UHL Emergency Performance

Author: Lisa Gowan, Head of Operations, Emergency Care **Trust Board paper G**

Executive Summary

Context

We remain under acute operational pressure caused by a combination of increased demand and sub-optimal processes internally and across the system.

A refocus on high impact actions via the new AE Delivery Board and AE implementation group aims to decrease attendance, reduce admissions and improve processes, thus improving 4 hour performance.

Red to Green methodology was implemented across the medical base wards at LRI on Monday 12 December and we remain optimistic about the impact it will have on discharges, flow, quality of care, patient and staff experience and ED performance. A more detailed verbal update on R2G will be provided at the Trust Board.

Questions

1. Does the Board agree with the action plan?
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. The growing imbalance between demand and capacity
1. Variable clinical engagement
2. The challenges in transforming a service when we are also trying to focus on the ‘here and now’

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: 2.2.17 Trust Board

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: **Lisa Gowan, Head of Operations, Emergency Care**
REPORT SUBJECT: **Emergency Care Performance Report**
REPORT DATE: **5 January 2017**

Four hour performance

2016/17 YTD

- We are seeing an average of 658 patients everyday through ED at the Leicester Royal Infirmary
- 16/17 performance YTD is 79.3% and November's performance was 77.6%
- 15/16 performance YTD was 90.0% and November 2015 was 81.7%
- YTD attendance 7% up on the same period last year
- YTD total admissions are similar to last year's levels

December 2016

- Month to date - December 1 to 14 is 75.2%
- Period ending 14/12/16 – we saw 688 patients on average every day

ED occupancy

High attendance, long waits to be seen and variable outflow from the department has resulted in ED occupancy continuing to be higher than we would like. We are unable to provide figures for occupancy in this update due to NerveCentre migration.

Discharges

Discharges remain lower than this time last year, primarily because we are admitting fewer patients because of GPAU.

Sustainability and Transformation Fund (STF)

November's STF was not achieved following high numbers of attendances, which resulted in an internal major incident being called during the first half of the month.

	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%		
Jan-17	89%		
Feb-17	89%		
Mar-17	91.2%		

At the Trust Board at the beginning of December, I said that our position remained very challenged but we were approaching the delivery of the emergency care pathway with a renewed sense of optimism and vigour. No problem, no matter how complex is unsolvable and our solution is focused on:

- GP assessment unit - increased volumes of patients going through there - reducing load in ED and admissions - working very well - 20 less admissions every day, this reduces some of the mismatch between admissions and capacity
- Ward 7 LRI and 23A GGH - increases capacity to the same level as last winter
- Use of Red to Green – which is a clear methodology for reducing unnecessary waiting for patients and unnecessary chasing up by our staff.
- A positive view that change is deliverable. Whether you think you can, or you think you can't - you're right. We are pushing the message that we can. This is of particular importance within ED and getting the team into a place where mentally they believe things can get much better.

So what have we delivered….

NerveCentre

The new IT system to replace EDIS was successfully implemented into the Emergency Department on 6-7 December. Despite some minor glitches, the system is, overall, working well and has been well-received by frontline staff. This was a massive undertaking, especially given the operational pressures across the department, and this has been acknowledged to the staff involved. The team continue to work on the reporting elements of the system, to ensure all data is being accurately recorded. The system will be used in the new Emergency Floor, and rolled out to the other areas of the Trust that currently use EDIS in 2017.

Progress on seven key UHL actions in the RAP for December

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

1. Reduction in patients breaching by ten minutes

Month	ED Type 1 Attendance	All ED Type 1 Breaches	Breaches between 241 and 250 Minutes	% of Total
Jun-16	12455	3613	145	4%
Jul-16	12624	4450	160	4%
Aug-16	12367	3716	153	4%
Sep-16	12963	3818	140	4%
Oct-16	12939	4333	126	3%
Nov-16	13063	4448	162	4%

There has been a small increase in the number of patients breaching by 10 minutes during the last month. This is largely due to the continued rise in number of attendances to ED. Reduction of breaches continues to be an area of focus for the team.

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

ED performance overnight continues to be an area of focus for the team; members of the team have carried out further diagnostics over the month. Discussions are ongoing with medical colleagues to fully understand the issues and agree potential solutions.

Despite high levels of activity, we are now consistently seeing compliant performance in the UCC following the change to the staffing model and model of care.

Day	Arrival Date	%<4Hrs
Wednesday	07/12/2016	98.65%
Thursday	08/12/2016	98.65%
Friday	09/12/2016	100.00%
Saturday	10/12/2016	100.00%
Sunday	11/12/2016	100.00%
Monday	12/12/2016	98.65%
Tuesday	13/12/2016	97.08%
Cumulative	***Mon and Tues***	**97.84%**
Last 7 Days	***recent data***	**98.99%**
Current Month	***December***	**97.51%**
Year to Date	**all data**	93.88%

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

During the launch week of the intensive coaching programme, there was a focus on the way the assessment bay works with ED, as this is often a bottleneck area.
The ambulatory pathways are in wide circulation in the ED department and with the support of the clinical team in GPAU are actively being used to identify appropriate patients.

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

GPAU moved from its current location on ward 16 (level 5 Balmoral) to the yellow zone space in the Emergency Department on Monday 7 November. In its new location, GPAU does not only see the patients that it usually does, it also takes appropriate ambulatory patients from the Urgent Care Centre and Emergency Department, including those patients that arrive by ambulance.

As reported last month, this relocation continues to be a success; the acute medical team regularly 'pull' patients from ED, helping to decongest the department; and there has been a decrease in overall admissions to hospital over the last month. Further details are available in the AMU update, referenced further on in this report.

5. Ambulance handovers

November saw long waiting times for handover, and the position has deteriorated at the start of December. A potential solution of creating an ambulance offload area in the corridor accessed via the old ED entrance is currently being reviewed by the medical and nursing teams; this would mean cohorting patients in this area,

to be looked after by an Amvale crew until space becomes available in the assessment bay. Following a 2 day trial, this will be discussed further, with a plan developed for implementation.

Handover data (CAD+) is detailed below:

	Under 15 Mins Delays %	% Delay Over 15 mins (CAD+)	% Delay Over 20 mins (CAD+)	% Delay Over 30 mins (CAD+)	% Delay Over 45 mins (CAD+)	% Delay Over 60 mins (CAD+)	% Delay Over 120 mins (CAD+)
Apr-16	59%	41%	30%	17%	10%	6%	1%
May-16	57%	43%	30%	18%	9%	6%	1%
Jun-16	60%	40%	29%	16%	9%	6%	1%
Jul-16	51%	49%	38%	24%	14%	9%	2%
Aug-16	54%	46%	35%	21%	11%	7%	1%
Sep-16	51%	49%	38%	24%	15%	10%	1%
Oct-16	48%	53%	42%	28%	15%	9%	1%
Nov-16	47%	53%	43%	29%	17%	11%	2%

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

Both wards and the newly refurbished discharge lounge are open.

7. SAFER bundle and Red to Green

Red to Green was implemented across 14 medical wards at the LRI on Monday 12 December 2016. The main aim of Red to Green is to reduce overall bed occupancy and improve patient flow by changing behaviours and identifying areas where we can work better and do things differently.

An executive lead is working with each ward, attending board rounds twice a-day and resolving issues as they arise, for the next two weeks. External partners are supporting the Trust with the process via attendance at daily meetings to review delays and potential solutions. Embedding of the Red to Green process will then continue, with an additional focused week during the first week of January.

Initial themes identified during the first week include:

- The need to speed up the process of arranging medication for patients to take home (TTOs)
- Length of stay for patients waiting for diagnostics is high
- Swifter psychiatric input is required

The ward teams have embraced the process, and made a positive start. The importance of embedding and sustaining these efforts is not underestimated, and will remain a focus of the team.

Details about **Red** to **Green** are included as an appendix.

Work streams

At EQSG on 7 December 2016, progress on the Acute Medical Units (AMU) and the Clinical Decisions Unit (CDU) work streams were discussed. Key updates are in the attached.

Clinical Decisions Unit (CDU)

The RAP actions attributed to CDU have now all been completed, and are working as 'business as usual' at Glenfield. Key achievements include:

- Opening of ward 23a as additional winter capacity ahead of schedule on 4 December.
- Agreement in place to run the low risk ambulatory service in CDU for five days a week from January
- Reduction is waits for patients to access the Cath Lab, and the overall length of stay on this pathway

The CDU operational team will continue to explore collaborative working with ED for cardiology patients to prevent the need to transfer to CDU.

AMU

The RAP actions for AMU largely focus on the GPAU relocation to ED, and the impact of acute physicians working closely with ED colleagues. Key achievements include:

- Reduction in the number of patients who attend ED who are then admitted to a hospital bed
- Continued increase in patients being seen in GPAU rather than ED
- Ongoing use of Rapid Flow area on ward 16, to relieve pressure on ED

Due to the success of GPAU, an options appraisal is being completed to look at the sustainability of increased staffing to open the service for longer periods (it currently operates from 8am-10pm).

Overall in December

It feels like we have made a lot of progress on three of the four key areas of focus; GP assessment unit (GPAU), opening additional ward capacity and use of red green. Disappointingly, despite vastly reduced admissions, improvements in flow (albeit flow remains imperfect) and a renewed level of organisational support linked to red to green, we still have very poor emergency care performance and restoring pride and belief within the emergency department is where we must really focus.

Seven key UHL actions in the RAP for January

During December and January, we are releasing our senior clinical team from meetings and non-critical administrative work to be based on the shop floor to provide coaching and support to our clinical teams who are in co-coordinating roles, such as majors coordinator, doctor in charge, and nurse in charge, to ensure a consistent approach and reduce variability.

The seven key actions in January are (noting many of them are continuing the themes from December):

1. Reduction in patients breaching by ten minutes

The team have a target of no more than 1% of their patients breaching by 10 minutes. November's position was 4%, however as mentioned, the Trust was on a critical incident between 6-14 November, subsequently calling an internal major incident on 15 November. (NB: We are unable to provide December's position to date due to the change in IT system from EDIS to NerveCentre on 6 December).

Daily validation of all patients breaching by 10 minutes is undertaken, but the challenge remains around overcrowding in the department and the ability to efficiently process all patients.

To support the reduction of overcrowding, rapid flow to AMU continues, which enables the team to move 5 patients by 10am each morning; embedding of the Red2Green process all supports this. Pro-active management of the cohorting areas continues, with support from EMAS, with a clear plan that the team follow.

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

The new model for GPAU has started to support the reduction in non-admitted breaches based on recent data. This will continue to be review and refined by the clinical team to ensure fully embedded and sustainable processes.

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

The coaching and leadership work that the senior clinical team is doing in December and January as described previously, will include focus on the rapid assessment process, and increasing usage of ambulatory pathways.

4. Continuation of GPAU based in the yellow zone and utilisation of the space GPAU leaves behind

As described above, a rapid flow area (formerly the GPAU space) has been utilised since Monday 14 November, to provide early transfer from ED of patients who require a ward based bed.

An options appraisal for sustainably staffing GPAU for extended periods will be reviewed in January.

5. Ambulance handovers

The team will continue to ensure handovers are as efficient as they can be. Working with the assessment team to embed use of the ambulance offload area (as described above) will support the increase in flow through the assessment bay, and reduce the ambulance handover times.

Working with EMAS, a new initiative whereby a UHL GP goes to all 999 calls from nursing and care home took place over the weekend before Christmas, with the aim to reduce the number of frail, elderly patients coming into hospital where clinically appropriate. If successful, this will be utilised over weekends in January.

6. SAFER (Senior review, All patients will have an expected discharge date, Flow, Early discharge, Review A systematic MDT review of stranded patients) bundle and Red to Green

This continues to be a key action, as described above, and will continue to be embedded in medical wards in January, alongside plans for roll-out to other wards including Glenfield and Leicester General.

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.

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 we are part of and will therefore receive additional support.

UHL continue 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.

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

Key Intervention No:	National Guidance ref/detail:	Action Detail	Lead Organisation	Accountable Officer	Action no.	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%	**4**
1	1.4	Maximise use of ambulatory pathways to avoid ED attendance	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	ED attendance	1. Audit of yellow zone scheduled for 28/9/16 not completed as plan due to staffing issues (further date to be arranged). 2. ECIP ambulatory audit took place on 25.10 3. Action plan now being developed based audit findings. 4. Awaiting feedback; meeting planned with HOS to discuss further and agree revised timeline.	Baseline to be established in the 'on the day' review	20%	TBC	**2**
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan (Vivek Pillai)	**18**	Implement Rapid assessment: 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	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 and 18b 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. Huddles now in place (not consistently). 'Perfect huddle' action learning tool being created to use with teams. 2. Ensuring appropriate use of escalation in place (not consistently) 3. SOP revised and being reviewed by senior team prior to circulation. 5. Leeds and Ipswich professional standards circulated and discussed with ED consultant body 19.10.16. UHL proposed standards, along with updated watershed policy, to be discussed at Clinical Directors meeting 26.10.16. 7. Daily validation and review of all 10 minute breaches by service managers and 'did not wait' breaches. Expansion of role of ED trackers to ensure decisions are made in timely manner. 8. Internal escalation process updated, to improve timely ambulance handovers	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.	48% (% patients with decision made within 180mins)	95%	Aug: 45% Sept: 43% Oct: 42% Nov: 45%	**3**
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**
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 staffing being sourced. 9. Ward opened as per above plan on 1.11.16.	0%	28 beds open on the ward	0%	**5**
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: Trial senior acute physician in ED to challenge admissions - GPAU relocation to ED	UHL	Julie Taylor (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 admissions	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	21.2% (ED conversion rate)	18.70%	21.30%	**4**
4	NA	Reduce handover times for medical team in ED	UHL	Julie Taylor (Matt Metcalfe)	**15 New action**	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. Data on number of handovers obtained 2. ECIP to facilitate the required improvements 3. RAG reduction due to time slippage on actions 4. Senior team to observe handovers to produce 'perfect handover' action learning pack, with approach, key purpose and function. To be included as element of intensive coaching programme, starting in ED w/c 28.11 5. Deputy Medical Director now supporting diagnostic and development of key actions, hence change in timeline.	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	Julie Taylor (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	Julie Taylor	**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 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	All actions to be complete ~~1 November 2016~> 16 December 2016	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 (LG) - New escalation process agreed and in place - Review approach and capacity to processing patients in the evening/overnight (VP)	Currently 29% of patients arriving between 7pm and midnight are treated within 4hrs	70%	~~32%~~ ~~Oct: 30%~~ Nov: 31%	**3**

4	NA	Rapid Flow (formerly - Implement Safer Patient Placement across UHL)	UHL	Julie Taylor (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	1. Reduce breaches in ED 2. Reduce time from bed request to allocation	admitted breaches	1. Rapid Flow to AMU started 16.11.16, supported by HOS and matron. SOP, flowchart and risk assessment in place 2. Continued push on early morning discharges on medical wards, to release 2 beds by 11am 3. Discharge lounge to open 28.11; criteria circulated to all wards. Opened as planned 4. Further work required to develop plans to rapid flow from AMU to base wards.	55% of patients allocated a bed within 60 mins	75%	~~58%~~ ~~Oct 48%~~ Nov: 46%	**3**
4	4.1 4.3 4.4	Implement SAFER patient flow bundle Trust wide	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'	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**
4	NA	Implement specialty in-reach/ownership of referred patients to ED	UHL	Julie Taylor (Matt Metcalfe Lee Walker)	**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. Clinical director discussed with consultant colleagues 2. Medical director discussed further with clinical director 3. GPAU move to yellow majors will support increase in medical in-reach to ED; 2 physicians in ED as part of job plan 4. UHL proposed professional standards, along with updated watershed policy, to be discussed at Clinical Directors meeting 26.10.16 5. Senior clinician leading clinical discussion among specialities on implementation of watershed policy. 6. Associate medical director supporting implementation of speciality in-reach from all other CMGs 7. Medical in-reach in place (GPAU) 8. Deputy medical director to meet with majors HOS to discuss further and agree actions	21.2% (ED conversion rate)	TBC	21.30%	**3**

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) 2. Develop Red and Green Day Criteria for implementation 3. Develop launch pack 4. Communicate to and educate staff 5. Roll out across ESM -audit following roll-out	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. Project delayed due to resourcing and staff sickness - resourcing being reviewed by exec team. 2. New approach to implementation from 1.11 - director leadership and change team to work directly with one medical ward to change practice and implement approach; once embedded and resource identified, roll-out to other wards. 3. Focus of ongoing ECIP support 4. Safer Champions to be identified to support roll-out across Trust. 5. 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 6. Director leads identified for each ward as part of roll-out.	5.82 (average length of stay for Medicine)	4.67	5.82	**2**
4	NA	Implement direct admissions from ED to specialities	UHL	Julie Taylor (Matt Metcalfe)	**68 (new)**	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	**3**

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

Leicester, Leicestershire & Rutland Local A&E Board

6th September 2016 submission

B-RAG	Description
Blue	**Scheme already in place/alternative in place** (Please provide details in commentary)
Green	**Actions in place and on track for initiative to be implemented within rapid implementation guidance timeframes**
Amber	**In plans, but risks associated with delivery** (Please provide details in commentary)
Red	**No evidence of existing implementation or in system plans**

Initiative		Statement of good practice	B-RAG	Commentary
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.
	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
	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
	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.
	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.

	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.
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	**Amber**	Modelling for the Clinical Navigation Hub suggests that this will be delivered by 31/3/2017.
	2.1	Clinical expertise availability is planned according to demand	**Amber**	As above
		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.
	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**	
	2.7	There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed oustide A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls	**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.
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**
	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**	
	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
	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
	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

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
	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 inplace but needs relaunching & refocus with support of ECIP
	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
	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
	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.
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.
	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.
	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.
	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
	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.
	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

	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

EMERGENCY DEPARTMENT METRICS DASHBOARD

Monthly updates

	1	2	3	4	5	6	7	8	9	10	11	
	Apr-16	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	
ED 4 Hour Performance													**Trend**
Type 1 Attendances (ED)	11449	12817	12094	12275	12098								
Type 2 Attendances (Eye Cas.)	1895	1848	1802	1925	1844								
Type 3 Attendances (UCC)	5580	6318	5566	5949	5435								
TOTAL Attendances	**18924**	**20983**	**19462**	**20149**	**19377**								
TOTAL Breaches (Type 1+2+3)	3549	4227	3771	4652	3859								
Total within 4 Hours	15375	16756	15691	15497	15518								
% within 4 Hours	**81.2%**	**79.9%**	**80.6%**	**76.9%**	**80.1%**								
ED Admissions													**Trend**
A&E Admissions	3583	3854	3737	3633	3545								
All Emergency Admissions	7390	7879	7483	7322	7253								
Trolley Waits													**Trend**
4-12 Hour Trolley Waits	508	610	586	863	526								
12 Hour Trolley Breaches	0	0	0	0	0								
Bed Metrics (Excluding Maternity Wards)													**Trend**
Total Beds Available	1650	1620	1636	1632	1633								
Beds Occupied	1502	1509	1498	1473	1467								
% Beds Occupied	**91.0%**	**93.1%**	**91.5%**	**90.3%**	**89.8%**								
Delayed Transfer of Care													**Trend**
Bed Days Lost	710	838	795	1108	1127								
Average Per Day Lost	23.7	27.0	26.5	35.7	36.4								
Number of Patients	32	30	30	32	39								
EMAS CAD Handovers													**Trend**
Total CAD Handovers	5119	5443	5229	5107	5122								
Total CADOver 30 Minutes	1110	1227	1143	1586	1496								
% Over 30 Minutes	**21.7%**	**22.5%**	**21.9%**	**31.1%**	**29.2%**								
Cancelled Operations													**Trend**
Urgent Cancellations	4	4	1	1	2								
Subsequent Cancellations	0	0	0	0	0								
Stranded Patients (Length of Stay 10+ Nights)													**Trend**
Number Discharged	1315	1264	1262	1236	1216								
Avg. Number Patients (Per Day)	434	417	412	405	412								

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

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.
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		NHS Improvement recommended presentation on from South Warwickon 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

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

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	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	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

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

4	NA	Increase utilisation of yellow zone (ambulatory majors)	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	**16 New action**	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

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

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

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 b	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	26% (patients leaving dept within 15mins of bed allocation)	50%	31%	**5**

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**
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**

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	**4**

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 b	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**

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	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. 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 r	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	44% (% pts treated and redirected)	55%	44%	**5**

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 b	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	106 short stay beds	134	106	**5**

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 a	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	21.2% (ED conversion rate)	18.70%	21.30%	**5**

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	68% (Majors yellow area 4hr performance)	95%	61%	**5**

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 breache	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	`	3.5	3.4	**5**

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 Gold command; comms to EMAS 4. Paper to CDU Ops team with outcome and next steps 5. To be managed by CMG as BAU.	Oct	96 (10% reduction)	50 to date in Sept (ED LRI to GGH)	**5**


University Hospitals of Leicester NHS
Caring at its best
Red2Green Week
12-16 December
Remember:
If a patient is waiting for something, please update your patient's red and green status form.
#red2green #last1000 days
For more details
please contact extension:
ADD NUMBER or
visit INsite/ADD Section
Everybody Counts...

Review of week

- What went well
- Less well
- Themes
- Internal actions
- External actions

What went well

- Executive sponsorship of wards - 'Buddy wards'
- Red 2 Green knowledge/language improved
- Team working – helping to unblock the delays
- Recognition of internal and external waits
- Importance of roles (TAPs)

What went less well

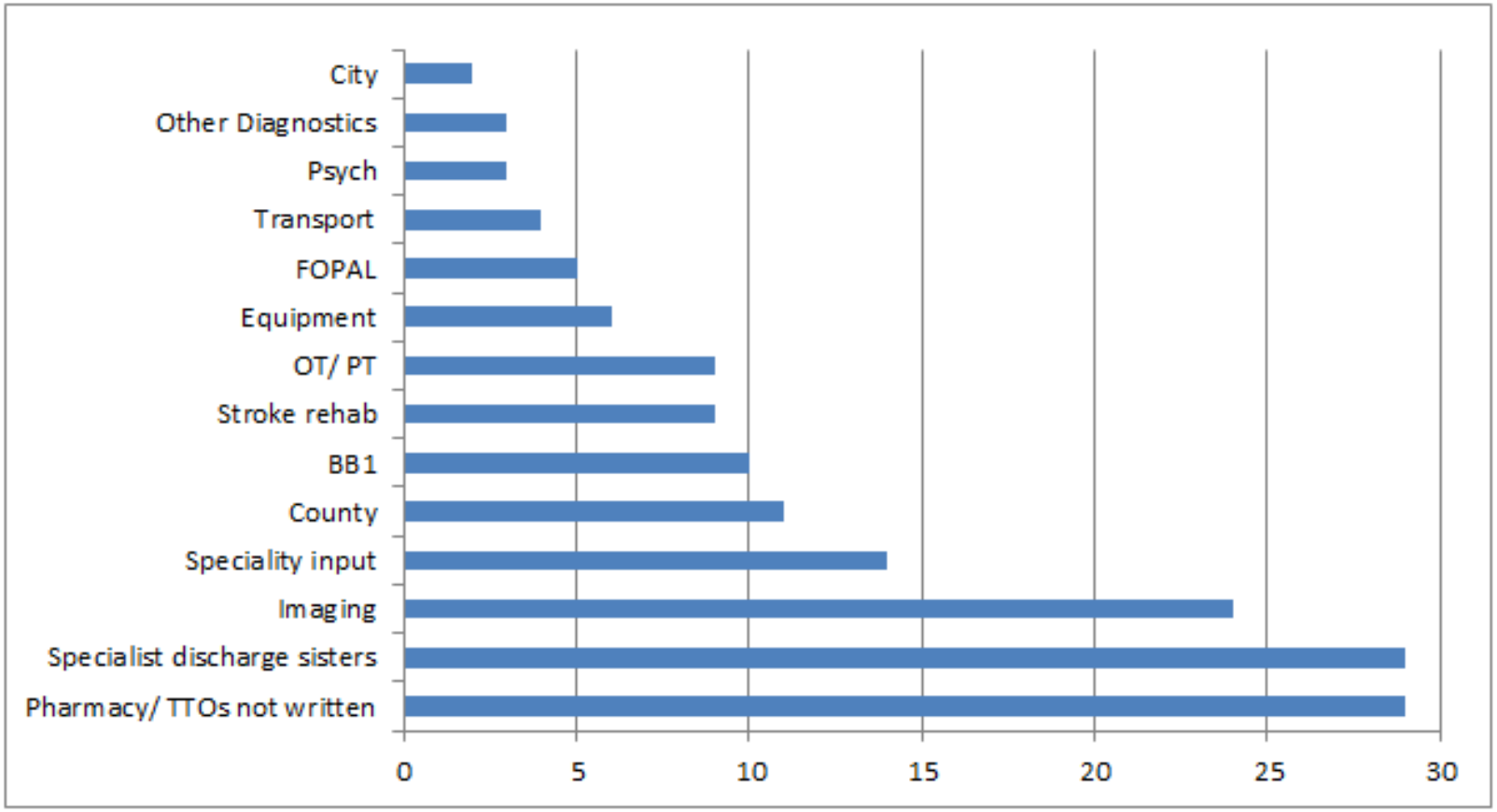
- Not all board round action orientated
- Ability to respond to surges in discharges
- Attitudes, behaviours and cultures – in particular medical leadership

Red 2 green compliance

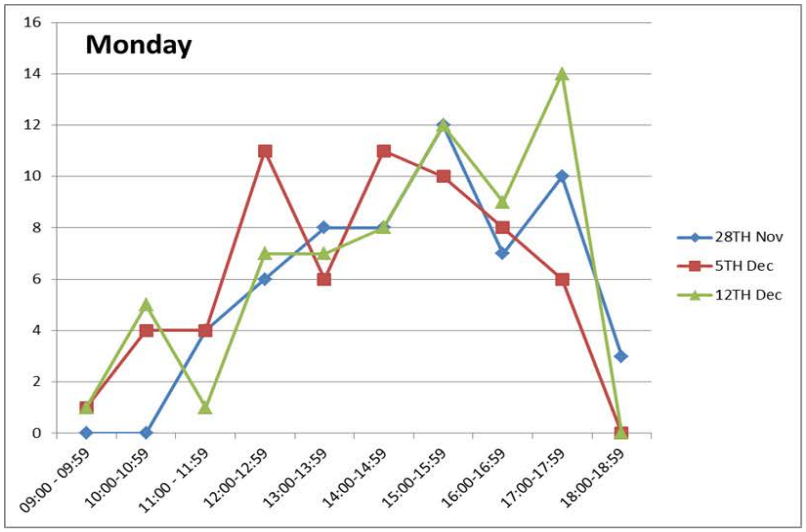
		14/12/2016			15/12/2016			16/12/2016		
Ward Code	Bed Stock	Red	Green	% of Red Days	Red	Green	% of Red Days	Red	Green	% Of Red Days
R07	20	6	14	30%	9	11	45%	20	0	100%
R23	28	7	21	25%	16	12	57%	16	12	57%
R24	27	6	21	22%	10	17	37%	13	14	48%
R25	18	3	15	17%	4	14	22%	4	14	22%
R26	18	4	14	22%	12	6	67%	6	12	33%
R29	29	17	12	59%	16	13	55%	21	8	72%
R30	29	8	21	28%	12	17	41%	9	20	31%
R31	30	15	15	50%	19	11	63%	19	11	63%
R34	26	8	18	31%	5	21	19%	13	13	50%
R36	28	5	23	18%	9	19	32%	19	9	68%
R37	24	8	16	33%	11	13	46%	14	10	58%
R38	28	6	22	21%	16	12	57%	20	8	71%
REDU	20	8	12	40%	6	14	30%	4	16	20%
RIDU	18	8	10	44%	6	12	33%	8	10	44%
Total	343	109	234	32%	151	192	44%	186	157	54%

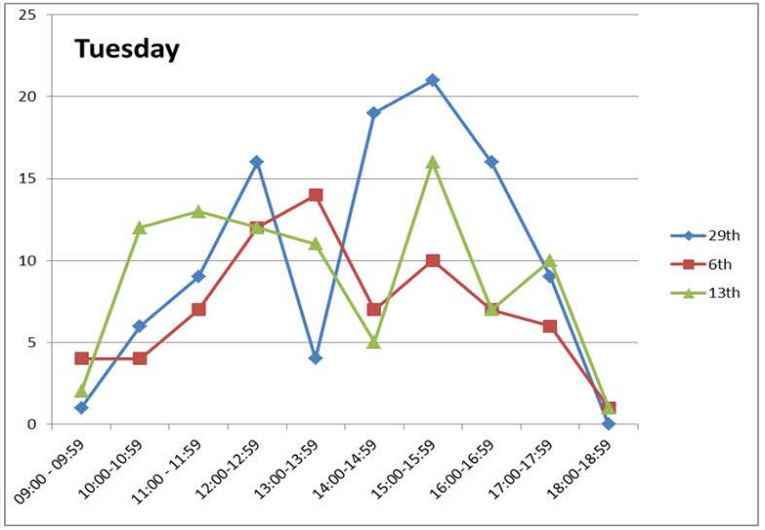
We became more compliant as we progressed through the week

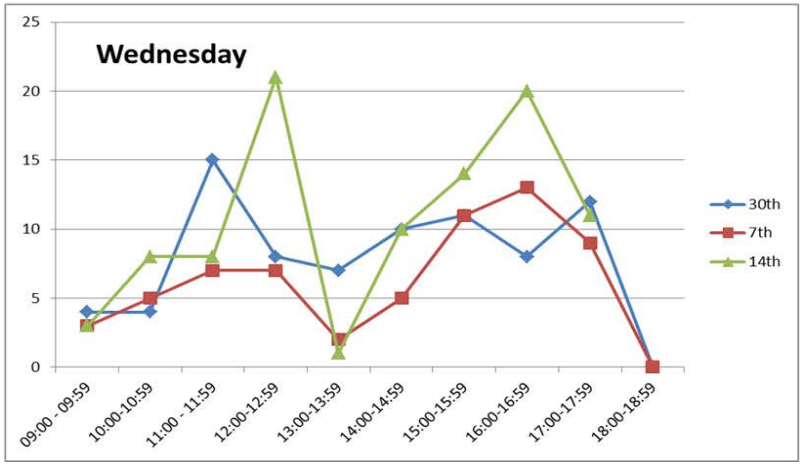
Delays at 1000am on 16/12

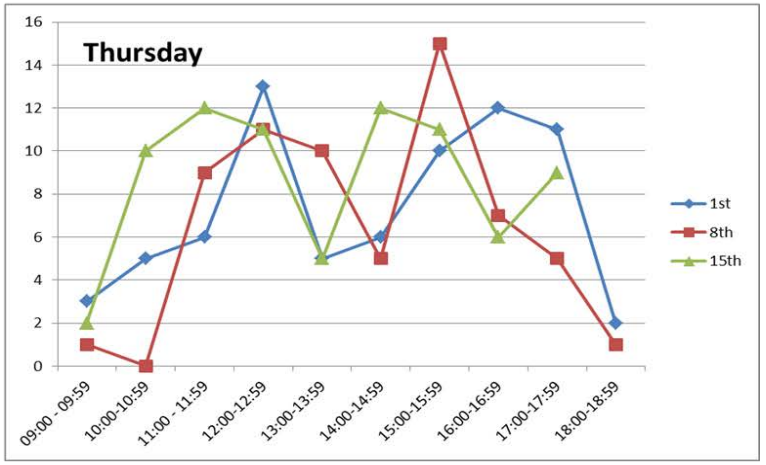


Times of TTOs









Total discharges

- We discharged 275 more patients Mon- Fri last week compared to the week before

Monday	203	246	121%
Tuesday	184	245	133%
Wednesday	186	279	150%
Thursday	232	263	113%
Friday	244	291	119%

Total	1049	1324	126%

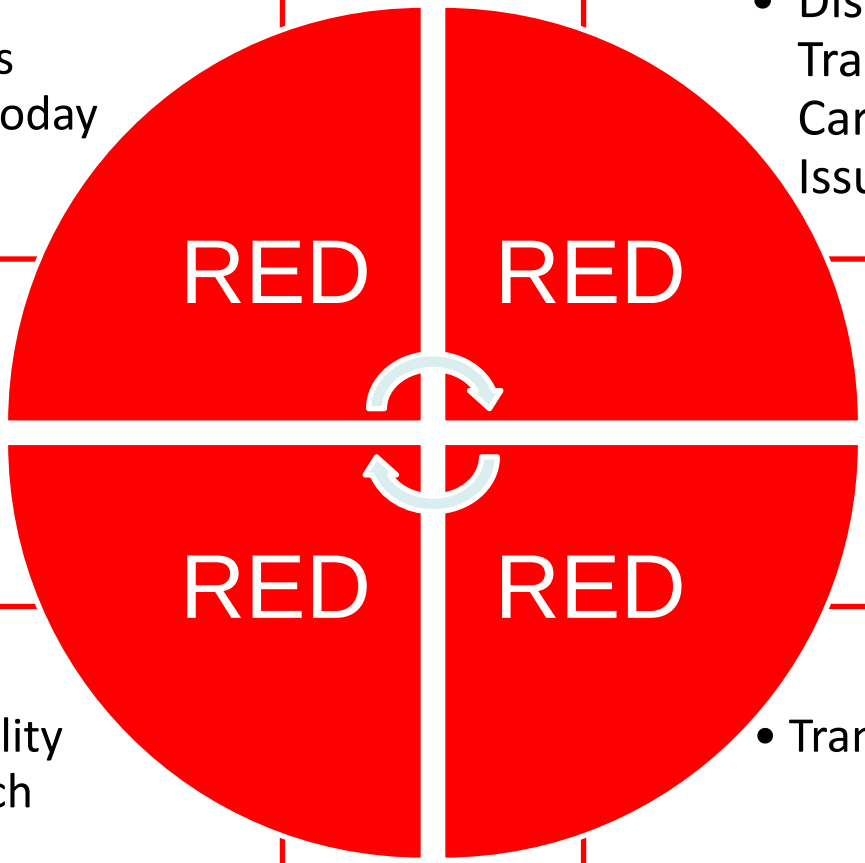
ESM capacity

- This is the predicted medical capacity at 1800
- Important to note that not all of these discharges came off, particularly because of TTOs and transport but if we can resolve those issues we will have a much better medical capacity
- Focus needs to be on earlier decision making and discharge

	Last week	This week
Tuesday	83	93
Wednesday	79	87
Thursday	73	101
Friday	80	105
Total	315	386
Increase		23%

Key themes

- Doing today's work today
- Discharge/ Transfer of Care Issues



- Speciality In reach
- Transport

Internal delays – themes (1/2)

- Attitudes, Behaviours and Cultures – passivity from medics
- Board Rounds – EDD's/ Clinical Criteria for Discharge
- Handover of new patients – no plans
- Not action orientated – assignment of jobs
- TTO's – pre-empting with EDD's
- Use of IT systems to inform decisions at board rounds
- FLOW from wards to discharge lounge
- Communications between MDT – change in plans
- Delays for completion of referrals – FOPAL, CHC, Section 2/5, DST's, transfer letters, BBI's
- 'Baseline'/ no History
- SALT
- Speciality In reach – Oncology, ENT, Orthopaedics, Tissue Viability, # Clinic, Plastics, MDT's, Hepatobiliary , Rheumatology, Max Fax
- IT County Social Services (2 years)

Internal delays – themed (2/2)

- PEG insertion/ HENs, ECHO's, Audiogram, Audiograms, nerve conduction studies, orthotics
- Psychiatric Liaison
- Communication between MDT staff
- Safety questionnaire for
- ESDS (Stroke) – capacity
- Ward 3 – TTO's for transfer
- Bloods – timing/ results
- Consistency of medics on ward 7
- Issuing of Choice letters
- BBI's – form completion/fax
- Fast Tracks/ CHC process -

External delays – themed

- Ambulance waits - bariatric , timings of conveyance
- Cut off Times – Nursing Homes
- Nursing Home assessment delays
- Relatives – (lack of response, handing over of keys)
- Relatives viewing of Nursing homes
- Funding – delays
- Community Beds – handover delays/ IP (different policy)
- Equipment delivery

Next steps

- Keep momentum up – continue with 2 hour 'RED' review meeting – onsite external support is required going forwards
- Thursday Session planned with ECIP and wards to recap and focus on what a GOOD board Round looks like – repeat in the New Year
- Support board rounds
- Video – of Board Round/ Red review patients
- Education / handy hint packs
- Improved patient involvement
- Continued communications and promotion
- Confirm roll out plan for wider UHL

Internal actions

- The below will be included in a formal action plan by the end of this week:

1. Pharmacy/ TTOs not written - Email from AF to be circulated early this week
2. Specialist discharge sisters - Review of function, which is probably overworked this week - RM
3. Imaging + other diagnostics - continue with the point of contact at red review meeting
4. Speciality input - Email from AF to be circulated early this week
5. OT/ PT - continue with the point of contact at red review meeting
6. Equipment - to be picked up through the SDS review (above)
7. FOPAL – SL to look at team and referral process this week

External actions

- Support is required for the following delays:
- County
- BB1
- Stroke rehab
- Transport
- Psych input
- City

A&E Improvement Group Highlight Report template

Project Highlight Report	
This highlight report updates the A&E Improvement Group about the project's progress to date. It also provides an opportunity to raise any concerns and issues with the IG, and alert them to any changes that may affect the project. Complete all fields where applicable and state "nil return" where there is nothing to report in this month.	
Project name:	Intervention one: Streaming
Project Sponsor:	SRO: Ian Lawrence
Project Lead:	Lisa Gowan
Report Date:	16.12.16

1.Project Status	
Current Status:	Green
RAG Status previous month:	Amber
Reason for current status:	Achievement of key actions in plan – see below
2. Progress since last Highlight Report (output focused)	
Achievements:	• Intensive coaching programme started – The way we do things here – in November, with increased nursing and medical leadership in ED. • Single queue system in majors launched 25.11.16.
Slippage (give reasons):	• Action plan following ambulatory audit scheduled to be completed by 7.12.16; slippage due to HOS annual leave; meeting scheduled with HOS to develop plan and agree revised timeline.

3. Key milestones and deliverables *(as per your project plan: noting slippage - anything significant that has an impact on key actions / outputs)*

Milestone(s)	**Planned Completion Date**	**Progress / Slippage**

4. Actions and outputs for next month

- Action plan to maximise use of ambulatory pathways following completion of audit
- Ongoing monitoring of UCC performance and breach numbers

5. Most significant current risks *include a short description of your mitigation plans*

- Embedding and consistent use of new processes

Overall project risk level - Amber

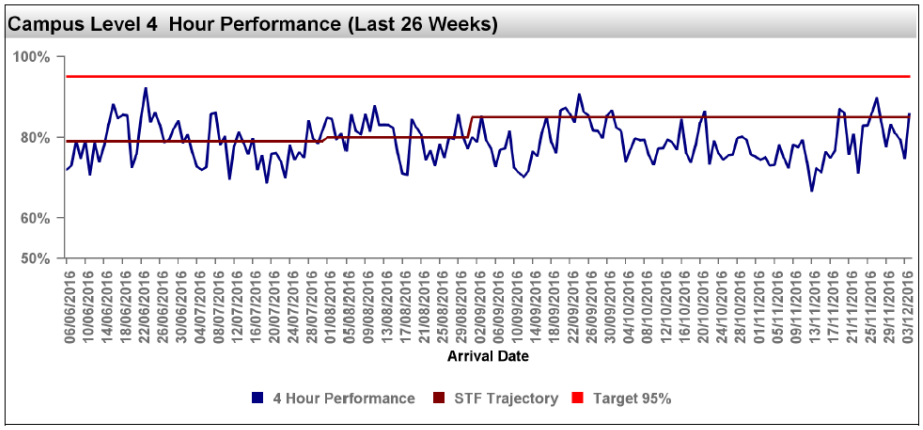
6. Most significant current issues *include a short description of your mitigation plans*

- Attendances remain above plan
- Team undertaking transformational change while fire fighting
- Competing priorities on time with demands of new build

7. Outcomes and KPIs – *give details of KPIs either in numbers or graphs with comparisons against baselines*

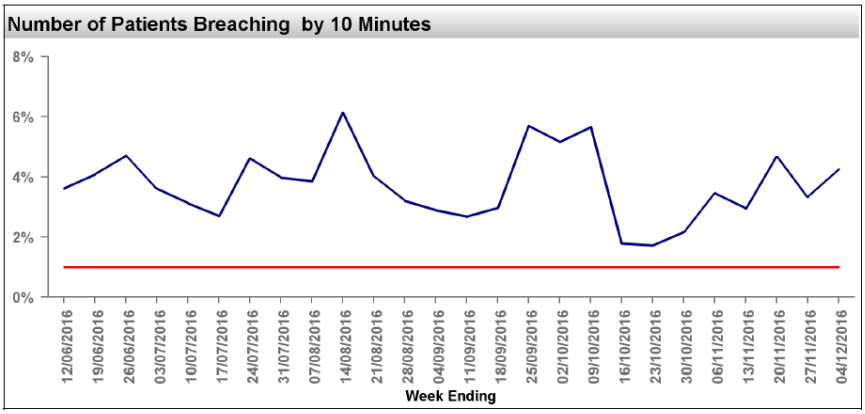
Data to 5/12/16, due to switch to NerveCentre 7/12/16

FOUR HOUR PERFORMANCE



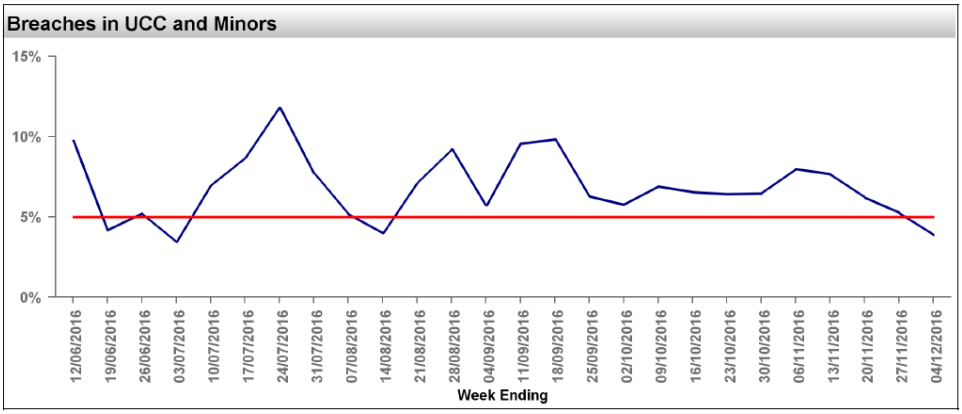
30 Oct 2016	6 Nov 2016	13 Nov 2016	20 Nov 2016	27 Nov 2016	4 Dec 2016
77%	75%	75%	77%	81%	81%

Volume of Patients Breaching by 10 Minutes



30 Oct 2016	6 Nov 2016	13 Nov 2016	20 Nov 2016	27 Nov 2016	4 Dec 2016
23	39	34	50	29	39
2%	3%	3%	5%	3%	4%

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

8. Financial variances – *give details of any variances to your project finances where applicable, e.g. actual expenditure against planned expenditure*	
Year to date actual costs incurred	NA
Forecast outturn costs	NA
WTE year to date plan	NA
WTE year actual in post at date (*then if appropriate details of when the scheme will be fully staffed)*	NA
Further information	NA
9. Decisions required from the Improvement Group – *include any exceptions that need escalating*	
None at this time	
Change control: (all removed actions on 'UHL completed actions' tab of spreadsheet) - Action 11 now RAG 3 from RAG 4 - Action 18a now RAG 4 - Action 18b now RAG 4	

(x) RAP action number

A&E Improvement Group Highlight Report template

Project Highlight Report	
This highlight report updates the A&E Improvement Group about the project's progress to date. It also provides an opportunity to raise any concerns and issues with the IG, and alert them to any changes that may affect the project. Complete all fields where applicable and state "nil return" where there is nothing to report in this month.	
Project name:	Intervention 4: Flow
Project Sponsor/SRO:	Ian Lawrence
Project Lead:	Julie Taylor, Sue Mason, Gill Staton, Lisa Gowan
Report Date:	16.12.16

1.Project Status	
Current Status:	Amber
RAG Status previous month:	Amber
Reason for current status:	Slippage on key actions (see below)
2. Progress since last Highlight Report (output focused)	
Achievements:	• Relocation of GPAU to ED continues to have a positive impact on reducing admissions to AMU, and numbers of patients seen in GPAU rather than ED. • Additional bed capacity fully open at both LRI and GH • Deputy medical director supporting team to look at medical handover times and specialty in-reach to ED • Discharge lounge opened • Red2Green launched on 14 medical wards 12.12.16, with resources identified
Slippage (give reasons):	• Timeline for review of direct admissions from ED and specialty in-reach now 13.01.16, following input from deputy medical director into team • Slippage on action plan to reduce overnight breaches following delay to completion of diagnostics; timeline for key actions now being agreed and will be discussed at EQSG 21.12.16.

3. Key milestones and deliverables *(as per your project plan: noting slippage - anything significant that has an impact on key actions / outputs)*

Milestone(s)	Planned Completion Date	Progress / Slippage
Complete options appraisal on extended GPAU opening to support overnight flow	4.1.17	On track

4. Actions and outputs for next month

- Continued focus on sustainability of Red2Green on medical wards
- Continued focus on ED process improvements

5. Most significant current risks *include a short description of your mitigation plans*

- Continued high acuity and volume of patients

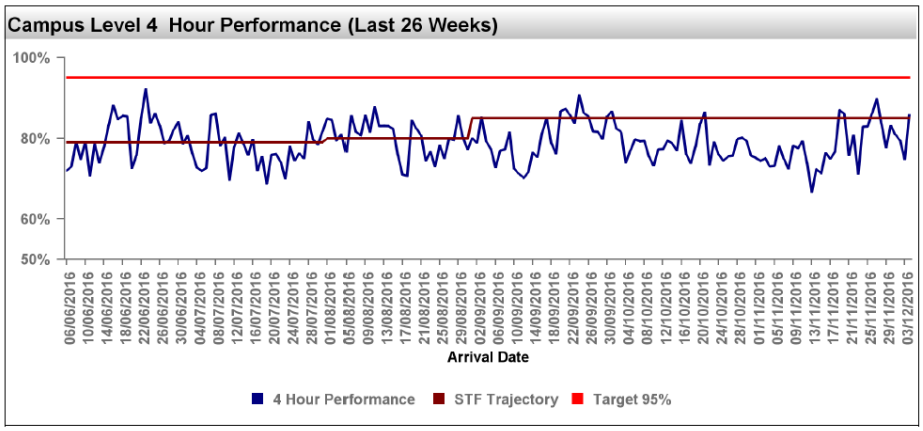
Overall project risk level – Amber

6. Most significant current issues *include a short description of your mitigation plans*

-

7. Outcomes and KPIs – *give details of KPIs either in numbers or graphs with comparisons against baselines*

FOUR HOUR PERFORMANCE



30 Oct 2016	6 Nov 2016	13 Nov 2016	20 Nov 2016	27 Nov 2016	4 Dec 2016
77%	75%	75%	77%	81%	81%

8. Financial variances – *give details of any variances to your project finances where applicable, e.g. actual expenditure against planned expenditure*

Year to date actual costs incurred	NA
Forecast outturn costs	NA
WTE year to date plan	NA
WTE year actual in post at date (*then if appropriate details of when the scheme will be fully staffed)*	NA
Further information	NA

9. Decisions required from the Improvement Group – *include any exceptions that need escalating*

None at this time

Change control (all removed actions on 'UHL completed actions' tab of spreadsheet)

- New action 69

BOARD ASSURANCE FRAMEWORK

Author: Lisa Gowan Sponsor: Richard Mitchell **Trust Board paper G appendix 5**

Executive Summary

Context

The proposal to disaggregate the Board Assurance Framework with each principal risk presented to the relevant Executive Board by the principal risk owner, for endorsement, prior to being reported to the Trust Board was approved at the Trust Board Thinking Day in March 2016.

Questions

1. Does the principal risk title and content provide an accurate reflection of the risks to the achievement of the annual priorities (and strategic objective)?
2. Does the current principal risk score and assurance rating accurately reflect the current position in terms of achievement of the annual priority and performance / effectiveness of controls in place?
3. Do any gaps in control and/or assurance have an action plan (with a due date) to mitigate the level of risk?
4. Is the action plan completed correctly and where an action is not 'on track' is the delay and the steps being taken to resolve the issue accurately described?
5. What important point(s) (if any) relating to the principal risk needs to be reported to the next available Trust Board?

Conclusion

1. Yes
2. Yes
3. Yes
4. Yes
5. Regular item in Trust Board for update and discussion.

Input Sought

We would welcome the Trust Board's input to:

a. Receive and note this report;
b. Provide the corporate risk team with details of any further amendments required to the BAF in order that a final version can be submitted to the next TB meeting. Please recognise that Trust Board papers are required by midday on the Thursday before the Trust 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 No

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, please explain why not? Eg. Current Risk Rating is LOW

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

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: [2.2.17 TB]

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

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

UHL Board Assurance Dashboard:		AUGUST 2016						
Strategic Objective	**Risk No.**	**Principal Risk Description**	**Owner**	**Current Risk Rating**	**Target Risk Rating**	**Risk Movement**	**Assurance Rating**	**Executive Board Committee for Endorsement**
Safe, high quality, patient centred healthcare	1	Lack of progress in implementing UHL Quality Commitment.	CN	12	8			EQB
	2	Failure to provide an appropriate environment for staff/ patients	DEF	12	8			EQB
An excellent integrated emergency care system	3	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity	COO	25	6			EPB
Services which consistently meet national access standards	4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.	COO	16	6			EPB
Integrated care in partnership with others	5	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.	DoMC	12	8			ESB
	6	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision	DoMC	16	10			ESB
Enhanced delivery in research, innovation and clinical education	7	Failure to achieve BRC status.	MD	9	6			ESB
	8	Failure to deliver an effective learning culture and to provide consistently high standards of medical education	MD	12	6			EWB / EQB
	9	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	12	6			ESB
A caring, professional and engaged workforce	10a	Lack of supply and retention of the right staff, at the right time, in the right place and with the right skills that operates across traditional organisational boundaries	DWOD	16	8			EWB / EPB
	10b	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care	DWOD	16	8			EWB / EPB
	11	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review	DWOD	12	8			EWB / EPB
A clinically sustainable configuration of services, operating from excellent facilities	12	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme	CFO	16	12			ESB
	13	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	CFO	16	8			ESB
	14	Failure to deliver clinically sustainable configuration of services	CFO	20	8			ESB
A financially sustainable NHS Trust	15	Failure to deliver the 2016/17 programme of services reviews, a key component of service-line management	CFO	9	6			ESB
	16	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17	CFO	15	10			EPB
	17	Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10			EPB
Enabled by excellent IM&T	18	Delay to the approvals for the EPR programme	CIO	16	6	⟺		EIM&T
	19	Lack of alignment of IM&T priorities to UHL priorities	CIO	12	6	⟺		EIM&T

Board Assurance Framework:	Updated version as at:	Nov-16										
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity								**Risk owner:**		Sam Leak, Director of Emergency Care and ESM	
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 Ensure whole system response to decreasing attendance and admissions								**Risk Assurance Rating**		Exec Board RAG Rating = EPB: 25/10/16	
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 **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.	ED 4 hour wait performance (threshold 95%) Poor performance continues to be primarily driven by increased ED attendances and emergency admissions and variability in medical leadership across the emergency floor. 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 in ED and delayed ambulance handover.	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. intensive support predicted in October New ECIP team started in November to support delivery over the next 12 months.	Lack of effectiveness of admissions avoidance plan Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity

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.	See plan	see plan	Plan has been produced Confirm and challenge session on 14.9.16 AE Delivery Board started 21.9.16 and will meet fortnightly New AE implementaion group started 12.10.16	4
Increased medical base ward capacity ward 7 (for medicine) and Ward 23a for Cardiology and respiratory	~~01/09/2016~~ Oct-16 Nov 1st and Dec 1st (respectively)	SL / COO	Ward 7 now fully open Ward 23a at GH opened as planned Refurbished discharge lounge now open	5
Move to new build	Mar-17	SL / CF	Ensure pathway reconfiguration and workforce matches requirement to address this risk	4
Escalation areas in ED to be used proactivley	Nov 1st	SL	Protocols further updated and implemented on 21.12.16 - to ensure clear and consistent approach into using escalation areas to minimise ambulance handover delays.	4

Expansion of Majors by moving minors to DVT and TIA	Jul-16	SL	**Complete.** Updated at EQSG - on track	5
ORG action plan to decrease attendances		ORG	**Complete.** Acton plan in place and progress against milestones managed via ORG	5
Ensure patients are conveyed to the most appropriate to access e.g. UCC, Assessment bay, AAU (amb and non amb)		SL	**Complete.** SOP developed and audited on a regular basis	5
Bed capacity demand for 16/17 and 17/18 to be updated to show the bed gap by	Jul-16	COO	**Complete**	5
LLR plan to reduce admissions (including access to Primary Care)	~~Review Jun - 16~~ Sept-16	COO	Admissions and attendance continue to increase. The existing RAP has been closed and a new system wide RAP has been produced and is being managed via the AE	5
Develop a detailed action plan demonstrating actions to impact on bed capacity and demand, ED processes to improve non admitted performance and CDU performance.	Aug-16	SL / COO	Actions to August IFPIC on 28.8.16	5

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.								**Risk owner:**		Will Monaghan, Director Of Performance And Information	
Strategic objective:	Services which consistently meet national access standards								**Objective owner:**		COO	
Annual Priorities	Maintain 18-week RTT and diagnostic access standard compliance Deliver all cancer access standards sustainably								**Risk Assurance Rating**		Exec Board RAG Rating = EPB 27/7/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16								
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Insourcing of external consultant staff to deliver additional sessions. Outsourcing of elective work to independent sector providers. Productivity improvements in-house. Additional premium expenditure work in house.	RTT Incomplete waiting times (threshold 92%). Currently 92.2%. Diagnostics: 0.7% (threshold 1%) Cancer Access Standards (reported quarterly). 2 ww for urgent GP referral (Threshold 93%). 94.5% 2 ww for symptomatic breast patients (threshold 93%). 96.2% 31 day wait for 1st treatment (threshold 96%). 89% 31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%). 100% (Surgery - threshold 94%). 77.5% (Radiotherapy - threshold 94%). 96.4% 62 day wait for 1st treatment (threshold 85%). 83.6% 62 day wait for 1st treatment (CSS referral-	Cancer recovery action plan managed across the Trust, NHS Improvement and the CCG. Monthly performance call with NTDA. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016. Elective IST have assured the action plans in Diagnostics and the Cancer plan.	(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (4.1). (c) insufficient theatre staff to undertake additional sessions required to match growth (4.3). (c) Referral growth outmatching capacity growth (4.4).

	threshold 90%). 70% Cancer wait 104 days (threshold TBC). 12		

Action tracker:	Due date	Owner	Progress update:	Status
Sustained achievement of 85% 62 day standard (4.1)	Sep-16	DPI	62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. The extension to deadline comes as part of our submission to the TDA for our sustainable transformation plans.	4
Development of ITU additional capacity plan including increased frequency of step downs. (4.1)	Sep-16	HoO ITAPS		4
Further insourcing of external ENT consultant staff to deliver additional sessions (4.2)	Jul-16	DPI	**Complete**	5
Insourcing alternative suppliers of theatre staff (4.3)	Aug-16	DPI		4
Serving Activity query Notices to the commissioners (4.4)	Oct-16	DPI		4

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.