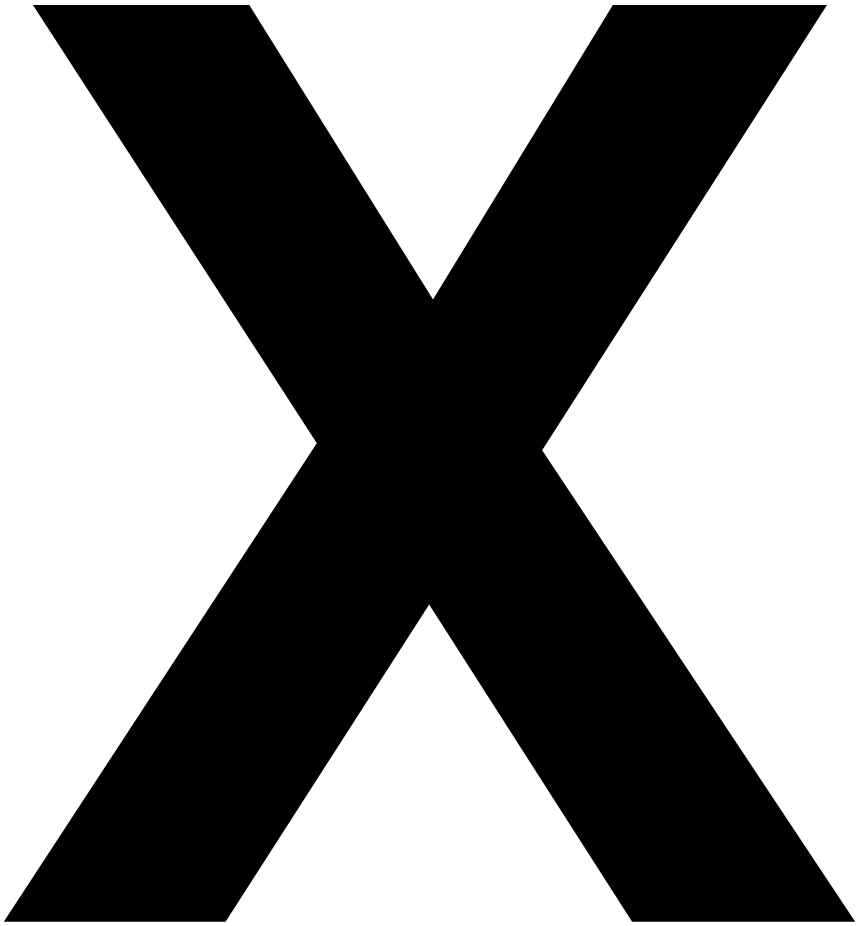


Trust Board paper X

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**26 June 2014**
CQC regulation:	**As applicable**

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

Purpose of the Report:
To provide an overview on ED performance.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in May was 83.07%
- Performance month to date (17 June 2014) was 88.90%
- Performance for June started at a low level but has improved in the last week. This improvement is partly due to:
- Recent improved discharge rate from LRI medical wards
- Some days with lower than usual admissions
- Improved position on Monday morning.
- The current level of performance remains unacceptable

Recommendations:
The Trust Board is invited to receive and note this report.

Previously considered at another UHL corporate Committee N/A

Strategic Risk Register Yes	**Performance KPIs year to date** Please see report

Resource Implications (eg Financial, HR)
Yes

Assurance Implications
The 95% (4hr) target and ED quality indicators.

Patient and Public Involvement (PPI) Implications
Impact on patient experience where long waiting times are experienced

Equality Impact
Considered and no implications

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

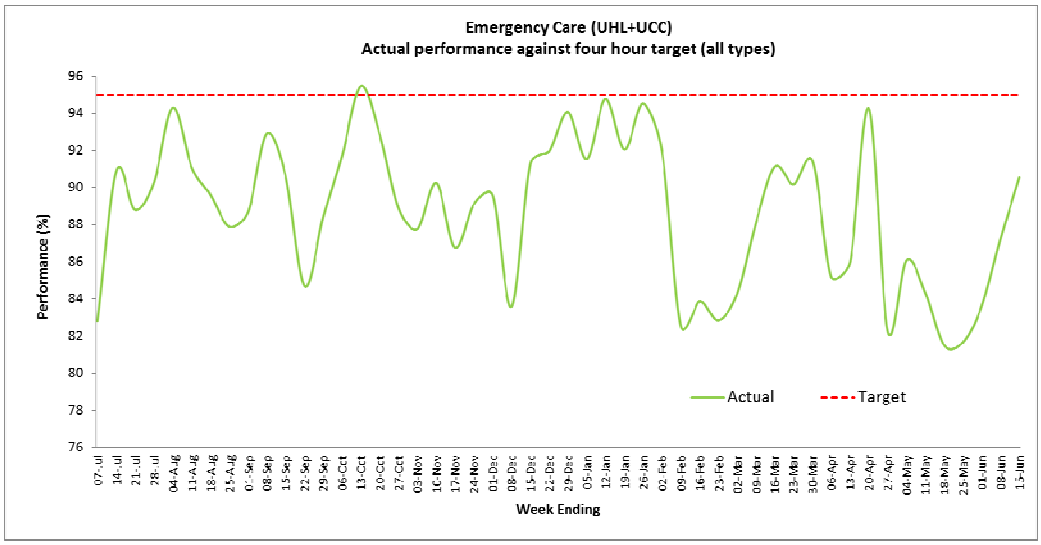
REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**26 June 2014**

Introduction

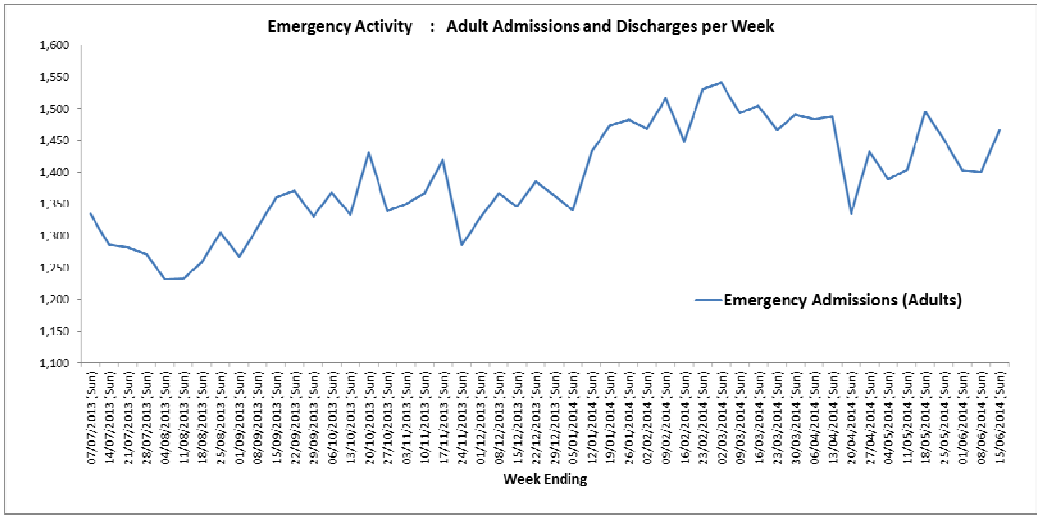
Performance in May 2014 was 83.4%. Emergency admissions remained at a similar level to April. UHL continued to struggle with high numbers of emergency admissions. The discharge process remained problematic with an impact on the emergency access performance. This has improved in mid-June with subsequent improvements in performance.

Performance overview

Performance in May was poor across the month (graph one). There were no days of performance above 95% in May and high levels of admissions throughout the month (graph two).



(graph one)



(graph two)

Reasons for deterioration in performance

High admissions – Admissions remain as high as previous months.
Internal process - Internal processes in May remain a concern. This is a key feature and is where Dr Ian Sturgess is focussing most of his work. This is the central feature of the updated plan (attached) and the focus of the new Emergency Quality Steering group.
Delayed transfers of care – DTOCs remain high for the majority of the month.

Key actions:

- Reduction in the number of GP patients being admitted – work continues with the UCWG regarding improving this position
- Reduction in the number of admissions – work continues with the UCC and EMAS regarding avoiding patients coming to ED as a first point of contact with healthcare
- Move towards seven day services and use of 'super weekends'. Discharge rate is now consistently higher than before the super weekends
- A revised action plan with trajectory for improvement has been submitted to the TDA (attached)
- The new Emergency Quality Steering Group will replace the Emergency Care Action Team. Its focus will be to oversee activities to improve the Emergency Care Pathway and to act as an escalation point and to give guidance over issues that cannot be resolved in the 4 working groups that will report to it. (Organisation, Front Door, Base Wards and Frailty)

Recommendations
The board are asked to:

- Note the contents of the report and action plan
- Acknowledge the reasons for why performance continues to be poor
- Support the actions being taken to improve performance.
- Support the formation of the Emergency Quality Steering Group

DRAFT AT 19-6-14 SUBJECT TO FINALISATION & APPROVALS

University Hospitals of Leicester NHS Trust

EMERGENCY PERFORMANCE IMPROVEMENT PLAN

Action Note	Action	Lead	By When	Progress Update	RAG Status*
6 June 2014					
1.	Agree new focus for Emergency Care Action Team to understand, measure and manage the emergency pathway process	Richard Mitchell (RM	27th June	New programme structure being reviewed at ECAT 20/6/14. To be implemented for July 4th. Focus on key areas of emergency pathways with clinical leadership embedded within workstream groups.	
2.	Agree plan with CCG colleagues to reduce the volume of attendances in ED	(RM)	Plan to be agreed by the 31st of July 2014	Working with Ian Sturgess (IS) and UCWG to set targets There is a risk that this will not happen if the QUIPP plans fail to deliver the expected outcomes	
3.	Agree plan with CCG colleagues to increase the proportion of patients who are treated in the UCC	RM	Plan to be agreed by the 31st of July 2014	Working with IS and UCWG with TDA support to set targets	
4.	Stop specialty 'ping pong' - ED are getting repeatedly bounced between specialties – simple rule – **when ED refers the answer is 'yes'** – if that team assess the patient (in ED if physiologically unstable or in their assessment area if stable) and feel it should be under another specialty, they refer on.	Kevin Harris (KH)	25th June 2014	Pathways being written to ensure that areas with high likelihood of 'ping pong' have clear processes that can be adhered to	

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

DRAFT AT 19-6-14 SUBJECT TO FINALISATION & APPROVALS

Action Note	Action	Lead	By When	Progress Update	RAG Status*
5.	Stop unnecessary specialty referral routing through ED when they should be direct to specialty – **the only patients who should go to ED from a GP referral are those that are or become unstable.**	KH	30th June 2014		
6.	Improve specialty response times to ED – 30 mins to arrive to assess in ED if unstable or probable direct home or 30 mins to leave Department	KH	30th June 2014	KPIs agreed. Need to agree escalation process when the response times are above 30 minutes. *Risk of not being able to obtain appropriate staffing to support this*	
7.	Standardise process and performance manage teams to improve floor management in ED.	Ben Teasdale (BT)	Review 25th July 2014	Weekly performance meetings are being instigated with ED team, IS and Julie Dixon Use mentorship/training to improve performance amongst ED leaders (consultants and senior nurses). (Build on work undertaken by Mr Dingle)	
8.	Increase the number of patients pulled from AMU by speciality medical teams	Catherine Free (CF)	25th July	For all appropriate medical specialities to have identified and 'pulled' 2 patients from AMU by 10:00 each morning *Risk of delays in discharge reducing the ability of specialty teams to pull to their own bed base*	
9.	Standardise process and performance manage teams in assessment units.	CF	Review 25th July 2014	The cycle time for medical assessment and definitive plan to be managed through key metrics and evidence of performance at the new ECAT/Emergency Process group	

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Action Note	Action	Lead	By When	Progress Update	RAG Status*
10.	RAT in assessment area – variable. **Set 15 min processing time, senior led** (Consultant or ST5 and above – training opportunity for more junior docs to shadow seniors) with support of Band 5 nurse +/- generic worker with phlebotomy, ECG etc skills	BT	Review 25th July 2014	Weekly performance meetings are being instigated with ED team, IS and Julie Dixon. RAT process to be monitored live by the site management team. Suitable level of support and challenge to be in place when performance is below KPI *Risk of not being able to obtain appropriate staffing to support this*	
11.	Review the opportunity and benefit of Acute Physician and Acute Geriatrician at front door during key demand period 10:00 hrs until 20:00 hrs seeing the query admit and query discharge patients	CF	27th June 2014	Likely impact to be up to 3 admissions per day avoided for geriatrician (experience from other hospitals) *Risk of not being able to obtain appropriate staffing to support this* *Risk of the cost impact of delivering this throughout the winter*	
12.	Seven day analysis of the breach standards to understand causes of breaches.	Jane Edyvean (JE)	Complete	From national standards checklist • Seven day analysis using IT records is undertaken on a weekly basis • Daily analysis using patient records on days where there were 30 or fewer breaches implemented from the beginning of May • As performance improves, the number of days when full notes analysis is completed will increase. • Breach analysis to be part of daily learning process. High level themes to be addressed at new ECAT	

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DRAFT AT 19-6-14 SUBJECT TO FINALISATION & APPROVALS

Action Note	Action	Lead	By When	Progress Update	RAG Status*
13.	100% minor case compliance in ED	BT	Reviewed weekly	From national standards checklist • Exception reports to UCWG – increased emphasis on non-admitted breaches – action and monitoring	
14.	Prompt booking of patients - Review potential mechanisms to speed handover between from both EMAS and UCC to release staff	BT	Reviewed weekly	From national standards checklist Discuss option to extend handover times when there are higher ambulance attendances at ED e.g. greater than 15 in an hour. *Risk of the fines assigned to this area leading to reduced ability to manage* *Also risk due to high volume of ambulance attendances in short period of time (up to 25 in an hour) leading to an inability to manage this workload in the confined space available.*	

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DRAFT AT 19-6-14 SUBJECT TO FINALISATION & APPROVALS

Action Note	Action	Lead	By When	Progress Update	RAG Status*
15.	Improve access to diagnostics in line with national standard 'waits due to delays in pathology or radiology should be rare. There should be 7 day access to diagnostics for A&E, EAU and all wards including admission avoidance schemes. Requests from A&E should be prioritised for immediate response. There should be escalation processes in place if delays are occurring.' **Confirm what the key performance indicators are for access times.**	Andrew Furlong (AF)	Reviewed weekly	From national standards checklist • Imaging has scoped compliance with 7 day access for each of the key areas – A&E, AMU's, SAU's and base wards across each site against the existing internal UHL standards and the Keogh 7 day service standards. This will now form part of standard report for imaging. • All areas have 7 day access to diagnostic imaging and ED patients are prioritised as per the standard. • An action plan with proposed work streams for delivery of the Keogh 7 day clinical standard for assessment units and base wards for diagnostic imaging will be presented to ECAT on 22 May 2014. *Risk of not being able to obtain appropriate staffing to support this* *Risk of the cost impact of delivering this throughout the winter*	

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Action Note	Action	Lead	By When	Progress Update	RAG Status*
16.	Time to medical assessment in line with national standard 'Delays due to first medical assessment should be rare. **Patients should be seen by a clinician within one hour and there should be appropriate escalation where this is not delivered**. This should be monitored daily with the breach analysis.'	BT	Reviewed weekly	From national standards checklist •Limit admitting rights to Consultant / senior decision makers only •Review of admissions rates by clinician **Next Steps** •Audit of current performance of standard •Report back to UCWG with recommendations *Risk of not being able to obtain appropriate staffing to support this* *Risk of the cost impact of delivering this throughout the winter*	
17.	Agree specific process with each speciality to improve medical in-reach into AMU.	CF	Review progress on a monthly basis	Will be picked up through new emergency performance steering group.	
18.	AMU assessment and decision timelines are not being performance managed. Set **'door to doctor' of 30 minutes and 'door to consultant' of 4 hours (80% of the time) for ED referrals.** For GP referrals – rapid assessment by Consultant - at least 30-50% of GP referrals can have a zero LOS.	CF	Review progress on a monthly basis	Need to understand reasons for and agree process for monitoring and supporting performance when these standards are not delivered	

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DRAFT AT 19-6-14 SUBJECT TO FINALISATION & APPROVALS

Action Note	Action	Lead	By When	Progress Update	RAG Status*
19.	Deliver an improved consultant triage service. Confirm what the key metrics are for the service. The implementation plan requires: • Appointment of 4 ortho-geriatricians and 3 acute physicians – (these jobs are out to advert) • Revision of existing consultant job plans which will include daily consultant ward round and increased weekend presence in support of emergency flow– formal notification has commenced and job plan review meetings are scheduled for June 2014 • General Surgical triage service – the CMG is developing a plan to pilot but a definitive service will require new substantive appointments and job plan review for existing consultants.	AF	Reviewed weekly	From national standards checklist *Risk of not being able to obtain appropriate staffing to support this*	
20.	Implement one stop ward rounds – this is a ward round where EDD and CCD are re-enforced to everyone, where actions required are carried out immediately eg requests, discharge summary, TTOs etc.	CF	31st July 2014		
21.	Implement 'assertive board rounding' and follow up with observation and feedback and a peer to peer process	CF	Review 18th July 2014	Agreed that there will be shadowing of ward 38 board round as that is an example of best practice from other consultants	

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Action Note	Action	Lead	By When	Progress Update	RAG Status*
22.	Ward referrals to other specialties for advice – variable response times – **standardise to <4 hours if non-urgent and <1 hour if urgent and at an appropriately senior level** – default is Consultant.	KH	Review 25th July 2014		
23.	Construct of the Consultant clinical decision – EDD and CCD not consistently being done – ie an end to end case management plan which is then assertively delivered.	CF	Complete 31st July 2014	KPIs for assessment times in AMU agreed with acute physicians. Monitoring of performance and reporting back to clinical teams to be fully implemented by 31st July	
24.	Improve bed availability in line with national standard	Julie Dixon (JD)	Review 25th July 2014	*Risk of failure to decrease DTOCs leading to increased bed occupancy and lack of bed availability.* *Risk of ongoing re-beds due to failure to take patient home on PTL*	

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Action Note	Action	Lead	By When	Progress Update	RAG Status*
25.	Senior medical review in line with national standard 'Senior medical review is critical to ensure the day's discharges are made; a particular day's discharges will need to be preceded by a senior medical review early the following morning. Unless this happens, there will be insufficient beds made available during the morning to meet that day's demands. Daily senior review rounds and during periods of peak demand twice daily senior review ward rounds should take place.'	KH	Review end of July 2014	• Match of required ward rounds to consultant job plans • Recruitment of sufficient acute medicine and geriatric consultants to move towards 7 day consultant working on base medical and elderly wards and extension of EFU hours • Review of effectiveness of ward rounds • All medical patients in AMU or ED to be seen by Acute Physician before the evening Acute Physician leaves. *Risk of not being able to obtain appropriate staffing to support this*	
26.	Agree process for morning discharge rate in line with national standard	JD	Review progress on a weekly basis	• Learning from acute trusts identified as already hitting the 70% target • Confirmation every night of the patients suitable for discharges the next morning • Confirmation every day at 0830 of the patients who will be discharged before 1100 Confirmation every day at 1100 of the patients who will be discharged before 1300 • Weekly review of ward by ward compliance with 70% target	

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DRAFT AT 19-6-14 SUBJECT TO FINALISATION & APPROVALS

Action Note	Action	Lead	By When	Progress Update	RAG Status*
27.	Improve use of discharge lounge in line with national standard	JD	Review progress on a weekly basis	Further audit to be undertaken to audit against best practise and improve on operational performance at LRI *Risk that improved performance will increase discharges on the day leading to less patients available the following day for early discharge*	
28.	Standardise site meetings	JD	Immediately and continuously monitored		
29.	Agree with CCGs and LPT a plan to reduce DTOCs down to 3.5% as a minimum	RM	Review progress on monthly basis	Working with IS and UCWG to set targets *Risk of failure to decrease DTOCs leading to increased bed occupancy and lack of bed availability.* *Risk of ongoing re-beds due to failure to take patient home on PTL*	
30.	Begin process of creating a 'social movement' to back the change – similar to 'NHS Change day'	IS	25th of June 2014	Will work with Damian Rolland on this	
31.	Review key performance indicators to monitor performance across LLR health economy	IS	20th June 2014		
32.	Review ED Medical staffing to ensure that resources (processing power) are best matched to demand	IS	20th July 2014		
33.	Review working protocols with the UCC to ensure the most efficient possible patient pathway and monitor compliance with KPIs	JD	31st July 2014		

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A&E Performance Diagnostic and Recovery Action Plan

Submission Details

TDA area name	Midlands & East
Trust Name (please choose from drop down list)	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
Trust Contact Number	0116 258 5672
Trust Contact Email	phil.walmsley@uhl-tr.nhs.uk
Date of Submission	17th June
Trust Chief Executive signature:	
Return To (email address):-	TDA.MidlandsEast@nhs.net return by 17th June 2014
Queries should be addressed to:-	deborah.poxon@nhs.net

TDA Area Director of Delivery & Development:
Midlands & East

Dale Bywater (dale.bywater@nhs.net)

Midlands & East Current Performance, agreed delivery dates and trajectory

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

2013/14 A&E Performance

Trust	Trust Code	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	YE 2013/14
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	RWE	85.31%	89.26%	90.24%	89.07%	88.42%

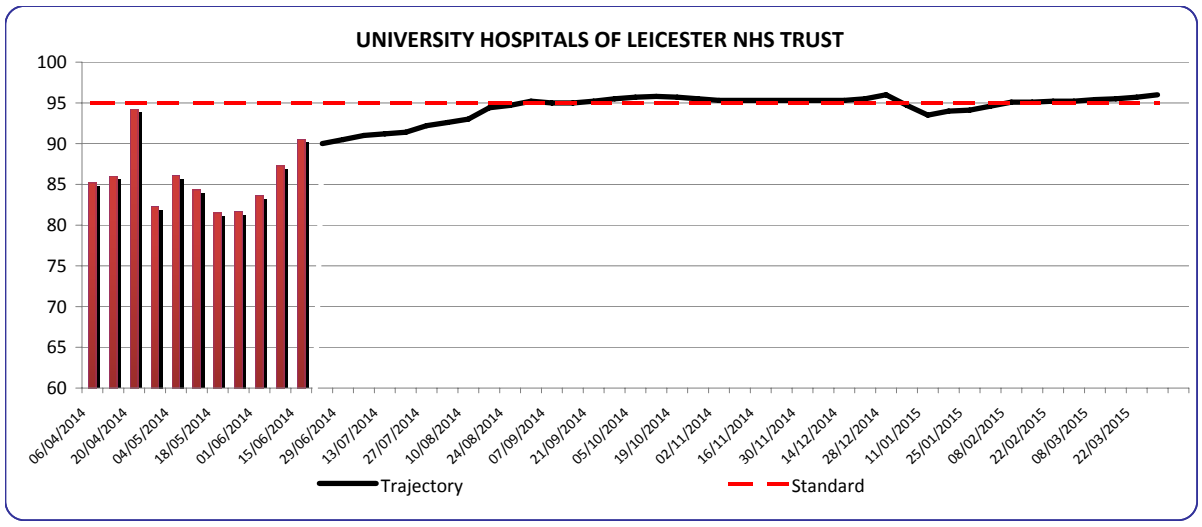
2014/15 A&E Recovery Trajectory

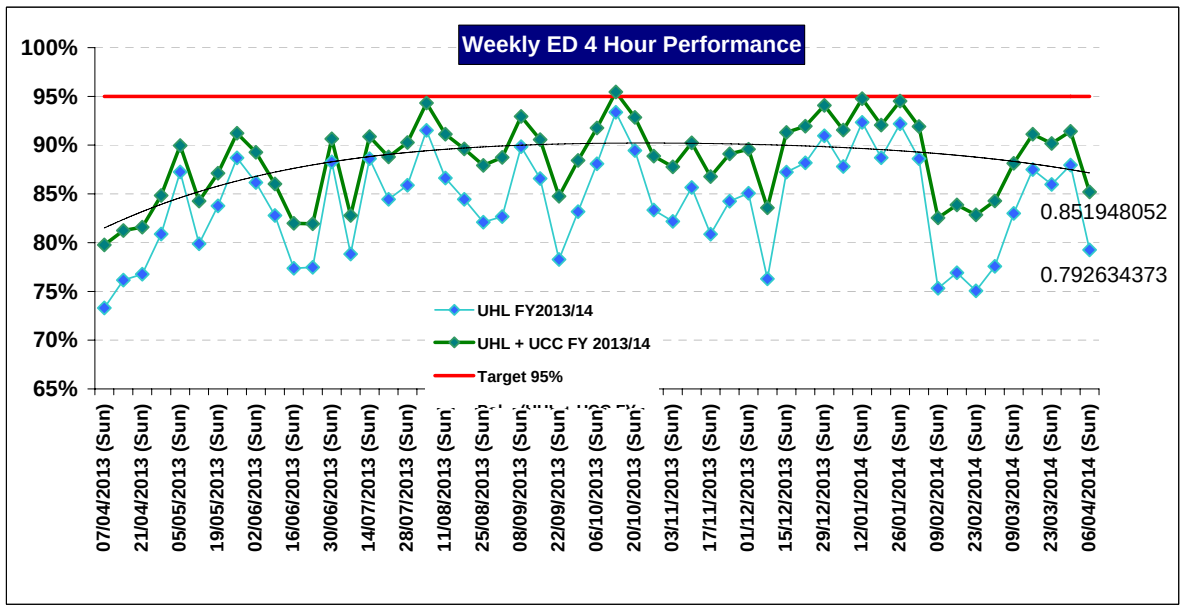
Please populate the highlighted (blue) section below with your proposed recovery trajectory

Week Ending	Trajectory	Actual Performance	Standard
06/04/2014		85.19	95.00
13/04/2014		86.02	95.00
20/04/2014		94.24	95.00
27/04/2014		82.28	95.00
04/05/2014		86.09	95.00
11/05/2014		84.33	95.00
18/05/2014		81.50	95.00
25/05/2014		81.68	95.00
01/06/2014		83.62	95.00
08/06/2014		87.28	95.00
15/06/2014		90.53	95.00
22/06/2014	90.00		95.00
29/06/2014	90.50		95.00
06/07/2014	91.00		95.00
13/07/2014	91.20		95.00
20/07/2014	91.40		95.00
27/07/2014	92.20		95.00
03/08/2014	92.60		95.00
10/08/2014	93.00		95.00
17/08/2014	94.40		95.00
24/08/2014	94.70		95.00
31/08/2014	95.20		95.00
07/09/2014	95.00		95.00
14/09/2014	95.00		95.00
21/09/2014	95.20		95.00
28/09/2014	95.50		95.00
05/10/2014	95.70		95.00
12/10/2014	95.80		95.00
19/10/2014	95.70		95.00
26/10/2014	95.50		95.00
02/11/2014	95.30		95.00
09/11/2014	95.30		95.00
16/11/2014	95.30		95.00
23/11/2014	95.30		95.00
30/11/2014	95.30		95.00
07/12/2014	95.30		95.00
14/12/2014	95.30		95.00
21/12/2014	95.50		95.00
28/12/2014	96.00		95.00
04/01/2015	94.70		95.00
11/01/2015	93.50		95.00
18/01/2015	94.00		95.00
25/01/2015	94.10		95.00
01/02/2015	94.60		95.00
08/02/2015	95.10		95.00
15/02/2015	95.10		95.00
22/02/2015	95.20		95.00
01/03/2015	95.20		95.00
08/03/2015	95.40		95.00
15/03/2015	95.50		95.00
22/03/2015	95.70		95.00
29/03/2015	96.00		95.00

Please complete the highlighted sections (blue) below with your forecasted quarterly positions for 2014/15

Q1 2014/15		Q2 2014/15		Q3 2014/15		Q4 2014/15	
Forecast	Actual	Forecast	Actual	Forecast	Actual	Forecast	Actual
	85.70	93.50		95.10		95.00	





Performance Diagnostic and Recovery plan information

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Diagnostic

Diagnostic	Can you explain what the specific reasons are for the Trusts' A&E Q1 14/15 underperformance?	The main issue remains access to acute medical beds. Work is being done to improve flow through these beds and out in to the community. Dr Ian Sturgess from ECIST is working with us for 6 months to improve patient flow. Work is being done to pull discharges forward in the day as well as to speed up the time to a definitive medical decision in ED and AMU.
	Could you please provide details and data on : * What is the change in A&E attendees (in-year and yr-on-yr)? * Actual 14/15 attendees vs. plan/outturn for 2013/14. * Emergency Admissions 14/15 vs. plan/outturn for 2013/14. * What is change in Non-elective activity (in-year and yr-on-yr)? * Has your A&E conversion rate changed and what is it (in-year and yr-on-yr)? * Are there any bed capacity constraints currently (staffing / norovirus)? * If the level of acuity has changed -could the Trust evidence this? * Has the Trust had any workforce challenges (A&E staffing)?	Please see attached spreadsheet for information on activity changes. There is no ability to open a significnat numebr of additional beds so the focus has to be on improving utilisation. There are capacity constraints in terms of ability to recruit enough nurses to open all beds. There is some indication that the acuity has changed in terms of the age profile as well as the expected impact of the UCC front door managing the shorter term patients A&E medical and nurse staffing has been an issue but a focussed approach to recruitment has led to an improved position. Short term sickness continues to be difficult to manage due to lack of suitable bank/agency/locum staff
	Is there any other issues to highlight which is impacting on A&E performance? If so, could you quantify that impact and its effect on your A&E performance?	Delayed transfers of Care remain at around 60 patients. This leads to discharges late in the day and a subsequent impact on ED performance. In additio ambulatory care pathways remain significantly under-developed and this should eb a priority area for development in the system.
	Could the Trust quantify both the number of 8hr and 12hr trolley waits/ breaches that have taken place during 13/14 and 14/15? Could you confirm that the Trust is adopting a zero tolerance approach to 12hr breaches?	There have been 5, 12 hour breaches in 13/14 and 1 in 14/15. The number of 8 hour breaches is not currently available due to data quality issues
	Could the Trust outline if there have been any quality & patient safety issues (SUIs)raised in A&E (in-year)? What actions have the Trust taken to minimise and mitigate avoidable harm?	There have been a number of SUIs (but not an increasing trend). These have been reported through the appropriate system. In the light of the conntinuing pressures a formal safety review of the emergecny care system was undertaken on 18-6-14, at which the NTDA and commissioners were represented. THis is being formally written up and an action plan produced.
Breach Analysis	Could the Trust confirm and provide evidence that 7 day breach analysis is being used?	The 7 day analysis goes to the LLR UCWG. There has been a strong focus on non-admitted breaches, as well as understanding the impact of delays in speciality assessment and imaging.
	What are the key features/ Themes that have or are appearing from the breach analysis?	The main two breach reasons are bed availability and clinical issues.
External Support	Has the IST visited the hospital and if so when?	Dr Ian Sturgess formerly of the from the IST is working with us for 6 months from May 2014. In addition the IST itself is visiting w/c 23/6/14
	Have you fully implemented the IST recommendations made? If not when will this be completed?	Recommendations have been incorporated into the work of the Emergency care Action team and have in the main been implemented. However, those relating to some aspects of clinical process have been hard to embed, hence the request fro input from Ina Sturgess, who is focussing initially on this area.
	What further support is required (TDA/IST)?	UHL is using work from Dr Sturgess to ensure concentration on improving its performance. Support on avoiding admissions and improving UHLs ability to discharge patients would be areas that TDA/IST could look at.
Winter	Has your winter contingency capacity and/or escalation remained open? If so, how many beds?	All winter capacity from 2013/14 has remained open
	Could the Trust quantify the amount of winter monies received in 2013/14?	circa £9.36million
	Outline how the winter monies were deployed and what impact this had on A&E performance?	See attached plan for spend. All schemes were focussed on improving performance through avoiding admissions, managing the patient process faster or through improved discharge processes. Due to the complex nature of service and scheme interactions it is not possible to attribute an impact on A&E performance to each scheme.
Flow	What is the current level of DTOCs (Q1 to date)?	Please see blue DTOC tab for further information
	What is the maximum and minimum number of DTOCs? And what is the average compared to the same period last year?	52 and 73 from the snapshot audit. Average for Q1 to date is 62 patients per day. Average for similar period in Q1 2013 was 58
	What are the actions you are taking to improve flow through your adult inpatient bed capacity during the period?	New targets and escalations within ED and AMU for agreeing a definitive medical plan Restructuring the ECAT to focus on elements within the emergency pathway Increased communication with the site team to improve the use of the discharge lounge, and to get more patients to the discharge lounge earlier in the day Identification of weekend (discharge) plan by the responsible consultant for the weekend discharge team to enact Renewed focus on specialty support for ED especially speed of response
	What actions have you put in place to improve the rate of discharge of simple and complex discharges?	Identification of weekend (discharge) plan by the responsible consultant for the weekend discharge team to enact Increase patient transport capacity to reduce delays Increased use of medical step down beds in the community
	How are you working with social care and commissioners to reduce your DTOCs and improve flow?	There is an agreed action plan that is managed by the UCWG that is a collaborative approach with commissioners and social care. This has not so far produced consistent improvement.
	What is the average weekly pattern of discharges by day and against plan for Q4?	See green tab
Partnership working	What actions is the urgent care group undertaking to improve performance?	There is an agreed UCWG action plan that focusses on actions that will help to improve performance. This is based on the national checklist promoted by NHS England.
	What are the arrangements with commissioners in terms of: * Level of mutual support (financial/other) provided by commissioners? * Do you share breach analysis with commissioners? * Are their local health system TCs when required? * What is the current status regarding community bed capacity? * What additional support has been provided by IS or other providers i.e. mutual support during Q3 and Q4?	There is a common escalation plan used to co-ordinate responses from all areas as needed Breach analysis is shared with commissioners The current community capacity remains good. Work is being done with Leicester Partnership Trust to ensure best use of this capacity The IS has been approached regarding support UHLs workload and where possible has been used to deliver services

Recovery Plan

Recovery Plan	Is there a Board agreed Recovery Action Plan in place? (If so please attach with your response)	
	If yes, when was it agreed and could you confirm this has been agreed with commissioners?	There is a monthly report to the UHL board on the emergency performance. The action plan discussed as part of this report is the one that is managed by the UCWG.
	What date does the Trust expect to be back on track and achieving A&E safely and sustainably?	31st August 2014
	If no RAP is in place, when will one be agreed?	

Could you briefly provide in the box below details on the current short/medium and more longer term actions to address A&E underperformance. In addition, based on the recovery trajectory outlined on the "Trust Summary" tab, could you quantify (where possible) the impact of these actions on A&E performance:	
Short/ Medium term:	Dr Ian Sturgess is currently working with UHL to identify actions that would improve the ED performance, focussing on improvements to clinical --------- New targets and escalations within ED and AMU to get to a definitive medical plan faster Identification of weekend (discharge) plan by the responsible consultant for the weekend discharge team to enact Renewed focus on specialty support for ED especially speed of response Increased use of ambulatory pathways Commissioning of new modular ward block to reconfigure medical bed capacity (October 2014)
Long term (sustainable measures)	Identification of weekend (discharge) plan by the responsible consultant for the weekend discharge team to enact Increased use of medical step down beds in the community

Greater East Midlands
Commissioning Support Unit

Delayed Transfers of Care : 2014-15 Performance Monitoring at University Hospitals Leicester (UHL), Leicestershire Partnership Trust (Community Hospitals, Mental Health and Learning Disabilities and City inpatient wards)

Census Date 12 June 2014

Data source: weekly SITREP returns from providers (UHL, LPT (Community, Mental Health, Learning Disabilities Services and City inpatient wards)

Monthly Year To Date

Delayed Transfers of Care Snapshot as at 12 June 2014

University Hospitals of Leicester (UHL) NHS Trust

	Month	County				City				Combined			
		Average Monthly Patients Delayed	Average Monthly Occupied beds	Average Monthly %Delay	Average No of Delays per 100,000 population	Average Monthly Patients Delayed	Average Monthly Occupied beds	Average Monthly %Delay	Average No of Delays per 100,000 population	Average Monthly Patients Delayed	Average Monthly Occupied beds	Average Monthly %Delay	Average No of Delays per 100,000 population
Q1	Apr- 2014	39	827	4.66%	6.8	26	551	4.72%	10.2	65	1378	4.68%	7.9
	May-2014	38	818	4.66%	6.7	24	549	4.37%	9.4	62	1367	4.54%	7.6

Q1	May-2014	38	818	4.66%	6.7	24	549	4.37%	9.4	62	1367	4.54%	7.6
	Jun-2014	39	818	4.79%	6.9	23	549	4.22%	9.1	62	1367	4.56%	7.6
Q2													
Q3													
Q4													

University Hospitals of Leicester NHS Trust

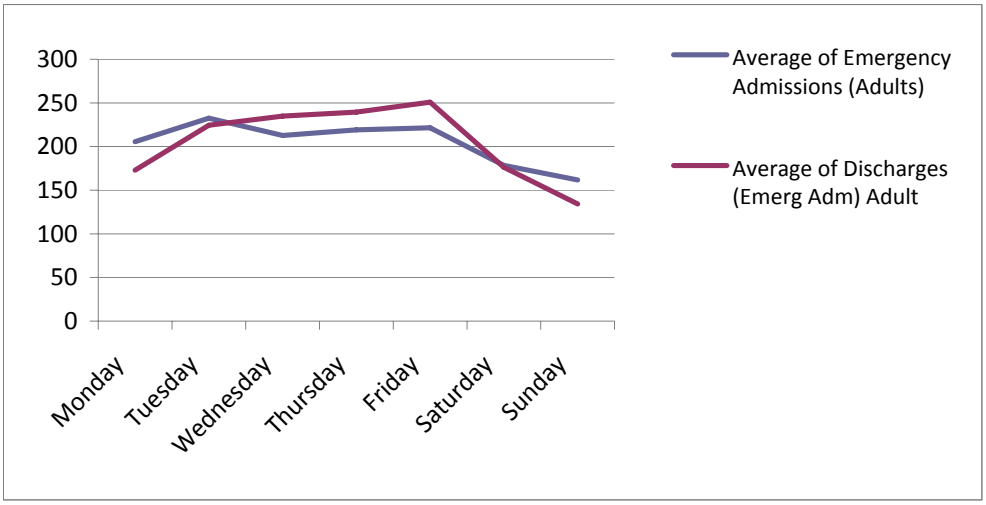
Delayed Transfers of Care Snapshot as at 12 June 2014

Weekly Census data

Month	Census Date as at midnight	County				City				Combined			
		Total No of Patients Delayed	Total Occupied Beds	%Delayed	No. of Delays per 100,000 population	Total No of Patients Delayed	Total Occupied Beds	%Delayed	No. of Delays per 100,000 population	Total No of Patients Delayed	Total Occupied Beds	%Delayed	No. of Delays per 100,000 population
Apr-14	03/04/2014	34	840	4.05%	6.0	23	573	4.01%	9.0	57	1413	4.03%	6.9
	10/04/2014	42	836	5.02%	7.4	23	540	4.26%	9.0	65	1376	4.72%	7.9
	17/04/2014	38	809	4.70%	6.7	25	545	4.59%	9.8	63	1354	4.65%	7.7
	24/04/2014	40	823	4.86%	7.1	33	545	6.06%	13.0	73	1368	5.34%	8.9
May-14	01/05/2014	41	827	4.96%	7.2	26	550	4.73%	10.2	67	1377	4.87%	8.2
	08/05/2014	41	760	5.39%	7.2	19	536	3.54%	7.5	60	1296	4.63%	7.3
	15/05/2014	30	831	3.61%	5.3	22	556	3.96%	8.7	52	1387	3.75%	6.3
	22/05/2014	42	818	5.13%	7.4	23	549	4.19%	9.0	65	1367	4.75%	7.9
	29/05/2014	35	818	4.28%	6.2	22	549	4.01%	8.7	57	1367	4.17%	6.9
Jun-14	05/06/2014	38	818	4.65%	6.7	17	549	3.10%	6.7	55	1367	4.02%	6.7
	12/06/2014	50	818	6.11%	8.8	22	549	4.01%	8.7	72	1367	5.27%	8.8

Average Admissions and Discharegs 1st May to 15th June 2014

Row Labels	Average of Emergency Admissions (Adults)	Average of Discharges (Emerg Adm) Adult
Monday	206	173
Tuesday	233	225
Wednesday	213	235
Thursday	219	239
Friday	222	251
Saturday	178	176
Sunday	162	134
Grand Total	204	204



University Hospitals of Leicester NHS
NHS Trust

Caring at its best

UHL Emergency Care Quality Improvement Charter

One team shared values

June 2014 vo.3

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Background & Purpose

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Background

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

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

However, these recommendations have not been embedded in a consistent manner.

Purpose

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

1. Reduced Mortality
2. Reduced Harm
3. Reduction in Long Term Care Placements from Hospital
4. Reduced Re-Admissions
5. Reduction in Complaints – Increase in Compliments
6. Reduced Cancellations of Electives

Scope

Emergency Care Pathway

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

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

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

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

Working Groups

1. **Organisation** - this covers the communication strategy, organisational development, customer service processes

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

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

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

Approach

Membership of Working Groups

The Working Groups will be Consultant led and will be made up of a multi-disciplinary team of clinicians.

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

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

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

Initial Actions

A detailed list of specific actions, broken down by working group, are captured in Annex A, however, the specific outcomes for each of the clinical Working Groups is captured below:

Working Group	Measure of Success
Front Door	A 5% to 10% reduction in A&E referrals for admission from the non-GP stream.
	Admitting Specialties to achieve 30% of discharges within 12 hours of referral, with a further 40% discharged with a length of stay of 2 midnights or less.
Base Wards	Reducing the number of beds occupied by patients aged under 75 by 10% to 20%.
Frailty	Reducing the number of beds occupied by patients aged over 75, with a stay of over 14 days, by 25% to 50%

Governance

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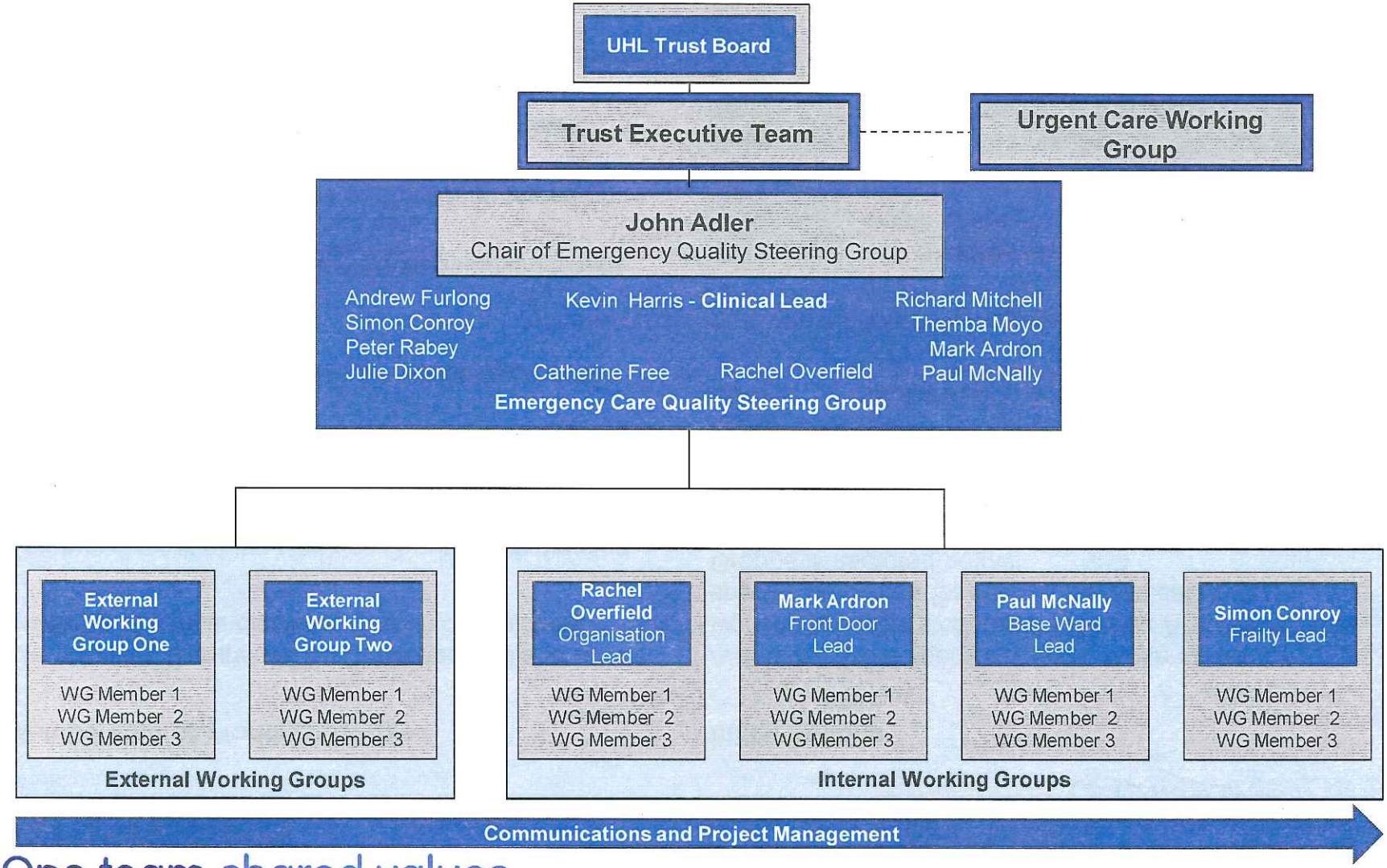

One team shared values

Roles and Responsibilities

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

Meetings

Working Group Meetings

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

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

The key items to be discussed are:

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

Steering Board Meetings

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

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

Reporting and Feedback

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Creation of KPI Measures

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

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

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

1. *Clinicians*
- To receive live feedback on interventions
- To make quick improvements to processes
- To identify what works well, quickly
- Share good practice rapidly

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

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

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

Appendices

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Appendix A – Working Group Actions (1/5)

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	Working Group	Action
1	Steering Group	Agree plan with CCG colleagues to reduce the volume of attendances in ED
2	Steering Group	Agree plan with CCG colleagues to increase the proportion of patients who are treated in the UCC
3	Front Door	Stop specialty 'ping pong' - ED are getting repeatedly bounced between specialties – simple rule – **when ED refers the answer is 'yes'** – if that team assess the patient (in ED if physiologically unstable or in their assessment area if stable) and feel it should be under another specialty, they refer on.
4	Front Door	Stop specialty dumping – here the specialty suggest to GP for the patient to go to ED when they should be direct to specialty – **the only patients who should go to ED from a GP referral are those that are or become unstable.**
5	Front Door	Improve specialty response times to ED – 30 mins to arrive to assess in ED if unstable or probable direct home or 30 mins to leave Department
6	Front Door	Standardise process and performance manage teams to improve floor management in ED.
7	Front Door	Standardise process and performance manage teams in assessment units.

Appendix A – Working Group Actions (2/5)

DRAFT FOR DISCUSSION

	Working Group	Action
8	Front Door	RAT in assessment area – variable. **Set 15 min processing time, senior led** (Consultant or ST5 and above – training opportunity for more junior docs to shadow seniors) with support of Band 5 nurse +/- generic worker with phlebotomy, ECG etc. skills
9	Front Door	Review the opportunity and benefit of Acute Physician and Acute Geriatrician at front door during key demand period 1000 hrs. until 2000 hrs. seeing the query admit and query discharge patients
10	Front Door	Seven day analysis of the breach standards to understand causes of breaches.
11	Front Door	100% minor case compliance in ED
12	Front Door	Prompt booking of patients - Review potential mechanisms to speed handover between from both EMAS and UCC to release staff
13	Front Door	Improve access to diagnostics in line with national standard 'waits due to delays in pathology or radiology should be rare. There should be 7 day access to diagnostics for A&E, EAU and all wards including admission avoidance schemes. Requests from A&E should be prioritised for immediate response. There should be escalation processes in place if delays are occurring.' **Confirm what the key performance indicators are for access times.**

Appendix A – Working Group Actions (3/5)

DRAFT FOR DISCUSSION

	Working Group	Action
14	Front Door	Time to medical assessment in line with national standard 'Delays due to first medical assessment should be rare. **Patients should be seen by a clinician within one hour and there should be appropriate escalation where this is not delivered.** This should be monitored daily with the breach analysis.'
15	Front Door	Agree specific process with each speciality to improve medical in-reach into AMU.
16	Front Door	AMU assessment and decision timelines are not being performance managed. Set **'door to doctor' of 30 minutes and 'door to consultant' of 4 hours (80% of the time) for ED referrals.** For GP referrals – rapid assessment by Consultant - at least 30-50% of GP referrals can have a zero LOS.
17	Front Door	Deliver an improved consultant triage service. Confirm what the key metrics are for the service. The implementation plan requires: • Appointment of 4 ortho-geriatricians and 3 acute physicians – (these jobs are out to advert) • Revision of existing consultant job plans which will include daily consultant ward round and increased weekend presence in support of emergency flow– formal notification has commenced and job plan review meetings are scheduled for June 2014 • General Surgical triage service – the CMG is developing a plan to pilot but a definitive service will require new substantive appointments and job plan review for existing consultants.

Appendix A – Working Group Actions (4/5)

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	Working Group	Action
18	Base Wards and Frailty	Implement one stop ward rounds – this is a ward round where EDD and CCD are re-enforced to everyone, where actions required are carried out immediately eg requests, discharge summary, TTOs etc..
19	Base Wards and Frailty	Implement 'assertive board rounding' and follow up with observation and feedback and a peer to peer process.
20	Base Wards and Frailty	Ward referrals to other specialties for advice – variable response times – **standardise to <4 hours if non-urgent and <1 hour if urgent and at an appropriately senior level** – default is Consultant.
21	Front Door	Construct of the Consultant clinical decision – EDD and CCD not consistently being done – i.e. an end to end case management plan which is then assertively delivered.
22	Base Wards and Frailty	Improve bed availability in line with national standard
23	Base Wards and Frailty	Senior medical review in line with national standard 'Senior medical review is critical to ensure the day's discharges are made; a particular day's discharges will need to be preceded by a senior medical review early the following morning. Unless this happens, there will be insufficient beds made available during the morning to meet that day's demands. Daily senior review rounds and during periods of peak demand twice daily senior review ward rounds should take place.'

Appendix A – Working Group Actions (5/5)

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	Working Group	Action
24	Base Wards and Frailty	Agree process for morning discharge rate in line with national standard
25	Base Wards and Frailty	Improve use of discharge lounge in line with national standard
26	Organisation	Standardise site meetings
27	Steering Group & Organisation	Agree with CCGs and LPT a plan to reduce DTOCs down to 3.5% as a minimum
28	Steering Group & Organisation	Begin process of creating a 'social movement' to back the change – similar to 'NHS Change day'
29	Steering Group & Organisation	Review key performance indicators to monitor performance across LL health economy
30	Organisation	Begin process of creating a 'social movement' to back the change – similar to 'NHS Change day'
31	Organisation	Review key performance indicators to monitor performance across LLR health economy
32	Organisation	Review ED Medical staffing to ensure that resources (processing power) are best matched to demand
33	Front Door	Review working protocols with the UCC to ensure the most efficient possible patient pathway and monitor compliance with KPIs

Appendix B – Working Groups ToRs (1/5)

DRAFT FOR DISCUSSION

Organisation ToRs

The key a activities for this workstream are:

- Development of communication strategy
- Development of high-level metrics
- Organisational development
- Development of internal and external customer processes
- Act as arbiter across working groups
- Escalate inter-Working Group issues not resolved to Steering Group

Front Door ToRs

The key a activities for this workstream are:

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

Front Door ToRs Continued:

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

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

Key outcome measures:

- 5% to 10% reduction in A&E referrals from non-GP referred stream
- Admitting specialties to achieve 30% of discharges within 12 hours of referral, with a further 40% discharged within 2 midnights or less

Peer to peer measures to include

- 6 week rolling average of discharges with LOS of 0
- Stays < 3 days by consultant balanced by re-admission rate

Key outcome metrics will be deaths and harm events within the first 48hrs and re-admission numbers/rates.

Appendix B – Working Groups ToRs (2/5)

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Base Wards ToRs

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

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

Key outcome measures:

- A reduction in beds occupied by patients aged under 75 with the aim to reduce this by 10% to 20%

Peer to peer measures to include either:

- Monthly league tables of discharges by ward
- Or 6 week rolling averages against expected discharge rate for that ward

Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

Frailty ToRs

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

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

Key outcome measures:

- The number of beds occupied by patients aged 75 and over who have been in hospital 14 calendar days or more, with an aim to reduce this by 25-50%

Peer to peer measures to include either:

- Monthly league tables of discharges by ward
- Or 6 week rolling averages against the expected discharge rate for that ward

Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

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Appendix B – Working Groups ToRs (3/5)

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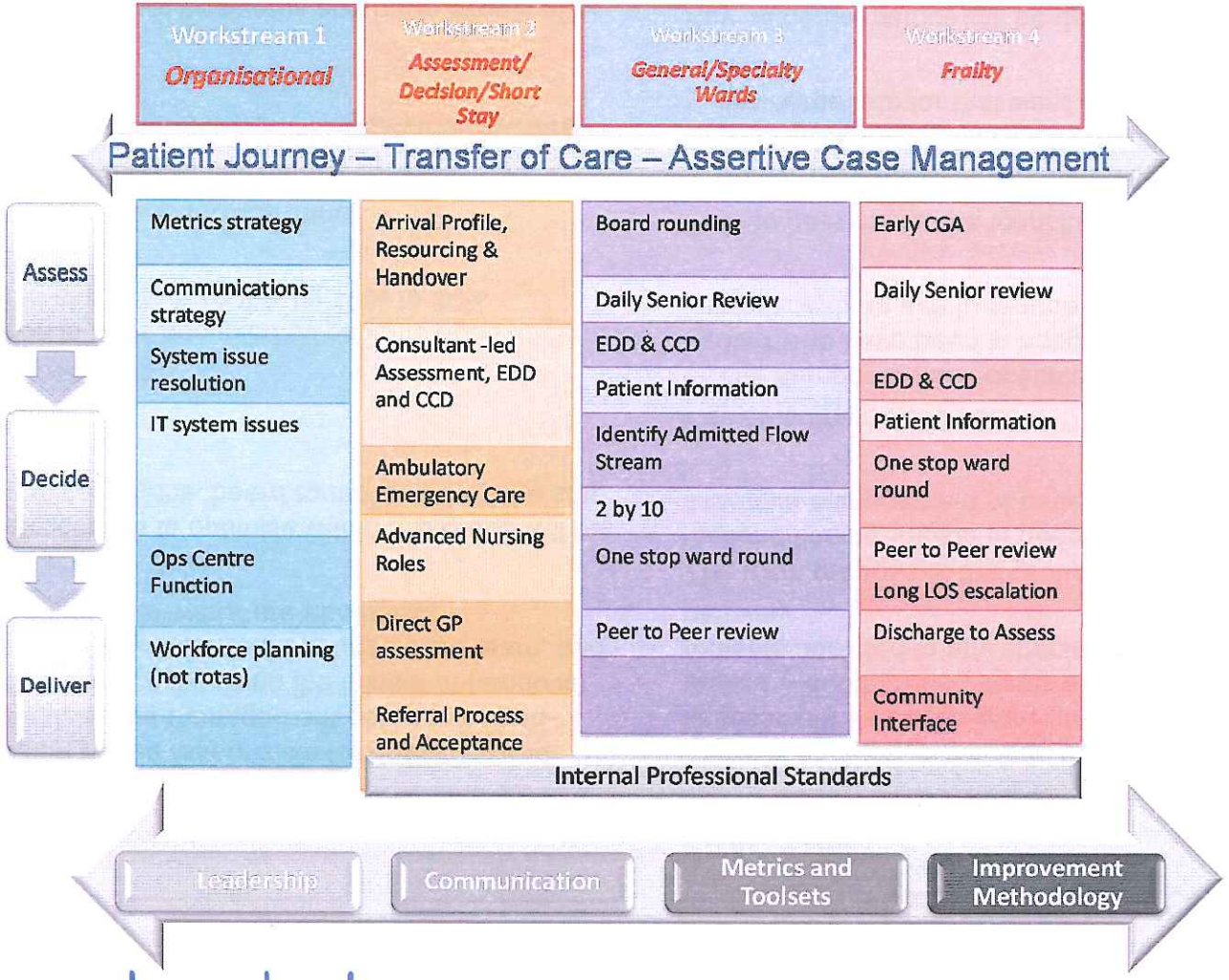
Emergency Care Programme – Work-stream Overview



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Appendix B – Working Groups ToRs (4/5)

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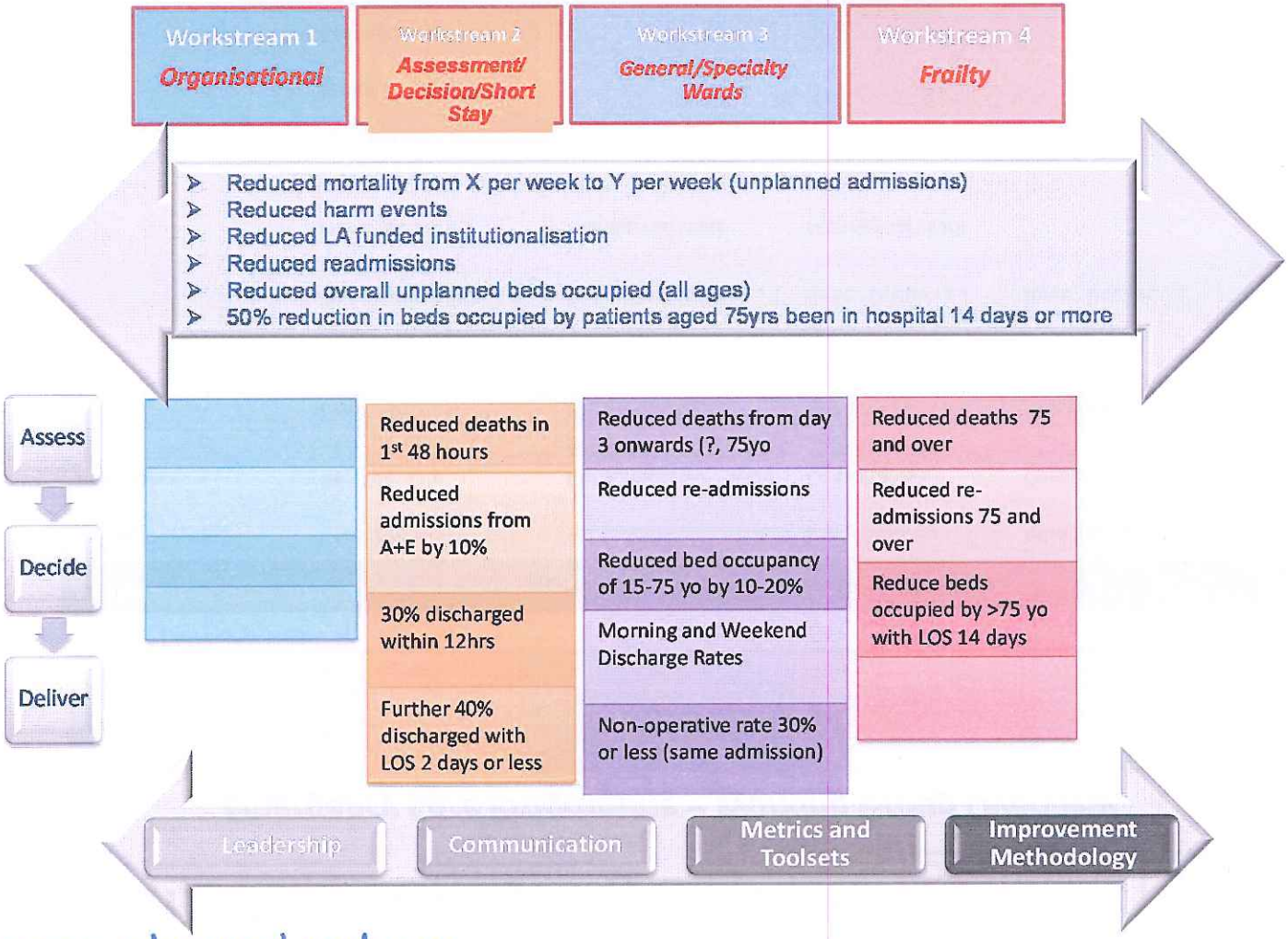
Emergency Care Programme – Outcome Metrics Overview



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Appendix B – Working Groups ToRs (5/5)

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Emergency Care Programme – Working Group Overview

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

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

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Appendix C – Steering Group ToRs (1/3)

Purpose

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

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

To ensure all actions are completed within timescales set.

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

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

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

Appendix C – Steering Group ToRs (2/3)

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Scope

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

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

Membership

The following are the substantive members:

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

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Appendix C – Steering Group ToRs (3/3)

Constitutional Arrangements

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

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

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

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

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

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

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

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

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

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

Appendix D – Project Management (1/4)

DRAFT FOR DISCUSSION

Defining and Capturing Risks

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

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

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

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

Appendix D - Project Management (2/4)

DRAFT FOR DISCUSSION

Caring at its best

Probability Scoring Matrix

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

Impact Scoring Matrix

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

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

Risk Score Matrix

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

Potential Impact

Appendix D - Project Management (3/4)

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

DRAFT FOR DISCUSSION

Defining and Capturing Issues

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

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

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

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

Appendix D - Project Management (4/4)

Purpose of the Action Log

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

The action log should capture:

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

Review of Action, Risk and Issue Logs

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

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

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

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