UHL Emergency Performance

Author: Richard Mitchell, Chief Operating Officer **Trust Board paper G**

Executive Summary

Context

Despite many improvements so far this calendar year including a new ambulance cohorting policy, Red2Green embedded across the 14 medical wards at the LRI and GPAU reducing admissions by 20 patients per day, we remain under acute operational pressure. This continues to be caused by a combination of increased demand and sub-optimal processes internally and across the system. Delays to ambulance handovers remain our biggest area of concern.

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

The RAP has been agreed by LLR, NHSE and NHSI as a credible plan to deliver change and progress is being made on delivering the actions via the AE implementation group externally and EQSG internally. ECIP have launched Cohort two (Midlands and East Region) of their Emergency Care Improvement Programme which we are part of and will therefore receive additional support. UHL continued to focus on internal actions and working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. It is acknowledged that there is a great deal of work to be done as we head into a challenging time of year with expected increase in attendances and admissions.

Our key risks remain:

1. Variable clinical engagement

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: 2 March 2017

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: **2 February 2017**

Four hour performance
2016/17 YTD

- We are treating an average of 655 patients everyday through ED at the Leicester Royal Infirmary
- 16/17 performance YTD is 78.9% and December's performance was 75.5%
- 15/16 performance YTD was 89.5% and December 2015 was 85.1%
- YTD attendances 7% up on the same period last year
- YTD total admissions are 1% higher than last year (noting the impact of GPAU)

Sustainability and Transformation Fund (STF)

December's STF was not achieved and December was the worst month of performance so far this year. January's will not be achieved either. Struggling to deliver the emergency care STF also impacts on our ability to deliver the Ca and RTT STF.

	STF Trajectory 4hr Performance	**Actual 4hr Performance**	STF Achieved?
Apr-16	78%	**81%**	Achieved
May-16	78%	**80%**	Achieved
Jun-16	79%	**81%**	Achieved
Jul-16	79%	**77%**	Not Achieved
Aug-16	80%	**80%**	Achieved
Sep-16	85%	**80%**	Not Achieved
Oct-16	85%	**78%**	Not Achieved
Nov-16	85%	**78%**	Not Achieved
Dec-16	85%	**76%**	Not Achieved
Jan-17	89%		
Feb-17	89%		
Mar-17	91.2%		

January 2017

- Month to date – January – 1st to 30th is 78%
- January has been another month of high attendance, long waits to be seen and variable outflow from the department often resulting in poor ambulance handover times.

As reported at Trust Board in January, our position remains very difficult and challenging. We are focused on working as a team within UHL and across LLR to deliver improvements in emergency care in 2017. Key areas of improvement so far this year are:

- GP assessment unit – There continues to be increased volumes of patients going through this service each day which reduces the load in ED and admissions to the assessment units by circa 20 patients per day, helping to reduce the mismatch between admissions and capacity. Currently GPAU is only open until 10pm between Monday to Friday and then 9am to 5pm at weekends but we are exploring how the hours can be increased permanently. A verbal update on this will be given at Trust Board.
- Ward 7 LRI and 23A GGH – we now have all of our winter capacity open which has reduced the volume of medical outliers, in particular at the LRI. Unfortunately we have seen an increase in non-medical emergency patients which means that elective patients are still being cancelled at a rate faster than we want.

- Use of Red to Green – Red to green is well embedded across the 14 medical wards at the LRI, with a clear action plan focussed on the thematic reasons for delay in place. We now regularly have a medical capacity in excess of 90 beds per day at the LRI which is supporting the reduction in medical outliers. We are working on plans to roll the methodology out across other CMGs.
- Nervecentre – nervecentre has been working for over a month without any problems.
- The UCC cared for 99% of patients within four hours in December and January. This is a fantastic achievement representing great care for large volumes of our emergency patients.
- We have a new cohorting process in place, which was signed off by the three ED heads of service, head of operations and head of nursing. It enables us to offload patients from ambulances more quickly than previously and we can cohort up to 11 patients between 0800 and midnight and 17 patients from midnight to 0759.
- On 10th and 11th January we declared a System Critical Incident (SCI). This followed an extended period of pressure both in UHL and across LLR since the festive period. It was a step up in response as we had been on a Critical Incident (CI) since the New Year, however the CI did not improve our position. On 8th and 9th January our situation worsened with patients experiencing very long waits for ward beds and this led to CDU and ED being extremely busy and occupancy was excessively high, causing significant ambulance handover delays. Following the decision to declare the SCI, we put a number of additional actions in place to ensure we moved to an improved position as quickly as possible. They included:

    - Specialities continuing to review all of their patients in ED and to provide timely speciality in reach including pulling proactively patients out of ED to alternative assessment areas to decongest the department
    - All specialties converting non-clinical activities/SPA into clinical activities
    - Ensuring that every patient has a consultant review
    - Additional medical support supplied on the base wards through the day to support ongoing review and discharge decisions
    - CMGs took down elective/ RTT operating and outpatients where appropriate to increase medical decision making
    - Safe and timely rapid flow took place i.e. making sure that patients are moved in a timely way as soon as they are ready out of ED and assessment units
    - Using the discharge lounge where appropriate with additional support from theatres and corporate nursing teams
    - TTOs completed in a timely manner
    - All CMGs reviewing safe staffing levels on wards and if there were any issues, other activities were to be reviewed
    - Ensuring plans are in place for the evenings and this weekend
    - All corporate nursing teams who are not undertaking critical duties to support where required.

We also asked staff, when reviewing their patients, to focus on asking the following four questions for every patient:

1. **What is matter with me?** (what is the patient's main diagnosis)
2. **What is going to happen today?** – (is there a clear plan for today and tomorrow with clinical criteria for discharge documented in the notes?)
3. **What is needed to get me home?** (can test and investigations be completed in an alternative setting or be done as an outpatient. If you were seeing this patient as an outpatient – would you admit them?)
4. **When am I going home?** (what is the expected date of discharge?)

These questions are from our quality commitment and are integral to the SAFER care bundle / Red 2 Green. The benefits from the SCI were very clear, with much lower ward, CDU and ED occupancy, improvements in flow to Leicester Partnership Trust (in particular) and much lower waits for ambulance handovers.

- External support – we continue to work with the Emergency Care Improvement Programme and Dr Ben Owens from Sherwood Forest FT who is providing support across the emergency care pathway.

Despite the improvements detailed above, January was a poor month:

- Our four hour performance remains very poor and is worse than this time last year.
- Our ambulance handover performance can be extremely poor.
- When we were on the SCI, we cancelled the vast majority of the elective work at the LRI, in particular, which will impact on quality of care to elective patients, waiting times and financial performance.

Progress on seven key UHL actions in the RAP for January

As detailed in the RAP and the CEO briefing to all staff, the key actions and metrics focussed on in January were:

1. Reduction in patients breaching by ten minutes

Month	ED Type 1 Attendances	All ED Type 1 Breaches	Breaches between 241 and 250 minutes	% of Breaches	Target
Apr-16	11,757	3,406	152	4%	1%
May-16	13,247	4,080	159	4%	1%
Jun-16	12,455	3,614	145	4%	1%
Jul-16	12,624	4,450	160	4%	1%
Aug-16	12,367	3,716	153	4%	1%
Sep-16	12,963	3,818	140	4%	1%
Oct-16	12,938	4,332	126	3%	1%
Nov-16	13,063	4,447	161	4%	1%
Dec-16	12,704	4,842	224	6%	1%
Jan-17	5,729	2,204	78	4%	1%
16/17 YTD	**119,847**	**38,909**	**1,498**	**4%**	

December was a poor month for patients breaching by 10 minutes; this is largely due to the sustained pressures on the emergency pathway.

2. Reduction in non-admitted/out of hours breaches

As detailed above, the Urgent Care Centre continues to perform very well. There was a small reduction in 'out of hours' breaches after 1900 in December (29% compared to 31% in November).

3. Implementation of rapid assessment and early decision to move to ambulatory

More work is required in this area and is being supported by the work that Dr Ben Owens is working on.

4. Move GPAU to yellow zone and utilisation of the space GPAU leaves behind

As detailed above, this works very well.

5. Ambulance handovers

Despite the change detailed above, ambulance handover times continue to be a significant issue and are our key weakness.

Handover data (CAD+) is detailed below:

	Under 15 Mins Delays % (CAD+)	% Delay Over 15 mins (CAD+)	% Delay Over 30 mins (CAD+)	% Delay Over 60 mins (CAD+)	% Delay Over 120 mins (CAD+)
Apr-16	59%	41%	17%	6%	1%
May-16	57%	43%	18%	6%	1%
Jun-16	60%	40%	16%	6%	1%

Jul-16	51%	49%	24%	9%	2%
Aug-16	54%	46%	21%	7%	1%
Sep-16	51%	49%	24%	9%	1%
Oct-16	47%	53%	28%	9%	1%
Nov-16	47%	53%	29%	9%	2%
Dec-16	41%	59%	35%	17%	6%

A new ambulance handover improvement action plan has been developed with partners, and includes actions to:

- Reduce the attendance and admissions in the Emergency Department (ED)
- Increase the size and speed of take at CDU at Glenfield
- Increase the cohorting capacity of the ED or adjacent areas
- Actions to create a ward or wards on one of our three sites where patients who are medically fit for discharge can be cared for whilst arrangements are made for their discharge
- Reduce the time between beds becoming available and patients moving out of ED ('rapid flow')
- Immediate actions to reduce external delays to the discharge of individual patients (as opposed to medium-term system improvement actions)

6. Opening additional medical capacity at the LRI on ward seven and ward 23 at Glenfield

As detailed above

7. SAFER bundle and Red to Green

As detailed above

Work streams

At EQSG on 18 January 2017, progress on the front door work-stream was discussed and key updates are in the attached.

Front door

The RAP actions for the LRI front door focus on ensuring we continue to get the benefit from the increased streaming/treating and redirection of patients from the ED front door. There are also new actions related to the front door (CDU - Clinical Decisions Unit) at Glenfield. This includes implementing a CDU-EMAS direct streaming protocol, to minimise transfers from ED; a meeting has been held with the clinical team to discuss and agree next steps.

Overall in January

Despite the continuing pressures on our emergency service, we continue to see the benefit of GPAU as admissions decrease. The revised proactive cohorting policy is having some positive impact on ambulance handovers, but there is more to do. We have good medical and nursing support for this, and will continue to embed this in February. Red2Green continues, with full executive support, and is key to maintaining flow across our hospitals. Flow out of our hospitals remains a challenge; our collaborative working with partners is crucial here. There have been four meetings with the ED nursing team since November supported by executive colleagues to listen to their concerns about overcrowding, ambulance handovers and their ability to maintain safety within the department. A number of actions (as described above) have been agreed and implementation is being led by the Senior CMG leaders. The last meeting was held on 11 January 2017 following receipt of a formal statement and chaired by the COO supported by the Deputy Chief Nurse and Clinical Director.

Four key UHL actions in the RAP for February:

There are four key actions in February (noting they are continuing the themes from December):

1. **Work with the ED team and the Emergency Improvement Programme (ECIP) to understand how care and performance can be improved between 1800 and 0200** – this is a key area of focus as we often get into a good position early in the evening and then performance worsens dramatically overnight.
2. **Sustainably staff GPAU for extended periods –** as detailed above
3. **Reduce ambulance handovers, including: proactive cohorting in line with the policy, continuation of GP in EMAS Fast Response Vehicle (FRV); and ensuring full usage of discharges lounges at both LRI and GH –** as detailed above.
4. **Implement Rapid Flow -** At UHL we often have unnecessarily long delays in transferring patients from the ED to a bed. The principal of rapid flow is that as soon as a patient is discharged from the ward it triggers a patient to leave ED. The multiple moves should then occur concurrently to ensure a rapid process as possible. Rapid Flow is part of the national SAFER bundle that implements five clear steps which are proven to reduce blockages in the system and reduce mortality. We are conducting trials throughout February to see how we can deliver sustainable rapid flow.

Risks

The key risk is:

1. Variable clinical engagement

Work along all parts of the emergency care pathway continues to identify clinical engagement as the key risk.

It is also important to recognise three other risks which may increase in 2017-18:

1. We already do not have sufficient capacity to care for all our patients and the gap between demand and capacity (beds) will increase next year unless the best case scenario in contract planning occurs.
2. The gap between demand and capacity at GGH will increase in the winter 2017-18 because ward 23A will have vascular patients in it from May 2017. We either need to; increase ward capacity at GGH, see a reduction in demand, further increase our discharge rate or reduce the elective work on that site.
3. We now have 87 days until the new Emergency Floor (phase one) opens and we need to balance the demand on the teams who are caring for patients on a day to day basis and are also involved in the opening of the new EF.

Conclusion

The RAP has been agreed by LLR, NHS England and NHS Improvement as a credible plan to deliver change and progress is being made on delivering the actions via the A&E implementation group externally and EQSG internally. ECIP have launched Cohort two (Midlands and East Region) of their Emergency Care Improvement Programme which UHL are part of and will therefore receive additional support.

UHL continue to focus on their internal actions but are also working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. It is acknowledged that there is a great deal of work to be done across the system, but there is the desire and commitment to work together for the benefit of our staff and patients.

Recommendations

- Note the contents of the report
- Note the latest high impact RAP (attached)
- Note the continuing concerns about 4 hour delays and ambulance handovers in particular and the actions in the RAP to reflect the improvements that can be made within UHL to improve performance.
- Note the continued pressure on clinical staff with increasing demand and overcrowding

Leicester, Leicestershire and Rutland Urgent Care Network
System Overview & Recovery Action Plan
Version: 10
Last updated: 30th December 2016 **By who:** Tim Slater
Approval date: **By who:**

Programme Structure

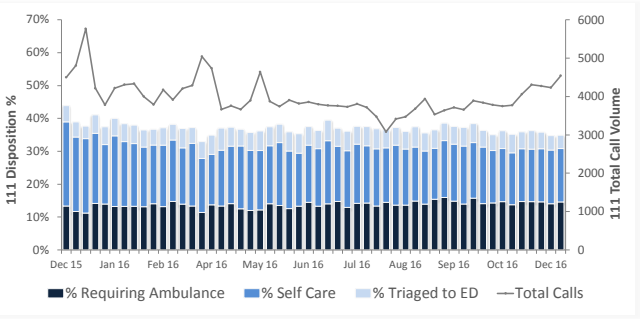
Workstream	Sub-workstream	SRO	Medical Lead	Link to National Actions	Link to SAFER bundle	SRO Update	Link to LLR Risk Register
Minimise presentations at LRI campus		Rachana Vyas	Dick Hurwood	2 (111)		16/12/16 S Smith	CL1, CL2
Improve ambulance response and interface		Mark Gregory		3 (Ambulance)		29/12/16 M Gregory	CL2 - reviewed by MG 29/12/16 and no change
Improve the LRI front door	Streaming and Assessment	Lisa Gowan	Ursula Montgomery, Ffion Davies	1 (Streaming)		30/12/16 R Pepper	
	Ambulatory care	Lisa Gowan	Vivek Pillai, Lee Walker	1 (Ambulatory care)		30/12/16 R Pepper	
Improve ED flow	Adults	Julie Taylor	Vivek Pillai	4 (Flow)		30/12/16 R Pepper	
	Children	Julie Taylor	Sam Jones	4 (Flow)		30/12/16 R Pepper	
Improve Ward Flow	Assessment units	Julie Taylor	Lee Walker	4 (Flow)	**S F E**	30/12/16 R Pepper	
	Base wards	Gill Staton	Rachel Marsh	4 (Flow)	**S A F E**	30/12/16 R Pepper	
Improve CDU Flow		Sue Mason	Caroline Baxter	4 (Flow)		30/12/16 R Pepper	
Improve discharge processes		Tamsin Hooton		5 (Discharge)	**R**	22/12/16 C O'Donohue & 28/12/16 T Hooton	CL3
Overall lead for UHL-led workstreams		Sam Leak	Ian Lawrence				

S Senior Review
A Expected date of discharge
F Early flow
E Early discharge
R Review >14d stays

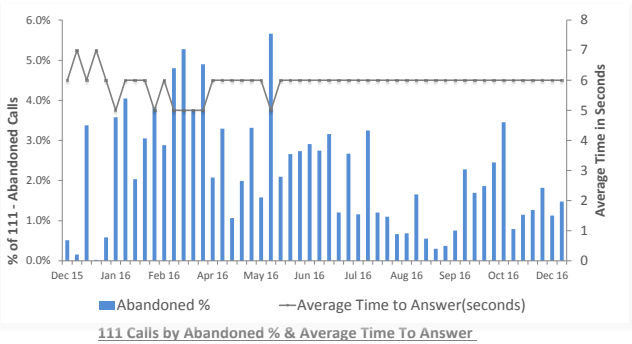
A&E Delivery Board - Dashboard

21st December 2016

NHS 111

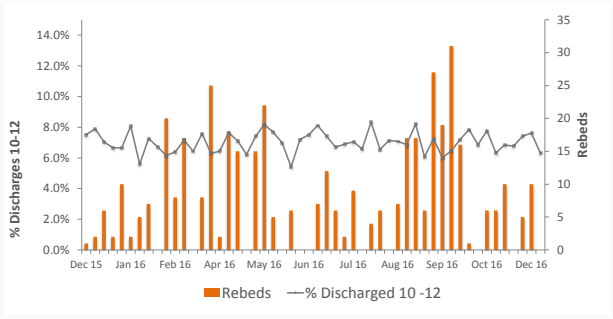


111 Calls by Disposition



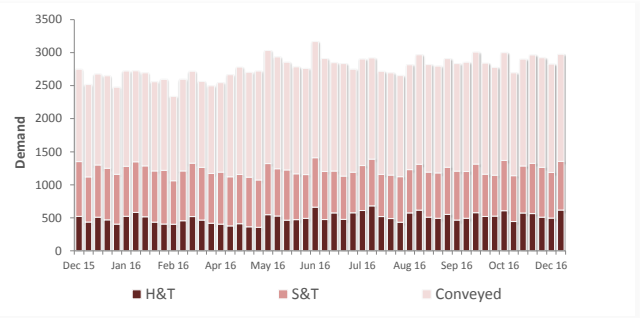
111 Calls by Abandoned % & Average Time To Answer

Discharge

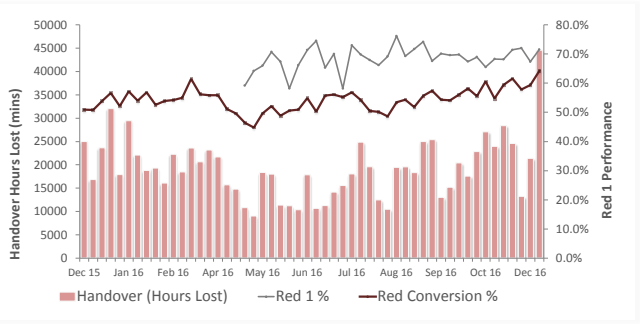


Discharges 10am-12pm and NEPTS Rebeds

Ambulance Response Programme

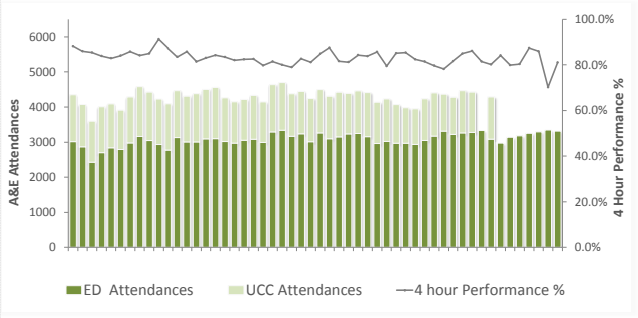


EMAS Demand

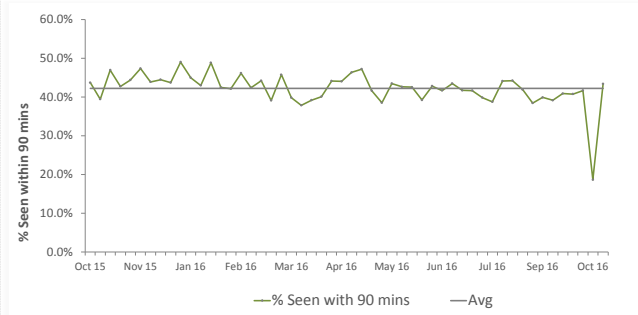


EMAS: Handover Hours and Red 1 Performacne

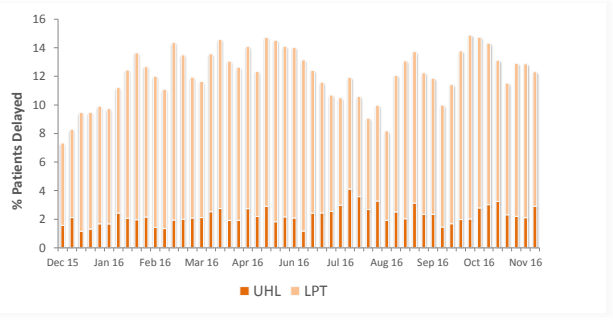
Streaming into A&E



A&E Attends & 4 Hour Performance

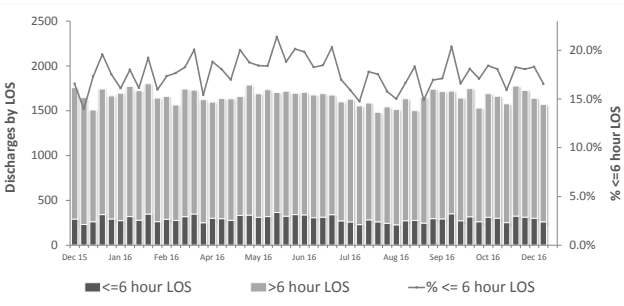


Time from Arrival to Treatment:% Seen within 90 mins



Delayed Transfers of Care: % Patients Delayed

Improving Flow



Short Stay Emergency Admissions

A&E Delivery Board - Dashboard

Work Stream	Metric	Data up to	Status	Latest Week	Previous Week	Comments
NHS 111	Cases requiring ambulance (%)	11/12/2016	↑	14.60%	14.06%	The proportion of calls requiring an ambulance has shown a step change increase from the beginning of September compared to the 12 month average. From week ending 23rd October 2016, there's been a shift decrease in the proportion of cases closed with self care. The last 2 weeks has seen the highest volume of calls since May 2016
	Cases triaged to A&E (%)	11/12/2016	↓	4.05%	4.37%	
	Cases closed with self-care (%)	11/12/2016	↓	16.23%	16.33%	
	Abandonment rate (%)	11/12/2016	↑	1.48%	1.13%	The weekly Abandonment rate varies between 0.5% & 5%, no significant variance or special cause noted.
	Average Answer Time (seconds)	11/12/2016	↓	6	6	The average time to answer a call is consistent - averaging 6 seconds since May 16
Ambulance Response Programme	Red 1 performance	11/12/2016	↑	71.6%	67.4%	There was a step change improvement in weekly performance between 24th July and 11th September, since 11th September weekly performance remains around the 52 week average for the period (c68%)
	Handover lost hours (mins)	11/12/2016	↑	44576.4	21371.2	There is a significant increase in the reported time lost for the weekending 11th December at Leicester Royal Infirmary
	Demand	11/12/2016	↑	2993	2858	There has been a shift increase in demand from May 2016, the proportion of cases conveyed has shown a shift increase since 3rd Apr 16
	Red conversion (%age)	11/12/2016	↑	64.2%	59.4%	There is a shift increase in weekly Red Conversion from September 2016
Streaming into ED	4 hour performance (Admitted and non-admitted breaches)	16/10/2016	● ↑	81.1%	70.2%	No special cause variation in long term weekly performance noted Incomplete data for UCC from w/e 9th October
	UCC & ED Weekly Attendance	04/12/2016	↓	3312	3344	Whilst not yet a special cause variation, for the last 6 weeks of data the number of ED attendsis higher than the weekly average for 52 week reportng period Incomplete data for UCC from w/e 9th October
	Time from arrival to treatment (% Seen with 90 mins)	16/10/2016	↑	43.4%	41.7%	No special cause variation in long term weekly performance noted Incomplete data for UCC from w/e 9th October
Improving Flow	*Beds allocated within 60 minutes - %age and target*					Due to change in IT system in ED, information provided in the UHL Metrics report to AGEM unavailable from the 4th December
	Short Stay EM Admissions (LoS <=6 hrs & >6 hrs)	11/12/2016	↓	16.6%	18.3%	There has been a shift decrease in % LOS <=6hours from 10th July 2016
Discharge	% patients discharged before 12 noon	11/12/2016	↓	6.31%	7.63%	No special cause variation in long term weekly performance noted for % discharges before 12 noon Due to change in IT system in ED, weekly Rebed information provided in the UHL Metrics report to AGEM unavailable from the 4th December
	DTOC (% Patients Delayed)	01/12/2016	↓	6.16	6.44	
	Re beds	04/12/2016	↓	0	10	

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. Figures are dated)	Metric			RAG rating
1	1.2	**Impact monitoring action:** increase the streaming/treating and redirection of patients from ED front door	UHL	Lisa Gowan (Ffion Davies)	**8a**	1. Ongoing monitoring of new model of care and impact on performance metrics	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Fortnightly review of the service - on-going, to inform opening of new service, 1.4.17	Continuation of effective service 1.4.17	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. First of fortnightly review meetings with Lakeside commenced; metrics for the new clinical model of care agreed. 2. Nurse in Charge role started 1.11.16 to have overview of department 3. Interviews for additional GPs and ECPs to take place in December 4. In-reach ENP for see and treat to begin 3.12.16	44% (% pts treated and redirected)	55%	~~Sept 44%~~ ~~Oct 46%~~ Nov 48%	**4**
1	1.4	Maximise use of ambulatory pathways across the front for, ED and CDU	UHL	Lisa Gowan (Ursula Montgomery/ Ffion Davies)	**11**	1. ED on the day review of utilisation of ambulatory pathways planned. 2. Develop action plan to address any gaps 3. Implement change 4. Reaudit 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them.	1. Increase number of patients accessing ambulatory pathways	1. ED on the day review of utilisation of ambulatory pathways planned 28/9/16 2. Develop action plan to address any gaps 14/10/16 3. Implement change 4/11/16 4. Reaudit 25/11/16 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them 7/12/16	Complete by 07/12/2016	1. Decreased ED attendances 2. Decreased non-admitted breaches 3. Decrease late referrals to ED	ED attendance	1. Work underway to forward plan for ways of working within new front door of new build 2. Review current list of ambulatory pathways, and sense-check for ease of use and explanation about services to ensure pathways are clear and meaningful for use by clinical teams. 3. Update at 1 March EQSG on ongoing pilot of ambulatory unit at CDU	% late referrals to ED	5% (Revised to reflect late referrals)	Oct 18% Nov 15%	**3**
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan (Vivek Pillai)	**18**	Implement Rapid Assessment and Triage (RAT): 1. On the day observation to identify areas of improvement 2. Develop improvement plan 3. Implement improvement plan Patients to be seen by senior decision maker in 90mins & have decision made within 180 mins: 1. Two hourly huddles implemented with senior nurse, doctor and manager; from 1 September there will be a focus on time to be seen by doctor. 2. Implement process to ensure appropriate use of escalation areas 3. Revise SOP for Majors - COMPLETE 4. Reduce medical handover times to maximum of 20 mins	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	Implement rapid assessment: 1.Observation and plan - complete 31 Oct 2016 2. Implementation - complete 30 Nov 2016 Patients seen within 90mins/decision within 180mins: 1. Huddles began 1/9/16. 2. Implement process to ensure appropriate use of escalation areas - in place 3. Revise SOP for Majors - 30 October 4. Rapid cycle test new medical model - 30 October	All actions to be complete by ~~30 October 2016~~ 28.11.16 (actions now picked up in 18a, 18b and 18c below)	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Internal escalation process updated and in place, to improve timely ambulance handovers 2. Doctor in Charge role card updated and circulated 3. Role card for majors leader finalised 4. External support for implementation of RAT is required; contact has been made with Sherwood Forest Hospitals FT, via NHS Improvement. 5. ECIP visit to Trust 12 and 13 January 2017, including external ED consultant input. 6. ECIP feedback following 2 days 13.1.17 - awaiting report	48% (% patients with decision made within 180mins)	95%	~~Aug: 45%~~ ~~Sept: 43%~~ ~~Oct: 42%~~ Nov: 45%	**2**
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan	**18a**	Intensive coaching programme to commence 28.11; increased leadership presence on the shopfloor, alongside senior nursing teams.	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances		Ongoing to January 2017	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Develop action plan 2. Confirm key staff members involvement 3. Develop robust communication plan 4.Develop presentation for 23.11.16 EQSG 5. Confirm medical approach 6. Programme began as planned; initial positive feedback from staff. Impact of increased operational pressures has reduced availability of coaches on shopfloor. 7. Programme methodology embedded into planning for new emergency floor	48% (% patients with decision made within 180mins)	95%	Aug: 45% Sept: 43% Oct: 42% Nov: 45%	**4**
1	NA	Develop ED internal professional standards	UHL	Vivek Pillai	**18b**	Rapid cycle test single queue working w.c 28.11	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances		RCT complete by 2.12.16	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Updated role cards now in place 2. Nursing teams realigned to support change in process 3. Communication to all A&E teams to be circulated by 25.11.16 4. Debrief and review to take place w.c 5.12.16, ensuring SOPs are up-to-date and relevant 5. Actions completed as planned 6. Ongoing monitoring of impact on metric and performance overall	48% (% patients with decision made within 180mins)	95%	Aug: 45% Sept: 43% Oct: 42% Nov : 45%	**4**
1	NA	Develop and implement tighter protocols for use of ED 'red light' and CDU 'stop'	UHL	Lisa Gowan	**79 (new)**	1. Produce CDU operational policy, clearly outlining when a 'stop' can be put in place 2. Review use of ED 'red light'	1. Reduction in stops to CDU		30.01.17			1. CDU operational policy ratified in CDU Operational Group and implemented. 2. 'Red light' review part of revised escalation process and HALO action cards.	Reduction in number of CDU stops			**4**
1	NA	Implement CDU-EMAS direct streaming protocol, to minimise transfers from ED.	UHL	Lisa Gowan	**80 (new)**	1. Develop protocol for direct streaming 2. Engage with clinicians on revised Standard Operating Procedure (SOP) for CDU	1. Reduction in ED transfers to CDU		30.01.17			1. CDU SOP revised, including direct streaming protocol 2. Meeting with clinicians planned for 16 January 2017 3. Review of weekend cardiology and respiratory in-reach to CDU (EQSG 18.1.17)	Reduction in transfers from ED to CDU			**4**
2	1.1	Ensure GP's have direct access to a Consultant for clinical discussions prior to acute referral	UHL	Rachna Vyas	**2**	~~1. Secure funding for pilot extension~~ ~~2. Implement roll out plan to Paeds and geriatrics~~ 3. Re-launch service to all GP's 4. Evaluate CC activity to agree BAU from 01 Apr 2017	Increase in avoided EAs in specific specialities (from 66% to c.70%) Increase in utilisation rates in Primary care from 74% to 95%	~~1. Agree to continue CC~~ ~~2. Roll out to Paeds & Geriatrics~~ 3. Re-launch at PLT using clinical case studies (City) / Lynn Lee writing new comms for dist Dec 2016 4. Ensure connectivity with community services	~~1. Complete~~ ~~2. Paeds live Oct 2016 / Geriatrics due Nov 2016~~ 3. ~~21st Sept 2016~~ / Dec 2016 4. Jan-Feb 2017	Reduction in admitted breaches	ED attendance Emergency admissions Ambulance conveyance	~~1. Funding secured for pilot to 31 Mar 2017~~ ~~2. Comms for CC Dec 2016 via LLR UC Team~~ 3. Case studies for PLT outstanding SLS to chase if still appropriate 4. Will be undertaken by SQW Vanguard evaluation- particular emphasis on clinical outcomes and ?lack of clinical resources to support the service	Increase in utilisation rates in Primary care Baseline 74%	95%	74%	**2**

4	NA	**Impact monitoring action:** UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9a**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. Opening of remaining beds, to create 28 bedded-ward 31.12.16 2. Ongoing review of use and impact on performance metrics	Ward fully open 31.12.16 Complete	1. Reduction in breaches linked to poor flow and ED occupancy	Admitted breaches	1. Weekly review of staffing levels and potential for opening additional beds on ward 2. New HCAs begin in December 3. Plan to open ward fully by end of December, HCA recruitment dependent. 4. 18 beds now open 5. Continue to try and staff to 28 beds - ward now able to take 28 patients. 6. Significant decrease in number of medical outliers across the hospital	55% of patients allocated a bed within 60 mins	75%	~~58%~~ ~~Oct: 49%~~ Nov: 46% Dec MTD: 53%	**4**
4	NA	Impact monitoring action: Impact of GPAU model of care into ED	UHL	Lee Walker, Ian Lawrence	**10a**	Ongoing monitoring of impact of change of model for GPAU pull of patients from ED and UCC by senior acute physicians	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. Monthly review of impact	Ongoing	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admission	1. Weekly meetings in place to review impact 2. Update to EQSG 23.11.16 3. Initial 2 week data is positive, showing marked reduction in admissions to AMU and increase in patients being seen directly in GPAU, rather than ED. 4. Options appraisal on extending opening hours on sustainable basis, to be completed by 4.1.17 5. Discussion at EQSG 18.01.17 on extended hours of GPAU and financial impact. Next steps agreed for securing additional resource for extended opening.	% with GPAU or AAU as first location	33%	Oct: 25% Nov: 36% Dec MTD: 38%	**4**
4	NA	Reduce handover times for medical team in ED	UHL	Matt Metcalfe	**18c (Was 15)**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete ~~27 November 2016~~ 13 January 2017	1. Reduction in wait to be seen in ED	breaches	1. Deputy Medical Director now supporting diagnostic and development of key actions, hence change in timeline. 2. Slippage due to annual leave and operational pressures; meeting being held 16.1.17 to agree approach and next steps 3. To be included as part of observation provided by external ED consultant support - awaiting report.	Handover time: Medical: 3 hours (out of 24)	Maximum 1 hour (out of 24)	3 hours	**2**
4	NA	Improve leadership and behaviours in ED.	UHL	Ian Lawrence	**21**	1. Appoint OD consultant 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. 3. Delivering coaching for key leaders within ED	Improved staff morale	1. OD consultant in post May 2016 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. - on-going 3. Delivering coaching for key leaders (Heads of Service & Key managers) within ED - complete August 2016 4. Agreement with Exec colleagues on tackling challenging behaviour and reducing variation. 5. Implement consistent daily action learning	This is on-going work until 31 March 2017	Non specific	Breaches	1. Pulse check baseline complete July 2016 (174 responses) 2. Follow up taking place September 2016 (20 responses) 3. LiA recruitment & retention event planned Oct 16 4. NHS Elect (coaching leaders) began on 24.10; next session in January 5. OD sessions complete - outcome and next steps discussed at 26.10 EQSG; multi-media alternatives being developed to increase uptake. 6.UHL change programme developed to focus on 30,60,90 day high impact actions. To be aligned with updated OD focus and plan (8 below) 7. Area of ECIP focus. 8. Following presentation at EQSG on findings from OD Sept-Nov actions, OD plan to be refreshed and refocused on delivering interventions and support to the team 'in situ' to support cultural change in ED. 9. Link to action 18: Intensive coaching programme, supported by OD team, Associate Medical Director, and senior leadership team. 10. Plan presented to EQSG 23.11.16 11. NHS Elect resilience training for band 7 nursing staff and service managers, taking place in December 12. Actions linked with RAP action 18 - internal professional standards	Sickness rate: 3.9% Turnover: 9.7% Vacancies: 30%	Sickness rate:3% Turnover: 9.5% Vacancies: 10%	Sickness rate: 3.8% Turnover: 9.7% Vacancies: 28%	**4**
4	NA	Reduce overnight breaches	UHL	Lisa Gowan	**22**	1. Senior leadership shift change (2pm - 10pm) over winter 2. Pro-active use of escalation areas to allow space in ED for decisions to continue to be made 3. Ensure consistent huddles over the night period 4. Open additional beds (as per previous action re ward 7)	1. Reduction in breaches 2. Improved patient experience	1. Implementation of the late shift rota (senior management 2pm -10pm) 3rd October - COMPLETE 2. Increased clinical matron presence 7 days per week including evening 3rd October 3. Ensure safety huddles are completed during the night (SMOC or duty manager to lead) 5th September 4. Open additional ward capacity 1st November 2016 - Complete	All actions to be complete ~~1 November 2016~~ ~~16 December 2016~~ March 2017	1. Reduction in breaches overnight	Breaches	1. Intensive coaching programme to include overnight in ED in January. 2. Actions to be progressed following completion of overnight diagnostics: - Review of medical rota versus demand overnight - New escalation process agreed and in place - COMPLETE - Review approach and capacity to processing patients in the evening/overnight 3. Included as part of external request for medical leadership support 4. ECIP to run a red2green style diagnostic between 6pm-2am, to support team understanding of key problems and potential solutions	Currently 29% of patients arriving between 7pm and midnight are treated within 4hrs	70%	~~32%~~ ~~Oct: 30%~~ ~~Nov: 31%~~ Dec: 29%	**2**
4	NA	Rapid Flow (formerly - Implement SAFER Patient Placement across UHL)	UHL	Lisa Gowan (Ian Lawrence)	**36**	1. Launch communication throughout UHL 2. Project plan to be developed on how UHL roll-out on wards 3. Roll-out across Medicine 4. Full roll-out across UHL 5. Re-opening of discharge lounge	1. Increase discharges from wards before 1pm 2. Reduce breaches in ED 3. Reduce congestion in ED 4. Improve patient experience 5. Decrease use of escalation areas	1. Launch communication throughout UHL - complete 7th September 2016 2. Project plan to be developed on how UHL roll-out across wards - complete 14th July 2016 3. Roll-out across Medicine - go live 10th October 4. Full roll-out across UHL - phased roll out January to March 2017 5. Re-opening of discharge lounge - 28th November 2016	~~Go live of Safer across medicine on 10 October 2016~~ ~~30.11.16~~ March 2017	1. Reduce breaches in ED 2. Reduce time from bed request to allocation	admitted breaches	1. Further work required to develop plans to rapid flow from AMU to base wards. Outline plan developed; meeting planned for 03.01.17 to discuss next steps and implementation. 2. Initial proposals being presented to EQSG 18.01.17 for discussion and approval of next steps. 3. Plan for roll-out of Rapid Flow to Glenfield to be developed post LRI implementation 4. Proposal for dedicated Rapid Flow Transfer Team led by the AMU Tracker and including some additional HCAs and existing porters being worked up; further two week trial to be held to test model	55% of patients allocated a bed within 60 mins	75%	~~58%~~ ~~Oct 48%~~ Nov: 46%	**3**
4	NA	Implement specialty in-reach/ownership of referred patients to ED	UHL	Matt Metcalfe	**40**	1. Review Trust Watershed policy 2. Benchmark against specialty in reach services in other Trusts 3. Work with HOS and CD to communicate policy to all other specialty CDs 4. Re-implement Trust watershed policy	1. Reduced wait times for ED patients by releasing ED medical staff 2. Improve patient experience	1. Review Trust Watershed policy - complete by 17/10/16 2. Benchmark against specialty in reach services in other Trusts - complete by 17/10/16 3. Work with HOS and CD to communicate policy to all other specialty CDs - complete by 17/10/16 4. Re-implement Trust watershed policy - complete by 17/10/16	All actions to be complete by 30.11.16 13.01.17	1. Reduction in breaches 2. Improvement in time to be seen by a doctor and time for a plan 3. Reduction in conversion rate	breaches	1. Deputy medical director to meet with majors HOS to discuss further and agree actions 2. Slippage due to annual leave and operational pressures; meeting being held 16.1.17 to agree approach, support required and next steps 3. Criteria for 30 minute specialty review of ED patients agreed and in place. 4. ED liaison for all consultants being included in job planning reviews as part of ongoing CMG-wide initiative for in-reach structure to ED.	21.2% (ED conversion rate)	TBC	21.30%	**4**

4	4.2 4.5	Implement Red Day / Green Day as part of SAFER	UHL	Gill Staton (Ian Lawrence)	**47**	1. Investigate feasibility of method of capture of Red and Green Days (white boards or electronic) - complete 2. Develop Red and Green Day Criteria for implementation - complete 3. Develop launch pack - complete 4. Communicate to and educate staff - complete and ongoing 5. Roll out across ESM -audit following roll-out - complete	1. Decrease LOS for ESM	1. Agree Nerve Centre feasibility of recording of R&G days by 1st October 2. Agree R&G Day Criteria by 29th September 3. Roll-out of launch packs on 10th October 4. Audit 14th November 2016	All actions complete by 14 November	1) Improve base ward capacity for admissions from ED.	Admitted breaches	1. Red to Green being rolled out in all wards in ESM from 12 December. Resource identified and planning commenced week commencing 28.11.16. ECIP are supporting the start of the project - COMPLETE AND ONGOING 2. Director leads identified for each ward as part of roll-out. 3.Full R2G action plan in place, plan for phased roll-out plan to the whole Trust by end March 2017 4. Key themes being identified for escalation and solutions to embed and sustain new ways of working	5.82 (average length of stay for Medicine)	4.67	5.82	**3**
4	NA	Implement direct admissions from ED to specialities	UHL	Matt Metcalfe	**68**	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 2. Data analysis to determine impact change will have 3. Agree Patient criteria 4. Write SOP 5. Communicate process to teams 6. Implement 7. Feedback session to ensure the team capture any changes and improvements required	1. Decrease admitted breaches 2. Decrease overcrowding in ED 3. Improved patient experience	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 10th Oct 2. Data analysis 31st Oct 3. Agree Patient criteria 31st Oct 4. Write SOP 11th Nov 5. Communicate process to teams 18th Nov 6. Implement 28th Nov 7. Feedback session to ensure the team capture any changes and improvements required 19th Dec	~~28.11.16~~ 13.01.17	Decrease breaches	admitted breaches	1. Meeting planned with MD, CD to agree implementation plan 2. Electronic system in place for referrals/accepting patients directly onto acute medical wards 3. Discussions begun on directly admitting patients from ED to SSU. Pathway developed and shared with colleagues. 4. GPAU move to yellow majors space 7.11.16, includes active medical in-reach into ED embedded in way of working. 5. Deputy and associate medical directors to agree which pathways/specialities need to be focused on to increase direct referrals 6. Direct admissions to specialties from GPAU rolled out 19.12	80%	77%	TBC following data analysis	**4**
4	NA	Improve ambulance handovers	UHL	Lisa Gowan	**78**	Reduce delayed ambulance handovers by proactive and continuous use of escalation areas	1. Reduce time patients wait on ambulances 2. Release EMAS crews quicker.	~~1. Create ambulance offload area using space in the corridor at the back of ED (GPAU waiting area) from 12pm-12am~~ ~~2. Arrivals crew to monitor patients in this area~~ ~~3. Develop joint SOP with EMAS~~ REVISED APPROACH 1. Ensure all escalation areas are appropriately staffed and utilised continuously 2. Consider all potential solution for creation of additional cohorting space	Test day 13.16.16 Roll out 19.12.16	Decrease breaches	admitted breaches	1. Relocate vending machines from area to create GPAU waiting space - COMPLETE 2. Issue comms to team - COMPLETE 3. Run concept test day 13.12.16 - COMPLETE 4. Develop robust SOP and circulate to teams -ongoing to reflect revised approach 5. Full roll-out w.c 19.12.16 - COMPLETE (new approach) 6. Cohorting policy and locations to be reviewed by external ED consultant (13.01.17) 7. Review of additional/potential space for cohorting is ongoing; this includes creation of ward for MFFD patients whilst discharge arrangements are confirmed.	Ambulance handover within 30mins of arrival			**4**
5	5.6, 5.1	Additional packages of care/DRT input will need to be purchased to reduce delayed discharges from the acute trust	UHL	Tamsin Hooton	**48**	Commission extended capacity in DRT to support discharge. £155k = up to 5 beds until the end of March 2016	Increased flow, Reduced delays in discharges	Funding source to be identified. Business Case to EQSG, Discussion at AEDB 5/10	01/01/2017	Reduction in LOS	% discharges before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % of UHL DTOC	Help to Live at Home is now settling into 'business as usual' and hospital discharges have been prioritised. Providers are reporting flow is improving. **Suggest reviewing this action again in 4 weeks. RAG rate changed to Green 4**	TBC	increase by 5	TBC	**4**

5	5.2	Provide electronic means of sharing the trusted assessment with partner organisations at point of transfer of care	UHL	Tamsin Hooton	**56**	42 + 43. Commence a task and finish group to review and agree interoperability across LLR health, social care, and partner agencies. Hospital social care teams to use VPN connection in short term.	Provides initial access to trusted assessment for new pathways (enabler for success of pathways) Agree preferred option via BCT IMT group Progress Options analysis for information sharing, including Everis solution	Initial task and finish group 3rd October 2016 Options analysis to IMT group November ROI	March 31st 2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Group continues to meet. Rutland has made significant progress involving use of System 1 and Liquid Logic for in-reach team. Plan to watch Rutland's trial period in January and then review replicability across the rest of LLR. Business case to follow review of trial. **RAG remains of amber 3**	Number of MDS assessments completed by UHL , number TBC at task and finish group	Number of MDS assessments accessed by other agencies. Baseline 0, December TBC	NA	**3**
5	5.1, 5.4	Provide an efficient system wide 'D2A' pathway	UHL	Tamsin Hooton	**59**	45. Switch off existing D2A pathway to coincide with commencement of Pathway 3	Pathway 3 becomes the discharge to assess route out of hospital.	Initial discussion required with UHL to start closing the pathway down ready for January	30-Jan-17	Increased flow, reduced admitted breaches, reduction in LOS		Await outcome ofspot/block purchase for pathway 3 plan B before commencing planning for switching off existing D2A pathway. Integrated in-reach discharge team to provide support initially to existing D2A cohort in order to close down beds quickly. **RAG remains of amber 3**	Number of open cases. Baseline: 80.	November: 45. January: 30. March: 0	80 open cases	**3**
5		**Moved from KIA2 21/12/16:** To ensure that patients discharged from the Acute Trust with a Nerve Centre PARR+ score of +5 are provided with adequate community support to prevent readmission within 30 days	UHL	**TBC**	**66**	1. Roll out use of PARR30 tool 2. Update Nerve Centre with PARR score for at risk patients 3. Identify and implement community/primary care support within 48 hours of discharge	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	1. Nerve Centre being updated by 30/11/2016 2. Primary/community care support secured and implemented 3. CTR liaising with Jane Busman for conf. that ICRS can undertake all LLR calls daily (anticipated volume 10 daily)	1. November 2016 2. November 2016 3. November 2016	Reduction in attendances at ED and admitted breaches	Reduction in readmissions	Patient needs to be f/u by UHL staff Establish what ICRS are currently offering Establish what HART are currently offering Call handlers could be non-clinical but need access to the UHL clinical record Need to agree an LLR offer	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	10% reduction	Awaiting data	**2**

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. Figures are dated)	Metric			RAG rating
4	NA	Reduce time from bed allocation to departure from ED	UHL	Julie Taylor	14	1. Establish baseline 2. Identify themes for delay 3. Allocate Rapid Flow team to ED 4. Communicate and promote change in process 5. Rapid cycle test the new process 6. Implement	1. When beds are available, patient will leave within 15mins	1. Establish baseline - complete 18th July 2. All other actions were completed in August	All actions complete 1 September 2016	1. Improve flow from ED 2. Decrease congestion in ED	admitted breaches	1. Work with the rapid flow team has shown an reduction in the average time from 30 mins to 19 mins. 2. Delay themes identified: * Photocopying issues - resolved * Patient status issues -resolved 3. Currently looking at issues around bulking of bed availability and transport issues. 4. Data requested on % of patients with bed request outside of LRI as impacting on 15min performance. Data will then be cleansed to provide a true reflection of improvement made.	26% (patients leaving dept within 15mins of bed allocation)	50%	31%	5
4	NA	Reduce handover times for nursing team	UHL	Julie Taylor	15	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 7 November 2016	1. Reduction in wait to be seen in ED	breaches	Handover time : 20mins	Handover time: 15 mins	Maximum 15 mins	20 mins	5
4	NA	Reduce delays in diagnostics for patients in ED	UHL	Julie Taylor	20	1. Baseline audit to be completed 2. Identify reasons for delay from audit 3. Complete trial of dedicated porter for 3 days in ED	1. Decrease congestion in ED 2. Improved efficiency of diagnostics	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters	All actions to be complete 17 October 2016	1. Reduction in patient wait times 2. Reduction in breaches	Breaches	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters 4. Porter trial took place on 13-15 September; further meeting planned this week to discuss and review the data gathered and look at potential service improvements. Being picked up in workstream.	Transfer time from ED to imaging metric is being reviewed	TBC	TBC	5
1		NHS Improvement recommended presentation from South Warwick on how they improved system performance.	UHL	Lisa Gowan	25	-CD to make contact with South Warwickshire Trust - Invite to present to senior leadership team to identify any further actions for UHL to implement	Unable to comment on expected outcome until contact has been made	Unable to comment on expected outcome until contact has been made	Exchange visit to be complete by 1 November 2016	Unable to comment on expected outcome until contact has been made	Breaches	1. Clinical Director made contact with South Warks Director of Ops and Medical Director to confirm next steps. 2. Contact made; South Warwickshire to provide dates for UHL visit. 3. Action to be picked up by workstream	Unable to comment on expected outcome until contact has been made	TBC	TBC	5
4	NA	Improve discharge from UHL by decreasing transport delays	UHL	Gill Staton	45	1. Meet Arriva and CCGs to establish reasons for delays 2. Implement actions to address delays 3. Implement a weekly meeting to review patients that were re-bedded and identify themes and develop actions to resolve 4. Establish process of prospectively booking discharges 5. CCG to complete procurement of NEPTS	1. Increase early discharge 2. Decrease failed discharge	1. Set up meeting with Arriva & CCGs by 1st October 2016 2. Set up weekly review to start w/c 26th September	All actions complete by end of October	1) Reduction in breaches 2) Improved flow out of ED	admitted breaches	1. CCG UHL meeting 29.9.16 to discuss contract arrangements and overbooking processes to manage demand until new contract confirmed 2. Arriva UHL meeting 30.9.16 to jointly improve processes 3. Meeting took place with Arriva; new way of working agreed, including focus on discharge from assessment areas and increase ambulance utilisation.	4.5% (discharges pre 11am) 13% (discharges pre 1pm)	33% before 12.00	4.2% (discharges pre 11am) 12.9% (discharges pre 1pm)	5
4	NA	Implement low risk ambulatory service on CDU	UHL	Sue Mason	26	1. Business case to be written for EQSG 2. Meeting with CCGs to discuss commissioning 3. Implement if commissioned	1. Maintain LOS on CDU achieved during pilot (July/August) 2. Average LOS in low risk ambulatory service 2 hours 3. Improve quality for patients by decreasing time in CDU	1. Business case went to EQSG on 31st August 2. Met with CCGs to discuss commissioning 6th September 3. Implement if commissioned 1st December	If commissioned, 01/12/2016	1. Decrease in frequency of CDU going on a 'stop' therefore decreasing congestion in ED and number of breaches	breaches in ED	1. Funding agreed; service begins on 1.11, four days a week. Clinical lead actively seeking GP cover to provide five day service.	13 (Length of stay in CDU)	13 (target to achieve length of stay achieved during the pilot)	13.3	5
1	1.2	Increase the streaming/ treating and redirection of patients from ED front door.	UHL	Lisa Gowan (Ffion Davies)	8	1. Model streaming service integrating Lakeside with primary care team & UHL. 2. Develop staffing model to allow increased streaming. 3. Develop clinical model to enable increased treat and redirect.	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Paper to JA confirming the service integration plans 23/9/16. 2. Continuation of the streaming service 1/11/16 3. Remodelling of the streaming service 1/12/16 4. Monthly review of the service - on-going 5. Opening of new service 1/4/17	Continuation of service 1/11/16	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. Contract with Lakeside extended from November 2016 to 1st April 2017 2. Integrated model of care agreed 3.New integrated workforce model implemented from 10/10 4. Paper outlining the clinical model for procurement from April 2017 being drafted for discussion. 5. Regular KPI monitoring meetings with Lakeside in place from 1.11.16.	44% (% pts treated and redirected)	55%	44%	5
1	NA	Review short stay capacity & demand and determine if we are going to increase the short stay capacity and reduce base ward capacity	UHL	Lisa Gowan (Lee Walker)	13	1. Review literature on how many AMU beds are required to match demand and capacity 2. Visit other Trusts to compare the size of their AMU capacity to ours 3. Determine if we are going to increase our short stay capacity or not	1. Improvement in flow from ED 2. Improvement in patient experience 3. More efficient way of working, leading we hope to a reduction in LOS	1. Review literature on how many AMU beds are required to match demand and capacity - 9/9/16 2. Visit HEFT to compare the size of their AMU capacity to ours - 2/9/16 3. Determine if we are going to increase our short stay capacity or not - 28/9/16	Agree on whether we will increase AMU capacity or not 28/9/16 30.11.16	1. Improvement in flow from ED resulting in a reduction in non admitted breaches	Admitted breaches	1. ECIP suggested we are 28 to 50 beds short. 2. Contact being made with HEFT to discuss their capacity and clarify numbers. 3. Agreed to move GPAU to yellow zone 7.11.16 until March 2017; vacated capacity to be used as four additional AMU beds (opening dependent on safe staffing). This will provide insight into future short stay capacity requirements. 4. Nursing and medical staffing pressures and space potentially restrict further increase in bed numbers. 5. Fire, health and safety and infection control reviews of vacated space to be carried out to determine number of bed spaces available: UPDATE: 3 bed spaces available in vacated area. 6. GPAU capacity extended from 6 to 9 spaces. 7. Ward 7 open as transitional ward/discharge area. 8. No other space to add additional beds currently.	106 short stay beds	134	106	5
4	NA	Trial senior acute physician in ED to challenge admissions	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	10	1. Three day trial in September 2. Two further trials to take place to confirm results 3. Collate results and review outcome of trials 4. If results positive review medical job plans to check if it can be staffed within existing resource. 5. Implement (if outcome positive)	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. 15th August complete 1st trial 2. 29th August completed 2nd trail 3. 26th September complete 3rd trial 4. 3rd October review outcomes and confirm benefits and decision to progress	Decide by 14/10/2016 11/10/16 if this will be fully implemented COMPLETE	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admissions	1. First two trials complete-provisional data showing decreased conversion to admission 2. CHKS data to be used to benchmark target against peers, and develop key further actions for UHL. 3. Acute physician in ED not sustainable long term due to resource constraints. 4. GPAU to move to yellow zone space from 7.11.16 for GPAU patients, UCC referrals from ED, and pull from majors. This will allow challenge of admissions and appropriate pts to be pulled from ED to ambulatory stream by acute physicians. 5. Weekly review of model of working with GPAU next to ED	21.2% (ED conversion rate)	18.70%	21.30%	5
4	NA	Increase utilisation of yellow zone (ambulatory majors)	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	16	1. Determine different staffing models to test 2. RCT models 3. Review outcomes 4. Develop model 5. Implement change	1. Reduce non-admitted breaches 2. Improve patient experience	1. 29.6.16 RCT an Acute physician model running this area 2. Collate results 3. If positive see if this model is viable (resources)	30.11.16	1. Reduction in breaches	breaches	1. Initial day trial (RCT) went well; needs longer trial to prove concept and collect meaningful data to support approach. LW to action. 2. Obtain data from Leeds Hospitals via ECIP re their model and criteria. 3. HOS to review criteria for local use 4. Daily reminder to clinical matrons to be responsible for ensuring patients are identified for yellow zone. 5. Yellow zone area to become ambulatory area for GPAU patients, UCC referrals to ED, and pull from majors beginning 7.11.16. This is in line with model that will be used in new Emergency Floor. 6. Weekly review of new model of care, including pull of ambulatory patients from ED, to take place following relocation of GPAU. 7. Monitoring as part of action 10a. 8. Yellow majors no longer exists; GPAU in ED now in place	68% (Majors yellow area 4hr performance)	95%	61%	5
4	NA	Develop hospital internal professional standards (incl speciality in-reach to ED)	UHL	Sue Mason	43	1. Implement UHL Better Change project to decrease Cardiology inpatient LOS pre Cath Lab 2. Implement daily review of patients on monitored beds 3. Review capacity and demand of monitors available	1. Improved LOS in Cardiology 2. Decreased delay of transfer of patients from ED to CDU	1. Baseline data collection of cath lab waits - complete 2. Implement electronic referrals for Cath lab - complete 3. Implement Hot lab Cath lab sessions - complete 4. Reaudit Cath lab waits 11th November - this has been brought forward to October	All actions to be complete by 11 November 2016	1) Reduce delay of transfer of patients from ED to CDU	ED breaches	1. Baseline data collection of cath lab waits complete 2. Implement electronic referrals for Cath lab complete 3. Implement Hot lab Cath lab sessions complete 4. Reaudit of Cath lab waits taking place w/c 24.10 to confirm if changes have had necessary impact. 5. Post-change audit complete; shows decreased wait time for patients and decreased LOS. Contributing factors include improved communication between ward and lab; increase in timely referrals	-	3.5	3.4	5
4	NA	Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	UHL	Lisa Gowan	27	1. Establish baseline activity 2. Review the criteria 3. Case note review to determine if the patient was conveyed to the right location 4. Develop action plan 5. Implement any required changes	1. Decrease conveyance of cardiorespiratory patients from LRI to Glenfield 2. Improve quality to ensure that patient gets to the right specialty first time	3. Case note review to determine if the patient was conveyed to the right location 30 September 4. Develop action plan 31st October 5. Implement high impact and short term rapid interventions 30th November	Full implementation 30 November 2016	1. Reduce attendances at ED 2. Reduce overall breach rate	breaches	1. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September 2. 2 FY2's have been identified to carry out audit on those patients transferred from LRI to gather evidence on process and define next steps. 3. Audit complete - shows 34% conveyance due to lack of available beds. Actions to follow include: clear comms to CDU that all stops to be agree via	Oct	96 (10% reduction)	50 to date in Sept (ED LRI to GGH)	5
5	5.6, 5.1	Increase OPAT provision (up to 2 beds) to provide a service that delivers IV antibiotics in the patient's own home, in order to reduce LOS	UHL	Tamsin Hooton	49	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	Increased flow, reduced LOS	MRET funding to be utilised to March (£100K) Advertise for 3 nurses (Sept 16) Identify consultant Pas (complete)	Expansion scheduled for 1/12	Reduction in admitted breaches, reduction in LOS,	Patients discharged from UHL	3 nurses in post with another due to start soon. Providing a 7 day service. Now need to work up a business case for longer term funding (funding agreed for 9 months). **Suggest closing this action. RAG changed to Green 5.**	current numbers of patients supported	2 bed expansion up and running (can be phased if recruitment requires)	TBC	5
5	5.5	ICS to provide a programme of education to hospital ward teams in order to increase the usage of ICS.	UHL/LPT	Tamsin Hooton	50	Share referral criteria for ICS - 10/09 Clinical ward rounds to identify suitable people (joint with LPT)	More appropriate referrals, increased utilisation of ICS	Circulate ICS criteria Communication exercise internally and on wards Ward rounds weekly - senior LPT and UHL staff - agree frequency and put in place	30/09/2016	Increased flow, reduced admitted breaches, reduction in LOS, ICS Capacity utilisation (baseline 80%, increase to 90%)	% of LPT ICS Beds used by patients	**Suggest closing this action.** ICS utilisation has improved (although it is more step up capacity being used than step down). **Rag changed to Green 5**	Number of referrals to ICS from UHL wards. Baseline TBC	TBC	TBC	5
5	5.1, 5.5	Review model of ICS for opportunities to increase usage, focus on County pathways	LPT	Tamsin Hooton	51	Integration of ICS with county POC provision/HTLAH model	More appropriate referrals, increased utilisation of ICS	Initial paper to Integration Exec 5/10 Full Cusiness Cases 5/11 Decision on further integration to go to Integration Executive Pilot in Loughborough of inreach/joint working with ICS	**Business case 2nd November to IE**	Reduced LOS/Reduced discharge delays, also supports 'step -up' and reduced ED admissions	% of LPT ICS Beds used by patients, % UHL DTOC	**Suggest closing this action.** ICS model to be reviewed as part of 'Home First' workstream within the STP. Loughborough pilot is in place. **RAG changed to Green 5**	Business case for social care input to work alongside ICS agreed	Business case agreed	Implementation	5
5	5.1, 5.5	Review future model of ICS to support discharge to assess and 'Home First' model	UHL/LPT	Tamsin Hooton	51a	Discharge Steering Group to agree strategic direction for **Discharge to assess,**	Better integrated discharge to assess approach across LLR, increased use of ICS	Agree future integrated discharge to assess short term model by November 2016 Trial changes to ICS model by November - March 2017 Agree Business Case with commissioners/BCT - Jan 2017	31/03/2017	Reduced admissions, reduced admitted breaches, reduced LOS, improved flow	UHL DTOC %	**Suggest closing this action.** ICS model to be reviewed as part of 'Home First' workstream within the STP. Integrated in-reach discharge team is now planned to support discharge to assess model. Discharge steering group has agreed short term vision of D2A, further planning required for medium/long term strategy. **RAG changed to Green 5**	Discharge to Assess model agreed.	Reduction in numbers of patients assessed for CHC in acute setting (baseline TBC) but target only 10%	Business case for social care input to work alongside ICS agreed	5
4	NA	UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	9	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. 10th October 2016 identified staffing to be confirmed 2. Equipment to be ordered and delivered by 22nd October 3. Planned opening 1st November 2016 4. Fortnightly progress update meeting in place with COO	Ward open 1 November 2016	1. Reduction in breaches linked to poor flow and ED occupancy	admitted breaches	1. Estates work on ward 7 started on 14/9/16 2. Communications have gone out to all staff in September 3. Equipment ordered on 25/8/16 4. Nurse staffing rosters set up and shifts sent out agency on 08/08/16 5. There is a fortnightly meeting in place chaired by COO to progress 6. On Track to open November 1st (The main risk to opening remains staffing) 7. Ward 7 delayed opening as a 28 bedded ward as unable to staff safely, continue to monitor weekly to establish if we can open a bay at a time 8. Ward to be used as discharge and transitional care ward (6-10 beds overnight) to support increase in morning discharges; appropriate	0%	28 beds open on the ward	0%	5
4	4.1 4.3 4.4	Implement SAFER patient flow bundle Trust wide **TS: When will Red2Green be Trustwide?**	UHL	Gill Staton (Ian Lawrence)	37	1. Baseline audit of wards to be completed on utilisation of the SAFER flow bundle 2. Develop actions to address gaps identified in audit 3. Re-audit once actions put in place 4. Phased roll-out across UHL	1. Increase in the number of patients discharged before 1100 2. Increase in the number of patients with EDD 3. Consistent board rounds on all wards 4. Decrease number of 'stranded' patients 5. Improve ward ownership 6. Increase patient experience by ensuring patient is part of the decision making process 7. (Percentages to be confirmed once baseline audit complete)	1. 29th August 2016 audit of 5 wards completed 2. 19th September 2016 baseline audit of 2 further wards to identify areas for improvement 3. Collation of results and feedback w/c 1st October 4. Action plan developed by 10th October 5. Implementation of plan to start 17th October on key wards 6. Start of baseline audit of remaining wards on 14th November 7. Action plan and full roll-out by mid-December	SAFER patient flow will be rolled out on two key wards by 01/11/2016 COMPLETE	1. Improve base ward capacity for admissions from ED.	admitted breaches	1. 29th August 2016 audit of 5 wards completed 2. Week of 19th September:2 further wards audited and data being collated for baseline 3. Resource for implementation of actions being identified 4. Re roll-out of professional standards 5. Increase rigour of board rounds to create consistency 6. Internal professional standards updated and will be re-launched with team throughout November. 7. Roll out across medical wards complete. 8. Trust wide roll-out - Area of focused support from ECIP; to be discussed further at UHL Beds Programme Board 3.11.16 9. Now being rolled out as part of Red/Green Trust wide initiative	5.82 (average length of stay for Medicine)	4.67	5.82	5
4	NA	Glenfield to open additional beds to decrease bed capacity/demand mismatch	UHL	Sue Mason	39	Open 28 beds on ward 23a	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in CDU 3. Contribute to an improved LOS on CDU 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward 5. Reduced frequency of CDU going on a 'stop' **TS: review of stop protocol required - see streaming action**	1. 18th November 2016 staffing to be confirmed 2. Equipment to be ordered and delivered by 31st October 3. Planned opening 1st December 2016	Ward is due to open on Monday 5 December 2016	1. Decrease breaches linked to better flow to GGH	admitted breaches	1. Communication to staff started 15th August 2016 2. Compiled list of equipment requirements - ordered w/c 18th Sept 3. Out to recruit for staff 4. Discussed with medical staff to provide cover 5. Funding agreed and phasing needs finalising - now complete 6. Rota now agreed; ward sister position filled; ward kit etc being ordered for 5.12.16 opening. 7. Ward opened ahead of schedule	0	28 beds open on the ward	0	5
2	1.8	Increase utilisation of step up capacity to prevent acute activity (interdependency with action 3)	LPT	Rachana Vyas	67	1. Develop additional guidance with GP's and circulate. This should include medical management template with pre-populated prescribing guidance and parameters 2. Improve engagement and understanding of service across General Practice through use of case studies 3. Consider viability of Bed Bureau referring to Step Up	Increase utilisation of step up capacity by > 2 patients per day by CCG	1. Guidance, template and Comms complete 2. Rolling programme of case studies and direct feedback to GP's to be implemented using Board GP's 3. GP review of clinical referrals into Bed Bureau to assess viability of proposing alternative pathway of care	1. 31 Oct 2016 2. 31 Oct 2016 3. 30 Nov 2016 TBC	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	Team identified at City CCG to lead development of template and guidance in partnership with LPT. Includes LPT team, nursing & quality, Medicines optimisation, IT leads and lead clinician GW writing a review of the triage ambulance pilot by 30/11/2016 - will recommend that the referral link between paramedics + MH Crisis Team is revisited. Aim to take to MH Clinical Forum Dec 2016 or Jan 2017	Increase utilisation of step up capacity by > 2 patients per day Baseline: City CCG: 1 per day West: 3 per day East: 2 perday Total: 6 pts/day	> 8 pts/day	w/e 14.10: City CCG: 1 per day West: 2 per day East: 2 perday Total: 5 pts/day	5

3		Implementation of Dispatch on Disposition	EMAS	Mark Gregory	34	1. Trust identified as adopter site 2. Timescales for implementation Negotiated with NHSE 3. NHSE assurance review and sign off 4. Mobilisation 5. Secure exec lead for ARP/DoD at the delivery board 6. Map Nature of Call list against current keyword flows	Reduction of Resources to scene by 0.2 from 1.4 baseline Linked to above non conveyance trajectory	1. Work with NHSE to register as implementer site 2. negotiate and agree timescales for mobilisation 3. Assurance review to be arranged and undertaken 4. Mobilise scheme	1. September 16 2. September 16 3. 10th Oct 16 4. 31st October 16	Reduction in A&E attendances		1. Trust approved as implementer site 2. Timescales agreed Update 20 Oct 2016 DoD live as at the 3rd October. Further review of call codes being undertaken as progress is made towards ARP. Current RPI rate of 1.34 07/11/16 - DoD implemented succesfully. RPI rate currently @1.32 1/12/16 - Current RPI @ 1.36	1.4	Oct 16 - 1.4 Nov 16 - 1.36 Dec 16 - 1.32 Jan 17 - 1.28 Feb 17 - 1.24 Mar 17 - 1.2	TBC	5

LLR A&E Delivery Board

Risk Register - November 2016

		Potential Risk Description	Initial risk level			Mitigating actions in place	Assurance	Further mitigating Actions	Expected date of completion	Reduced Risk Score			Comments
Risk Owner	Risk Ref	Should be high-level potential risks that are unlikely to be fully resolved and require on-going control	Impact	Likelihood	Rag Status	Systems and processes in place and operating that mitigate this risk	Evidence that this risk is being effectively managed	Additional actions required to mitigate this risk further	For further mitigating actions	Impact	Likelihood	Rag Status	
Tim Sacks	CL1	**RISK:** Keeping a patient in their usual place of residence with a treatable condition, managed by primary care and the patient dies. **CAUSE:** Capacity & confidence in primary care, OOH GPs adherence to pathways, availability of community staff to support primary care management, inconsistency across City & County. **Impact:** potential adverse outcome for patient	4	4	16	RAP - Area 2 Actions (link) Development of support services in community: - AVS/CRS, NHS 111, EMAS, OOH Workforce planning for primary care Consultant connect	Implementation of actions in RAP Area 2 by AEDB **KPIs:** ED attendance Unexpected deaths in the community	Undertake work to understand the variability across City & County Implement actions to change the culture of staff and patients regarding end of life care at home Support more GPs to take appropriate risk management in the community	TBC	4	3	12	
Rachana Vyas Mark Gregory	CL2	**Risk:** Too many people with a perceived need for emergency ambulance response **Cause:** Inappropriate assessment and or Access **Impact:** Patients waiting 'unsighted' in the community for a first response following initial telephone triage - EMAS crews unable to attend urgent cases in the community	5	5	25	RAP - Areas 2 and 3 (Links)	Implementation of actions in RAP Areas 2 & 3 by AEDB **KPIs:** SIs relating to patients waiting for ambulance response Red conversion rates Ambulance handover delays	Review actions relating to NHS 111 warm transfers Review interfacility transfers (UHL originated) Review Primary Care Access Rates	TBC	5	3	15	
Tamsin Hooton	CL3	**Risk:** Discharge breakdown **Cause:** Limited community capacity in health and social care, inappropriate early discharge, poor post discharge follow up, failure to plan discharge at the point of admission. CHC capacity, avaiability of HTLAH packages **Impact:** Patients not being discharged or patients being readmitted	4	5	20	RAP area 5 (Link)	Implementation of actions in RAP Area 5 by AEDB **KPIs:** DTOC Medically Fit for Discharge (MFFD) rates Stranded patient data Readmission data Discharges before 12pm	Review actions for post discharge follow up DTCO - conbined plan to be developed through discharge group CHC operational plan in pace HTLAH operational plan in place	TBC	4	4	16	
Caroline Trevithick	CL4	**Risk:** Management of a dying patient in the community results in hospital admission **Cause:** Lack of Advanced Care plan, failure to follow advanced care plan, lack of DNACPR, failure to follow DNACPR, pressure from families and carers **Impact:** Patients being admitted inappropriately at end of life.	3	4	12	End of life BCT plan	**KPIs:** Reports from UHL/EMAS regarding inappropriate admission			3	3	9	
Pete Miller	CL5	**Risk:** There is a risk that sufficient staff cannot be recruited or retained to fulfil the needs of the new operating models **Impact:** service changes the changes will either be delayed, or not made, or delivered at too high a cost, resulting in a failure to achieve the overall goals of the programme **Cause:** Insufficient staff	4	5	20	Workforce strategy complete Action plan in place to address known capacity risk areas (eg primary care, nursing)	BCT workforce group review	Develop approach to strategic workforce planning to assess new capacity risks as they arise - Ongoing Link with clinical workstreams to provide Ongoing workforce planning support - Ongoing Develop joint attraction strategy		3	5	15	

Trust:	**University Hospitals of Leicester NHS Trust**
Ambulance Trust:	EMAS
NHS 111 Provider:	Leicestershire & Rutland NHS 111 (DHU)

Submitted to NHSE 8/12/16

B-RAG	Description
Blue	**Recommended good practice has been implemented effectively in many areas throughout the organisation & is culturally embedded**
Green	**Good practice implemented in all key areas / recommended good practice is widely adopted although implementation may still be fragile**
Amber	**Gaps in good practice / behind planned schedule; recommended good practice is not widely adopted / behind agreed schedule with cultural or practical obstacles to implementation**
Red	**Significant gaps in good practice - recommended good practice has been adopted in single departments only and/or is not accepted by key clinicians**

Initiative		Statement of good practice	B-RAG	Commentary	B-RAG	Updated Commentary for Dec 16	Overall B-RAG
1. Streaming at A&E	1.1	All major specialties have a consultant immediately available on the telephone to provide advice & streaming for ED & primary care	Amber	24/7 on call cover across all major admitting specialities with 24 hr ED access. Consultant Connect available to GPs for acute medicine, Paediatrics and Geriatric medicine.	Green	Consultant connect available in acute medicine, geriatrics, paeds, diabetes, haematology, endocrinology	
	1.2	There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand	Amber	Streaming service (Lakeside) supported by urgent care in place. Challenges around workforce and ability to recruit. Reduction in treated/redirected patients since November as service scale reduced. Winter approach to be finalised by 30/9/16	Green	Lakeside now working alongside UHL to provide integrated primary care streaming service. Capacity and performance improved, will continue over winter	
	1.3	Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard	Green	Access to 24/7 liaison mental health services is available, and this is part of our overall improvement plan. Standard not always met for pts requiring admission	Green	No change	
	1.4	There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take	Green	Medical specialities. Access to ambulatory services exist but currently not taking 25% of patients. Surgical specialities via SAU with General Surgery offering a triage service Monday to Friday 0730 to 2000hrs at both LGH & LRI site.	Green	No change	
	1.6	There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients	Blue	Access to frailty pathways are appropriate for the criteria described within 24 hours of admission.	Blue	No change	
	1.8	Community and intermediate care services respond to requests for patient support within 2 hours	Amber	ICRS (City) in place and responsive. CRS (County) in place but challenged with response time due to capacity constraints.	Amber	HART team facing some challenges due to HTLAH implementation. ICS and ICRS response time within two hours	
2. NHS 111 calls transferred to clinicians	2.0	Given there is a requirement to increase from 22% to an national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&E Delivery Board has plans in place to meet this requirement	Amber	Modelling for the Clinical Navigation Hub suggests that this will be delivered by 31/3/2017.	Green	We now have 24/7 ED disposition triage in place, some MH and green ambulance in place, further expansion in January 2017	
	2.1	Clinical expertise availability is planned according to demand	Amber	As above	Amber	No change	
		The A&E Delivery Board has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH	Green	Led by Director of Urgent Care. Will be in place as pilot from Oct 2016 and procured in 2017/18 as part of integrated urgent care model within the Vanguard.	Green	LLR CNH test commenced 21st Nov.	
	2.6	The A&E DoS service type is ranked as low as possible, apart from other A&E-type services and services not commissioned within the CCG	Blue		Blue		
	2.7	There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed outside A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls	Blue		Blue		
	2.8	The A&E Delivery Board knows demographics of the area, including if there is a greater demand for OOH services are generated from the elderly	Amber	Trialled urgent care system metrics and Board will receive regular dashboard.	Amber	No change	
3. Ambulance Response Programme (DoD and coding pilots)	3.1 & 3.2	There is an ambulance trust executive lead on the A&E Delivery Board able to deliver the required service changes	Blue	Acting CE of EMAS is a member of A&EDB **BLUE**	Blue	No change	
	3.2	There are working definitions of 'Hear and Treat' and 'See and Treat' agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions	Green		Green	No change	
	3.2 & 3.4	There are alternative services which can accept ambulance dispositions or referrals and these mapped across localities	Amber	Services mapped through Mobile Directory of Service. However, some local pathway confirm and challenge required to confirm details.	Green	Services in place, include UCC and AVS/CRT provided by SSAFA	
	3.4	The A&E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand	Amber	Clinical Hubs being developed to support patients with a green disposition	Amber	Green ambulance service to commence Jan	
	3.4 & 3.5	The A&E Delivery Board has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'	Amber	In development across health and care economy	Green	Vanguard plans	
4. Improved Patient Flow	4.1	SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum , to improve patient flow	Amber	Safer bundle' concept initiated two years ago across the Acute medical wards at the LRI site. Needs re-launching and more dedicated focus- ECIP are providing support to UHL to implement SAFER bundle, work will begin with 2 pilot wards 7th Sept 2016	Amber	Full roll out of red green planned for 12/12/16	
	4.1	What percentage of the base wards on each acute site has SAFER in place?	Amber	100% of Acute medical wards at the LRI has the safer bundle in place but needs relaunching & refocus with support of ECIP	Amber	2 wards currently - will be all 14 wards from 12/12	
	4.2	The use of the red and green day approach has been considered	Amber	To be implemented- with assistance from ECIP- attending 2 medical wards on 7th Sept	Green	Red Green process roll out from 12/12	
	4.3	A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out	Green	Audits are currently being undertaken on the medical wards at the LRI site	Green	No change - but fuller plans developed since audit	
	4.4	Ward round checklists are in use in all wards in the acute hospital/s	Amber	Initiated about two years ago but not used consistently in practice - need to be relaunched.	Amber	no change - need confirmation from UHL	
5. Improved Discharge	5.1	A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards	Amber	Plans to deliver -pathways being implemented over next four months. Delays to discharge to assess need addressing. Significant work re comms and implementation across all wards. ICS has potential to enhance Home First approach.	Amber	D2A pathway in existence, being replaced by 'pathway 3' and HTLAH. Some issues with capacity	
	5.2	Trusted assessor arrangements are in place with social care and independent care sector providers	Amber	Amber in terms of pathway 2 and 3, with MDS as tool to shape the discharge work. Trusted assessor framework in place but risks to rollout.	Amber	Social Care now working as trusted assessors into the D2A/HTLAH pathways, Health Case Managers and discharge team working as trusted assessors for CHC/D2A/HTLAH. Trusted assessment agreed for HTLAH and pathway 3	
	5.4	At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings	Red	Not currently in place. Existing plans for D2A will improve % assessed outside acute settings, but we have not established whether they will deliver 90% of assessments outside hospital.	Amber	see row 34	
	5.3	A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance	Red	Plans still to be developed - Discharge Steering Group to lead	Amber	review of process for communicating Choice underway, including staff training	
	5.6	Systems are in place to review the reasons for any inpatient stay that exceeds six days	Amber	Baseline to be established in September, trialled on couple of wards. Roll out plan in development.	Green	Review of stranded patients in place as part of SAFER roll out. Further discussions about these patients to take place daily commencing 12/12	
	5.6	There is a responsible director in the trust who will monitor the DToC situation daily and report regularly to the board on this specific issue	Blue	Chief Operating Officer	Blue		
	5.6	Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.	Green	Senior discharge leads in place, confirmation and communication across system required. DSG to lead	Green		

BOARD ASSURANCE FRAMEWORK – PRINCIPAL RISK 3

Author: Head of Operations, Emergency Care Sponsor: COO Date of meeting: 24/01/17

Executive Summary

Context

The BAF is the primary means of providing assurance to the Trust Board that the principal risks to the achievement of our strategic objectives are being effectively controlled. This paper, presented by the principal risk owner, provides the Exec Board with a draft version of the relevant principal risk for discussion and endorsement prior to being reported to the TB. The discussion at the Exec Board should scrutinise the effectiveness of the controls and focus on outcomes of assurances. The Exec Board should also agree the current principal risk score and an assurance rating, using the scoring criteria in the tab on the BAF spread sheet. A set of questions have been provided below to guide the Exec Board through the update.

Questions

1. Does the current principal risk score accurately reflect the position in terms of achievement of the annual priority?
2. When is the principal risk expected to achieve its target risk rating?
3. What is the current principal risk assurance rating taking into account the current position in terms of positive / negative performance of controls and outcomes of assurances in place?
4. Do any gaps in control and / or assurance have action plans (with a realistic due date) to mitigate the level of risk?
5. Where an action is not 'on track' is the delay and the steps being taken to resolve the issue accurately described?
6. Are there any specific elements of these risk entries that need to be escalated to the next available Trust Board?

Conclusion

Principal Risk Owner to complete in response to questions above:

1. The current principal risk score of 25 reflects the ongoing pressures on the emergency system, and the significant challenges to achievement of the annual priorities
2. Unknown at this stage given the current pressures
3. 25
4. Yes
5. N/A
6. No

Input Sought

We would welcome the Executive Board's input to:

a. Receive and note this report;
b. Hold to account the principal risk owner to ensure that answers have been provided to the questions above;
c. Endorse any further amendments required to the risk entry in order that a final version can be submitted to the next TB meeting. **Note to the Risk owner**: Please submit all amendments to the corporate risk team ASAP following the exec board.

For Reference

Edit as appropriate:

1.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]

2.This matter relates to the following governance initiatives:

a.Organisational Risk Register [N/A]

b.Board Assurance Framework [Yes]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk No.	Principal Risk Title	Current Rating	Target Rating
No. 3	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity	25	6

3.Related Patient and Public Involvement actions taken, or to be taken: [None]

4.Results of any Equality Impact Assessment, relating to this matter: [None]

5.Scheduled date for the next paper on this topic: [monthly]

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

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

Board Assurance Framework:	Updated version as at:	Jan-17										
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity								**Risk owner:**		Lisa Gowan, Head of Operations, Emergency Care	
Strategic objective:	An effective and integrated emergency care system								**Objective owner:**		COO	
Annual Priorities	Reduce ambulance handover delays in order to improve patient experience, care and safety. Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS). Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps. Diagnose and reduce delays in the in-patient process to increase effective capacity								**Risk Assurance Rating**		Exec Board RAG Rating = EPB: 24/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25			
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16). Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report Bed capacity demand for 16/17 and 17/18 updated to show the bed gap by month.	ED 4 hour wait performance (threshold 95%): Poor performance continues to be primarily driven by increased ED attendances and emergency admissions but has also been contributed to by staffing issues (staff sickness and vacancies) Total attendances and admissions (compared to previous year) 1.% increase in emergency admissions 7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 29.0% over 30mins 12% over 60mins, 2.1% over 120 mins: Difficulties continue in accessing beds from ED leading to congestion	National benchmarking of emergency care data New AE Delivery board chaired by CEO of UHL. RAP approved by NHSE and NHSI and being progressed by the new AE implementation group. ~~ECIP 3 day gap analysis in July and 2 days in August to review ward processes.~~ ~~1 Day ECIP review in October and new team expected to support delivery in November 2016.~~ New ECIP team started in November to support delivery over the next 12 months.	(c)Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity (3.1) Lack of capacity to operate (3.2)

Detective Controls Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP being revised to ensure priority on decreasing attendance and admissions Comparative ED performance summaries showing total attendances and admissions.	in ED and delayed ambulance handover.	In-depth ECIP review 12 & 13 January, including external ED consultant	

Action tracker:	Due date	Owner	Progress update:	Status
New LLR AE recovery plan to be progressed (as per the action dates on the plan) through the new AE recovery board. (3.1)	See plan	See plan	~~Plan has been produced~~ ~~Confirm and challenge session on 14.9.16~~ AE Delivery Baord started 21.9.16 and meets fortnightly New AE implementaion group started 12.10.16 Recovery plan updated fortnightly by SROs, and monitored via EQSG fortnightly	4
Move to new build (3.2)	~~01/03/2017~~ 26.04.17	LG / CF	~~Ensure pathway reconfiguration and workforce matches requirement to mitigate this risk~~ Operational plan for moving the service to new build now in place. Ongoing discussions with workstream leads, including workforce and HR, to ensure pathways are updated and staff engaged in new processes prior to opening.	4
Escalation areas in ED to be used proactively (3.1)	01/12/2016	LG	New pro-active co-horting policy now in place to support reduction in delayed ambulance handovers; up to 17 patients, both in and out of hours, can now be co-horted whilst awaiting admission.	5

Reasonable assurance rating:

Green	G	Effective controls in place and satisfactory outcomes of assurance received.
Amber	A	Effective controls thought to be in place but outcomes of assurances are uncertain / insufficient.
Red	R	New controls need to be introduced and monitoted and outcomes of assurances are not available to the Board.

Risk rating criteria:

Current Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures in place.

Target Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures and future actions applied.
Risk target (also referred to as residual risk) is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to in an ideal world.
As the BAF is focussed on the risks to achieving its most important annual objectives the risk target score should be achieved when all actions are applied or by year end (31st March).

Impact / Consequence			Likelihood of occurrence	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

Action tracker status:

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.
0	Objective revised.

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Front Door workstream summary

EQSG: 18 January 2017

What has gone well?

(caveat – loss of data in migration EDIS to NCtr)

- Fewer late referrals from UCC to ED seen in Nov/early Dec
- UCC and Minors breaches showing promise of downward trend
- UCC performance November month to date: 96.83%, end Dec/January 99.62%, Achieved 100% 4 hour performance between the period of 23/12 to 29/12
- Fewer ambulances waiting to offload to ED in last 2 weeks (noting challenges over the New Year bank holiday period)
- Booked appointments (Hubs, GP surgeries): access granted by CCGs: up and running and being utilised well, patients happy
- Cancelled 1x morning and 1x afternoon UCC GP slot – surplus to requirements as triage and streaming running much better. Evening slot added, but still cost saving
- ACPs now getting protected time to consolidate competencies
- Co-ordinator and NIC roles in UCC becoming stronger

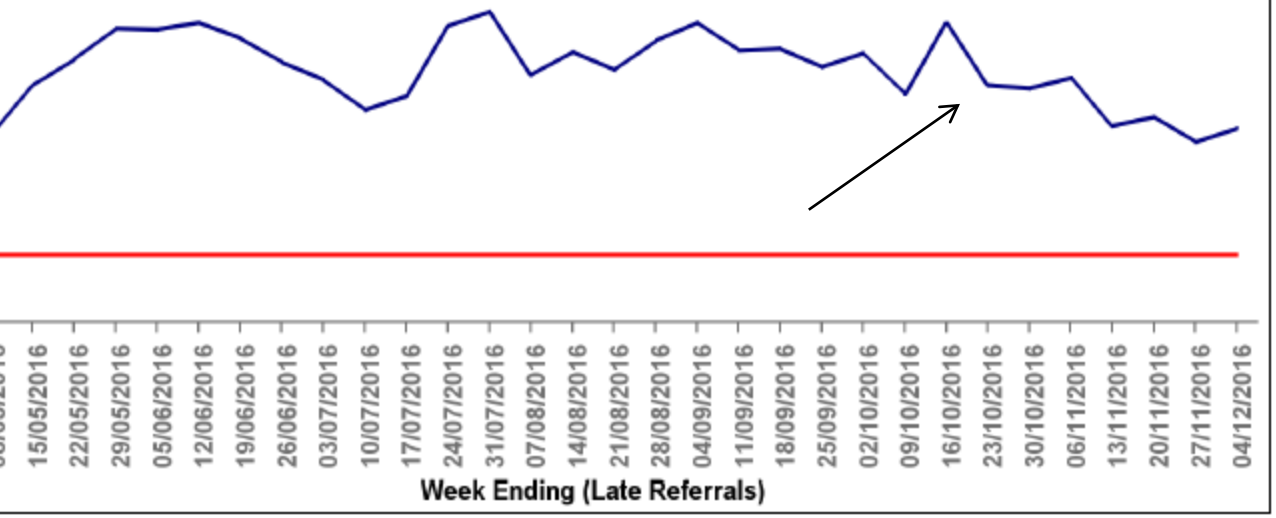
Emergency Department Arrivals 01/04/2015 to 05/12/2016

ONT DOOR

te Referrals to ED (Referrals Over 30 Minutes)

ed using Nurse Order "!" "ED USE ONLY" entered by Reception Staff

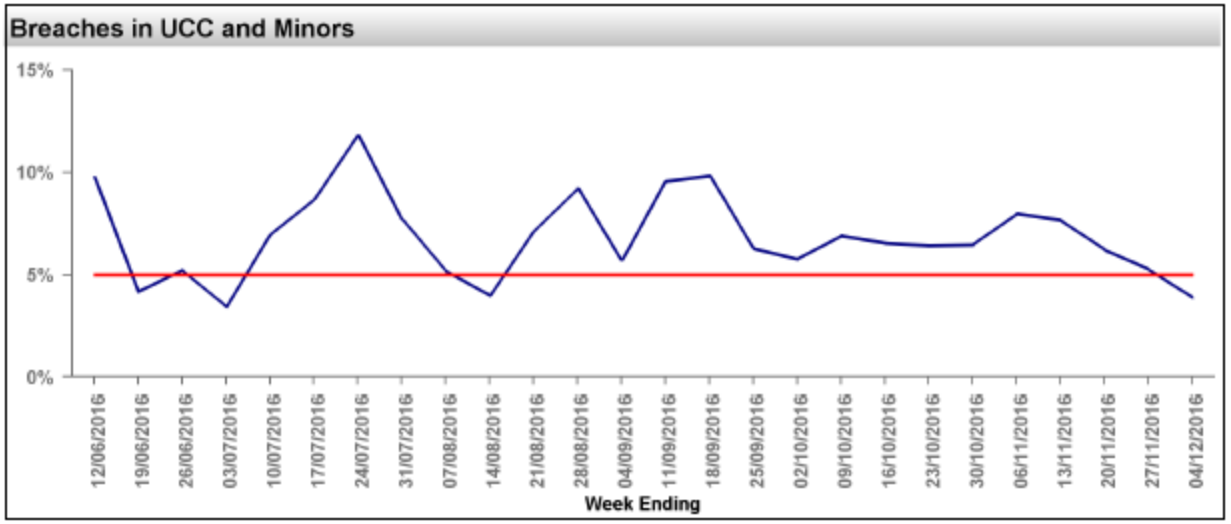
ndances with 'Late Referral' Nurse Orders



Month of Arrival Date	Attendance Count	No of Late Referrals	A
Apr-16	11,757	338	
May-16	13,247	2,342	
Jun-16	12,455	2,525	
Jul-16	12,624	2,410	
Aug-16	12,367	2,410	
Sep-16	12,963	2,630	
Oct-16	12,938	2,354	
Nov-16	13,063	1,917	
Dec-16	1,792	275	
	103,206	**17,201**	

30 Oct 2016	6 Nov 2016	13 Nov 2016	20 Nov 2016	27 Nov 2016	4 Dec 2016
17%	18%	14%	15%	13%	14%

Breaches in UCC and Minors



30 Oct 2016	6 Nov 2016	13 Nov 2016	20 Nov 2016	27 Nov 2016	4 Dec 2016
156	190	177	148	126	92

Month	A
Jan-16	
Feb-16	
Mar-16	
Apr-16	
May-16	
Jun-16	
Jul-16	
Aug-16	
Sep-16	
Oct-16	
Nov-16	
Dec-16	

SRO update – position against RAP metrics

*NerveCentre reports not yet available.

Action detail	Delivery date	Update	Metric target	Metric current	RAG
Impact monitoring action: increase the streaming/treating and redirection of patients from ED front door	Ongoing	Faster triage processes launch 21.11.16, triage metrics initially worse for several reasons, now improving	44% (% pts treated and redirected)	55%	~~Sept 44%~~ ~~Oct 46%~~ Nov 48%
Maximise use of ambulatory pathways from Urgent Care Centre and ED	7/12/16	GPAU taking pressure off Assessment Bay	% late referrals to ED	5%	Oct 18% Nov 15% Dec TBC*
Relocation of OOH clinic 4 into UCC	Can offer mutual aid from 10th Jan	IT issues addressed internally but caused delay: plan to move 08.01.16	**N/A**		**N/A**
Develop and implement tighter protocols for use of ED 'red light' and CDU 'stop'	30.01.17	1. CDU operational policy ratified in CDU Operational Group and implemented. 2. 'Red light' review part of revised escalation process and HALO action cards.	**TBC**		**TBC**
Implement CDU-EMAS direct streaming protocol, to minimise transfers from ED.	30.01.17	1. CDU SOP revised, including direct streaming protocol 2. Meeting with clinicians planned for January 2017	**TBC**		**TBC**

Next Steps

Action/Initiative	Next step	Revised delivery date
Reprofile GP consultation slots UCC	Continue to cancel morning shifts and add extra evenings	Through Jan and first half Feb
Maximise use of cohort areas outside ED to enable EMAS offload	Review staffing of these areas and see if a more suitable area can amalgamate the small separate ones	Ongoing January
Further reduce late referrals to ED from UCC	Continue coaching of triage and streaming staff	Ongoing January
Reprofile staffing model away from agency staff, to those on UHL substantive contracts	Interviews 5 Jan nursing, open day 21 Jan all staff, interviews 30 Jan GPs	Review success <7th Feb
Review staffing model existing vs that needed for new Emergency Floor	Meeting with HR, finance, medical and nursing to assess gaps / costs / savings, and define new EF establishment. Delays due to data gaps and comparisons SystmOne/EDIS/NerveCentre	18th Jan

Risks/issues impacting on delivery of key metrics

Risk/issue	Impact	Mitigation/Support required
Loss of staff through resignations and unfilled agency shifts	50% of UCC staff are agency so if management of change results in unfilled shifts, service may be compromised: worse performance and threat of sustainability overnight	Internal to UHL: Careful MOC, rewriting of contracts by HR, positive messaging about benefits of UHL contract and ways of working in new EF
Metrics to measure impact of changes proving difficult to draw from SystmOne and EDIS/NerveCentre migration	Difficult to assess ideal workforce establishment if unable to see added value of enhancing key stages of patient journey	Support from IM&T and CCGs to develop reporting templates through joint data entry from SystmOne and Nerve Centre