# UHL Emergency Performance

Author: Richard Mitchell, Chief Operating Officer

## Executive Summary Paper H

**Context**

There is an acknowledgement that, previously, our approach to improvement has not been robust enough. Moving forward, we must get better at implementing, embedding and sustaining service improvements, to give our patients a consistent and improved patient experience.

Organisation of Care is a new element to our Quality Commitment which brings together several aspects of operational improvement including maximising the potential of our new Emergency Department and balancing demand and capacity. This will be the driver of our new approach to service improvement, with clear actions, responsible officers, and realistic timelines for improving our overall four-hour performance.

**Questions**

1. Does the Board agree with the actions outlined in the paper?
2. Are there any other actions that the Board thinks we (LLR) should be taking?

**Conclusion**

Our performance remains below the national standard, but we have seen some positive improvements in June, despite sustained high numbers of attendances at our hospitals. The new Organisation of Care approach to sustaining improvements offers a robust process to this important programme of work. This is not about forgetting all the hard work that has gone before, and continues every day, but about embedding the changes and bringing all our staff with us as we work to fundamentally change the way we do things to improve the experience of our patients. Using the beds we have more efficiently is key, and will help us to get the most from our new emergency floor.

**Our key risks remain:**

1. Variable clinical engagement
2. Embedding and sustaining service improvements

**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: July 2017 EPB & August 2017 TB

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

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

**REPORT TO:** **Trust Board**
**REPORT FROM:** **Richard Mitchell, Chief Operating Officer**
**REPORT SUBJECT:** **Emergency Care Performance Report**
**REPORT DATE:** **July 2017**

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**Overall Performance**
**May 2017**
**Four hour performance**

- During May we treated on average of 659 patients everyday through ED, Eye Casualty and UCC at the Leicester Royal Infirmary
- May 2017 performance was 76.3% which is below the trajectory submitted to NHSI as part of the 17/18 planning submission – see below
- May 2016 performance was 79.9%
- There is no growth in total ED and Eye Casualty attendances compared to the same period last year
- Adult emergency admissions are at the same level as last year

| | NHSI Trajectory 4hr Performance | Actual 4hr Performance | Achieved? |
|---|---|---|---|
| Apr-17 | 80.7% | 81.0% | Achieved |
| May-17 | 81.9% | 76.3% | Not Achieved |
| Jun-17 | 83.8% | | |
| Jul-17 | 85.1% | | |
| Aug-17 | 87.9% | | |
| Sep-17 | 90.0% | | |
| Oct-17 | 90.1% | | |
| Nov-17 | 90.2% | | |
| Dec-17 | 90.1% | | |
| Jan-18 | 90.1% | | |
| Feb-18 | 90.3% | | |
| Mar-18 | 92.2% | | |

**Ambulance handover performance**

| Indicators | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | 17/18 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulance Handover >60 Mins (CAD+ from June 15) | 6% | 6% | 9% | 7% | 9% | 9% | 11% | 17% | 13% | 6% | 6% | 6% | 7% | 6% |
| Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15) | 12% | 10% | 15% | 14% | 15% | 18% | 18% | 18% | 15% | 12% | 13% | 13% | 13% | 13% |

**June 2017**

- Month to date (19 June) 81%

As we move into the third month in our new Emergency Department (ED), we have seen some improvements to both our four-hour performance and ambulance handovers, despite continued high

demand on our emergency care pathway. However, despite improvements during the day, performance falls apart overnight, largely due to the availability of senior decision makers, staffing issues across the department, and having sustainable and meaningful outflow from the emergency department. The long-standing problem of deterioration both overnight and in the evening remains, largely because medical and nursing resources do not match our demand and this has been exacerbated as we have moved into the new ED.

We continue to have insufficient bed capacity for the number of patients we are admitting (baseline shows we are 105 short), and of the capacity that we do have, we do not use it efficiently enough.

Overall, we acknowledge that our approach to improvement, and sustaining those improvements, has not been robust enough. There are now a number of key areas, covered under the Organisation of Care programme workstreams that will support us to focus our efforts to generate continuous and sustained improvement:

**1. Bed capacity and efficient use of beds**

A plan has been identified to bridge the current 105 capacity gap. So far this has been reduced to 71 through the vascular move to Glenfield combined with keeping open Ward 21 at the Royal where Vascular was previously located.

The focus over the next two months will be on:

- Embedding Red2Green and SAFER on the medical wards at the Royal and rolling out to Glenfield and the General
- Implement processes to maintain the Red2Green approach at weekends to avoid a slowdown in flow
- Identifying ways to address the relatively small shortfalls in beds in some of our surgical specialties, including at the General
- Agreeing a plan for winter paediatric bed capacity
- Identifying additional ward capacity at Glenfield for cardio-respiratory patients – so far this is proving to be the most difficult element as there are very limited physical options a Glenfield.

Our aim is to substantially reduce the bed capacity gap by October 2017.

**2. Discharge delays**

The Red2Green approach on our wards gives a daily insight into the multiple factors, both internal and external, that impact on the timeliness of patients being discharged from our hospitals. To support the reduction in delays across the system, a new integrated discharge team will be in place from July, made up of colleagues from UHL, LPT and social care. In addition, a new end-to-end Continuing Healthcare (CHC) pathway will be in place from July; these delays continue to be the largest single cause for our patients.

**3. ED performance evening/overnight**

For some time now, we have seen ED performance deteriorate overnight despite going into the evening in a good position with low numbers of breaches. This has been an ongoing problem and one that now needs a robust approach to ensure improvements are embedded and sustained long-term. One issue is that the medical and nursing resources on overnight do not match the demand that we now see. Early feedback from a recent deep-dive into the four hour breaches appears to support this.

The deputy medical director, working with the ED Heads of Service, is reviewing the ED medical staffing rotas both at consultant and middle grade level to look at how overnight resilience can be strengthened. This was formally presented to the ED group on 21 June 2017 and the report is attached along with a presentation that explains the importance of increasing medical staffing numbers and productivity overnight.

**4. ED leadership**

The ED senior leadership team has a newly appointed head of nursing and deputy head of service. The new team will be supported through the Emergency Department Group (EDG), chaired by the CEO with Chief Operating Officer, Medical Director, Chief Nurse, Deputy Medical Director and Clinical Director as members, to deliver and embed the actions needed to improve overall ED performance.

**5. Organising for improvement**

The Trust-wide Organisation of care programme is a new element to our Quality Commitment which brings together several aspects of operational improvement including workstreams to maximise the potential of our new Emergency Department and balance demand and capacity.

These workstreams have an executive-led group to support them – EDG and Bed Capacity Group (BDG). Both are chaired by the CEO and report monthly to the Executive Performance Board and IFPIC. This strengthened programme and governance structure will embed our actions, and more importantly, ensure we have an approach to change that is sustained and becomes 'the way we do things here'. The action plan for this is attached.

In addition to the above, the team continue to focus on:

**1. Making improvements at the Front Door**

The new model that began when we opened the Emergency Department on 26 April has now settled following initial turbulence. The model was the focus of the 15 May Emergency Care Improvement Programme (ECIP) visit; they endorsed the model with only minor adjustments. We continue to work with the team, through the deputy head of service, to embed the ECIP recommendations and new clinical model.

We are also working with our CCG colleagues to review Hub appointment availability. There are a number of admission and attendance avoidance schemes across LLR (attached) and it is hoped they will bring down the number of patients coming to our ED.

The Front Door will be subject to a competitive procurement process starting in October 2017.

**2. Learning from others**

We continue to learn from others and embed tried and tested approaches to improvement across our hospitals, including Red2Green, Effective Handovers, and Clinical Leadership. ECIP support is ongoing, with regular visits and subsequent action plans put in place to implement their recommendations.

**3. Improving performance across the system – High Impact Actions**

A revised high impact action plan for UHL and the wider Leicester, Leicestershire and Rutland health system is being developed. This plan is a refresh of the previous Recovery Action Plan, and will continue to be monitored by the A&E Delivery Board.

For us, the plan will form the structure of the Organisation of Care workstreams (as described above), and actions delivered by either the EDG or BCG. The UHL actions focus on improving hospital flow by both increasing efficiency across the ED, and making the current bed capacity more efficient and used more effectively.

**The Emergency Floor**

1. Phase Two

Work is well underway both on the construction and operational commissioning elements of the next phase of our emergency floor. The teams are reviewing their ways of working, in preparation for developing new Standard Operating Procedures (SOPs) that will be developed and embedded with staff across the assessment units. The programme remains on track for opening in Spring 2018.

2. Single Front Door for Children

The Children's and ED Senior Management teams met with the CEO and COO on Monday 5 June 2017. There had been an agreement previously to suspend implementing the Children's Single Front Door from 26 April 2017 to 3 July 2017.

The purpose of this meeting was to discuss whether it was still possible to action the move on 3 July.

Following extensive discussion, the following was agreed:-

A) That the status quo remains from 3 July 2017 (i.e.: Children's Assessment Unit continues to function in its current capacity and the Children's Short Stay Unit (CSSU) opens to a maximum of four beds. However, for ED, it is acknowledged that this is nurse staffing dependent. The ED Head of Nursing is currently working this through with her nursing team.

B) Further work is required by the Children's Hospital to understand their staffing challenges both nursing and medical. This will inform the feasibility and timeline for implementation.

C) It was noted that all agreed that the vision and model of care to move to a single front door was the right one.

3. Location of eye casualty

The agreed plan as part of phase 1 was for eye casualty to move into the new emergency department on 26 April 2017. However, due to initial teething problems in the department which were exacerbating high waits to be seen and increased ambulance handovers, a decision was taken to postpone the move of eye casualty temporarily. On 2 May 2017, the Trust called an internal critical incident and an agreement was reached that ED needed to increase their majors cubicles from 24 to 32. Therefore, GPAU moved into the eye casualty rooms in blue zone and eye casualty's move was further postponed.

A meeting was held on 5 June 2017, chaired by the Chief Operating Officer (COO) with the eye casualty and ED team to discuss the future location of eye casualty. The eye casualty team raised a number of concerns about the suitability of moving into the new ED. The agreed outcome of that meeting was that an options appraisal on their future location would be carried out. Options reviewed include:

1) Eye casualty moves into blue zone (the original plan)
2) Eye casualty moves into EF2 and GPAU stays in the blue zone
3) Eye casualty stays where it is
4) Eye casualty expands into ENT OPD

The eye casualty team and ED team are meeting with the COO again and a decision will be taken by 23 June 2017. A further verbal update will be provided at the next meeting.

**UHL key actions for July are**:

1) Continued work on EDG actions
2) Continued focus on maintaining improvement of ambulance handovers
3) Continued focus on R2G across the organisation to ensure meaningful flow out of the ED

**Conclusion**

Our performance remains below the national standard, but we have seen some positive improvements in June, despite sustained high numbers of attendances at our hospitals. The new Organisation of Care approach to sustaining improvements offers a robust process to this important programme of work. This is not about forgetting all the hard work that has gone before, and continues every day, but about embedding the changes and bringing all our staff with us as we work to fundamentally change the way we do things to improve the experience of our patients. Using the beds we have more efficiently is key, and will help us to get the most from our new emergency floor.

**Recommendations**

- Note the contents of the report
- Despite some improvement, note the continuing concerns about four-hour delays
- Note the high number of attendances to our hospitals despite demand management initiatives across the system

**ED medical overnight resilience and sustainable rota**

**Report to Organisation of Care Programme ED group 21.06.17**

## Context

The underlying causes for lack of resilience to patient care delivery overnight in the EF resulting in substantial delays in care pathways for patients and reflected in 4 hour breach rates have been agreed by the ED Heads of service, head of nursing for EM and the Clinical director of ESM. These are;

1. Gradual build-up of numbers of patients in the department through the evening such that the workload is unsustainable through the night. This is often exacerbated when pressures in the paediatric ED lead to pull of medical staff across from adults often at the time when the backlog is building.
2. A geographical footprint resulting in poor situational awareness for the medical and nursing leads overnight with the numbers of staff on duty.
3. Having only one ST4+ senior medical decision maker in the department through the night who is regularly subsumed by the need to directly manage the sickest patients and therefore not progressing the decision making for the majority of patients to allow the more junior doctors to process pathways.

The second point has been mitigated to good effect by contracting the footprint in the adult ED by consolidating the EF footprint overnight to give the senior medical staff better situational awareness. The first point is only a contributory factor to the night time performance deterioration, as even when the position in the department is good going into the night the performance consistently deteriorates.

This paper explores the third point as commissioned from the Organisation of Care, and subsequently expanded to include finance and rota sustainability considerations. Specifically, a task and finish group was established to appraise options designed to deliver the following;

1. To increase the resilience of medical care in ED overnight in the near term
2. To do this by increasing the minimum number of ST4+ doctors on the floor to 2, either through middle or consultant grade doctors or a combination of both
3. Preserve the health and wellbeing of the work force, in particular from work related stress due to excessive demands to back fill rota gaps (especially where the rotas are predicated on workforce above funded establishment). In particular backfilling rota gaps was deemed acceptable only for covering vacancy factor and sickness, not unfunded posts
4. Recognising the workforce gaps with a rota predicated on consultant numbers above funded establishment, and that bolstering the night cover may decrease daytime fragility, produce a new rota based on funded consultant and middle grade establishment
5. Ensure that options appraised have no net cost
6. Recommend an approach to aggressive recruitment of substantive staff to funded establishment levels to reduce premium spend and the risk to safety posed by temporary staff

**Task and finish group**

| | | |
|---|---|---|
| Matt Metcalfe | Deputy Medical Director | Chair |
| Vivek Pillai | Head of Service, ED (adult) | |
| Nick Scott | Deputy Head of Service, ED (adult) | |
| Sam Jones | Head of Service, ED (Paediatrics) | |
| Kerry Johnstone | Head of Nursing, Emergency Medicine | |
| Ian Lawrence | Clinical Director, ESM | |
| Rachel Williams | Deputy Head of Operations, ESM | |
| Amy Jones | Specialist registrar, ED | |
| Lee Walker | Deputy Clinical Director, ESM | |

**Meetings**

The task and finish group met twice on the 2nd and 16th June, to agree the scope of work and explore options. The scope of work was agreed with the parameters of the options. Various components of possible solutions were explored, suggested both from within the ED clinical leadership team and outside. These elements are considered separately in the following section alongside a narrative around the benefits and drawbacks as adjudged by the ED clinical leadership team.

The ED Heads of service were asked to derive overall consultant rota options which delivered 24/7 consultant presence in the ED which would deliver the stated aim of at least 2 ST4+ seniority ED doctors at all times.

The ED Specialist registrar representative reported that the senior trainees in ED had a solution through the middle grade rota, but that this was potentially in contravention of the new junior doctors' contract.

**Options considered**

1. **Replacing consultant of the week with new medical cover arrangements for EDU and employing a band 6 administrative and governance manager to reduce the DCC times spent by consultants directly on administrative functions.**
   The perceived benefits of this arrangement are that it releases the very scarce resource of ED specialist DCC from clinical functions in EDU which arguably could be covered by other specialities and substantially streamline patient related administration, again releasing DCC to the shop floor. The DCC released in this way could be re-invested in night time consultant cover.
   The drawbacks of this measure were perceived to be that;
   (i) the medical cover of EDU by other specialities may not be appropriate even if it may be a more readily available resource. In particular it was felt that acute physicians may not have the correct competencies to manage EDU patients. A subsequent suggestion relating to use of ED consultants with health related constraints to their practice who may be able to support EDU has not been considered by the full group.
   (ii) the administrative support would be welcomed by ED consultants, but it would make the workload manageable compared to the current situation, rather than releasing clinical time.

It was felt on balance by the ED leadership team that this was not an appropriate option to explore further.

2. **Review and reduce the number of externally funded PAs in the job plans of the ED consultant work force (currently 36 PA in total).**
   This is a high level of externally funded sessions, and the benefit of reducing these would be reducing the number of clinical shifts which need to be backfilled at premium rate. This would be capable of releasing huge potential DCC to support a consultant presence through the night. Recognising that some externally funded sessions are good for the reputation of the department and the professional development of the consultants and their emotional health and wellbeing, reducing the externally funded sessions by 50% would be the equivalent of putting approximately 3 whole time equivalents onto the shop floor, at substantive consultant rates of pay rather that premium.
   The drawbacks perceived to this approach were the reputational risk to the department, the loss of some activity essential for service delivery and improvement and the impact upon emotional health and wellbeing for the consultants. It was felt that recruitment and retention of consultants would be at significant risk of adverse impact.

   It was felt on balance by the ED leadership team that this was not an appropriate option to explore further.

3. **Moving the Paediatric night time registrar to a "twilight shift".**
   The benefit of this approach would be to improve processing power at a relatively busy time for the Paediatric ED and reduce the pull of medical work force to the paediatric ED. Overnight the inflow in paediatric ED is low, and therefore the loss of the registrar overnight is not felt to be a significant risk.
   The drawback to this approach is that currently there are only 2 of 8 posts recruited into, and therefore the net effect on ED pressures overnight is likely to be small.
   It will take some time to implement due to the need to consult.

   The ED leadership team felt that this option was worth pursuing, acknowledging that the impact will be limited.

4. **Removing a medical consultant locum post from the ED and using the funding released to trial an additional registrar post overnight.**
   The specialist registrars in ED have indicated that there is a willingness among their group to support a trial period of running a second ST4+ through the night in ED on a locum basis. They agree that the nights are not safe for patients with current levels of staff and the state the department is frequently in by late evening. They have suggested that this could be funded by removing a locum physician shift from the department during the day/evening indicating that in their assessment the loss of this support would have relatively little impact on the care provided to ED patients given the mismatch of their range of expertise and the breadth of presentations through the front door. The Deputy Head of Operations confirms that removing the locum physician post would cover the expense of the registrars overnight.

The downside to this option would be that the loss of physician input may have a detrimental impact when there is poor outflow from the department to those medical patients awaiting beds on the AMUs. Also the solution is predicated on registrars being prepared to go over and above in picking up additional shifts, and therefore if this were a long term solution it would depend on successful additional workforce recruitment. It was reported that this would put the registrars in breach of the new junior doctors' contract. However subsequent discussions with Joanne Tyler-Fantom indicate that with the consent of the registrars this obstacle can be successfully negotiated.

The ED leadership team are grateful to the registrars for their ownership and innovation and feel this is an option worth progressing.

5. **Reallocating some primary care funding to boost ED specialist cover in the department.**

It was noted that feedback from ECIP visits includes the observation that the primary care stream resource is significantly inefficient when assessed in terms of number of patients seen per hour, recognising that the acuity of patients presenting at ED may be higher than the average at surgeries. The appointment of a GP as primary care lead in ED provides an opportunity to manage the efficiency of this workforce. The opportunities here are firstly that a greater throughput during the day would result in the ED going into the night in a better position. Secondly, it was agreed that the profile of patients presenting through the night tend not to be suitable for primary care and therefore reduced night time GP cover would have little detriment to the department.
This would require robust management of the primary care stream to be instituted and relevant KPIs to be included in the procurement of the new provider.

Subject to this being possible in the context of an ongoing primary care procurement exercise the ED leadership team agreed this approach was supported. Subsequent conversations indicate that the procurement represents an ideal opportunity to "right size" the primary care stream.

6. **Arranging consultant rotas such that the night shifts are picked up by locums (internal or external) therefore already at premium rate, such that enhanced unsocial hours rates for overnight shifts are negated, reducing the cost implications of providing 24/7 consultant ED presence.**

The ED heads of service presented consultant rota options which were unable to meet the dual requirements of (i) providing a consultant on the shop floor 24/7 and (ii) remaining cost neutral, particularly as options 1 and 2 above are felt to be non-viable. To summarise from the options presented, the cost neutral option with a consultant present through the night left the cover during the day very thin and at times absent. The preferred cost neutral option appeared to be the current rota.

The chair suggested that, given the rota is currently heavily dependent upon locums to sustain it, then there would be ways to re-profile the way in which substantive sessions and

locum shifts are allocated throughout the 24 hour cycle. The advantage of this would be that as the locums are paid a flat rate irrespective of time of day then filling the night shifts preferentially with locums and using your substantive sessions to fill during social hours would substantially offset the cost of paying for a consultant through the night, as there would be no need for additional enhancement of substantive sessions.

The potential drawback to this approach was that it was felt that the night time locum shifts may be harder to fill than during the day. However it was also reported that traditionally it has been easier to fill vacant shifts with locums out of hours, therefore this concern may represent less of an adverse impact than feared.

The ED leadership team agreed that this was worth exploring further, and the deputy head of operations agreed to model the opportunity.

7. **Establishing a clinically lead ED workforce board to direct and oversee an aggressive recruitment and retention programme**

   It was agreed that the task and finish group did not have the scope to derive and implement a full recruitment policy, but that this was an essential component of a sustainable solution to the medical workforce challenges and the associated patient safety and workforce health and wellbeing consequences.

   It was recognised that historically the ED has had a very successful approach to recruitment and retention but that more recently this has tailed off significantly.

   It was agreed that a medical workforce board within ED would be established to oversee this and that external support (eg in terms of communications and advertising) would be facilitated corporately as needed.

**Summary**

This discussion paper has explored and identified some options for increasing the resilience of the ED overnight and how they may be funded internally. In particular the proposal from the registrars has the advantage that it could be implemented quickly and in the form of a rapid cycle for testing the hypothesis that the number of senior medical decision makers overnight.

**Recommendation**

Subject to approval by the Organisation of Care Programme ED Group, the options considered viable by the task and finish group are prioritised and worked up into an operational delivery plan by the ED and ESM leadership teams. It is recommended that progress against this plan is monitored through the ED workforce board, reporting into the ED group.

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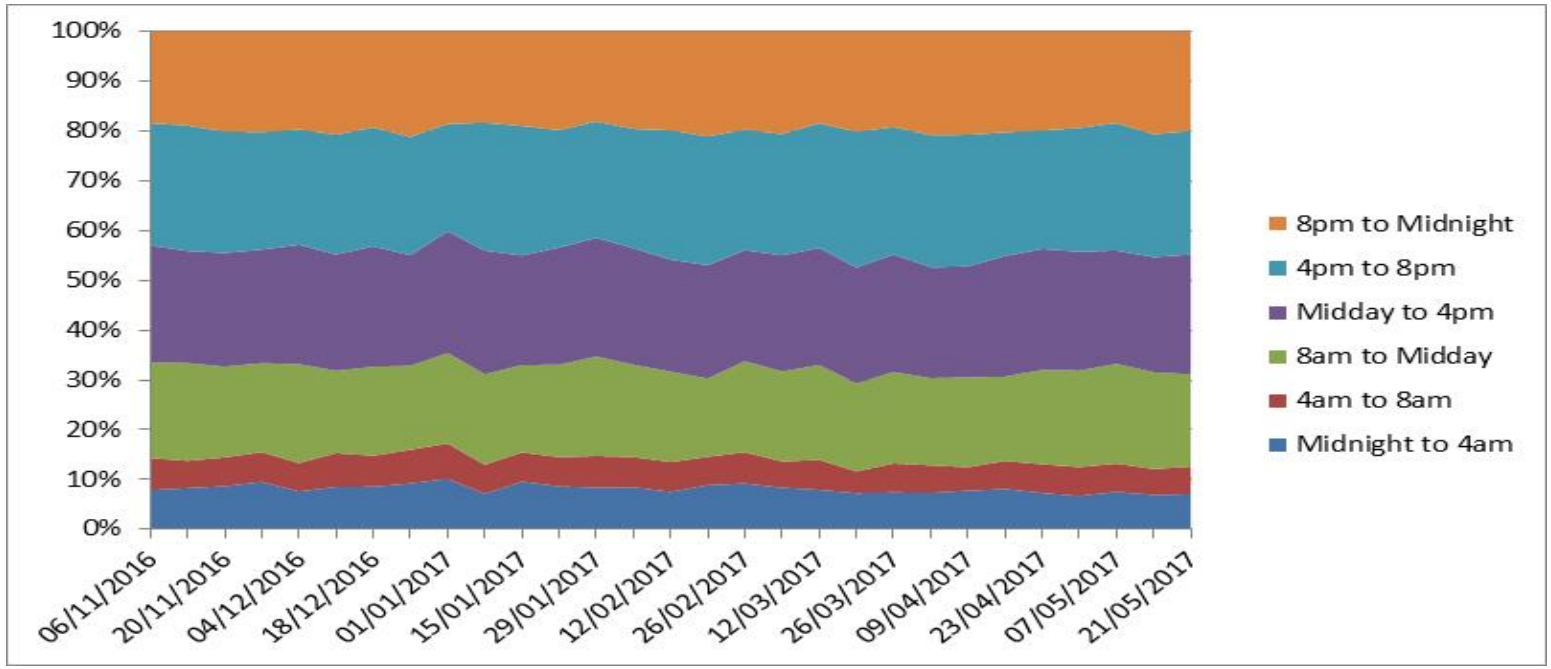
# What does the data show happens overnight?

One team shared values

University Hospitals of Leicester NHS Trust

# ED attendances by time of arrival

- April/May total ED and Eye Casualty attendances similar number to same period last year
- Attendances for the first 5 weeks since the new ED opened are similar to the number of attendances in the preceding 5 weeks.
- On average 28% of attendances arrive between 8pm and 4 am and this has remained relatively consistent over the last 26 weeks.



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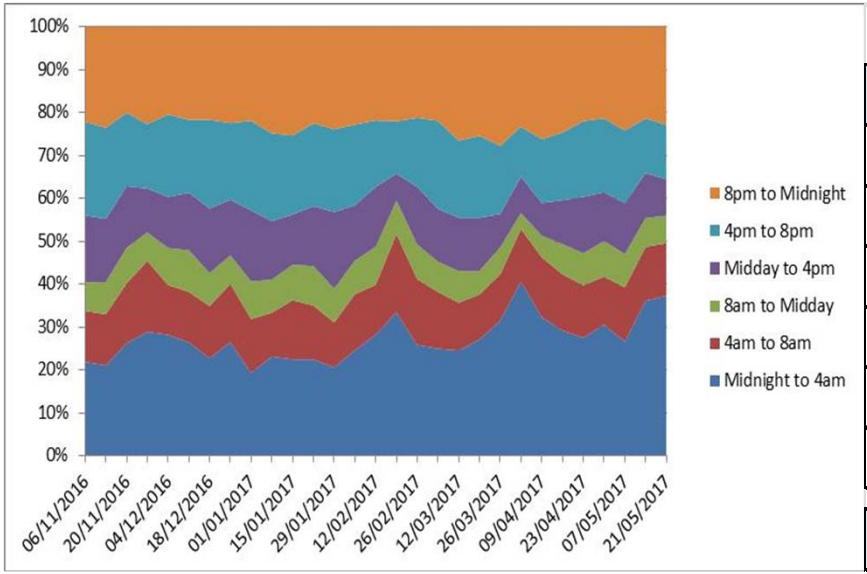
# Time of 4hr breaches

- The proportion of overnight breaches is increasing.
- The % of breaches between 8pm and 4am has increased from around 45% in November 16 to around 60% during May.
- The % of breaches between midnight and 4am has increased the most from 23% to 38%




| | Week Ending | | | | | |
|---|---|---|---|---|---|---|
| Breach Time Period | 07/05/2017 | 14/05/2017 | 21/05/2017 | 28/05/2017 | 04/06/2017 | 11/06/2017 |
| 4am to 8am | 13% | 12% | 13% | 12% | 11% | 12% |
| 8am to 12pm | 8% | 7% | 7% | 8% | 6% | 8% |
| 12pm to 4pm | 12% | 10% | 9% | 13% | 11% | 11% |
| 4pm to 8pm | 17% | 12% | 13% | 18% | 15% | 14% |
| 8pm to Midnight | 24% | 21% | 24% | 18% | 24% | 25% |
| Midnight to 4am | 26% | 38% | 35% | 30% | 33% | 30% |
| Breaches between 8pm and 4am | 51% | 58% | 59% | 49% | 57% | 55% |

# Breaches and escalation levels – 8th May to 15th May

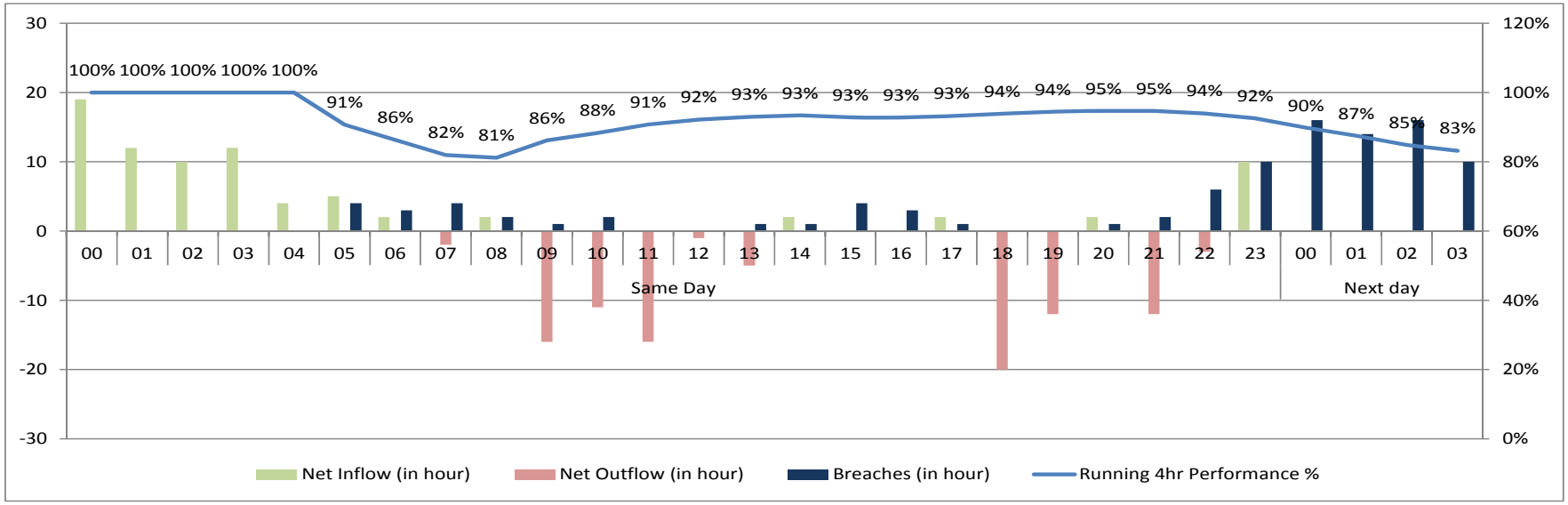
- Further daily analysis focuses on the period 8th May to 15th May
- The Trust started the week on Critical Incident which was stepped down during the week to OPEL level 2 before stepping back up to OPEL 4 at the weekend.
- The highest number of breaches every day occurred in the midnight to 4am bracket.
- The daily % of breaches between the time of 8pm and 4am ranged between 44% and 78%.
- The lower the escalation level and the lower the number of patients waiting for beds the higher % of breaches happened in that period.
- ED Majors accounts for the highest proportion of 4hr breaches

| | Breach Time Period | 08/05/2017 Critical Incident | OPEL3 | 10/05/2017 OPEL 3 | 11/05/2017 OPEL 2 | 12/05/2017 OPEL 2 | 13/05/2017 OPEL4 | 14/05/2017 OPEL 3 | 15/05/2017 OPEL 4 |
|---|---|---|---|---|---|---|---|---|---|
| | AMU Beds available at 8am | 0 | 1 | 3 | 17 | 10 | 1 | 0 | 0 |
| | Patients waiting for AMU beds at 8am | 3 | 2 | 0 | 0 | 2 | 4 | 5 | 9 |
| All ED Floor Locations | 4am to 8am | 20 | 14 | 21 | 11 | 10 | 18 | 22 | |
| | 8am to 12pm | 11 | 13 | 8 | 5 | 3 | 13 | 8 | |
| | 12pm to 4pm | 24 | 14 | 5 | 6 | 2 | 28 | 18 | |
| | 4pm to 8pm | 20 | 22 | 7 | 4 | 7 | 25 | 31 | |
| | 8pm to Midnight | 24 | 24 | 16 | 19 | 29 | 24 | 59 | |
| | Midnight to 4am | 45 | 63 | 36 | 56 | 42 | 42 | 66 | |
| | Total | 144 | 150 | 93 | 101 | 93 | 150 | 204 | |
| | %of breaches after 8pm | 48% | 58% | 56% | 74% | 76% | 44% | 61% | |

| Patients Last Location | Breach Period | 08/05/2017 | 09/05/2017 | 10/05/2017 | 11/05/2017 | 12/05/2017 | 13/05/2017 | 14/05/2017 |
|---|---|---|---|---|---|---|---|---|
| LRI-ED-MAJORS | 4am to 8am | 17 | 11 | 15 | 11 | 8 | 12 | 11 |
| | 8am to 12pm | 10 | 10 | 7 | 5 | 1 | 12 | 5 |
| | 12pm to 4pm | 17 | 12 | 2 | 4 | | 25 | 11 |
| | 4pm to 8pm | 12 | 17 | 6 | 4 | 5 | 17 | 18 |
| | 8pm to Midnight | 18 | 8 | 9 | 10 | 24 | 11 | 27 |
| | Midnight to 4am | 39 | 28 | 30 | 28 | 35 | 22 | 29 |
| | Total | 113 | 86 | 69 | 62 | 73 | 99 | 101 |
| | %of breaches after 8pm | 50% | 42% | 57% | 61% | 81% | 33% | 55% |

# Net outflow and 4hr breach performance – 11th May

- Net outflow - green more patients leaving ED than arriving and red more arriving than leaving
- Cumulative performance for those patients attending after midnight deteriorates in the early hours of the morning.
- Cumulative 4hr performance improves from 8am and this continues into the evening period.
- Late evening and overnight 4hr performance dips with highest number of breaches 11pm to 4am.
- A similar pattern was noted for most of the days during this week. However, some days recovery of performance during the day was not as great as the example below.




One team shared values

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# Correlation analysis – 11th May

- Correlation is not causation though it can be……
- Correlation coefficient formula is used to find how strong a relationship is between 2 sets of data. The formulas return a value between -1 and 1. The closer to 1 indicates a strong positive relationship.
- The following had the highest correlation :-
    1. Number and Grade of Dr and outflow (0.81) – further information on next slide
    2. Outflow to number of doctors in Department (0.78)
    3. Outflow to Occupancy (0.78)
    4. Time to be seen and Occupancy (0.43)
    5. Time to be seen and 4hr breaches (0.38)
    6. 4hr breaches and occupancy at time of arrival (0.27)

| | Same Day | | | | | | | | | | | | | | | | | | | | | | | | Next day | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hour Period** | **00** | **01** | **02** | **03** | **04** | **05** | **06** | **07** | **08** | **09** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **00** | **01** | **02** | **03** |
| Running 4hr Performance % | 100% | 100% | 100% | 100% | 100% | 91% | 86% | 82% | 81% | 86% | 88% | 91% | 92% | 93% | 93% | 93% | 93% | 93% | 94% | 94% | 95% | 95% | 94% | 92% | 90% | 87% | 85% | 83% |
| Breaches in the Hour | | | | | | 4 | 3 | 4 | 2 | 1 | 2 | | | 1 | 1 | 4 | 3 | 1 | | | 1 | 2 | 6 | 10 | 16 | 14 | 16 | 10 |
| Net Outflow | 19 | 12 | 10 | 12 | 4 | 5 | 2 | -2 | 2 | -16 | -11 | -16 | -1 | -5 | 2 | 0 | 0 | 2 | -20 | -12 | 2 | -12 | -3 | 10 | 9 | 15 | 26 | 21 |
| Occupancy | 91 | 72 | 60 | 50 | 38 | 34 | 29 | 27 | 29 | 27 | 43 | 54 | 70 | 71 | 76 | 74 | 74 | 74 | 72 | 92 | 104 | 102 | 114 | 117 | 106 | 98 | 83 | 55 |
| Average wait to be Seen | 91 | 85 | 98 | 117 | 153 | 119 | 68 | 37 | 29 | 30 | 46 | 59 | 69 | 44 | 55 | 47 | 57 | 72 | 80 | 77 | 141 | 112 | 122 | 122 | 140 | 118 | 83 | 109 |
| Patients waiting for a bed | 9 | 12 | 11 | 9 | 5 | 2 | 5 | 3 | 5 | 5 | 4 | 5 | 7 | 7 | 11 | 10 | 10 | 12 | 12 | 15 | 13 | 8 | 11 | 8 | 9 | 9 | 6 | 9 |
| Average wait for a bed | 40 | 48 | 27 | 31 | 42 | 50 | 85 | 27 | | 54 | 78 | 87 | 111 | 87 | 72 | 87 | 76 | 79 | 74 | 91 | 47 | 59 | 84 | 61 | 59 | 52 | | 76 |
| Dr Numbers | 19 | 12 | 11 | 11 | 11 | 11 | 11 | 11 | 14 | 14 | 15 | 15 | 18 | 18 | 21 | 27 | 29 | 22 | 21 | 21 | 21 | 20 | 14 | 24 | 13 | 12 | 12 | 12 |

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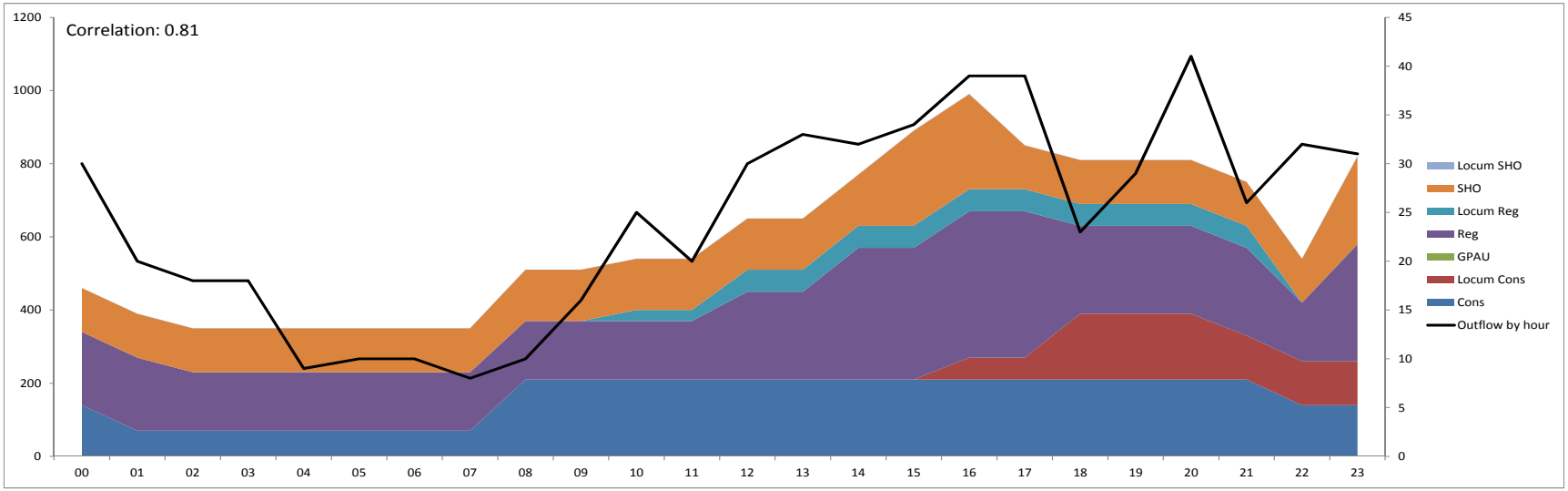
# Do numbers of Drs and grades of Dr impact on outflow?

- To enable correlation of Dr numbers/Grades a score has been applied to each grade of Dr – in simple terms the higher the grade of Dr the higher the score.
- This score was then multiplied by the actual number of Drs by grade in ED per hour and mapped to outflow per hour – the example below is for the 11th May.
- Out of all the correlation scores the link between Drs combined influence score and outflow scored the highest.
- This approach needs further refinement with colleagues in ED. We need to make sure we capture for all decision makers.



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# Most days occupancy increases between 5pm and 8pm

- Analysis of 15 minute net flow (inflow minus outflow) shows inflow is generally higher than outflow between 5.30pm and 8pm
- Average inflow during this time is 10 patients every 15 minutes – with a range of 3 to 17
- Average outflow during this time is 8 patients every 15 minutes – with a range of 1 to 17
- There is another period between 9.15 pm and 10.15 pm when outflow reduces whilst inflow remains high.
- This tends to put the overnight position in jeopardy as occupancy is too high.

Net Flow (Inflow - Ouflow)

| | 17:30 to 17:45 | 17:45 to 18:00 | 18:00 to 18:15 | 18:15 to 18:30 | 18:30 to 18:45 | 18:45 to 19:00 | 19:00 to 19:15 | 19:15 to 19:30 | 19:30 to 19:45 | 19:45 to 20:00 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Monday | -8 | 7 | -1 | 1 | -1 | 3 | -1 | -8 | -3 | -7 | -18 |
| Tuesday | 3 | 2 | -3 | 5 | -12 | -8 | -3 | -1 | 4 | -5 | -18 |
| Wednesday | -5 | 0 | -6 | 2 | -8 | -9 | -2 | -1 | -1 | -5 | -35 |
| Thursday | -2 | 7 | -7 | -10 | -3 | 0 | 0 | 3 | -3 | -12 | -27 |
| Friday | 6 | -2 | -2 | -4 | -3 | 0 | -6 | 6 | -2 | -1 | -8 |
| Saturday | -2 | 0 | 3 | 2 | 0 | 3 | 0 | 2 | 2 | 2 | 12 |
| Sunday | -2 | -10 | -2 | -5 | -4 | -4 | -4 | 5 | 2 | 2 | -22 |

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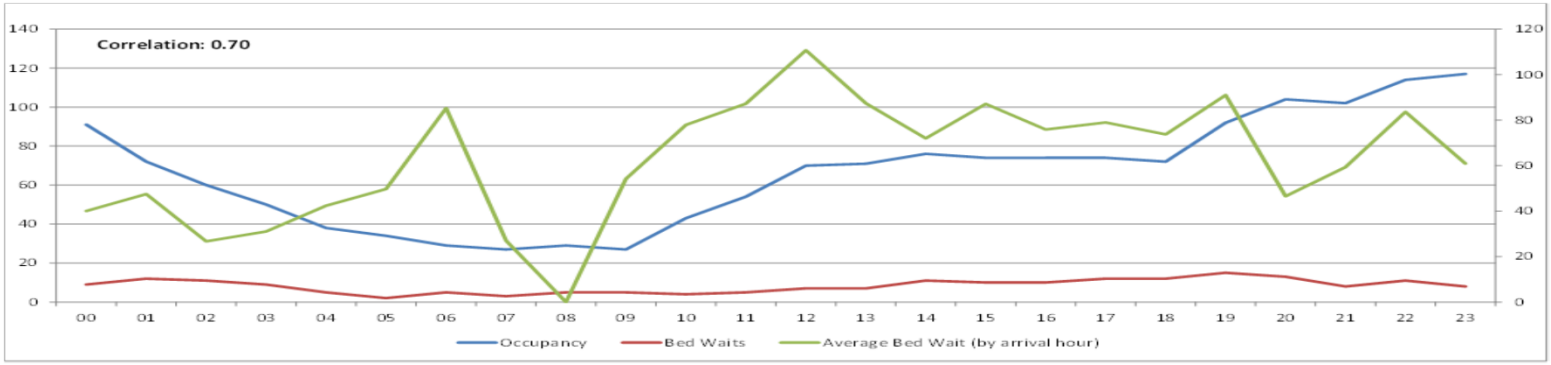
# Number of pts waiting for a bed and occupancy

- Correlation between patients waiting for a bed and occupancy gives mixed results.
- The chart for the 11th May shows a strong correlation – the Trust was on OPEL 2 and there was bed availability.




- The chart for the 8th May shows little correlation – the Trust was on Critical Incident and had limited bed availability.

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## Key Findings

- Breaches are driven in a large part by occupancy even in the new department.
- Occupancy is driven by number and grade of Drs on shift. Regardless of whether the department had flow or not the occupancy was correlated most closely with this.
- The relationship between occupancy and bed requests is inconclusive.
- More work is needed to get the influence score to be meaningful.
- More work is needed to see what changes in the ‘early evening’ period in terms of net flow.

**LLR AE Delivery Board Action**

| | Main Work-strand | Sub strand | Key Actions | By when | Leads | Measures |
|---|---|---|---|---|---|---|
| Flow | Hospital Flow - SRO Richard Mitchell | ED flow (Blue Zone) | A. Standardise process<br>B. Consistent implementation<br>C. Clear roles and responsibility well understood by all staff<br>D. Clear performance management with agreed remedial actions | 31/07/2017<br>31/03/2018<br>31/07/2017<br>12/06/2017 | Lisa Gowan (mgmt.) Nick Scott (Clinical leads) Kerry Johnston (Nursing) | Reduction in non-admitted breaches<br>Clear data to monitor GP activity<br>Improved ambulance handover position |
| | | ED Flow (Majors) | A. Standardise process<br>B. Consistent implementation<br>C. Clear roles and responsibility well understood by all staff<br>D. Clear performance management with agreed remedial actions | 31/07/2017<br>31/03/2018<br>31/08/2017 | Lisa Gowan (mgmt.)<br>Vivek Pillai/Matt Metcalfe (clinical) Kerry Johnston (nursing) | Reduction in breaches between 1900hrs to 0400hrs |
| | | ED Paediatrics | A. Standardise process<br>B. Consistent implementation<br>C. Work with the Children's Hospital to develop single front door model | 31/07/2017<br>31/03/2018<br>01/04/2018 | Lisa Gowan (mgmt.)<br>Sam Jones (clinical)<br>Kerry Johnston (nursing) | Reduction in breaches<br>Maintaining VAC first line assessment |
| | | ED Workforce | A. Retain, recruit and attract optimum workforce against budget<br>B. Workforce, organisational development plan, driven by appraisals aligned to CMG and Trust objectives, and UHL 5-year strategy<br>C. Clear performance management with agreed remedial actions | 31/12/2017<br>31/03/2018<br>31/03/2018 | Vivek Pillai, Nick Scott, Sam Jones, Kerry Johnston, Matt Metcalfe, Julie Smith | Vacancy reduction<br>Improved pulse check responses |
| | | ED Flow (EMAS) | A. Improve and sustain ambulance handover times | 09/06/2017 | Julie Dixon (mgmt.) Kerry Johnston (nursing) Nick Scott (Medical)Richard Lyne (EMAS) | improved handover summary<br>improved CAD compliance |
| | | Making the current bed capacity more efficient and effective (rigorous implementation of SAFER & Red to Green) | A. Review of current implementation on medical wards at LRI for learning with reference to a re-launch on these wards<br>B. Refocus the implementation of Red to Green and SAFER as a priority on the Medicine wards at LRI relentless tackling the top 3 delays (including the implementation of Inter professional standards)<br>C. Rigorous implementation of SAFER/Red to Green at Glenfield Cardiology & Respiratory wards<br>E. TTO project started with an aim of achieving standards relating to TTO writing 'day before' and discharges before noon<br>F. Discharge transport – working with CCGs/third party partners to better align demand and capacity for discharge transport | 19/07/2017<br>30/06/2017<br>31/07/2017<br>31/07/2017<br>20/06/2017 | Gill Staton / Ian Lawrence<br>Gill Staton/Ian Lawrence/Stuart Logan<br>Suzanne Khalid/Sue Mason/Gill Staton<br>Mark Taylor/Gill Staton<br>Simon Barton/Julie Dixon/Michael Dobson | TTOs day before %<br>% patients discharged via Discharge Lounge<br>No. of stranded patients (>7 days LOS)<br>Discharges before 1000 |
| | | Increasing physical bed capacity to meet demand and reduce occupancy | A. Ward 21 at LRI to remain open as a baseline medical ward rather than a Winter ward (28 beds)<br>B. Ward 7 EDU – surplus of 6 beds to be used as escalation but to be fully opened for winter 17/18<br>C. Marginal increase in beds on 3 medical wards at LRI (6 beds)<br>D. Physical capacity increase at Glenfield for cardio-respiratory emergencies as winter ward now has Vascular in situ<br>E. Ward swap to take place at LGH to reduce Orthopaedic elective beds and increase General surgical beds (+6)<br>F. Plan from Paediatrics for staffing beds in winter 17/18 that were routinely closed due to now staffing in winter 16/17 (+6) | Complete<br>31/10/2017<br>30/11/2017<br>31/10/2017<br>31/07/2017<br>30/06/2017 | Simon Barton / Stuart Logan / Sue Burton<br>Simon Barton / Lisa Gowan / Kerry Johnston<br>Simon Barton / Stuart Logan / Sue Burton<br>Simon Barton / Darryn Kerr<br>Simon Barton/Nicky Grant/George Kenney<br>Simon Barton/David Yeomandson/Hiliary Killer | Trust Occupancy (target 95%)<br>Occupancy of Medicine (target 90%)<br>Cancelled operations on the day and the week before due to no bed |

**ED flow (Blue Zone)**

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update (all actions required sign off at EDG on 21.6.17) | RAG Status |
|---|---|---|---|---|---|---|---|
| **A. Standardise processes** | | | | | | | |
| A1 | All UHL staff to sign that they are competent and understand their roles and responsibilities within the assessment zone as per SOP | Nick Scott, Kerry Johnston | 01/07/2017 | 31/07/2017 | 30 | | 5 Complete |
| A2 | Review and write procedure for requesting x-rays and bloods from triage to speed up the process further in the pathway. | Ian Lawrence | 05/06/2017 | 30/06/2017 | 25 | | 7 Not yet commenced |
| A3 | Review assessment zone SOP to ensure that it explicity includes that patients are to be moved directly to majors when capacity available. | Nick Scott, Julie Dixon | 22/05/2017 | 02/06/2017 | 11 | SOP reviewed | 5 Complete |
| A4 | Procurement process to secure a third party GP provider | John Adler, Lisa Gowan | 03/07/2017 | 28/02/2018 | 240 | CCG GB meeting 20/6/17; JA attending to present front door model | 2 Significant Delay - unlikely to be completed as planned |
| A5 | Performance metrics will be developed to monitor breaches daily of:<br>- 2 hour target<br>- VAC nurse streaming first time<br>- Patients direct to GP without triage<br>- Number of ENP see and treat patients<br>- Number of x-ray and bloods requested and completed from triage<br>- Number of patients sent directly to majors from handover | Lisa Gowan, Nick Scott, Kerry Johnston | 26/06/2017 | 10/07/2017 | 14 | LG to meet with John Roberts w/c 26/6/17 | 10 Not yet commenced |
| **B. Consistent implementation** | | | | | | | |
| B1 | GP lead to be nominated to receive full briefing on assessment zone SOP and GP role in delivering 2 hour target | Nick Scott | 19/06/2017 | 31/07/2017 | 42 | Advert on TRAC awaiting approval from RCB | 4 On Track |
| B2 | Daily briefing (written and verbal) to all staff to:<br>- see patients when they are available without the need for triage<br>- changes to SOP<br>- Ensure patients move to majors directly when capacity available<br>- daily sitrep on metrics achieved previous day | Nick Scott, Kerry Johnston | 02/06/2017 | 31/03/2018 | 302 | Extended end date to represent embedding as daily BAU as an ongoing process | 4 On Track |
| B3 | Briefing to all staff via internal comms channels and staff handover on procedures in place for requesting x-rays and bloods from triage | Kerry Johnston | 30/06/2017 | 31/07/2017 | 31 | Undertake for 1 month to embed as BAU | 8 Not yet commenced |
| **C. Clear roles and responsibilities** | | | | | | | |
| C1 | GP lead to brief all GP staff on assessment zone processes and their role and responsibilities | Nick Scott | 31/07/2017 | 31/03/2018 | 243 | Action reflects progress towards BAU | 4 Not yet commenced |
| C2 | All GPs to sign that they are competent and understand their roles and responsibilities | Nick Scott | 31/07/2017 | 31/08/2017 | 31 | Interim plan prior to completion of procurement process | 5 Not yet commenced |
| **D. Clear performance management** | | | | | | | |
| D1 | Breach consequences to be considered by head of governance/operations and head of service in ED daily, and training, education or capability process instructed | Lisa Gowan | 26/06/2017 | 31/03/2018 | 278 | Extended end date to represent embedding as daily BAU. | 1 Not yet commenced |
| | | | | | 0 | | 12 Not yet commenced |
| | | | | | 0 | | 13 Not yet commenced |
| | | | | | 0 | | 14 Not yet commenced |

**ED Flow (Majors)**

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update (all actions required sign off at EDG on 21.6.17) | RAG Status |
|---|---|---|---|---|---|---|---|
| **A. Standardise processes** | | | | | | | |
| **A1** | Majors SOP to be signed by all staff to agree they understand their roles and responsibilities | **Vivek Pillai, Kerry Johnston** | **01/07/2017** | **31/07/2017** | **30** | | **1 Not yet commenced** |
| **A2** | Assessment zone and majors SOP to be reviewed/updated to clearly articulate that when there is less than 24 patients in majors, ambulance patients are offloaded and assessed directly | **Vivek Pillai, Julie Dixon** | **22/05/2017** | **05/06/2017** | **14** | | **5 Complete** |
| **A3** | Develop procedure to ensure the Majors coordinator can review the waiting time by area to allow easier running of the dept. | **Vivek Pillai, Kerry Johnston** | **01/07/2017** | **31/07/2017** | **30** | | **4 Not yet commenced** |
| **A4** | IT to secure availability on Nervecentre for generic names for non-ED staff, e.g., mental health nurse, medical SpR's etc. to allow efficient access and reduce interruptions. | **Lisa Gowan** | **26/06/2017** | **26/07/2017** | **30** | | **7 Not yet commenced** |
| **A5** | Develop procedure for electronic handover process for other specialities such as surgery to ensure clear accountability for the area that the patient is to be moved to. | **Matt Metcalfe** | **26/06/2017** | **31/07/2017** | **35** | | **8 Not yet commenced** |
| **A6** | Performance metrics will be developed to monitor breaches daily of:<br>- 4 hour target<br>- Compliance for NerveCentre screen discipline ensuring that there is evidence of a senior review<br>- Reviewing of waiting times to be seen<br>- Number of patients pulled from assessment zone per day<br>- Number of electronic handovers by specialty | **Lisa Gowan, Nick Scott, Kerry Johnston** | **26/06/2017** | **10/07/2017** | **14** | LG to meet with John Roberts w/c 26/6/17 | **9 Not yet commenced** |
| **B. Consistent implementation** | | | | | | | |
| **B1** | Daily briefing (written and verbal) to all majors staff on:<br>- Updates/changes to SOP<br>- When less than 24 patients in majors, ambulance patients enter directly for assessment<br>- Reinforce pull from assessment zone when less than 24 patients in the area<br>- Daily sitrep on metrics achieved previous day<br>- Electronic handover process with other specialties | **Vivek Pillai, Kerry Johnston** | **02/06/2017** | **31/03/2018** | **302** | Extended end date to represent embedding as daily BAU as an ongoing process | **4 On Track** |
| **C. Clear roles and responsibilities** | | | | | | | |
| **C1** | Train all relevant staff on majors co-ordinator role and procedure for reviewing waiting time | **Vivek Pillai, Kerry Johnston** | **26/06/2017** | **31/07/2017** | **35** | Undertake for 1 month to embed as BAU | **5 Not yet commenced** |
| **D. Clear performance management** | | | | | | | |
| **D1** | Breach consequences to be considered by head of governance/operations and head of service in ED daily, and training, education or capability process instructed | **Lisa Gowan** | **26/06/2017** | **31/03/2018** | **278** | Extended end date to represent embedding as daily BAU as an ongoing process | **1 Not yet commenced** |

## ED Paediatrics

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update (all actions required sign off at EDG on 21.6.17) | RAG Status |
|---|---|---|---|---|---|---|---|
| **A. Standardise processes** | | | | | | | |
| A1 | All UHL staff to sign that they are competent and understand their roles and responsibilities within the children's ED as per SOP | Sam Jones, Kerry Johnston | 01/07/2017 | 31/07/2017 | 30 | | **1 Not yet commenced** |
| A2 | Procurement process to secure a third party GP provider | John Adler, Lisa Gowan | 03/07/2017 | 28/02/2018 | 240 | CCG GB meeting 20/6/17; JA attending to present front door model | **2 Significant Delay - unlikely to be completed as planned** |
| **B. Consistent implementation** | | | | | | | |
| B1 | Daily briefing (written and verbal) to all CED staff on:<br>- Updates/changes to SOP | Sam Jones, Kerry Johnston | 02/06/2017 | 31/03/2018 | 302 | Extended end date to represent embedding as daily BAU as an ongoing process | **4 On Track** |
| **C: Work with the Children's Hospital to develop single front door model** | | | | | | | |
| C1 | Establish a regular forum with CH lead clinicains and CED senior team to discuss clinical models | Sam Jones, Kerry Johnston | 01/07/2017 | 14/07/2017 | 13 | | **3 Not yet commenced** |
| C2 | Proposed model agreed by both CH and CED teams for presentation to EFPB and ESB | Lisa Gowan, Sam Jones | 11/07/2017 | 31/08/2017 | 51 | | **4 Not yet commenced** |
| C3 | Regular updates provided to ESB on development of model | Lisa Gowan | 31/08/2017 | 01/04/2018 | 213 | | **5 Not yet commenced** |

## ED Workforce

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update (all actions required sign off at EDG on 21.6.17) | RAG Status |
|---|---|---|---|---|---|---|---|
| **A. Retain, recruit and attract optimum workforce against budget** | | | | | | | |
| **A1** | Carry out a workforce review of capacity and skill mix of current nursing staff across ED | **Kerry Johnston** | 31/05/2017 | 31/07/2017 | 61 | | **4 On Track** |
| **A2** | Carry out a workforce review of capacity and skill mix of current medical staff across ED | **Matt Metcalfe** | 31/05/2017 | 21/06/2017 | 21 | Task and finish group in place, being chaired by MM. Presentation to EDG 21.6.17 | **4 On Track** |
| **A3** | Produce operating model with underpinning workforce plan based on findings from the above | **Kerry Johnston, Matt Metcalfe** | 21/06/2017 | 31/08/2017 | 71 | | **8 Not yet commenced** |
| **A4** | Seek exec lead approval for implementing new operating model and underpinning workforce model | **Andrew Furlong, Julie Smith** | 21/06/2017 | 31/08/2017 | 71 | | **9 Not yet commenced** |
| **A5** | Implement any HR, training and workforce changes to deliver the workforce model | **Kerry Johnston, Vivek Pillai, Nick Scott, Sam Jones** | 31/08/2017 | 31/12/2017 | 122 | | **10 Not yet commenced** |
| **B. Workforce, organisational development plan, driven by appraisals aligned to CMG and Trust objectives, and UHL 5-year strategy** | | | | | | | |
| **B1** | Assessment of competency against roles and responsibilities outlined in SOPs | **Kerry Johnston, Vivek Pillai, Nick Scott, Sam Jones** | 31/07/2017 | 31/08/2017 | 31 | | **3 Not yet commenced** |
| **B2** | Implementation of targeted training and development where competency gaps are identified | **Kerry Johnston, Vivek Pillai, Nick Scott, Sam Jones** | 31/08/2017 | 31/12/2017 | 122 | | **4 Not yet commenced** |
| **B3** | Implementation of senior leadership individual objectives and team development plans | **Lisa Gowan, Ian Lawrence** | 01/08/2017 | 31/08/2017 | 30 | LG has met with Sharon Smeeton and Bina Kotetcha to move this forward | **4 On Track** |
| **B4** | 100% staff have annual appraisal and underpinning development plan | **Lisa Gowan, Ian Lawrence, Kerry Johnston, Vivek Pillai, Nick Scott, Sam Jones** | 05/06/2017 | 31/03/2018 | 299 | Ongoing process | **4 On Track** |
| **B5** | 360 assessment of senior leadership team to identify ongoing development needs | **Lisa Gowan, Ian Lawrence** | 01/08/2017 | 31/08/2017 | 30 | | **5 Not yet commenced** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **B6** | Support staff to undertake all relevant development and training in line with appraisal | **Lisa Gowan, Ian Lawrence, Kerry Johnston, Vivek Pillai, Nick Scott, Sam Jones** | 05/06/2017 | 31/03/2018 | 299 | Ongoing process | **4 On Track** |
| **C. Clear performance management** | | | | | | | |
| **C1** | Monthly reinforcement of the 9 principles for effective emergency care (ECIP) at consultant and nurse meetings | **Lisa Gowan, Ian Lawrence** | 01/07/2017 | 31/03/2018 | 273 | | **5 Complete** |
| **C2** | Monthly reinforcement of the internal professional standards and whole hospital response at consultant and nurse meetings across the Trust | **Matt Metcalfe** | 01/07/2017 | 31/03/2018 | 273 | | **2 Not yet commenced** |
| **C3** | Develop workforce metrics to agree baseline for: sickness absence, leavers etc., staff survey, etc. | **Lisa Gowan** | 26/06/2017 | 31/07/2017 | 35 | | **11 Not yet commenced** |
| **C4** | Quarterly review of workforce metrics | **Lisa Gowan** | 31/07/2017 | 31/10/2017 | 92 | | **12 Not yet commenced** |

**ED Flow (EMAS)**

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update (all actions required sign off at EDG on 21.6.17) | RAG Status |
|---|---|---|---|---|---|---|---|
| **A. Improve and sustain ambulance performance** | | | | | | | |
| A1 | Establish a regular forum with EMAS and senior UHL ED team to review performance against agreed metrics | Julie Dixon | 19/06/2017 | 31/03/2018 | 285 | Extended end date to represent embedding as daily BAU. | **4 On Track** |
| A2 | Review EMAS SOP and roles and responsibilities within it, including clear articulation of all the avaiable ambulatory pathways, and management of patients across the department in time of both capacity and surge. | Julie Dixon, Kerry Johnston | 19/06/2017 | 31/07/2017 | 42 | | **5 Complete** |
| A3 | Ratify SOP at ED Guideline Committee | Ian Lawrence | 31/07/2017 | 31/08/2017 | 31 | | **2 Not yet commenced** |
| A4 | Production of an IT solution to record if crew leave the ED prior to full handover (CAD+). | Lisa Gowan, Julie Dixon | 26/06/2017 | 31/07/2017 | 35 | | **8 Not yet commenced** |
| A5 | Educate staff on how IT solution works | Lisa Gowan, Julie Dixon | 31/07/2017 | 31/08/2017 | 31 | | **9 Not yet commenced** |
| A6 | Roll-out ratified SOP to all staff via internal comms channels and briefings | Lisa Gowan, Julie Dixon | 31/07/2017 | 31/08/2017 | 31 | | **3 Not yet commenced** |
| A7 | Daily briefings to all staff:<br>- To offload and assess directly to majors if less than 24 patients in situ<br>- If no capacity, handover takes place in a cubicle with qualified nurse<br>- Task of turning on all screens/computers in bays allocated to staff on shift<br>- Daily sitrep on metrics achieved previous day | Kerry Johnston, Nick Scott, Vivek Pillai, Sam Jones | 31/07/2017 | 31/03/2018 | 243 | Extended end date to represent embedding as daily BAU. | **1 Not yet commenced** |
| A10 | Performance metrics will be developed to monitor breaches daily of:<br>- Number of patients who were offloaded and assessed directly in majors<br>- Handover taken by qualified nurse in cubicle (in line with daily demand)<br>- Number of patients identified where handover was not completed versus actual number<br>- EMAS use of available ambulatory pathways | Lisa Gowan | 26/06/2017 | 31/07/2017 | 35 | LG meeting with John Roberts 26/6/17 | **11 Not yet commenced** |
| A8 | Breach consequences to be considered by head of governance/operations and head of service in ED daily, and training, education or capability process instructed | Lisa Gowan, Ian Lawrence | 31/07/2017 | 31/03/2017 | -122 | Extended end date to represent embedding as daily BAU. | **7 Not yet commenced** |

**Making the current bed capacity more efficient and effective (rigorous implementation of SAFER & Red to Green)**

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update | RAG Status |
|---|---|---|---|---|---|---|---|
| **A. Review current implementation medical wards at LRI with reference to re-launch** | | | | | | | |
| A1 | Undertake staff feedback sessions/survey on each ward (whats worked, what hasn't, why) | Gill Staton | 26/06/2017 | 30/06/2017 | 4 | | **1 Not yet commenced** |
| A2 | Undertake a review of each medical ward at LRI highlighting the strengths and weaknesses with R2G/SAFER implementation | Gill Staton | 19/06/2017 | 11/07/2017 | 22 | | **1 Not yet commenced** |
| A3 | Review of performance data and staff feedback at ESM CMG Board for agreement of next steps | Gill Staton | 19/07/2017 | 19/07/2017 | 0 | | **1 Not yet commenced** |
| **B. Refocus the implementation of Red to Green and SAFER as a priority on the Medicine wards at LRI systematically tackling the top 3 delays** | | | | | | | |
| B1 | Establish league table of LRI medical wards against the key standard to add to the weekly data pack - award to top ward each month | Darryl Davison | 05/06/2017 | 09/06/2017 | 4 | | **5 Complete** |
| B2 | Create daily snapshot report of top internal delays | Gill Staton | 05/06/2017 | 09/06/2017 | 4 | | **5 Complete** |
| B3 | Create weekly trend analysis of top 3 internal delays | Darryl Davison | 19/06/2017 | 23/06/2017 | 4 | | **1 Not yet commenced** |
| B4 | Imaging trend report to be developed that shows % of scans completed witin 24 hours for medicine by ward | Matt Archer | 19/06/2017 | 23/06/2017 | 4 | | **4 On Track** |
| B5 | Weekly meetings to commence with internal services who are identified as a frequent top 3 delays for medicine wards working with them to reduce response times to an agreed level (likely to be 24 hours) | Simon Barton | 10/07/2017 | 04/08/2017 | 25 | | **14 Not yet commenced** |
| B6 | CMG to lead 4 weekly meetings with 4 lowest wards on R2G/SAFER league table on key support those wards may need to drive improvement | Raman Chhoker/Sue Burton/Ian Lawrence | 10/07/2017 | 04/08/2017 | 25 | This should be an ongoing rolling action | **15 Not yet commenced** |
| B7 | Sign off and agreement of the inter-professional standards policy for specialty and services to the LRI Medicine wards (such as imaging, specialty in-reach etc) | Matt Metcalfe/Julie Dixon | | | | Action dates to be agreed in meeting with MM scheduled for 19/6/17 | **16 Not yet commenced** |
| B8 | Ensure there is an understanding on each ward with regard to the weekly trend charts for those wards | Gill Staton/Darryl Davison | 10/07/2017 | 04/08/2017 | 25 | | **16 Not yet commenced** |
| **C. Rigourous implementation of Red to Green within Cardiology & Respiratory at Glenfield** | | | | | | | |
| C1 | Roll out of R2G at Glenfield to take place | Gill Staton | 03/07/2017 | 03/07/2017 | 0 | | **4 On Track** |
| C2 | Communication meetings to take place with Clinical teams within the target specialties at GH (what is R2G, why are we doing it etc?) | Louise Moran | 01/06/2017 | 30/06/2017 | 29 | | **4 On Track** |
| C3 | 4 week plan to be in place showing the key actions in run up to launch | Gill Staton | 05/06/2017 | 09/06/2017 | 4 | | **5 Complete** |
| C4 | Executive Director support to 0900 Board Rounds and 1300 Huddles to be in place for the week | Simon Barton | 12/06/2017 | 16/06/2017 | 4 | | **4 On Track** |
| C5 | Ward data packs to be in place showing the current performance against R2G/SAFER metrics | Darryl Davison | 05/06/2017 | 09/06/2017 | 4 | | **5 Complete** |
| C6 | Communications to take place at EPB with Executives supporting GH roll out (what is R2G, expectations, process for the week) | Gill Staton | 27/06/2017 | 27/06/2017 | 0 | | **21 Not yet commenced** |
| C7 | Escalation system for the daily delays to be in place at GH for target wards (teleconference) | Sue Mason | | | 0 | This has been in place for some months and has been observed by ECIP as good practice | **5 Complete** |
| C8 | Create daily snapshot report of top internal delays | Gill Staton | 03/07/2017 | 07/07/2017 | 4 | | **23 Not yet commenced** |
| C9 | Create weekly trend analysis of top 3 internal delays | Darryl Davison | 10/07/2017 | 14/07/2017 | 4 | | **24 Not yet commenced** |
| C10 | Establish league table of GH Cardiology & Respiratory wards against the key standards to be added to the weekly data pack | Darryl Davison | 19/06/2017 | 23/07/2017 | 34 | | **25 Not yet commenced** |
| **E. TTO Project with an objective of ensuring 80% of TTOs are competed the day prior to discharge and reduces the lead time in dispensary** | | | | | | | |
| D1 | Mapping and timings of current ward and dispensary TTO processes alogn with stakeholder feedback sessions | Mark Taylor | 01/05/2017 | 31/05/2017 | 30 | | **5 Complete** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D2 | Trialling revised TTO process in Main Dispensary | Mark Taylor | 08/06/2017 | 23/06/2017 | 15 | | **4 On Track** |
| D3 | Trialling new TTO process within identified Board round as part of red to Green processes | Mark Taylor | 01/07/2017 | 31/07/2017 | 30 | | **21 Not yet commenced** |
| **F. Patient Discharge Transport Project to be in place to align demand and capacity (and deal with its variation)** | | | | | | | |
| E1 | New project - project scoping to be undertaken with internal and external partners | | 12/06/2017 | 03/07/2017 | 21 | | **4 On Track** |

## Increasing physical bed capacity to meet demand and reduce occupancy

Return to AEDB Action Plan

| Number | Task | Responsible | Start Date | End Date | No. of Days | Progress Update | RAG Status |
|---|---|---|---|---|---|---|---|
| | Ward 21 at LRI to remain open after winter 2016/17 | Ian Lawrence/Sue Burton | 01/04/2017 | 01/05/2017 | 30 | Ongoing baseline ward for ESM | **5 Complete** |
| | Budget to be allocated to W21 to put it into ESM baseline | Paul Traynor | 01/06/2017 | 30/06/2017 | 29 | Executive team 20/6/17 | **4 On Track** |
| | EDU staffing model to be analysed to except escalation beds increase of extra bay | Simon Barton/Julie Smith/Kerry Johnston | 01/07/2017 | 31/07/2017 | 30 | Beds are being used as escalation when EDU staffing will allow but it requires to be more planned | **4 On Track** |
| | Capital feasibility study to be undertaken for LRI infill beds in Medicine (6) | Debra Green | 01/05/2017 | 31/05/2017 | 30 | | **5 Complete** |
| | Capital funding to be approved for LRI infill beds at LRI | Paul Traynor | 01/06/2017 | 30/06/2017 | 29 | Executive team 20/6/17 | **4 On Track** |
| | Staffing model to be agreed for LRI in-fill beds | Simon Barton/Julie Smith/Sue Burton | 01/06/2017 | 30/06/2017 | 29 | | **4 On Track** |
| | Assessment of options for modular ward at GH | Leigh Gates | 01/05/2017 | 16/06/2017 | 46 | Its is possible to put a modeular ward at GH but the capital costs are prohibitive in 17/18 - this will be planned for 18/19 | **5 Complete** |
| | Development of the Glenfield Ward 23 annex scheme | Leigh Gates | 01/06/2017 | 31/07/2017 | 60 | | **4 On Track** |
| | Capital funding to be approved for ward 23 GH Annex scheme | Paul Traynor | 01/06/2017 | 30/06/2017 | 29 | Executive team 20/6/17 | **4 On Track** |
| | Staffing model to be agreed for W23 Annex scheme | Simon Barton/Julie Smith/Sue Mason | 01/06/2017 | 31/07/2017 | 60 | | **4 On Track** |
| | Staffing adverts | Julie Smith | | | 0 | Rolling action for the Trust anyway | **4 On Track** |
| | LGH Ward swap - Elective Orthopaedics & General Surgery | Julie Smith/George Kenney/Nicola Grant | 01/06/2017 | 31/07/2017 | 60 | Staffing is a key risk within CHUGGs for this scheme and they are not currently able to staff these extra beds | **2 Significant Delay - unlikely to be completed as planned** |
| | Development of plan for Paediatric staffing for winter 2017/18 | Simon Barton/Julie Smith/Hiliary Killer | 01/07/2017 | 31/07/2017 | 30 | | **13 Not yet commenced** |

# MRET and Readmissions Investment 2017/2018 – Review of Schemes

## 1.0 Introduction

This paper outlines a proposed process for reviewing investment of the marginal rate emergency threshold (MRET) and readmission funds for 2017/2018.

The A&E Delivery Board has been asked to review LLR MRET reinvestment schemes to ensure that the funding is supporting an effective and evidence based range of schemes, in line with national guidance and responding to local conditions. The reinvestment should support system strategy for urgent care and therefore AEDB and stakeholder support for the range of proposed schemes is sought.

## 2.0 Background

The marginal rate rule for emergency admissions was introduced in 2010/11 in response to concerns about growth in the volume of patients being admitted to hospital as emergencies. The rule sets a baseline value tor income from emergency admissions for each provider. For emergency admission above this agreed baseline, the provider now receives 70% of the normal tariff.

The rule is intended to give acute providers an incentive to collaborate with other parties in the local health economy to manage demand for avoidable emergency admission and to treat patients in the most appropriate settings.

From 2013/14 commissioners have been required to invest the 30% retained funds in controlling demand for emergency care. Guidance from Monitor and NHS England requires that the retained funds should be reinvested transparently and effectively in appropriate demand management and improved discharge schemes, to be agreed locally. Schemes should have evidence for impact on reducing emergency admissions, accelerating discharge and recovery, or prevent re-admissions.

Readmission investment should support commissioners to provide the most appropriate care for patients when they leave hospital. Planning may include coordinating with the patient's family and GP regarding medication or arranging post-discharge equipment, rehabilitation or re-ablement with a community or social care provider.

## 3.0 Proposed Process for Reviewing 16/17 MRET and Readmissions Investment

### 3.1 Value of MRET and Readmissions adjustment

The tables below show the value of the MRET and readmissions adjustments in 2016/2017, based on the 30% marginal rate deduction, and the proposed values for 2017/2018, by CCG. The total value in 2016/2017 was £10.888m. The calculated value increases to £11.6m, due to increases in paediatric admissions, although this value is still to be signed off contractually between the CCGs and UHL.

| Scheme Description | Acute/Community Provider | NHS/Non NHS | Provider Name | East | West | City |
|---|---|---|---|---|---|---|
| | | | | 16/17 MRET & Readmissions Investment (£) | 16/17 MRET & Readmissions Investment (£) | 16/17 MRET & Readmissions Investment (£) |
| Intensive Community Support (BCF) | Community | NHS | LPT | 891,750 | 951,000 | 883,614 |
| Step Down Additional Therapy Services (BCF) | Community | NHS | LPT | 229,000 | 300,000 | - |
| Quality in care homes (BCF East) | Community | NON NHS | LA | 217,400 | - | 120,000 |
| Integrated Health & Care Crisis Response (ICRS) (BCF) | Community | NHS | LPT | 415,000 | 459,800 | 1,048,321 |
| Frail elderly (BCF) | Community | NHS | LPT | 159,000 | 300,000 | - |
| 7 day primary care service (BCF) | Community | NON NHS | GP's/SSAFA | 497,403 | 1,278,500 | - |
| Step Down Beds - CHC & Non Weight Bearing | Community | NON NHS | Nursing Homes - Various | 283,820 | 489,000 | 150,000 |
| Care Home Nursing Support (BCF East) | Community | NHS | LPT | 54,000 | - | - |
| Mental Health Triage Car | Community | NHS | LPT | 76,000 | 85,000 | 90,000 |
| Mental Health Discharge (BCF) | Community | NON NHS | LA | 117,300 | 154,300 | 42,462 |
| Frail older persons advice and liaison service (FOPALS) | Community | NHS | LPT | 48,376 | - | - |
| Proactive Care (BCF) | Community | NHS | LPT | 569,000 | 540,000 | - |
| End of Life (Pilot Extension) | Community | Non NHS | GP's | 325,302 | 369,000 | 41,667 |
| Pulmonary Rehab Funding | Community | NHS | LPT | 116,650 | 95,000 | 203,000 |
| LRI Urgent Care Centre | Acute | NHS | UHL | 1,045,061 | 834,800 | - |
| Parkinsons Nurse | Acute | NHS | UHL | 21,317 | - | - |
| Community Equipment | Community | NON NHS | LA | 12,000 | 100,000 | 19,995 |
| Dementia Nursing Care | Community | NHS | LPT | 62,000 | 33,400 | - |
| Assertive in reach (BCF County) | Community | NHS | LPT | 186,000 | 208,000 | 242,000 |
| Single point of access | Community | NHS | LPT | 208,000 | 240,000 | - |
| Primary Care Support >75's | Primary Care | NHS | GP's | 482,000 | 188,000 | 1,220,277 |
| Mental Health Triage Nurses | Community | NHS | LPT | 115,000 | 147,571 | 240,000 |
| Diabetes | Acute / Primary Care | NHS | UHL, GP's | 199,070 | 70,000 | 71,076 |
| Atrial Fibrilliation (Heart Failure) | Primary Care | NHS | GP's | 162,651 | - | - |
| Dementia | Community | NHS / Non NHS | Alzheimers Society | 33,400 | 33,400 | 36,000 |
| CVD & Rapid Access | Acute | NHS | UHL | - | - | 21,280 |
| Strengthening RIT - LPT CHS (BCF) | Community | NHS | LPT | - | - | 469,216 |
| Enhanced Night Nursing (BCF) | Community | NHS | LPT | - | - | 90,990 |
| Transforming End of Life and Care Plans | Community | Non NHS | GP's | - | - | 10,548 |
| Ambulatory Care admission avoidance GP team (BCF) | Community | Non NHS | SSAFA | - | - | 1,380,015 |
| Stroke Rehab | Community | NHS/Non NHS | LPT/GP's | - | - | 215,000 |
| Cardio-Vascular CBS | Community | Non-NHS | GP's | - | - | 45,150 |
| Cardio-Vascular Funding | Community | Non NHS | GP's | - | - | 127,000 |
| Chronic Kidney Disease/Renal Funding | Community | NHS | LPT | - | - | 103,000 |
| Care Homes Dietician | Community | NHS | LPT | - | - | 90,000 |
| Care Homes Pharmacist | Community | NHS | LCCCG | - | - | 90,000 |
| Hospital at Home | Community | Non NHS | RVS | - | - | 62,000 |
| Mental Health Facilitators | Mental Health | NHS | NH | - | - | 496,000 |
| Unscheduled Care (BCF) | Community | NHS | LPT | - | - | 232,025 |
| Mental Health Housing Enablement | Mental Health | Non-NHS | Voluntary provider | - | - | 40,440 |
| Stroke and Neurological Investment | Community/Acute | NHS | LPT/UHL | - | 174,400 | - |
| Chronic Kidney Disease | Acute | NHS | UHL | - | 35,000 | - |
| Loughborough Urgent Care Centre | Community | Non-NHS | DHU | - | 390,000 | - |
| | | | | | | |
| **TOTAL** | | | | **6,526,500** | **7,476,171** | **7,881,075** |

## 3.2 Current schemes and proposed process to review and agree 2017/2018 schemes

There is an existing range of schemes supporting admission avoidance and readmission prevention across LLR, funded by NHS commissioners as their response to the MRET guidance. The schemes were last reviewed in April

**UHL - EMERGENCY MARGINAL RATE & READMISSIONS**

**2016/17 OUTTURN**

| Commissoner | 08/09 Baseline £ (1617) | M12 1617 MRET Emergencies (1718) | **M12 1617 Readmissions Adjustment @ 20% (1718)** | M12 1617 Actual Net | M12 1617 Variance to Baseline | **M12 1617 MRET Adjustment @ 70%** |
|---|---|---|---|---|---|---|
| NHS EAST LEICESTERSHIRE AND RUTLAND CCG | 30,038,619 | 37,669,683 | (1,574,004) | 36,095,679 | 6,057,060 | (1,817,118) |
| NHS LEICESTER CITY CCG | 42,754,949 | 50,974,583 | (2,129,276) | 48,845,308 | 6,090,358 | (1,827,107) |
| NHS WEST LEICESTERSHIRE CCG | 30,207,085 | 38,649,353 | (1,439,862) | 37,209,491 | 7,002,406 | (2,100,722) |
| Grand Total UHL | 103,000,654 | 127,293,620 | **(5,143,142)** | 122,150,478 | 19,149,824 | **(5,744,947)** |

**2017/18 PAM (including assumptions for IR and ED Floor/CAU impact)**

| Commissoner | 08/09 Baseline £ (1718) | Plan MRET Emergencies (1718) | **Readmissions Adjustment @ 20% (1718)** | Actual Net | Variance to Baseline | **MRET Adjustment @ 70%** |
|---|---|---|---|---|---|---|
| NHS EAST LEICESTERSHIRE AND RUTLAND CCG | 31,205,230 | 39,489,803 | (1,659,751) | 37,830,052 | 6,624,822 | (1,987,447) |
| NHS LEICESTER CITY CCG | 44,510,189 | 52,972,489 | (2,211,883) | 50,760,606 | 6,250,416 | (1,875,125) |
| NHS WEST LEICESTERSHIRE CCG | 32,142,141 | 41,399,779 | (1,573,200) | 39,826,579 | 7,684,438 | (2,305,331) |
| Grand Total UHL | 107,857,560 | 133,862,071 | **(5,444,834)** | 128,417,237 | 20,559,677 | **(6,167,903)** |

2016. The majority of schemes are funded recurrently, and there is an assumption that they continue from one year into the next unless explicitly reviewed.

The total value of schemes identified in 16/17 exceeds the current MRET value in LLR, at £21.8m. It is therefore not expected that there will be any new cash resource released as a result of the review to allocate to new expenditure schemes.

For 2017/20189 it is proposed that the MRET and readmission schemes are matched to the value, so that the schemes which are judged to have the biggest impact on admission avoidance and preventing readmission, up to the value of the MRET and readmission adjustment, up to a value of £11.6m, are matched against the reinvestment pot. This does not mean that any ongoing services/schemes will be discontinued and the fuller list of schemes will be retained to illustrate the range of activity taking place in LLR which supports the urgent care system and admission avoidance agenda.

A table showing the list of schemes agreed in 2016/2017 is shown below. The table is being reviewed and refreshed to reflect known changes to services and commissioning plans in 2017/2018. This includes the recommissioning of some services as part of the Vanguard work in 2016/2017 and the creation of clinical navigation and 24/7 home visiting. This stage of the review is nearly completed and is being validated by CCG finance and commissioning leads.

A number of the above services are currently being reviewed, including ICS and the model of reablement discharge support (Pathway 3). The timeframe for these reviews is likely to take some time and should not hold up the overall review of MRET schemes. Where this is the case, this should be clearly stated in the final review, and the AEDB may want to agree a process to ensure it has involvement in discussing and approving any recommendations in relation to the future service model/funding of those services. For instance, business cases for Pathway 3 beds should be brought to the AEDB before final sign off by commissioners/BCF executives.

Criteria for reinvestment of MRET funding:

a. Meets national criteria guidance as described in section 2
b. Fits with local STP strategy/UEC improvement plan/other workstreams including Home First and Integrated Teams
c. Is considered to be value for money

The review of the reinvestments should report to the AEDB and be led by the LLR UEC team with the support of the LCCG contracting team, but should include wider stakeholders including UHL and LPT, CCG commissioning leads, integration leads, and the Home First workstream.

| Action | Date |
|---|---|
| Sign off refreshed investment table to reflect completed service redesign/commissioning changes already agreed within the STP. | Complete by 22nd May |
| Review of existing schemes against criteria for recurrent funding , other than schemes currently being reviewed under a separate process e.g. ICS, P3 | Complete by 5th June |
| Identification of any schemes to be removed or decommissioned | Complete by 5th June |
| Identification of any new schemes to be funded via MRET | Complete 12th June |
| Final report to AEDB | For consideration 21st June |

**4.0 Recommendation**

The AEDB is asked to approve the above process to review MRET reinvestment schemes.

UNIVERSITY HOSPITALS OF LEICESTER
TRUST BOARD 6 JULY 2017

# Emergency Floor Project: Monthly Update

Author: Lisa Gowan Sponsor: Paul Traynor **Trust Board paper H – appendix 5**

## EXECUTIVE SUMMARY

### Context

This scope of this paper is the operational commissioning and construction phase of Phase 2 of the Emergency Floor. Updates on the whole emergency care pathway, including performance, are included in other reports to the Board.

The development of the Emergency Floor continues, with phase 2 underway for delivery in Spring 2018. A revised governance structure is now in place, and work is underway with the clinical teams on the new ways of working and standard operating procedures.

A robust Benefits Realisation process, aligned to the full business case, has been developed. Engagement with the East Midlands Academic Health Science Network and the University of Loughborough to support evaluation against the benefits is ongoing.

The interim post project evaluation report will be considered by the Emergency Floor Project Board, and key recommendations incorporated into the work plan.

### Questions

1. Does the Board feel assured that there is a robust approach to delivery of Phase 2?

### Conclusion

The teams continue to adapt to the environment of the new Emergency Department, as phase one settles operationally. Phase two construction has now started and is on track for completion next year. The interim post project evaluation will support the teams to learn lessons from phase one, and share learning and best practice into phase two.

### Input Sought

The Trust Board is requested to note:

- Phase two of the emergency floor project is underway, with a revised governance structure.
- The benefits realisation process established to support the full Emergency Floor Business case.
- The work plan for Phase 2 will incorporate key lessons learned from Phase 1.

## For Reference

Edit as appropriate:

The following objectives were considered when preparing this report:

| | | |
|---|---|---|
| Safe, high quality, patient centred healthcare | | Yes |
| Effective, integrated emergency care | Yes | |
| Consistently meeting national access standards | Yes | |
| Integrated care in partnership with others | Yes | |
| Enhanced delivery in research, innovation & ed' | Yes | |
| A caring, professional, engaged workforce | Yes | |
| Clinically sustainable services with excellent facilities | | Yes |
| Financially sustainable NHS organisation | Yes | |
| Enabled by excellent IM&T | | Yes |

This matter relates to the following governance initiatives:

| | |
|---|---|
| Organisational Risk Register | No |
| Board Assurance Framework | Yes |

Related Patient and Public Involvement actions to be taken: Access and Way finding

Results of any Equality Impact Assessment relating to this matter: Completed

| | |
|---|---|
| Scheduled date for the next paper on this topic: | TBC |
| Executive Summaries should not exceed 1 page. | My paper does not comply |
| Papers should not exceed 7 pages. | My paper does not comply |

# Emergency Floor Project Update

## UPDATE FROM LAST MONTH

### Phase 1

1. Following the opening of phase 1 of the Emergency Floor Development on 26 April 2017, the operational team are adapting to their new environment. Work continues to refine the ways of working though review of the Standard Operating Procedures (SOPs), and working with ECIP to implement their recommendations following their visit on 15 May 2017.
2. The Estates and Facilities team continue to work closely with the contractor to ensure completion of outstanding building snags and overview of the defects programme.

### Access and Wayfinding

3. Given the fundamental change to the site, there continues to be some issues with access and wayfinding which need addressing. Concerns have been raised by patients and staff, not about the new signage, which has received positive feedback, but about access to Balmoral and the new ED.

4. Communications are creating a new plan to continue to get the message across about the new site layout. It will need continued support from all services (to ensure their letters have the appropriate directions), estates, volunteers and staff at the Royal as people get used to the new ways to access not only the new ED, but also Balmoral.

### Phase 2

5. Phase 2 building works started on 8 May 2017, and are on track for delivery in Spring 2018.
6. A revised Project Initiation Document (PID), including governance structure and terms of reference, for phase two has been prepared by the CMG for circulation to the new Board membership; the first Phase 2 meeting is scheduled to take place on 11 July. The clinical SRO for the project is Ian Lawrence, alongside Paul Traynor as executive SRO.
7. Project plan, with key milestones, has been drafted and will monitored by the Operational Delivery Group, chaired by the Emergency Care Head of Operations, which then reports to the Emergency Floor Project Board.
8. The operational planning of phase 2 has already begun, with clinical leads identified, and work is starting to take shape on the new ways of working across the emergency floor. An overarching Organisational Development plan is being progressed to support new ways of working.
9. A robust Benefits Realisation process, aligned to the full business case, has been developed. Engagement with the East Midlands Academic Health Science Network and the University of Loughborough to support evaluation against the benefits is ongoing.

**Acceleration of GPAU build**

10. When the new Emergency Department (ED) opened on 26 April, the GP Assessment Unit (GPAU) relocated to majors, utilising 8 cubicles within the ED footprint, prior to the move to new space in phase 2. Due to ED operational pressures and the need for additional space in majors, GPAU moved into the previously allocated eye casualty and primary care rooms in the Blue Zone in early May. This space is far from ideal, and restricts the number of patients that GPAU can see in one day. It also prevents eye casualty moving into the space until next year.
11. At the Emergency Floor Project Board on 15 May, there was a discussion on the current GPAU location, and the possibility of accelerating the move of GPAU to its final home within phase 2 during 2017.
12. An options appraisal and associated cost of accelerating the GPAU construction element of the phase 2 scheme was presented to the Executive Strategy Board (ESB).
13. ESB agreed in principle to the proposal to accelerate the plans for GPAU, at a cost of £100k.
14. A meeting between MSS and Emergency Care colleagues will be held w/c 3 July to make the final decision of the location of GPAU and eye casualty.
15. If GPAU acceleration is approved, the construction timeline is 16 weeks. Therefore completion would be by mid-October.

**Interim post project evaluation**

16. At their meeting on 24 May, the Audit Committee approved the proposal to start the interim post project evaluation process. The terms of reference for this evaluation were agreed, and diagnostic work with key representatives from across the project began on 12 June.

17. The timelines for the evaluation are as follows:
    - 29 June - Initial draft report to be issued to the Trust
    - 29 June - Meeting with PwC and UHL to review report
    - 30 June - Final draft report issued for circulation to Audit Committee
    - 6 July - Audit Committee receives report
    - 7 July - Audit committee discussions reflected in report
    - 14 July - Final report issued

18. The final report will be considered by the Emergency Floor Project Board, and key recommendations incorporated into the work plan.

**RECOMMENDATIONS**

The Trust Board is requested to note:

- Phase two of the emergency floor project is underway, with a revised governance structure.
- The benefits realisation process established to support the full Emergency Floor Business case.
- The work plan for Phase 2 will incorporate key lessons learned from Phase 1.