The purpose of today's session is to:

1.Discuss whether actions are the correct actions

2.Provide assurance on whether all possible steps to complete actions are being taken

Thinking should be structured around:

1	**Evidence – significance of the problem** • What issue are you trying to solve? • To what extent is this problem? What data do you have to support this claim? • Why are you prioritising this issue over others?
2	**Evidence – effectiveness of solution** • What is the discrete action you are proposing to solve the problem? • To what extent will it resolve the problem? What data supports this view? • What other actions were considered? Why were they discounted?
3	**Monitoring – delivery of the benefits** • How do you plan to track the efficacy of the action? • What changes in the KPIs are you predicting? What quantum of change? • How frequently will data be reviewed? What is the plan if the impact is not happening?
4	**Monitoring – delivery of the action** • Have you clearly articulated a timeline for the delivery, including sub-actions? • How will you know when the action is complete? i.e. what will be true once it's finished?

1. Occupancy is not low before spike in demand

Evidence of Issue	Likely Impact of Actions	Comments
Data analysis showed that each additional person in Majors equated to an extra 7 mins in dep't	Medium	The actions listed here address attempts to curb ED attendances and be more responsive if there are periods of high inflow. ED attendances lie largely out of UHL control

Action	Action Status	Owner	Completion Date
UHL-ED11: Co-design with ED staff a process for having (?hourly) Situational Awareness updates from all ED areas to help with timely escalation	4. On track	Ben Teasdale	28/05/2015
UHL-WHR1: Work with key specialties to improve the referral process when ED is an appropriate route and reduce numbers of patients which are inappropriately sent via ED	1. Not yet commenced	Julie Dixon	01/08/2015
UHL-WHR2: Complete "ED Road Tour" to improve links between specialties and ED and promote understanding of 'Exit Block'	1. Not yet commenced	Julie Dixon	30/06/2015
UHL-ED3: Review ED process delays through monthly journey meetings to identify causal factors	6. Complete and regular review	Julie Dixon	01/05/2015
UHL-ED7: Work with each area in the ED to reduce time from bed allocation to departure from department	4. On track	Ben Teasdale	30/09/2015

2. Patients waiting for beds before spike in demand

Evidence of Issue	Likely Impact of Actions	Comments
Evidence of strong correlation between time from bed request to bed allocation and performance against the 4 hour target (0.89)	Medium	Focussing on standardising discharge processes to remove variation between staff

Action	Action Status	Owner	Completion Date
UHL-AMU1: Improve the discharge process on AMU and utilisation of AMC to reduce the time from bed request to bed allocation	4. On track	Lee Walker	24/06/2015
UHL-WHR10: Create rapid bed turnaround (cleaning) team to reduce time from bed request to bed allocation	4. On track	Julie Dixon	30/06/2015
UHL-ED10: Map out EDU processes to understand areas of opportunity for improving flow through the unit.	4. On track	Mark Williams	30/06/2015

5. Period of handover slows decisions down

Evidence of Issue	Likely Impact of Actions	Comments
Anecdotal - needs further work to quantify impact of this	Low	Opportunity primarily lies in mitigating actions either side of handover period. Plan in place for diagnostic work – see supplementary slide

Action	Action Status	Owner	Completion Date
UHL-WHR9: Look into improving efficiency during handover times	4. On track	Julie Dixon	30/06/2015

6. UCC send patients up late

Evidence of Issue	Likely Impact of Actions	Comments
Anecdotal evidence in A&E tracker log and exclamation mark report – to be quantified	Low	Need to consider the implication of re-contracting the Front Door

Action	Action Status	Owner	Completion Date
UHL-ED14: Analyse patterns and reasons for UCC late referrals to inform solutions	1. Not yet commenced	Ben Teasdale	30/06/2015

7. Whole Hospital Response

Evidence of Issue	Likely Impact of Actions	Comments
Anecdotal - variation in performance between different on call teams	Medium	There needs to be further actions post June to embed use of WHR and cultural change

Action	Action Status	Owner	Completion Date
Define on call competencies for Whole Hospital Response roles and self assess current state to inform escalation training	4. On track	Julie Dixon	19/06/2015
Hold escalation scenario training for X% (?80%) of relevant staff to reduce variability in response	4. On track	Julie Dixon	19/06/2015
Create rapid bed turnaround (cleaning) team to reduce time from bed request to bed allocation	4. On track	Julie Dixon	30/06/2015
Complete "ED Road Tour" to improve links between specialties and ED and promote understanding of 'Exit Block'	1. Not yet commenced	Julie Dixon	30/06/2015
Design and implement a robust management framework for monitoring & addressing actions taken when on escalation to ensure consistent, timely response	4. On track	Julie Dixon	30/06/2015
Explore use of anaesthetists to support airways instead of ITU	5. Complete	TBC	30/06/2015
Look into improving efficiency during handover times	4. On track	Julie Dixon	30/06/2015
Work with specialties to update their whole hospital response and design role cards to improve confidence / consistency in performing escalation protocols	1. Not yet commenced	Julie Dixon	31/07/2015
Work with key specialties to improve the referral process when ED is an appropriate route and reduce numbers of patients which are inappropriately sent via ED	1. Not yet commenced	Julie Dixon	01/08/2015
Put in place new protocols to monitor adherence to outlier criteria to ensure that actions taken during escalation do not compromise patient experience and lead to sustainable performance the following day	4. On track	Julie Dixon	30/08/2015
Introduce iPorter across the Trust to reduce portering delays	1. Not yet commenced	Julie Dixon	01/09/2015

8. Minors closes during the night

Evidence of Issue	Likely Impact of Actions	Comments
Anecdotal evidence in A&E tracker log and exclamation mark report – to be quantified	Low	Need to consider the implication of re-contracting the Front Door

Action	Action Status	Owner	Completion Date
UHL-ED8: Analyse data to determine the optimal opening hours for ED Minors and develop action plan if changes are required to improve patient flow	4. On track	Ben Teasdale	15/06/2015

9. Outflow does not keep up with the rate that patients are added to the bed list

Evidence of Issue	Likely Impact of Actions	Comments
High correlation (0.89) between time from bed request to allocation and performance against 4 hour target	High	Need to assess impact of real time bed state once live

Action	Action Status	Owner	Completion Date
UUHL-AMU1: Improve the discharge process on AMU and utilisation of AMC to reduce the time from bed request to bed allocation	4. On track	Lee Walker	24/06/2015
UHL-ED7: Work with each area in the ED to reduce time from bed allocation to departure from department	4. On track	Ben Teasdale	30/09/2015
UHL-WHR10: Create rapid bed turnaround (cleaning) team to reduce time from bed request to bed allocation	4. On track	Julie Dixon	30/06/2015
UHL-BW2: Increase the accuracy of recorded discharge time to capture and encourage early discharges	2. Significant delay – unlikely to be completed as planned	Ian Lawrence	30/06/2015
UHL-BW3: Implement "real-time bed state-'light' " to capture and encourage early discharges	2. Significant delay – unlikely to be completed as planned	Jane Edyvean	30/06/2015
UHL-BW8: Review bed bureau processes to reduce discharge-delays HL-AMU1: Improve the discharge process on AMU and utilisation of AMC to reduce the time from bed request to bed allocation	4. On track	Julie Dixon	30/05/2015

10. Medical and nursing staffing capacity

Evidence of Issue	Likely Impact of Actions	Comments
A&E nursing not funded up to NICE guidance / acuity tool numbers Consultant numbers do not match requirements for new floor	Low	In the immediate term there is little that can be done with workforce capacity issues Need to explore investing in alternative roles e.g. ACPs

Action	Action Status	Owner	Completion Date
UHL-ED12: Look at each stream within the ED separately to determine if their independent staffing patterns can cope with 85 percentile of activity (including number of staff, skill mix and rotas) to increase robustness of staffing cover	4. On track	Ben Teasdale	30/06/2015

11. Portering

Evidence of Issue	Likely Impact of Actions	Comments
Simulation Tool found this had a measurable impact on performance Need to use iPorter data to quantify time spent waiting for porters	Medium	Outstanding issue of having sufficient numbers at peak times – need to explore ability to better flex numbers

Action	Action Status	Owner	Completion Date
UHL-ED5: Trial iPorter in ED with a view to permanent implementation to reduce portering delays	4. On track	Ben Teasdale	30/06/2015
UHL-WHR11: Introduce iPorter / CARPS across the Trust to reduce portering delays	1. Not yet commenced	Julie Dixon	01/09/2015

12. Flow to CDU

Evidence of Issue	Likely Impact of Actions	Comments
Anecdotal – pressure when Glenfield on a stop Simulation Tool indicates additional attendances reduce performance	High	This is being mitigated by the Glenfield action plan.

Action	Action Status	Owner	Completion Date
Ensure there is PCC (primary care coordinator) support at Glenfield to match AMU at LRI	4. On track	Sam Leak	13/05/2015
Review nursing rotas and working practices to ensure that patients are triaged within 15 minutes	4. On track	Lisa Graham	03/06/2015
Design a robust system to ensure that patients receive clinical assessment within 60 minutes	4. On track	Catherine Free	03/06/2015
Design a robust system to deliver cardiology consultant review within 14 hours to 95% of patients	2. Significant delay – unlikely to be completed as planned	Jan Kovac	03/06/2015
Design a robust system to deliver respiratory consultant review within 14 hours to 95% of patients	4. On track	Kim Ryanna	03/06/2015
Increase numbers of monitored cardiology beds in base wards	2. Significant delay – unlikely to be completed as planned	Jan Kovac	30/06/2015
Improve computer access and reduce overcrowding in CDU to reduce delays	4. On track	Kim Ryanna	30/06/2015
Develop SLA with CSI to optimise therapy cover in CDU to reduce discharge delays	4. On track	Jodie Billings	30/06/2015
Improve imaging access to match AMU /AFU to reduce discharge delays	4. On track	Dan Barnes/Cathy Lea	30/06/2015
Improve pharmacy support for CDU out-of-hours, to reduce discharge delays	4. On track	Bhavisha Pattani	01/07/2015

13. Dependency on nurse in charge and doctor in charge

Evidence of Issue	Likely Impact of Actions	Comments
Anecdotal – similar inflow / occupancy profiles result in very different performance	Low	Situational awareness and SOPs will support NIC & DIC however difficult to eradicate individual differences

Action	Action Status	Owner	Completion Date
UHL-ED11: Co-design with ED staff a process for having (?hourly) Situational Awareness updates from all ED areas to help with timely escalation	4. On track	Ben Teasdale	28/05/2015

14. Transfer ambulances

Evidence of Issue	Likely Impact of Actions	Comments
Within ED c.3% of ED attendances require a transfer – this equates to 9 per day EDU Awaiting Transfer pathway shows an average of 70 people per month with an average LoS of 2 hours. Anecdotal evidence of very long waits e.g. 4 hrs, 7 hrs Transport breaches due to waiting for transport were minimal in 2014 data; the biggest effect is likely to be in taking away EDU capacity Within AMU/AMC Anecdotal - Delays getting GP patients to AMC with 4hr ambulances Within Base Wards Booking ambulances using the discharge lounge causes delays due to process and batching	ED – Low AMU/AMC – Medium BW – Medium	For ED This is further compounded by the fact that often ED patients waiting for transfer are not accepted by the Discharge Lounge. No action is addressing the constraint this poses. For AMU/AMC If 1 hour contract implemented fully this would have a significant impact on attendance pattern For BW Base ward staff being trained to book patient transport using the Arriva online booking system.

Action	Action Status	Owner	Completion Date
UHL-BW9: Review transport booking process to reduce discharge delays	4. On track	Julie Dixon	30/06/2015
UHL-ED1: Work with EMAS and CCGs to introduce CAD+ as the sole data set to monitor ambulance handovers	4. On track	Rachel Williams	30/05/2015

16. Skill mix

Evidence of Issue	Likely Impact of Actions	Comments
	Low	Little in immediate term that can address. Need to explore investing in alternative roles e.g. ACPs

Action	Action Status	Owner	Completion Date
UHL-ED12: Look at each stream within the ED separately to determine if their independent staffing patterns can cope with 85 percentile of activity (including number of staff, skill mix and rotas) to increase robustness of staffing cover	4. On track	Ben Teasdale	30/06/2015

17. Resus (excessive activity)

Evidence of Issue	Likely Impact of Actions	Comments
Average Resus occupancy for Dec was 8.	Low	Ongoing capacity constraints in ITU, HDU & ACB makes changes in ED of minimal effectiveness

Action	Action Status	Owner	Completion Date
UHL-WHR8: Explore use of anaesthetists to support airways instead of ITU	5. Complete	TBC	30/06/2015

Action reference number	Actions	KPI trajectory	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL-AMB2	Establish current use of existing ambulatory care pathways in order to baseline performance and measure improvements	Reduce admissions by 10%	Catherine Free	~~06/05/2015~~ 06/06/2015	4. On track	Initial baseline complete. Further meetings needed with each service to understand coding and refine. Agreement that method for tracking delivery is reduction in admissions relating to targetted HRGs.
UHL-AMB1	Design and implement a headache and post fit pathway for EDU to reduce admissions	Reduce admissions by 10%	Catherine Free	27/05/2015	2. Significant delay – unlikely to be completed as planned	Headache pathway finalised and is being communicated to relevant staff. Post fit pathway in development. Both pathways due for roll out end of May. Update on 18/5: Final stages for headache pathway are upload onto intranet and signoff of patient information leaflet Update on 26/5: Awaiting finalisation of content for patient information leaflet from Martin Wiese ahead of uplodading. Post fit pathway due at consultant meeting this week - if signed off ready for
UHL-AMB3	Produce ambulatory pathway repository for UHL staff and GPs to increase use of existing pathways	Reduce admissions by 10%	Catherine Free	27/05/2015	2. Significant delay – unlikely to be completed as planned	Existing directory located. All services listed on directory being contacted to provide updated information. New services identified for inclusion in directory. Update on 26/5: This is a larger piece of work than anticipated due to need to meet with each service. This is on track for sharing with the GPs at event on 23rd June and being finalised following this.
UHL-AMB4	Establish neurology ambulatory clinic to increase capacity in the AMC to treat GP referrals	Reduce admissions by 10%	Catherine Free	24/06/2015	4. On Track	Feedback session from initial trial held 28/04/15. Next steps are to review registrar rota and confirm space requirements. Update on 12/5/15: staffing available for M-T and Friday AM. Working on staffing for Friday PM. Agreement at EQSG of need to clear Bay 0 for clinic. Update on 18/5/15: 1 registrar has resigned. This should not impact
UHL-AMB5	Work with CDU to develop ambulatory clinic to streamline flow through department	Reduce admissions by 10%	Catherine Free	30/06/2015	4. On track	Exploring potential staffing models. 18/5/15: Paper submitted for discussion at respiratory consultant meeting on 29/5
UHL-AMU6	Simplify discharge letters to reduce discharge delays	10% reduction in length of stay of patients	Lee Walker	~~29/04/2015~~ 20/06/2015	4. On track	Simplified TTOs received push back from various stakeholders. This was taken to EQB w/c 4/5 Update on 12/5/15: No decision taken at EQB. Providing further information for group to be able to make decision Update 14/05: further conversations with UHL MD and exploring possibility of redesigning digital layout of TTO form
UHL-AMB6	Trial AMB score on CDU		Catherine Free	01/05/2015	5. Complete	AMB score trialled for one day on CDU. 8 patients seen, or which 7 were seen, treated and discharged within 4 hours.
UHL-AMU3	Introduce EDIS as a discharge tool on SSU to decrease transfer delays from AMU	Increase in the proportion of discharges between 8am and 12pm	Lee Walker	11/05/2015	5. Complete	EDIS now live. Awaiting log in details for staff, training and process for transfer (pull from SSU vs push from AMU) Update on 12/5/15: EDIS live and staff have log in profiles. Meeting booked with flow coordinator manager to discuss transfer process.
UHL-AMU2	Refine escalation policy for AMU as part of the whole hospital response to improve flow through department	Increase the proportion of GP bed referrals going directly to AMU to 70%	Lee Walker	27/05/2015	2. Significant delay – unlikely to be completed as planned	Escalation policy is in draft form - to be shared with AMU staff at flow workshop on 9/6. Will be ready for EQSG sign off following this.
UHL-AMU7	Implement Ambulance/Transport service to convey GP referrals that need to attend within 1 hour of GP request for transport to increase the utilisation of the AMC	Increase the proportion of GP bed referrals going directly to AMU to 70%	Julie Dixon	13/05/2015	2. Significant delay – unlikely to be completed as planned	Trial of UHL ambulance crew bringing in GP referral patients unsuccessful due to requirement for technical crews. Discussions with EMAS revealed issue to be with GP understanding of criteria. Will aim to address at GP Event on 23/6
UHL-AMU1	Improve the discharge process on AMU and utilisation of AMC to reduce the time from bed request to bed allocation	Time from bed request to bed allocation/Time from decision to discharge to discharge	Lee Walker	24/06/2015	4. On Track	Initial flow workshop held - next workshop scheduled for 19/5/15. Focus is on Junior Doctor working practices, nurse co-ordinator role, therapy input. Update 26/5: Second flow workshop held - Junior Doctor handbook updated, nurse coordinator role clarified, communication sent to Senior Registrars regarding decision making overnight, feedback of successful therapies trial on AMU. Next workshop schedule 9/6 to include update on sitting patients out and AMU escalation plan
UHL-AMU4	Decrease LoS on SSU by 10% to increase throughput of patients through unit (Baseline LoS 2.8 days)	10% reduction in length of stay of patients	Lee Walker	24/06/2015	4. On Track	SSU pathway updated to exclude Dementia patients.

Action reference number	Actions	KPI trajectory	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL-AMU5	Improve BB processes to reduce the proportion of GP referrals going directly to ED	Increase the proportion of GP bed referrals going directly to AMU to 70%	Julie Dixon	27/06/2015	4. On track	Session between GPs and Acute Physicians being organised to communicate current services and assess need for alternate services
UHL-AMU8	Recruit to two Consultant vacancies on Acute Medical rota to ensure consistent 7 day early morning Consultant cover to facilitate morning discharges	Increase in the proportion of discharges between 8am and 12pm	Lee Walker	15/07/2015	1. Not yet commenced	
UHL-BW8	Review bed bureau processes to reduce discharge-delays	Reduce Los by 10%	Julie Dixon	30/05/2015	4. On track	Engagement with community providers in place
UHL-BW2	Increase the accuracy of recorded discharge time to capture and encourage early discharges	Increase in the proportion of discharges between 8am and 12pm	Ian Lawrence	30/06/2015	2. Significant delay – unlikely to be completed as planned	This impacts upon BW1-3. Need more clarity as to next steps.
UHL-BW3	Implement "real-time bed state-'light' " to capture and encourage early discharges	Increase in the proportion of discharges between 8am and 12pm	Jane Edyvean	30/06/2015	2. Significant delay – unlikely to be completed as planned	This impacts upon BW1-3. Need more clarity as to next steps.
UHL-BW4	Implement the 'home first' principle to reduce discharge delays	Reduce number of patients with length of stay greater than 10 days	Julie Dixon	30/06/2015	4. On track	Being achieved through D2A work and conference calls. Also ties in with proposed frailty stream.
UHL-BW5	Review internal processes (including discharge 2 assess) to reduce discharge delays due to internal processes	Reduce number of patients with length of stay greater than 10 days	Julie Dixon	30/06/2015	4. On track	Diagnostic completed. D2A process now being shortened.
UHL-BW6	Increase the availability of blood results by the end of the ward round to reduce discharge delays	Reduce number of patients with length of stay greater than 10 days	Julie Dixon	30/06/2015	2. Significant delay – unlikely to be completed as planned	Budget issues.
UHL-BW7	Increase the proportion of nurse-delegated or therapy-delegated discharge at the weekend to 50 % to reduce length of stay	Reduce Los by 10%	Maria McAuley	30/06/2015	4. On track	Nurse delegated discharge pilot in progress on ward 37 with good clinical engagement.
UHL-BW9	Review transport booking process to reduce discharge delays	Reduce number of patients with length of stay greater than 10 days Increase in the proportion of discharges between 8am and 12pm	Julie Dixon	30/06/2015	4. On track	Quick wins with transport process.
UHL-BW1	Every base ward to have 3 junior doctors per ward at 8am to facilitate one stop wards rounds and early discharges	Increase in the proportion of discharges between 8am and 12pm	Ian Lawrence	01/08/2015	4. On track	Shift in start times to achieve this.
UHL-BW10	Review nursing staff cover and processes to provide safe and efficient care	Reduce number of patients with length of stay greater than 10 days	Maria McAuley	30/06/2015	4. On track	
UHL-ED3	Review ED process delays through monthly journey meetings to identify causal factors	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	Julie Dixon	01/05/2015	6. Complete and regular review	First journey meeting held on 21/05. Next one scheduled for 04/06. In process of agreeing best framework for holding the sessions.
UHL-ED11	Co-design with ED staff a process for having (?hourly) Situational Awareness updates from all ED areas to help with timely escalation	95% patients seen within 4 hours	Ben Teasdale	28/05/2015	2. Significant delay – unlikely to be completed as planned	This was part launched on 23/05. Further work needs to be done to embed new process. Meeting set up with A&E Trackers on 05/06.
UHL-ED1	Work with EMAS and CCGs to introduce CAD+ as the sole data set to monitor ambulance handovers	Ambulance Handover - Hours Lost	Rachel Williams	30/05/2015	4. On track	11/05: Successfully trialled iPads and ordered those required Identified A&E staff who would be holders of the iPads Continuing with implementation 13/05: Go live confirmed for 01 Jun as CoWs will be used whilst computers on order. Staff training beginning 18/05. Connection fixed in Ops Room
UHL-ED6	Eliminate IT delays between visibility of results in imaging and in ED to reduce delays in decision making	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	John Clarke	30/05/2015	4. On track	Confirmed to IT that ED should be able to see unverified images. Awaiting confirmation that this is now in place. Further work to be done to understand the driver behind delays in seeing Reports. Also running pilot with Imaging to look at benefit from an exclusive ED CT scanner
UHL-ED8	Analyse data to determine the optimal opening hours for ED Minors and develop action plan if changes are required to improve patient flow	Patients with decision for onward care within 120 minutes	Ben Teasdale	15/06/2015	4. On track	Initial analysis completed using the Simulation Tool. In process of agreeing a small trial of different operating hours based on results
UHL-ED10	Map out EDU processes to understand areas of opportunity for improving flow through the unit. Numbers through unit were an average of 820 per month (Mar 14 - Feb 15)	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	Mark Williams	30/06/2015	4. On track	Working on First Fits, Toxicology and Headache/Neurology pathways Aim to present business case for additional pharmacy support mid May Need to confirm with CMG as to status of getting additional Monitors

Action reference number	Actions	KPI trajectory	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL-ED12	Look at each stream within the ED separately to determine if their independent staffing patterns can cope with 85 percentile of activity (including number of staff, skill mix and rotas) to increase robustness of staffing cover	Patients with decision for onward care within 120 minutes	Ben Teasdale	30/06/2015	4. On track	Looked at raw data from 2012-2014 to define 85 per centile of demand. Will now input into Simulation Tool
UHL-ED13	Work with EMAS and UCC to improve patient information (signage / meet & greet). Improve time to pain relief.		Rachel Williams	30/06/2015	1. Not yet commenced	
UHL-ED14	Analyse patterns and reasons for UCC late referrals to inform solutions	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	Ben Teasdale	30/06/2015	4. On track	20/05 - Agreed at EQSG that will start taking any late referrals for discussion at weekly meeting with UCC
UHL-ED4	Identify and plan next 5 priority areas based on learnings from Journey Meetings to reduce delays in ED processes	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	Ben Teasdale	30/06/2015	1. Not yet commenced	
UHL-ED5	Trial iPorter in ED with a view to permanent implementation to reduce portering delays	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	Ben Teasdale	30/06/2015	4. On track	Trial finished for 8am - 8pm. Interserve working up options of how this can be done on a permanent basis and extended to cover nights. Data from the trial is being analysed to understand ED portering demand profile
UHL-ED9	Investigate impact of inappropriate ED referrals by improving consistency of EDIS data capture with a view to reducing inappropriate referrals	10% reduction in ED attendances	Ben Teasdale	31/08/2015	1. Not yet commenced	
UHL-ED2	Use insight gained from analysis of EMAS / ED Auditors data to further reduce handover delays between EMAS and ED. Data from the Mar audit found average (max) handover times of: EMAS - 22 (59) ED - 14 (49)	Ambulance Handover - Hours Lost	Rachel Williams	15/09/2015	4. On track	13/05 - Assessment Bay Action Plan presented at EQSG Assessment Bay auditors will begin monitoring compliance with the SOP from 25/05 26/05 - Medical lead for Assessment Bay identified
UHL-ED7	Work with each area in the ED to reduce time from bed allocation to departure from department	95% patients seen within 4 hours	Ben Teasdale	30/09/2015	4. On track	Requested data on current performance - by ED area - against time from allocation to departure
UHL-GGH5	Ensure there is PCC (primary care coordinator) support at Glenfield to match AMU at LRI	CDU occupancy to remain below 35 at 95% of the time	Sam Leak	13/05/2015	4. On track	Awaiting discussion at UCB
UHL-GGH1	Review nursing rotas and working practices to ensure that patients are triaged within 15 minutes	95% of patients to be triaged within 15 minutes	Lisa Graham	03/06/2015	4. On track	Work in progress.
UHL-GGH2	Design a robust system to ensure that patients receive clinical assessment within 60 minutes	95% of patients to receive clinical assessment within 60 minutes	Catherine Free	03/06/2015	4. On track	Options to be presented at EQSG around optimal staffing based on modelling work
UHL-GGH3	Design a robust system to deliver cardiology consultant review within 14 hours to 95% of patients	95% of patients to receive senior (consultant) review within 14 hours	Jan Kovac	03/06/2015	2. Significant delay – unlikely to be completed as planned	Work commencing around job plans
UHL-GGH4	Design a robust system to deliver respiratory consultant review within 14 hours to 95% of patients	95% of patients to receive senior (consultant) review within 14 hours	Kim Ryanna	03/06/2015	4. On track	Work commencing around job plans
UHL-GGH10	Increase numbers of monitored cardiology beds in base wards	CDU occupancy to remain below 35 at 95% of the time	Jan Kovac	30/06/2015	2. Significant delay – unlikely to be completed as planned	Need cardiology consultant engagement
UHL-GGH6	Improve computer access and reduce overcrowding in CDU to reduce delays	95% of patients to be assessed by doctor within 60 minutes	Kim Ryanna	30/06/2015	4. On track	New equipment installation authorised and pending (included in service improvement costs)
UHL-GGH8	Develop SLA with CSI to optimise therapy cover in CDU to reduce discharge delays	CDU occupancy to remain below 35 at 95% of the time	Jodie Billings	30/06/2015	4. On track	Wider therapy recruitment issues to address

Action reference number	Actions	KPI trajectory	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL-GGH9	Improve imaging access to match AMU /AFU to reduce discharge delays	90% of plain films to be turned around in 30 minutes & 60 minutes out-of-hours (Feasilbilty of 90% of CT's to be scanned and reported in 1 hour TBC)	Dan Barnes/Cathy Lea	30/06/2015	2. Significant delay – unlikely to be completed as planned	Need clarity on CT utilisation going forwards
UHL-GGH7	Improve pharmacy support for CDU out-of-hours, to reduce discharge delays	CDU occupancy to remain below 35 at 95% of the time	Bhavisha Pattani	01/07/2015	4. On track	Better out of hours cover and pharmacy packs being finalised
UHL-WHR3	Define on call competencies for Whole Hospital Response roles and self assess current state to inform escalation training	95% patients seen within 4 hours	Julie Dixon	19/06/2015	4. On track	Created draft list of competencies & working to refine plus create training plan to support any identified gaps Doing a read across with the competencies expected for Major Incident management
UHL-WHR4	Hold escalation scenario training for X% (?80%) of relevant staff to reduce variability in response	95% patients seen within 4 hours	Julie Dixon	19/06/2015	4. On track	Confirmed date and initial invites sent Agreed split between Escalation and Major Incident focus Working to develop agenda & specific scenarios to be presented at the event
UHL-WHR10	Create rapid bed turnaround (cleaning) team to reduce time from bed request to bed allocation	Time from bed request to bed allocation within 30 minutes	Julie Dixon	30/06/2015	4. On track	In process of designing team job spec to discuss with Interserve
UHL-WHR2	Complete "ED Road Tour" to improve links between specialties and ED and promote understanding of 'Exit Block'	95% patients seen within 4 hours Specialties responding to consult / bed requests within 30 minutes	Julie Dixon	30/06/2015	1. Not yet commenced	
UHL-WHR6	Design and implement a robust management framework for monitoring & addressing actions taken when on escalation to ensure consistent, timely response	95% patients seen within 4 hours	Julie Dixon	30/06/2015	4. On track	Proposal to pilot new Operational Meeting structure and link with Trust wide work being led to introduce Safety Huddles across all Wards RM to speak with Heads of Ops about piloting
UHL-WHR8	Explore use of anaesthetists to support airways instead of ITU	95% patients seen within 4 hours Specialties responding to consult / bed requests within 30 minutes	TBC	30/06/2015	5. Complete	At the present moment, the pressure on ITU & Anaesthetics is such that this is not a viable option. The ED propose that this action is now replaced with the Trust exploring option of investing in ACPs
UHL-WHR9	Look into improving efficiency during handover times	95% patients seen within 4 hours	Julie Dixon	30/06/2015	4. On track	
UHL-WHR5	Work with specialties to update their whole hospital response and design role cards to improve confidence / consistency in performing escalation protocols	95% patients seen within 4 hours	Julie Dixon	31/07/2015	1. Not yet commenced	
UHL-WHR1	Work with key specialties to improve the referral process when ED is an appropriate route and reduce numbers of patients which are inappropriately sent via ED	95% patients seen within 4 hours	Julie Dixon	01/08/2015	1. Not yet commenced	
UHL-WHR7	Put in place new protocols to monitor adherence to outlier criteria to ensure that actions taken during escalation do not compromise patient experience and lead to sustainable performance the following day	95% patients seen within 4 hours	Julie Dixon	30/08/2015	4. On track	Meeting in place with Heather Leathem to discuss how to take this forward.
UHL-WHR11	Introduce iPorter across the Trust to reduce portering delays	95% patients seen within 4 hours	Julie Dixon	01/09/2015	1. Not yet commenced	Will review post trial of iPorter in ED and the introduction of the new version of iPorter in June/July which may be iPad compatible

Urgent Care Board - Dashboard

Updated to Sunday 17/05/2015

Arden&GEM

Inflow

- 111 Total Calls
- % of 111 Calls sent to 999/ED
- Total Calls to EMAS
- EMAS Disposition - Non Conveyed
- EMAS Ambulance Handover: Hours Lost
- GP OOH Activity
- ED: LRI Attendances
- ED: UCC Attendances
- UHL Emergency Admissions
- GP Referrals to Bed Bureau that are Diverted to ED
- % of UHL Emergency Admissions that were Avoidable

Flow

- % of UHL & UCC Attendances seen within 4 Hours
- % of UHL ED with Decision about Onward Care within 120 mins
- % of UHL Ward Response to ED/Bed Requests within 30 mins
- % of UHL GP Referrals Direct to AMU
- UHL Empty Beds at Start of Day on AMU Ward
- % of UHL wards Achieving Targeted Weekly Discharges
- Aged 75+ with Length of Stay >10 Days at UHL
- % of Discharges before 12pm at UHL

Discharge

- UHL Discharges against Admissions
- UHL Discharges
- LPT Discharges
- % of UHL Delayed Transfer of Care
- % of LPT Delayed Transfer of Care
- % of UHL Discharged to Admitting Address
- % of LPT Discharged to Admitting Address
- Community Beds Open
- UHL Delayed Transfer of Care - Bed Days Lost
- LPT Delayed Transfer of Care - Bed Days Lost
- 30 Day Readmission Rate

Information

New Metric added - Number of Re-Beds (Arriva Aborts)

GP OOH - Received up until 3rd May 2015

Avoidable Emergency Admissions data will show sudden decrease due to the data provided. This normally corrects itself each week

30 Day and 90 Readmissions data will show sudden decrease due to the data provided. This normally corrects itself each week

3 New pages have been added: 111 and 999, AE Interface, and Additional Discharge - covering new Metrics

Latest Week meets the Target

Latest Week is within 5% of the Target

Latest Week is > 5% from the Target

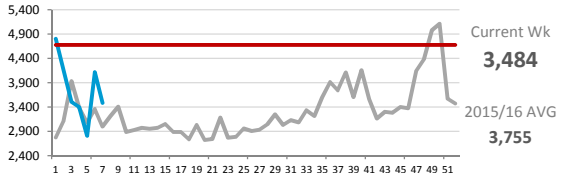
All Metrics are shown Weekly with the Year Running from 1st April

Urgent Care Board - Dashboard

Updated to Sunday 17/05/2015

INFLOW

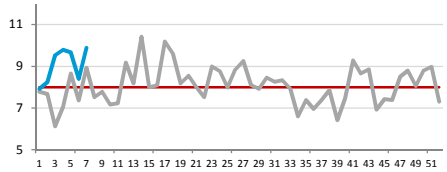
111 Total Calls



Current Wk **3,484**

2015/16 AVG **3,755**

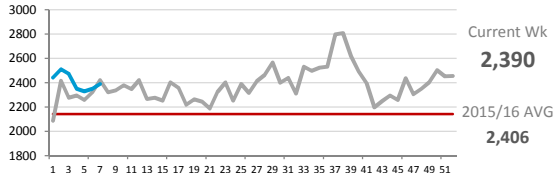
% of 111 Calls sent to 999/ED



Current Wk **9.9%**

2015/16 AVG **9.1%**

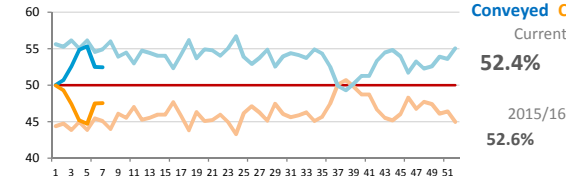
Total Calls to EMAS



Current Wk **2,390**

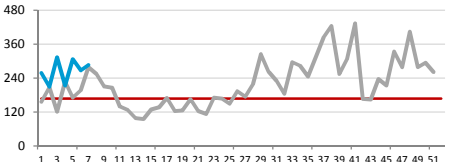
2015/16 AVG **2,406**

EMAS Disposition



	Conveyed	Non Conveyed
Current Wk	52.4%	47.6%
2015/16 AVG	52.6%	47.4%

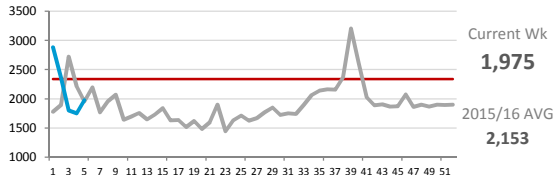
EMAS Ambulance Handover: Hours Lost



Current Wk **286**

2015/16 AVG **265**

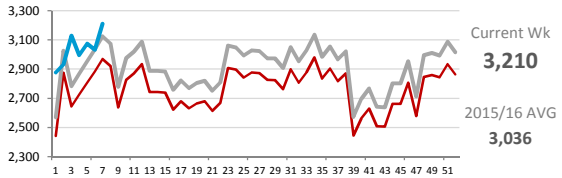
GP OOH Activity



Current Wk **1,975**

2015/16 AVG **2,153**

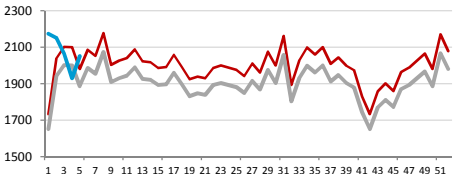
ED: LRI Attendances



Current Wk **3,210**

2015/16 AVG **3,036**

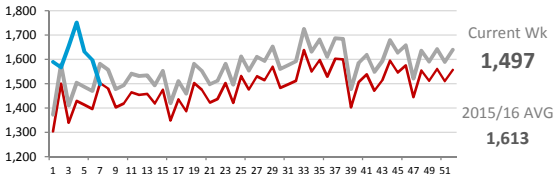
ED: UCC Attendances



Current Wk **2,051**

2015/16 AVG **2,074**

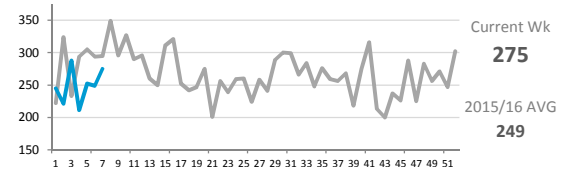
UHL Emergency Admissions



Current Wk **1,497**

2015/16 AVG **1,613**

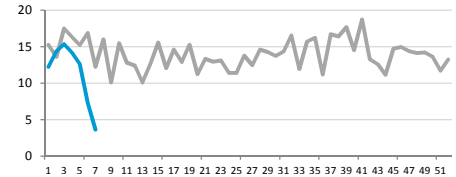
GP Referrals to Bed Bureau that are Diverted to ED



Current Wk **275**

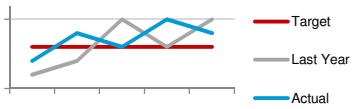
2015/16 AVG **249**

% of UHL Emergency Admissions that were Avoidable



Current Wk **3.6%**

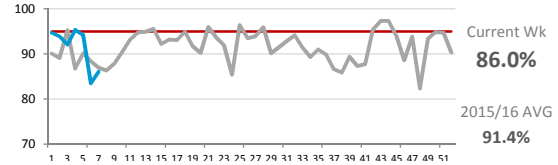
2015/16 AVG **11.4%**



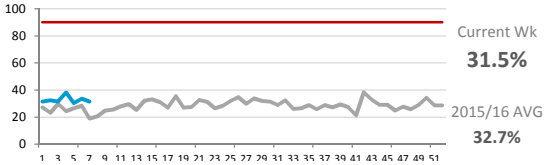
All Metrics are shown Weekly with the Year Running from 1st April

FLOW

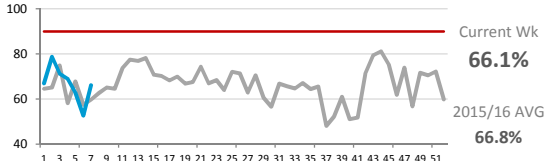
% of UHL and UCC Attendances seen within 4 Hours



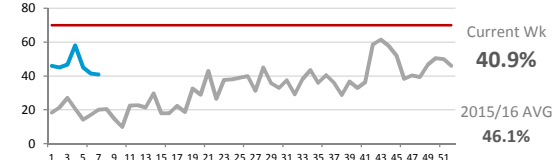
% of UHL ED with Decision about Onward Care within 120 mins



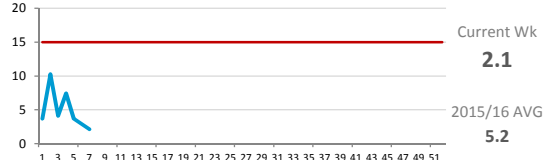
% of UHL Ward Response to ED/Bed Requests within 30 mins



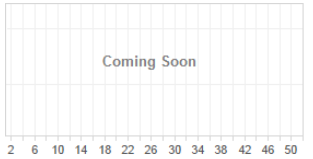
% of UHL GP Referrals Direct to AMU



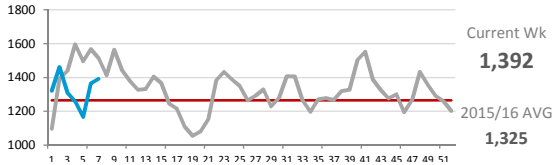
UHL Empty Beds at Start of Day on AMU Ward



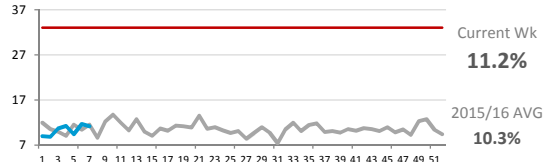
% of UHL Wards Achieving Targeted Weekly Discharges [Target = 90%]

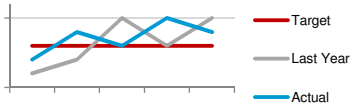


Patients aged 75+ with Length of Stay >10 days at UHL



% Discharges before 12pm at UHL

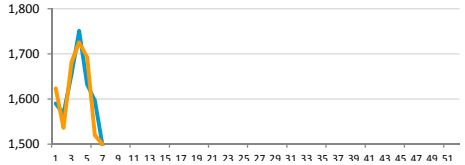




All Metrics are shown Weekly with the Year Running from 1st April

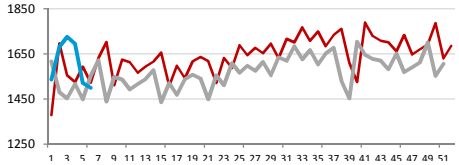
DISCHARGES

UHL Discharges against Admissions



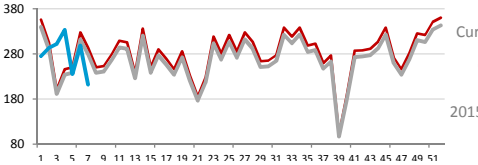
	ADM	DIS
Current Wk	1,497	1,500
2015/16 AVG	1,613	1,611

UHL Discharges



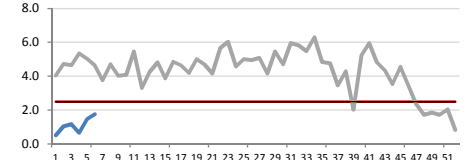
Current Wk: 1,500
2015/16 AVG: 1,611

LPT Discharges



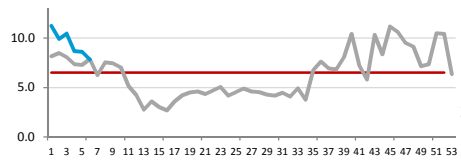
Current Wk: 212
2015/16 AVG: 278

UHL Delayed Transfers of Care



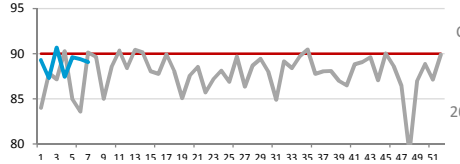
Current Wk: 1.7%
2015/16 AVG: 1.1%

LPT Delayed Transfers of Care



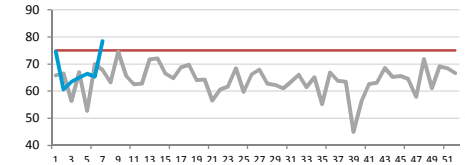
Current Wk: 7.8%
2015/16 AVG: 9.5%

% of UHL Discharged to Admitting Address



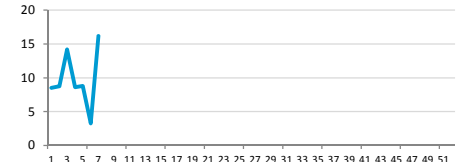
Current Wk: 89.0%
2015/16 AVG: 89.0%

% of LPT Discharged to Admitting Address



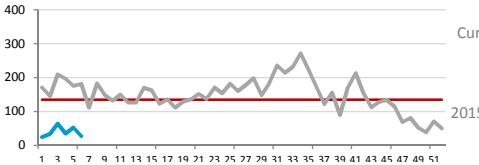
Current Wk: 78.5%
2015/16 AVG: 67.7%

Community Beds



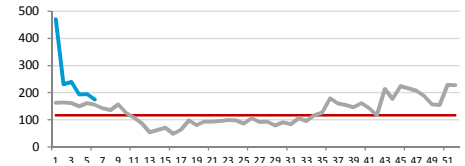
Current Wk: 16
2015/16 AVG: 10

UHL Delayed Transfers of Care - Bed Days Lost



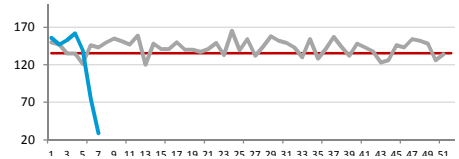
Current Wk: 27
2015/16 AVG: 40

LPT Delayed Transfers of Care - Bed Days Lost

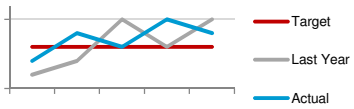


Current Wk: 175
2015/16 AVG: 251

30 Day Readmission Rate



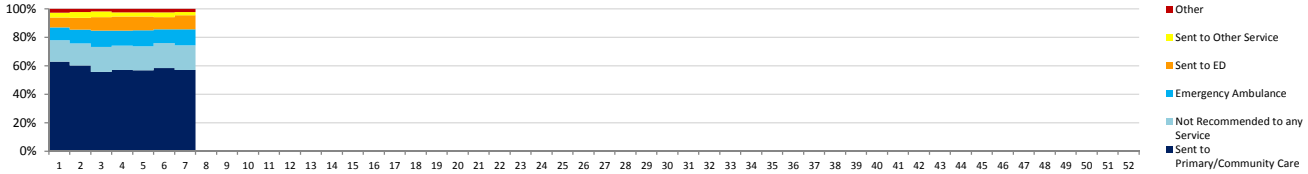
Current Wk: 29
2015/16 AVG: 123



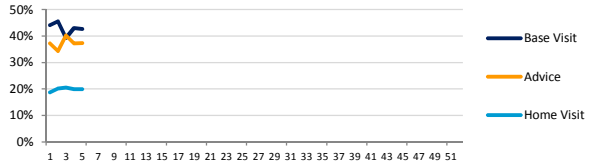
All Metrics are shown Weekly with the Year Running from 1st April

111 or 999

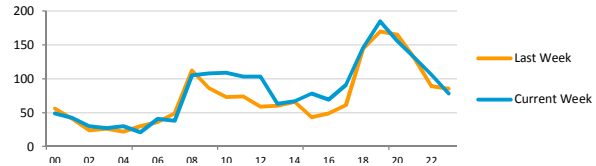
% of Dispositon of 111 Calls



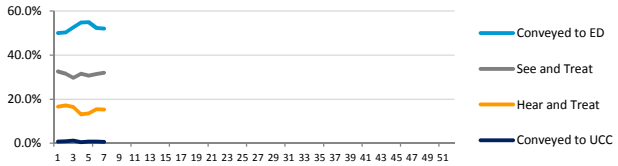
% of Disposition from Out of Hours

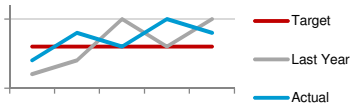


Time Profile of Out of Hours Utilisation



% of Disposition of EMAS Calls

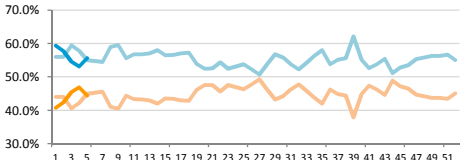




All Metrics are shown Weekly with the Year Running from 1st April

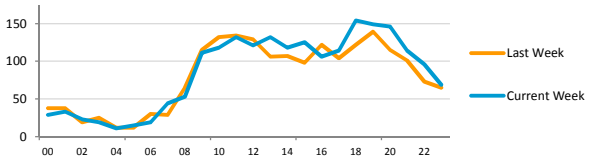
AE Interface

% of Outcome at LRI UCC

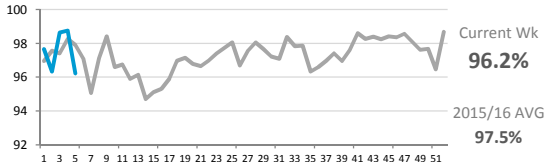


	Resolved	Referred
Current Wk	55.6%	44.4%
2015/16 AVG	56.1%	43.9%

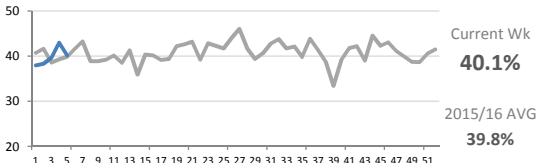
Time Profile of LRI UCC Attendances



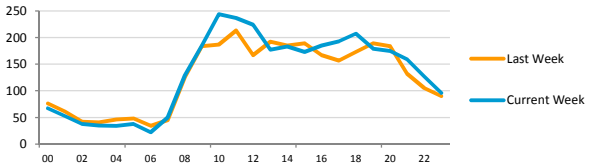
% of LRI UCC Triaged within 20 minutes



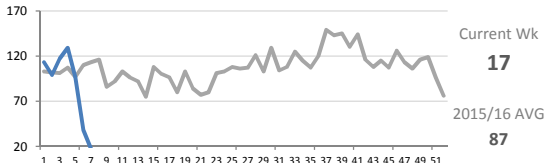
% of Transfers from LRI UCC to LRI ED



Time Profile of UHL AE Attendances



UHL Admissions with Ambulatory Care Sensitive Conditions

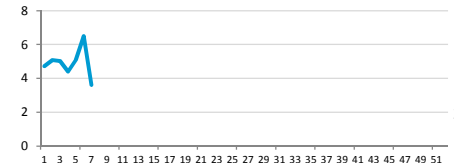


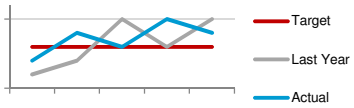
UHL AE HRG Categories of Treament

UHL AE HRG Categories of Treament	Last Week	This Week	
VB01Z: Any investigation with category 5 treatment	12	3	▼
VB02Z: Category 3 investigation with category 4 treatment	61	46	▼
VB03Z: Category 3 investigation with category 1-3 treatment	177	187	▲
VB04Z: Category 2 investigation with category 4 treatment	241	231	▼
VB05Z: Category 2 investigation with category 3 treatment	87	101	▲
VB06Z: Category 1 investigation with category 3-4 treatment	73	85	▲
VB07Z: Category 2 investigation with category 2 treatment	509	531	▲
VB08Z: Category 2 investigation with category 1 treatment	761	858	▲
VB09Z: Category 1 investigation with category 1-2 treatment	915	933	▲
VB11Z: No investigation with no significant treatment	197	232	▲
NULL		3	▲

The above chart will be removed in the next report if all agree, as explaining each Category would require Clinical input. There is greater interest in the HRG VB11Z Chart that is shown to the right.

% of AE VB11Z: No investigation with no significant treatment

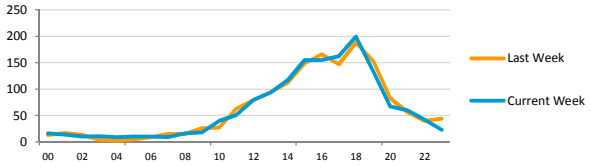




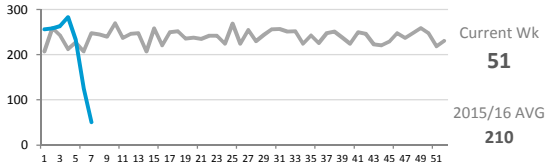
All Metrics are shown Weekly with the Year Running from 1st April

Additional Discharge

Time Profile of UHL EM Discharges



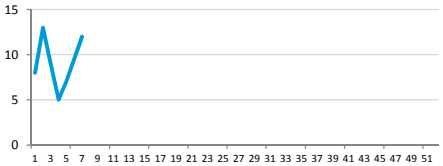
90 Day Readmission Rate



Current Wk
51

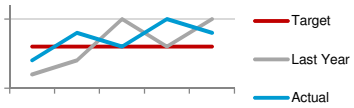
2015/16 AVG
210

Number of Re-Beds (Arriva Aborts)



Current Wk
12

2015/16 AVG
9



All Metrics are shown Weekly with the Year Running from 1st April