UHL Emergency Performance

Author: Sam Leak , Director of Emergency Care and ESM paper Q

Executive Summary

Context

The level of performance against the four hour measure is currently the worst it has ever been. Demand remains very high and the Emergency Department is experiencing the impact of exit block at various times of the day every day of the week.

Items included in this report are:

- Update on performance
- Key points to note
- Progress on key UHL actions over the last month
- LLR improvement plan and updates to the UHL plan and governance
- Demand and capacity update
- Prioritisation recommendation

Questions

1. Does the Board agree with the updated plan?
2. As requested at the Trust Board Thinking Day in July, does the Board agree with the recommendation for prioritisation?
3. Noting the well understand capacity deficit at the LRI, if the Board does not agree with the recommendation, what is the agreement for prioritisation in winter 2016-17?

Conclusion

1) Even with all known schemes factored into our plans, we are forecasting a greater deficit in capacity than last winter. This is unlikely to change. It is recommended that at the LRI, access to beds should be prioritised for RTT and Ca patients.

Input Sought

The Board is invited to consider the issues and support the approach set out in the report.

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: September 2016

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:	**Samantha Leak Director of Emergency Care and ESM**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**4 August 2016**

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4 Hour performance

The key reasons for the current level of performance are:

1. Increasing demand
2. Increasing imbalance between demand and capacity
3. Lack of space in ED resulting in process breaches
4. Variable internal flow
5. Process delays in ED, assessment wards and base wards

2016/17 YTD

- 16/17 performance YTD is 79.7% and June's performance was 80.6%
- 15/16 performance YTD was 92.3% and June 2015 was 92.6%
- YTD attendance 7% up on the same period last year – April to July.
- YTD total admissions 2% up on the same period last year – April to July. This is through a reduced medical bed base at the Leicester Royal Infirmary and Glenfield Hospital.

July 2016

- Performance was 76.9%

Sustainability and Transformational Fund (STF)

July STF will not be achieved, however this is a 'best endeavour' STF and does not attract a financial penalty. It is recognised that there is a requirement to improve performance going forward and as such a focus on i) non-admitted breaches, ii) addressing overnight deteriorating performance and iii) patients whose total time in the department is 4 hours to 4.5 hours is a priority (as seen in the action plan).

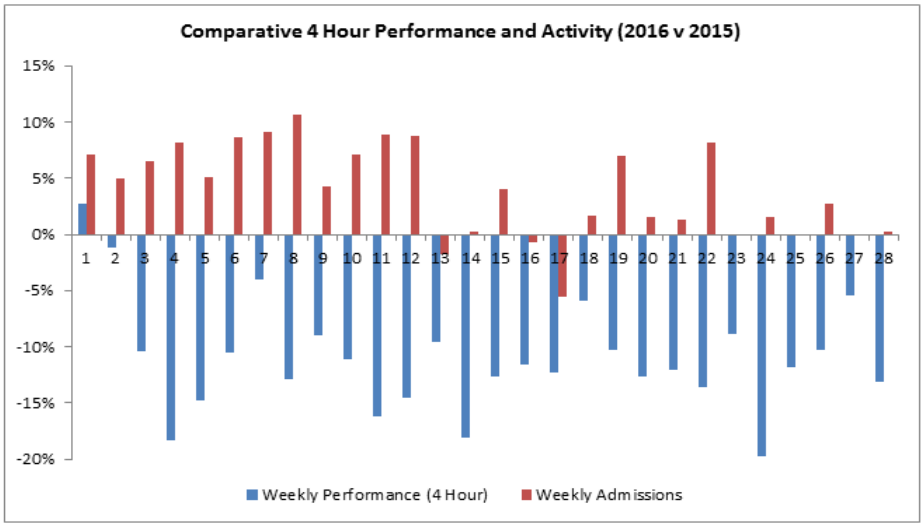
	STF Trajectory 4hr Performance	Actual 4hr Performance	STF Achieved?
Apr-16	78%	81.2%	Achieved
May-16	78%	79.9%	Achieved
Jun-16	79%	80.6%	Achieved
Jul-16	79%	76.9%	Failed
Aug-16	80%		
Sep-16	85%		
Oct-16	85%		
Nov-16	85%		
Dec-16	85%		
Jan-17	89%		
Feb-17	89%		
Mar-17	91.2%		

Key points to note

- The level of performance at the moment is the worst it has ever been. Demand remains very high and the ED is experiencing the impact of exit block at various times of the day every day of the week.
- We have managed to stop outlying on ward 7 and ASU but this has only been managed by outlying patients onto ward 18 which is a trauma ward. When trauma demand increases this winter, outlying here will not be possible.
- There is a 16% imbalance between demand and capacity.
- Whilst all forms of demand/ admissions have increased this year we can evidence that length of stay has reduced across UHL by 13%. The two may be interlinked ie the volume of patients on short stay pathways. Through the CIP programme and the associated KPIs we know ESM is being more productive than it was previously.
- At the beginning of this year, across LLR we signed up to six high level interventions which would alleviate some of the imbalance. An update on these is below:

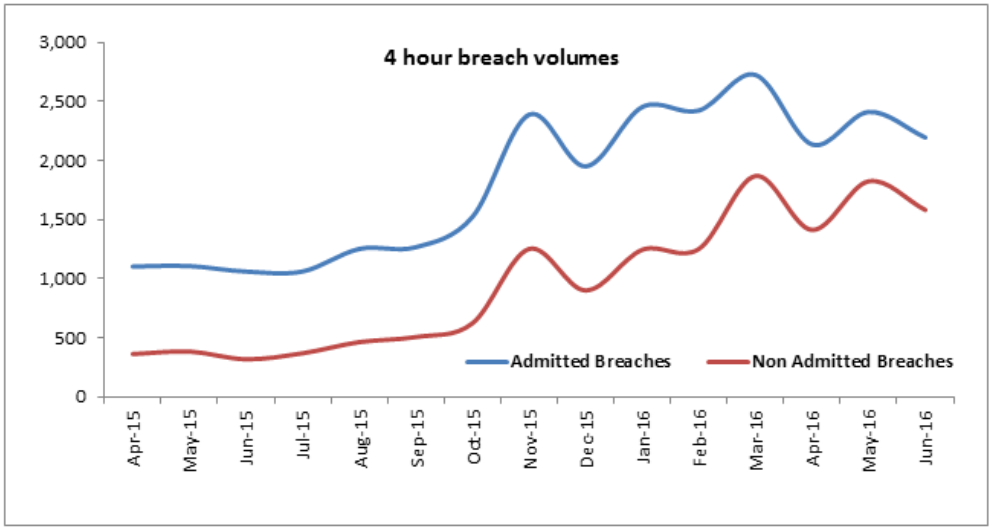
Intervention	Agreed evidence	Working
BCT admission prevention/ BCF admission prevention	Reduction in total admissions	No
Greater use of ambulatory care	Reduction in total admissions	No
Reduction in readmissions	Reduction in readmissions	Yes
LOS reduction in cardiology	LOS reduction in cardiology	Yes - evidence through CIP work that cardiology LOS is reducing
Greater use of ICS	Increased availability of beds within UHL	No
Move work to the IS	Increase volume of elective work in the IS/ alliance/ community	Yes

There has been a decreasing frequency of admission mismatch over the last 16 weeks but so far, no corresponding improvement in performance. This may partially be related to the decrease in bed capacity compared to last year, and increase in delayed transfers of care (DTOCs).



Breaches

Breach performance is poor as a result of increased attendance (7%), increased occupancy and deterioration in ED processes and outflow. The Yellow zone in majors opened on 12 July 2016 providing an additional 7 cubicles for fast track home patients and 2 RAP cubicles, however this has not yet seen the expected benefits as it has been necessary to use the area for patients waiting for admission and also because we have had problems staffing the area due to higher than normal sickness.



Ambulance handovers (CAD plus data is detailed below)

We have seen a deterioration in the handover times in July which has corresponded with periods of high inflow and numbers of patients waiting for beds. To minimise the effect this has on crews being able to continue responding to calls, we have agreed with EMAS that if we are holding more than two patients for more than half an hour, EMAS will provide a team to cohort 4 – 5 pts (depending on acuity) on the corridor outside majors.

	Under 15 Mins Delays %	% Delay Over 15 mins	% Delay Over 20 mins	% Delay Over 30 mins	% Delay Over 45 mins	% Delay Over 60 mins	% Delay Over 120 mins
Dec-15	38.0%	62.0%	50.0%	32.5%	19.6%	12.3%	2.6%
Jan-16	36.9%	63.1%	49.9%	33.6%	20.7%	14.5%	4.1%
Feb-16	43.3%	56.7%	43.0%	27.0%	16.2%	10.6%	2.5%
Mar-16	40.2%	59.8%	46.5%	29.5%	17.4%	11.9%	3.1%
Apr-16	42.3%	57.7%	41.0%	21.6%	10.6%	6.2%	1.1%
May-16	39.7%	60.3%	42.9%	22.3%	10.3%	6.0%	0.9%
Jun-16	41.7%	58.3%	41.8%	21.5%	10.4%	6.0%	0.6%
Jul-16	34.8%	65.2%	50.3%	27.5%	13.4%	6.8%	0.7%

Front Door/ Urgent Care Centre Process

Lakeside reduced its capacity by 50% on 1 May 2016. The below data shows with the reduction of 2 Lakeside GPs and 2 Lakeside nurses in May we have not seen a significant deterioration in the number of patients that are being seen treated or redirected.

Total	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Total
Treated / Redirected	55%	51%	50%	50%	48%	48%	47%	47%	49%
Admitted	6%	7%	7%	7%	7%	7%	6%	6%	7%
Majors	9%	10%	12%	11%	11%	12%	12%	13%	11%
Minors	24%	24%	24%	24%	24%	26%	28%	26%	25%
Resus	1%	1%	1%	1%	1%	1%	1%	1%	1%
Paeds	0%	0%	0%	0%	0%	0%	0%	1%	0%
Other	1%	1%	0%	0%	1%	0%	0%	0%	0%
Left before treatment	1%	2%	2%	2%	3%	2%	3%	3%	2%
Other pathway	4%	4%	4%	4%	4%	4%	4%	4%	4%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

Lakeside finish in November, however UHL does not have additional suitably qualified GPs to fill this gap. As a result Ursula Montgomery is working with the team to design a model for the provision of the front door process up until the end of March 2016. The funding for this is to be agreed with the CCGs.

LLR improvement plan

The LLR plan has been updated and the format changed but is not available for circulation this month as actions have not been agreed by all parties. Key UHL updates within the LLR plan include:

- The expansion of Majors by creating a fast track home stream. This will allow decongestion of majors and fast track of patients predicted to be non-admitted.
- Focus on decreasing DTOC's
- Continued provision of Consultant Connect until the end of July and being consider by the CCG to commission until the end of the year.

Nationally the '2016-17' A&E improvement plan was launched last week and this will be used as an opportunity to rework the LLR plan. Within the national plan, there is an expectation for health system improvement focussing on:

- An updated action plan
- Improved leadership and governance
- Delivery of five interventions
- Working with local government

The five key interventions to be delivered through an A&E delivery board are:

1. Streaming at the front door – to ambulatory and primary care
2. NHS 111 – increasing the number of calls transferred for clinical advice
3. Ambulances – aim is for a decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the ED
4. Improved flow – must do's that each Trust should implement to enhance patient flow

5. Discharge – mandating 'discharge to assess' and 'trusted assessor' type models.

Further information about this is included in the attached appendix.

Progress on key LRI actions in July

	Action	Update	RAG
1	Implement additional actions from CQC	• DPS review at 60 mins in place and being audited x2/52 • Once ambulance bay left available at all times spot audits • Pressure ulcer audits	Complete and regular review
2	Increase managerial and clinical leadership with the start of the new HON for ED and new Head of Operations	In place and being inducted in July	Complete
3	Advertise and appoint to the triumvirate model of HOS for ED (Paeds, Front Door, Majors and Resus)	3 new HOS appointed in July	Complete
4	Enable additional medical capacity in September when Ward 7 moves to ward 9 leaving a ward available for medicine.	Working group in place to staff the ward to allow additional capacity in September. Key staff will be moved from other areas and backfilled to ensure appropriate level of skill mix and bank: substantive	Complete
5	3Ws investigating and tackling delays experienced by patients in their pathway on the medical wards.	Paused due to CQC priority which has required the team to prioritise providing assurance that the management of the deteriorating patient is in line with trust policy	Significant delay – unlikely to be completed as planned
6	Non admitted breaches - Focus on decreasing non admitted breaches.	Focus on UCC and day time NAB	On-going
7	Consultant leadership support from ECIP	Gap analysis started 27.7.16	On-going

Organisational Development

The following improvements have been delivered in July:

- Classroom sessions on understanding the story so far and team working and team relationships
- A dedicated emergency floor INsite page for staff to access key documents and information about what they need to do to get ready for working in the new EF
- Development of Standard Operating Procedures for the new emergency floor in 2017
- Department Site visits by NerveCentre to enable staff engagement into new systems

Key LRI actions for month ahead

- Non admitted breaches - Focus on decreasing non admitted breaches by working with the ED team to ensure patients are seen within 90 mins and have a decision within 3 hours.

- Focus on the night time performance by having senior management overnight to identify issues and influence change.
- Progress actions in the refreshed ED action plan
- Incorporate ECIP feedback and actions into the plan and work with them to implement changes required.
- Identify staff to become 'ED advocates' and 'ED supporters' to take an active role in the EF project. We will be looking to create a team of 'go to' people who will have access to up-to-date information and can support their colleagues to have what they need in order to ensure a smooth transition into the new emergency floor.

Progress on key GGH actions in July

Admission activity continues to steadily increase and we have not had seen a decrease in activity during summer months that occurred in previous years. This may be linked to an increased frequency of being on a level one divert from ED which is resulting in increased admissions, particularly at weekends. Monitoring system for when diverts are in place will be implemented during August so we can correlate with admissions data.

- Nursing staff have been reassigned to CDU front door to support the assignment of DPS1. Two triage nurses have been assigned to support the two triage cubicles. This has seen an improvement in achievement of standards.
- Following the CDU operational work-stream meeting held on 12 July focusing on Vision and Strategy for the service, a CDU Commitment has been developed and action plans to take forward the service initiatives identified. These include revised metrics which we will measure our performance against. The CDU operational work-stream is now being chaired by RRCV Clinical Director and Head of Operations with input from Director for Emergency Care.
- Analysis from the extended GP Pilot is complete and is being reviewed at EQSG on 3 August 2016. Hot lab sessions for Cardiology inpatient LOS pre Catheter Lab have been created for 2 weekdays and 1 weekend session. Work remains underway to identify staff to support daily hot lab sessions.
- Meeting took place on 26 July to explore alternative pilot on CDU for emergency chest pain presentations being seen in an emergency clinic. An action plan is being developed.

Key GGH actions for month ahead

- Monitor progress against action plan through operational workstream meeting
- Increase attendance from Imaging and Pathology at operational workstream meeting
- Presentation of Ambulatory Pilot at CDU operational workstream meeting and EQSG with identification of next steps
- PDSA cycle tests for alternative pilot for non-cardiac chest pain
- Increase number of daily hot lab sessions available

Updated governance and action plan update

As part of the further work to try and improve emergency performance, we have updated our action plan and governance arrangements. The action plan is attached and the updated governance is below. The action plan has come primarily from the NHS Improvement work shop on 6 July 2016.

Key actions identified from this have been discussed through the Programme Leadership Board and at EQSG and were shared at the Trust Board Thinking Day. The plan in its entirety will be the UHL element of the wider LLR plan, which is also being reworked on. An update on the plan, key actions taken in the last month and key actions for the following month, will go to each Trust Board. This will be in the form of a standard report. More recently we have engaged with the Emergency Care Improvement Programme (ECIP). A consultant and a paramedic have spent three days within UHL reviewing our plan, and a verbal update will be provided at the Trust Board

Operational performance:

- Weekly Programme Leadership – Sam Leak and Ian Lawrence (co-chair) with written report going to:
- Fortnightly Emergency Quality Steering Group – Richard Mitchell (chair) with written report going to:
- Monthly Executive Performance Board – John Adler (chair) with written report going to:
- Monthly Trust Board – Karamjit Singh (chair)

Emergency floor build

- Monthly Emergency Care Strategy Board – John Adler (chair) with written report going to:
- Monthly Reconfiguration Board – Paul Traynor (chair) with written report going to:
- Monthly Trust Board – Karamjit Singh (chair)

Demand and capacity update

The two tables below detail the current UHL forecast for demand and capacity in 2016- 17 and 2017-18. Benefits that can be attributed to the new improvement actions have been factored into the plans.

Prioritisation

Following the conversation at the Trust Board Thinking Day in July, the executive team met on 26 July 2016 to discuss and agree the relative merits and demerits of prioritising one form of activity over another. We recognise that given previous demand over the winter period and forecast demand this winter, whilst there is the expectation that we should deliver all three access standards, we are unlikely to have sufficient capacity to do so.

The agreed recommendation was that access to beds should be prioritised for RTT and Ca patients. The rationale for this was:

- We know with a degree of certainty the number of beds we need on the LRI site to deliver the RTT and Ca standards. If we hold firm on the agreement for ESM to use ward seven and medical patients do not outlie beyond this, we should have sufficient beds to deliver the RTT and Ca standards, noting the ongoing challenges with ICU/HDU across all three sites.
- Within the above, we have the opportunity to change the ratio between AMU and base ward beds and this will be explored in August and September.

- The imbalance for medicine is so vast (circa 60 beds) that we would need to stop all RTT and Ca work at the LRI to have any hope of redressing the deficit in a meaningful way. This simply is not possible.
- By continuing with the RTT and Ca work we should be able to ensure all these patients including complex head and neck cancer surgery receive timely care. We felt this was important. We discussed the impact that patients having an extended stay in ED would have on their care but we unanimously felt the impact on a patient waiting six hours rather than five hours for a bed is more difficult to measure. We recognise this is a sub-optimal compromise.
- We need to do everything possible within the attached action plan to negate the impact of the above.
- Delivering the above should enable us to deliver the RTT (12.5%) and Ca (5%) STP trajectories and gives us the best chance of delivering the level of activity required to deliver our overall financial position (70%). It does give us a real risk of delivering the emergency care trajectory (12.5%), but as this is the only trajectory based on 'best endeavours', we have mitigated the risk.
- At times of increased activity and therefore pressure this winter, as long as we can ensure safe care for all of our patients, we must hold firm on the recommendation above. This may be a considerable problem, as medicine continue in July and August to occupy 14-18 more beds than their agreed bed base.

Conclusion

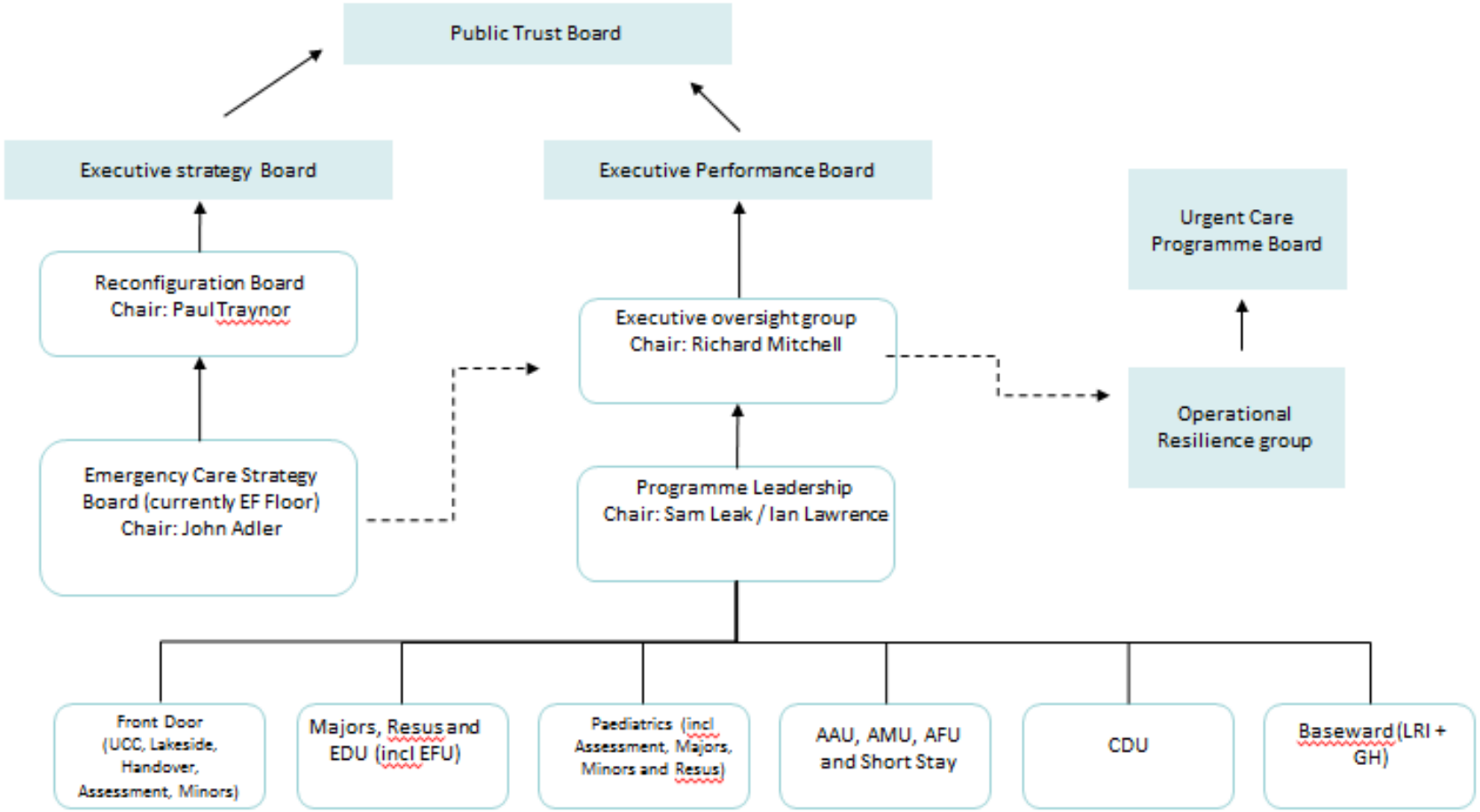
Due to the poor performance and the negative impact overcrowding has on mortality, dignity and privacy for patients in the month of August, ED will be focusing on actions related to improving the four hour performance and the Acute Medical Wards will be focusing on earlier flow by ensuring appropriate patients are sat out and made ready earlier for transport.

1) Even with all known schemes factored into our plans, we are forecasting a greater deficit in capacity than last winter. This is unlikely to change.
2) Internal inefficiencies will only get us so far and we have identified a way of prioritising and therefore protecting RTT and Ca standards.
3) Reducing demand, reducing the imbalance between demand and capacity AND improving internal flow all need to be delivered to improve performance.
4) Key decisions on ward 23a, vascular, ICU and the second phase of the emergency floor will be taken as soon as access to capital is better understood.

Recommendations

- **Note** the contents of the report
- **Note** the recommendation for prioritisation
- **Confirm** support for the recommendation or other appropriate actions

Updated UHL governance structure



Updated 2016-17 demand vs capacity

GGH

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Open Capacity (Jan '16 Census)	412	412	412	412	412	412	412	412	412	412	412	412
Beds required for predicted 16/17 activity	423	435	409	383	364	406	430	423	428	441	437	425
Bed Gap	-11	-23	3	29	48	6	-18	-11	-16	-29	-25	-13

LGH

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Open Capacity (Jan '16 Census)	390	390	390	390	390	390	390	390	390	390	390	390
Beds required for predicted 16/17 activity	402	394	389	389	372	361	387	415	397	410	412	387
Bed Gap	-12	-4	1	1	18	29	3	-25	-7	-20	-22	3

LRI

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Open Capacity (Jan '16 Census)	976	976	976	976	976	976	976	976	976	976	976	976
Beds required for predicted 16/17 activity	979	976	995	965	961	994	1007	1008	1042	1008	1019	1033
Bed Gap	-3	0	-19	11	15	-18	-31	-32	-66	-32	-43	-57
Opening of ward 7							18	18	18	18	18	18
Additional packages of care								5	5	5	5	5
Increased OPAT								2	2	2	2	2
Bed Gap	-3	0	-19	11	15	-18	-13	-7	-41	-7	-18	-32

Points to note:

- The opening of ward 7 does not increase the number of beds medicine can access this winter compared to last winter. It gives them a greater ring-fenced bed base and will reduce the medical outliers, as they were on ward 7 and ASU last winter. Most importantly, if we can keep medicine from moving out of their current bed base plus ward 7, it will not impact on RTT and ca performance. Whilst this is good for elective and ca care, it will give medicine access to fewer beds than last winter.
- The above does not include the impact of the BCT/ BCF interventions but does include the impact of internal schemes and any new additional UHL schemes.

Updated 2017-18 demand vs capacity

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Open Capacity (Jan '16 Census)	412	412	412	412	412	412	412	412	412	412	412	412
Beds required for predicted 17/18 activity	421	431	411	431	421	411	431	431	426	457	426	421
Bed Gap	-9	-19	1	-19	-9	1	-19	-19	-14	-45	-14	-9

LGH

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Open Capacity (Jan '16 Census)	390	390	390	390	390	390	390	390	390	390	390	390
Beds required for predicted 17/18 activity	387	391	387	401	387	368	405	405	382	410	377	410
Bed Gap	3	-1	3	-11	3	22	-15	-15	8	-20	13	-20

LRI

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Open Capacity (Jan '16 Census)	976	976	976	976	976	976	976	976	976	976	976	976
Beds required for predicted 17/18 activity	1025	1062	1025	1013	1000	988	1037	1050	1025	1062	1064	1074
Bed Gap	-49	-86	-49	-37	-24	-12	-61	-74	-49	-86	-88	-98
Opening of ward 7	18	18	18	18	18	18	18	18	18	18	18	18
Additional packages of care	5	5	5	5	5	5	5	5	5	5	5	5
Increased OPAT	2	2	2	2	2	2	2	2	2	2	2	2
Bed Gap	-24	-61	-24	-12	1	13	-36	-49	-24	-61	-63	-73

Points to note:

1) Growth assumptions include:
   - 3.5% growth in emergencies (5% in Medicine. Respiratory and Cardiology)
   - No growth in electives – there was a large increase built in in 16/17
   - Additional beds modelled at 90% occupancy – this modelling is inconsistent with the 16/17 modelling and will be amended with time
   - No change in LOS
   - No impact from ICS/BCT/BCF
2) ICU supported services moving to LRI will remove ward 7 for medicine to use and will use the vascular ward, when vacated (net reduction)
3) EF phase two could give three additional wards at LRI which are not currently factored into our plans (net increase)

To: CCG Accountable Officers

Acute Trust Chief Executive Officers

Ambulance Trust Chief Executive Officers

Community Trust Chief Executive Officers

Mental Health Trust Chief Executive Officers

Local Authority Chief Executive Officers

2016/17 A&E Improvement Plan

Dear Colleagues,

You will have seen the recent communication on strengthening financial performance and accountability in 2016/17. This communication refers to the plan for improving A&E waiting time performance.

The purpose of this letter is to expand upon this and outline our plans for the recovery of England's performance to 95% by the end of 2016/17. We plan to work with you to focus on improvement over the remaining summer months, so that we can enter winter in a much healthier position, and be back on track by March 2017.

As we reflect on what was another tough winter, we recognise that clinical and managerial leaders and front line colleagues have worked hard to maintain service flows. Despite challenging performance there were fewer incidents of severe operational pressures and fewer 12 hour trolley breaches than the previous winter, and we believe this was due to better preparations. Your staff deserve immense credit for this.

However, performance overall has been very disappointing and far too many patients are waiting too long for the treatment that they need. Performance across our region for the past 6 months demonstrates this:

	December 15	January 16	February 16	March 16	April16	May 16
Midlands & East Region	91.0%	88.2%	87.1%	86.5%	88.7%	88.9%

We have looked carefully at performance over the last year to learn lessons. One of the differences from previous years is that there has been less opportunity to expand the bed base to cope with demand and we have found that systems which had already reformed their processes and pathways have fared much better. It is clear that we need a much greater focus on improvement and for some this will require a fundamental re-think about how things are done. We also need refreshed local leadership arrangements to encourage whole system focus and accountability, as well as new regional oversight arrangements. Finally, we need improvement actions that are consistent with the wider strategy set out in the Urgent and Emergency Care Review.

NHS England and NHS Improvement have been engaging with local government in recognition of the important role that social care plays in supporting the overall performance of local health and care systems, and we welcome the support of local government colleagues in this work.

Action plan

Our new joint NHS England and NHS Improvement regional team has identified those systems requiring the most support based on their current and historic performance. These systems will be the subject of the most intensive support and attention, provided by an expanded ECIP (Emergency Care Improvement Programme).

At the other end of the spectrum the strongly performing systems will experience very little intervention and will be encouraged to share their success and approach with other neighbouring communities. The attachment to this letter shows the allocation of systems to one of the four segments.

Leadership and Governance

Following careful consideration at national and regional level we have come to the conclusion that System Resilience Groups (SRGs) should be transformed into **Local A&E Delivery Boards.** These will focus solely on urgent and emergency care, and to be attended at the executive level by member organisations. Testing this out with local leaders suggests that this would generally be welcomed. **More detail is available in Annex A and B.**

The new joint regional team, together with sub regional local government representatives, will work with localities to ensure these Boards are in place from 1st September.

Local authority executives must be invited to be full members of the board and all accountable officers involved must make sure they are fully and regularly engaged with their Local Authority counterparts.

Five Interventions

The reset document refers to five mandated improvement initiatives. These have been developed by experts in the field of emergency care (such as Cliff Mann – President of the RCEM, and Vince Connolly – Consultant Physician & Medical Director, Emergency Care Improvement Programme). The initiatives that relate to streaming, flow and discharge represent actions that have already been adopted by the most successful systems. This is about implementing these actions everywhere and also about a focus on outcomes and processes:

1. **Streaming at the front door – to ambulatory and primary care**.
   This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
2. **NHS 111 – Increasing the number of calls transferred for clinical advice'**
   This will decrease call transfers to ambulance services and reduce A&E attendances.
3. **Ambulances – DoD and code review pilots; HEE increasing workforce.**
   This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the ED.
4. **Improved flow – 'must do's that each Trust should implement to enhance patient flow.**
   This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the 'SAFER' bundle will facilitate clinicians working collaboratively in the best interests of patients.
5. **Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models.**
   All systems moving to a 'Discharge to Assess' model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.

Further detailed guidance will follow. Local A&E Delivery Boards will coordinate and oversee these initiatives.

Working with Local Government

To support wider system improvement, it will be critical for local government to be fully engaged with local plans and we want to encourage strong partnership working between local authorities and NHS bodies. ADASS and LGA have supported the sharing of best practice through the sector-led improvement programme and will continue through 16/17 to offer support local authorities in taking forward plans on discharge. On social care specifically, given the pressure on community and social care provision, we would expect local board to focus on strengthening local care markets and taking collective ownership for future capacity planning.

Timetable

Work has already started with the completion of local operational plans and the agreement of performance trajectories backed up by S&T funding.

Our new joint regional team will commence formally from August and our first task is to ensure that new local A&E Delivery Boards (see Annex A) are set up in every

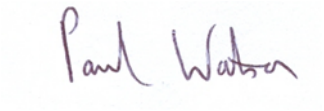
locality. These new arrangements should be fully up and running from 1st September.

The joint regional team will lead a dialogue with every local A&E Delivery Board and agree an action plan appropriate to the segment each system is in. This will include local milestones and a demonstration of how the 5 national initiatives will be deployed locally along with any other local opportunities that require focus.

At national level, preparations for winter 2016/17 have already commenced; two areas of particular focus will be: the development of a common, single escalation system and the development of greater seven day resilience to smooth the flow of patients over the working week. Further details will follow.

Conclusion

It is important that all of our front line staff work in a well ordered and managed system that is tailored to workflow demands. We look forward to working with you to deliver the improvements set out in this letter that can lead to a recovery of A&E performance, and in so doing improve both the safety and experience of patients which after all is why this matters.



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Annex A - Leadership and governance

A review of current arrangements for System Resilience Groups (SRGs) has identified the need for local leadership structures to focus specifically on A&E and to be attended at the executive level by member organisations. **Therefore, SRGs should be transformed into Local A&E Delivery Boards.**

Below is a summary of what we are asking local systems to do.

Scope

The focus of Local A&E Delivery Boards is to be entirely on Urgent and Emergency Care. Initially this will all be about recovery of the 4 hour target but A&E Delivery Boards should also be working with STP groupings on the longer term delivery of the Urgent and Emergency Care Review.

Geography

Localities will be asked to review their geographies. Ideally they should be based around local emergency care systems but with an eye to the future. So if two neighbouring A&E departments already have a lot of inter-dependency and may in future be working even more closely together in some form, then the geography may best extend to both. Groups should nest within existing STP boundaries and could be co-terminous with smaller STP geographies. Many will find that the existing SRG boundaries remain appropriate and we would not want to see unnecessary disruption or change for changes sake. Local Delivery Boards may span one or more local authority and should be determined by what makes most sense within the local area.

Leadership and accountability

It is important that every statutory body (including local authorities) has a seat on the A&E Delivery Board and is represented at executive level with the authority to commit to decisions on behalf of their organisation. We would like each group to work with our joint NHSI/E regional team to appoint a named leader to chair the group. The local governance arrangements need to empower the lead to represent the board externally and to ensure that decisions can be made that bind each of the organisations represented by the group.

There needs to be a mutual holding to account for systems to work effectively. This arrangement will not be dissimilar to the arrangements that STP groupings have successfully put in place. However, it is crucial that there is support and confidence in whichever person is chosen as chair.

Joint NHSI/E regional teams will form a regional delivery board and will appoint a Trust CE, a CCG AO and a Local Authority executive to the regional Board along

with clinical advisors. There will be a smaller national Board supported by an expert reference group.

Annex B – A&E Delivery Board Core responsibilities

- Leading A&E recovery
- Developing plans for winter resilience and ensuring effective system wide surge and escalation processes exist
- Supporting whole-system planning (including with local authorities) and ownership of the discharge process
- Participating in the planning and operations for local ambulance services
- Participating in the planning and operations of NHS 111 services including oversight of local DOS development
- Agreeing deployment of any winter monies
- Agreeing how money used via sanctions and incentives is deployed for maximum benefit of the system
- Working with in the STP footprints (& UEC Networks) deliver the UEC Strategy locally with specific focus to be given to
    1. expanded access to primary care
    2. Creating an out of hospital hub combining NHS 111 and OOH services
    3. Delivering on the 4 key UEC hospital standards
- Supporting Vanguard and New Care Models (where applicable) to ensure good outcomes and supporting spread.
- leadership of the BCF will continue to be at local CCG / LA level but the A&E Delivery Boards will have an important role in helping to implement action plans, particularly in the case of BCF DTOC plans where they could help align the discharge elements of A&E plans and DTOC plans

Actions to improve four hour performance and patient experience

Scheme Lead Sam Leak	Immediate actions taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
Reduce imbalance between demand and capacity	1. X1 Additional bed to be placed on AFU 2. X 2 patients from AMU, RAU and 34 (6 in total) to be identified before 10am that require tests and home to be discharged to GPAU 3. Direct admit from yellow zone to ward 34 (short stay) to ensure the right patients are placed on ward 34. (Prospective audit of numbers and suitability in August – Elaine Graves)	1	Implement a new set of metrics to measure performance against the below action plan	Sam Leak		In circulation by 1 September 2016		
		2	Open additional ring fenced beds for medicine = net increase of 18 beds at LRI	Gill Staton		Open by 1 October	Confirmation of the following is required: • Financial agreement to open the ward • Staffing • New flooring on ward 42 and 43 which will delay ESM moving onto ward 7 • CHUGGS beds requirement	Whilst ward 7 is a 28 bedded ward, it will not increase ESM's bed base at the LRI because ESM were already using the ward and ASU last winter. The net increase in 18 beds is across all specialities when the additional paediatric ward opens. Nb – current request to use ward 7 from March 2017 for EDU.
		3	Implement Safer patient placement - All base wards to sit out two patients and pull two patients before 10 am and the safe reopening of the LRI discharge lounge.	Julie Taylor/ Gill Staton		In place for ESM 1 October 2016	HON implemented this initiative at HEFT with positive results and will be taking the lead on role out within UHL. This should be a 3 way pull process: • Ward **pulls** from AMU/SAU • Discharge Lounge **pulls** from Ward • AMU/SAU **pulls** from ED	22.7.16 Project plan complete (draft attached required updating based on change to action.) Review the opportunity for the lead nurse for GGH discharge lounge to be seconded to LRI discharge lounge. Wards initiative charter - safer placen
		4	Review our current implementation of the SAFER flow bundle and identify ways to improve implementation	Gill Staton		Full review by 1 November 2016 with fortnightly updates to EQSG	The diagnostic will begin in August and will be rolled out through all wards by mid-October. Detailed actions will come back to EQSG at a regular occurrence on a ward by ward basis.	22.7.16 Project plan will be complete by the end of the first week in August
		5	Reduce process delays by implementing 3W using UHL change methodology	Gill Staton		Roll out delayed because of CQC sepsis work	Key function of this is implementing learning from NHSI improvement day looking at non valued add time.	22.7.16 Project plan will be updated by the end of the first week in August Supernumerary support is required to run this project
		6	Purchase additional packages of care / DRT input £155k = up to five beds until end of March 2016	Julie Dixon		If agreed, in place for 1 November 2016		Funding dependent. In discussion with CCG about supporting this initiative.

Scheme Lead Sam Leak	Immediate actions taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
		7	Plan to outlie: Cancel elective cases to allow medicine to take on surgery	Ian Lawrence and Catherine Chadwick		Currently not planning to do	Medicine continues to have +15 outliers every day in July. Choosing to implement outliers in a prospective way will mean a better experience for patients on the emergency care pathway and less on the day cancellations	22.7.16 We have agreed that we cannot do this and deliver RTT and Ca performance. Our RTT performance dropped by 4% last year because of medical outlying.
		8	Run an accurate three day trial to understand if the introduction of an increased senior decision maker in ED reduces the volume of patients admitted. If it does, identify the actions that need to be taken to embed the learning.	Paul McNally through Lee Walker		Trial and benefits identified by 19 August 2016	This will be in advance of 'Super challenge' days to start in September where three days a week an appropriate clinician will be challenging all decisions to admit.	Two additional acute physicians have been appointed to work in ED.
		9	Increase OPAT provision = up to two beds	Elaine Graves		Benefits seen by 1 November 2016	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	
		10	Review current use of the Ambulatory Care pathways, including: • Applying of the AEC grid • Educating ED staff • Up skilling and educating GP's by providing rotations and joint working in UCC and ED • Reviewing impact of a specific chest pain clinic	Catherine Free		Review in place by 1 November 2016		22.7.16 Project plan will be complete by the end of the first week in August
		11	Review the opportunity for delivering a fundamental change to the frail elderly pathway across LLR	Mark Wightman		Review in place by 1 November 2016	This is building on the conversation from the Trust Board Thinking Day in July	
		12	Confirm if ward 23A at GGH can be used for RRCV medical patients this winter	ESB August 2016		Currently not planning to do	If 23A is not used for medical outlying in winter 2016-17, RRCV will have fewer beds than winter 2015-16. The long term plan is this ward is to be used for vascular surgery.	Paper with recommendation on (de)coupling) vascular and ICU going to ESB in August 2016.
		13	Understand why we are admitting more short stay patients and agree a plan to either reduce the demand or rebalance the capacity required for this demand.	Ian Lawrence		Confirmation of understanding 31 August 2016 Confirmation of plan 30 September 2016	We have previously identified we are 17 AMU beds short at LRI. This number will have increased as demand has increased in Q1 2016-17. A long standing conversation has been	

Scheme Lead Sam Leak	Immediate actions taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
							whether we should increase the volume of AMU beds at the expense of the base ward beds. In the past, the team have been unwilling to do this, but we need to revisit.	
		14	Identify how Oxford FT have reduced their DTOC rate and confirm which learnings can be implemented within UHL. http://shelfordgroup.org/article/delayed-transfers-of-care-reduced-at-oxford-university-hos	Sam Leak		Learning complete by 31 August 2016		

Scheme Lead Sam Leak	Immediate actions taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
Improve ED flow	1. Direct stream from Yellow zone to ward 34 (short stay) if beds are available 2. Direct stream from UCC to yellow zone 3. Increase in Management / Leadership support with 3 new Consultant HOS a new HON and a Head of Operations	1	Implement a new set of metrics to measure performance against the below action plan	Sam Leak		In circulation by 1 September 2016		
		2	Work with the ECIP team to implement a plan that decreases delays from bed allocation to leaving ED	Lisa Gowan		Implemented by 1 September 2016	Analysis of FY15/16 data showed approx 30 mins on average is spent from 'bed allocation' to patient departure in ED (variance up to 300 mins). This equates to approx 18,000 ED hours per year. This initiative will reduce turnaround times by: • Improving processes of rapid flow team with clearly defined roles and responsibilities. • Setting jointly owned targets for majors and rapid flow team, and • Performance management	ECIP are spending time within UHL in the last week in July and throughout August
		3	Work with the ECIP team to implement a plan that reduces the length of time medical and nurse handovers take	Ian Lawrence		Implemented by 1 November 2016	Observed handovers vary in length and form. ECIP will work with the team to support the implementation of a streamlined efficient handover process.	
		4	Work with the ECIP team to maximise yellow zone as fast track home pathway	Vivek Pillai		Benefits seen by 1 September 2016	An additional 9 cubicles (yellow zone) were added to majors on 11.7.16. The pathway is for fast track home patients identified from assessment bay, UCC or majors. This will decongest majors and decrease non admitted breaches	
		5	Work with the ECIP team to improve rapid assessment in assessment bay	Ian Lawrence and ECIP		Benefits seen by 1 September 2016	Observed processes in assessment bay vary in length and form. ECIP will work with the team to support the implementation of a rapid assessment process.	
		6	Work with the ECIP team to improve speciality in reach to meet the 30 mins target	Ian Lawrence		In place by 1 October 2016	The current policy states patients should be reviewed within 30 mins of referral by the specialty. If this does not happen, ED will then list the patient for that specialty's ward. This is not being adhered to resulting in long delays for speciality patients to be moved out of ED.	

Scheme Lead Sam Leak	Immediate actions taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
		7	Work with the ECIP team to implement a plan where 90% of patients are seen by a decision maker within 90 mins. Key actions are: • Responsible and accountable Leads • Space • Appropriate staffing and skill mix	Vivek Pillai		In place by 1 October 2016		11.7.16 Yellow zone opened 20.7.16 ECIP KPI's include review of job roles which will ensure there is clear responsibility and accountability to achieve this metric. 21.7.16 Additional cohorting space identified to be staffed by EMAS to improve flow
		8	Work with the ECIP team to implement a plan where decisions are made on 90% of patients within 180 mins Key actions are: • Responsible and accountable Leads • Space • Appropriate staffing and skill mix	Vivek Pillai		Implemented by 1 October 2016		11.7.16 Yellow zone opened 20.7.16 ECIP KPI's include review of job roles which will ensure there is clear responsibility and accountability to achieve this metric. 21.7.16 Additional cohorting space identified to be staffed by EMAS to improve flow
		9	Implement an updated plan to reduce diagnostic delays	Lisa Gowan		Implemented by 1 September 2016	82 % of diagnostics are Xray, 93% of patients are scanned within 1 hr (internal standard) of request. 16% of diagnostics are CT and 18% of patients are reported on within the hour (internal standard) Super diagnostic days are to be run 2 days a week in September as a RCT to challenge tests requested and ensure turnarounds are faster.	
		10	Deliver the OD plan based on the ideas of 'listening, developing, leading and being led'			Fully delivered by 1 March 2017	OD plan has been developed and is being implemented in the team	22.7.16 3 New Consultant HOS appointed. HON started 4.7.16 Head of Ops started 28.6.16
		11	Work with ECIP to systematically review what can be done to reduce the surge in breaches overnight and in the evening and identify actions which will deliver an improvement. The exam question is 'what is the most effective way at keeping flow going?'	Lisa Gowan, Julie Taylor, Rachel Williams		Review delivered by 31 August 2016 Benefits delivered by 30 September 2016		
		12	Continue the improvement in processes and maximise space opportunities to decrease ambulance handover times	Sam Leak		1 November 2016	Working with EMAS to ensure processes are as efficient as possible. Fully achieving this is dependent on decreasing demand / opening the new floor.	22.7.16 Increase ambulance cohorting (4-5 pts) for times of escalation was implemented on 21.7.16

Scheme Lead Sam Leak	Immediate actions taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
		13	Deliver the new EF floor	Sam Leak and Catherine Free		March 20017	Ensure capacity and staffing is modelled to ensure maximum performance within the financial envelope.	
		14	Work with ECIP to examine the South Warwick model to identify how we can change the use of our assessment bays in majors. Confirm actions that can be taken.	Ffion Davies and Vivek Pillai		Work with ECIP complement 31 August 2016 Confirmation of actions 14 September 2016		

Scheme Lead Suzanne Khalid	Immediate action taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
Improve CDU processes to ensure all appropriate patients are seen at the Glenfield		1	Implement a new set of metrics to measure performance against the below action plan	Sam Leak		In circulation by 1 September 2016		
		2	Confirm if GP ambulatory support will continue at the front door of CDU to deflect patients	Ursula M		Confirmation on 3 August 2016	Extended GP Pilot commenced on the 9th May for 8 weeks this will be formally reviewed at EQSG first week of August	
		3	Complete a demand and capacity review in Respiratory Medicine with recommendations for closing the gap	Sarah Taylor		Review including recommendations complete by 12 August 2016		
		4	Complete a demand and capacity review in cardiology with recommendations for closing the gap	Sarah Taylor		Review including recommendations complete by 12 August 2016		

Scheme Lead Suzanne Khalid	Immediate action taken		Medium to longer term actions				Supporting information	Update
			Action	Lead	Exec lead	Due date		
		5	Deliver a UHL Better Change project review to decrease Cardiology inpatient LOS pre Catheter. Implement the recommendations.	Sarah Taylor		Review complete by 26 August 2016 Recommendations implemented by 30 September 2016		22.7.16 Initial data collection complete, this shows an average pre-op LOS of 5.5 days across all procedures.
		6	Increase the usage and improved recording of ICS through ward education	Sue Mason		Usage increased by 30 September 2016		
		7	Explore alternative pilot on CDU for emergency chest pain presentations being seen in an emergency clinic	TBC		Exploration complete by 30 September 2016		
		8	Review CDU criteria to ensure appropriate patients are taken by EMAS to Glenfield first	Sarah Taylor		Implemented by 1 September 2016	In April there were o 142 transfers from LRI to GGH CDU, and in May 171.	22.7.16 A task and finish group has been put into place to review the criteria for EMAS to GGH to ensure the right patients get to the right place the first time.
		9	Deliver a space review for CDU	Sarah Taylor		Space review complete by 19 September 2016		22.7.16 A space utilisation review of CDU has been requested. Options and cost need to be considered.