

HEALTH AND WELLBEING BOARD

4 June 2013

Title:	BHRUT Progress on Actions Identified by CQC		
Report of the Medical Director, Barking, Havering & Redbridge University Hospitals NHS Trust			
Open	For Comment		
Wards Affected: None	Key Decision: No		
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Sponsor: Dr Mike Gill, Medical Director, Barking, Havering & Redbridge University Hospitals NHS Trust			
Summary: <p>This report presents the Emergency Care Improvement Plan for Barking, Havering & Redbridge University Hospitals NHS Trust, which incorporates the actions that the Trust has planned in response to the inspection report undertaken by the Care Quality Commission in late 2012.</p> <p>The Board is invited to comment and to contribute to the discussion about the wider whole system response, which will be planned through the proposed Urgent Care Board, a workshop for which took place on 24 May 2013.</p>			
Recommendation(s) Board members are recommended to:			
<ul style="list-style-type: none">• Note the actions being taken by BHRUT to improve emergency care at the Hospital, and provide comment on the plans and progress described;• Provide comment on the system wide implications of this work, to inform proposals for future co-ordination of urgent care improvement activity.			

1 Introduction

- 1.1 This transformational plan will set out how Barking Havering and Redbridge University Hospitals NHS Trust (BRUHT), will achieve the 95% A&E access target and improve patient experience in line with the agreed trajectory by August 2013, following identification of issues by the Care Quality Commission (CQC). It has been developed in the context of the Health for North East London proposals which received the approval of the Secretary of State, and is focused on a series priority actions across the whole hospital system. The overarching approach is one that seeks to deliver sustainable change: a platform from which more medium and long term goals, designed to deliver the Trust vision, can be successfully realised.
- 1.2 In terms of monitoring the improvement work, the internal processes for the Trust are described in paragraph 3.3, below. The Trust is also subject to reporting to the NHS Trust Development Authority, as well as periodic further inspection by CQC.

2 Context

- 2.1 BHRUT has a vision 'to place excellence in patient care at the centre of all we do in healing, caring for and serving our community'. The Trust is on a mission to create a viable and sustainable organisation, working with clinicians, managers, external partners and local people, that meets the needs and expectations of its patients and one which the local community can be proud.
- 2.2 At the end of 2012 the Care Quality Commission (CQC) made an unannounced visit to the emergency care department at Queen's Hospital and conducted a comprehensive assessment which included observing how the department was being run and talking to staff, patients and their relatives. The CQC concluded that the department was falling short on key national quality standards by highlighting excessive delays for patients receiving treatment and patient dissatisfaction with their experience in the department. Subsequently the Trust has designed a comprehensive plan for addressing the findings of the CQC with particular reference to the whole hospital system and patients flows, rather than a plan based squarely on the Emergency Department only. In parallel the London Quality Programme's Acute Medical and Emergency Surgery Standards have been published and in order to take account of the recommendations, the standards have been embedded into the 'Improving Emergency Care Programme' of workstreams as a 'golden thread'.
- 2.3 In 2010 the commissioners for North East London consulted with multi-stakeholders and the public on Health for North East London (H4NEL) proposals, aimed at creating a 'hot' site at Queen's Hospital (QH) and a 'cold' site at King George's Hospital (KGH). The proposals outlined in the Decision Making Business Case which was approved by the Secretary of State for Health are now included in the Acute Reconfiguration Programme, and included the following:
- The A&E at King George Hospital (KGH) to close, whilst upgrading the Urgent Care centre (UCC) to operate 24 hours a day.
 - The Maternity unit at KGH to close during the 4th Quarter of 2012/13 with births moving to the Queen's site.
 - Planned surgery to move from Queen's Hospital to KGH except where there are benefits in co-locating services or on the basis of clinical need.

- Non-elective surgery to be centralised at the Queen's site, with no acute medical or Paediatric beds remaining in the KGH site.

3. The Improving Emergency Care Programme Plan

- 3.1 This transformational plan has been set out with 10 workstreams scheduled to deliver in August 2013. These will provide the foundation for the transformational capability of a further 3 workstreams which will be executed in the medium to longer term time period, reaching a conclusion in June 2015 when the A&E department at KGH will close in favour of 24 hour Urgent Care Centre with some activity transferring to the Queen's Hospital and Whipps Cross Hospital sites.
- 3.2 The Gantt chart, figure 1, summarises the scheduled timescales and milestones between now and June 2015.
- 3.3 The plan is monitored via a series of meetings, as follows:
- **Weekly Emergency Care Project Meetings**
(12 locked work plans, 12 weekly progress reports)
 - **Fortnightly Emergency Care Programme Board**
chaired by David Gilbert (each executive will briefly present updates on their workstream)
 - **Monthly TEC**
chaired by Chief Executive Averil Dongworth (executive updates will feed into the master plan which will be reviewed by the PMO monthly)
 - **Internal Acute Reconfiguration Board**
chaired by Chief Executive Averil Dongworth
 - **Board Meeting**
decide on resource allocation and hold those overall responsible to account for undelivered action
- 3.4 The five operational priorities, and their workstreams for 2013-2015, to deliver the Improving Emergency Care Programme are as follows:
- 1) Accelerate recruitment and retention of medical and nursing staff in ED (Emergency Department)
 - a) Consultant recruitment
 - b) Improving staff experience
 - 2) Delivering improved pathways to redirect patients from ED and provide improved assessment capacity and capability particularly focusing on older patients
 - a) Improving acute medical assessment including GP direct access
 - b) Improving assessment for frail elders
 - c) Improving the Urgent Care Centre
 - d) Improving the ED/UCC estate
 - 3) Improving the experience of patients in the ED
 - a) Improving patient safety and experience
 - b) Improving the emergency department
 - c) Improving paediatric emergency care
 - 4) Implementing 7-day working
 - a) 7-day working
 - 5) Improvements focused on the London Quality Programme's Acute Medical and Emergency Surgery Standards and achieving them

- a) Surgical assessment unit including direct GP access
- b) Improving ambulatory care
- c) Care planning and discharge

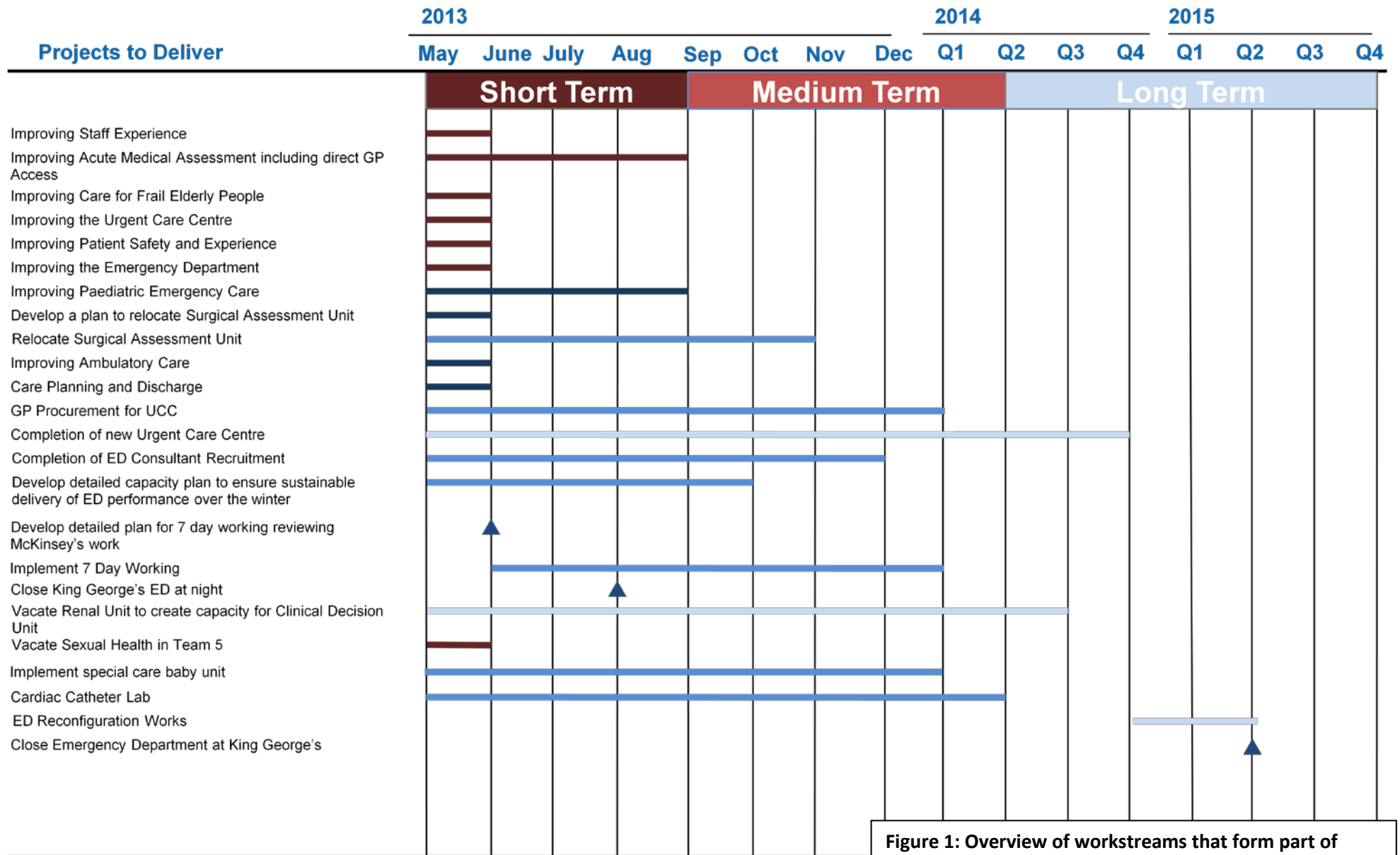


Figure 1: Overview of workstreams that form part of BHRUT's 'Improving Emergency Care Programme'

4 Progress on delivering the immediate priorities of the Emergency Care Improvement Plan

Immediate term priorities

4.1 Appendix 1 contains slides that provide an overview of the progress against the 10 workstreams which have been identified as those critical to the transformation of the whole system and which are scheduled for completion by the end of August 2013. They include priority actions which are already showing signs of improvement and are aligned to the delivery of the London Quality Programme's Acute Medical and Emergency Surgery Standards.

4.2 Those workstreams are:

- Improving patient safety and experience;
- Improving staff experience;
- Improving acute medical assessment, including direct GP access;
- Improving care for frail elderly people;
- Improving the Urgent Care Centre;
- Improving the Emergency Department;
- Improving paediatric emergency care;
- Surgical Assessment Unit including direct GP access;
- Improving ambulatory care;
- Care planning and discharge.

Medium term priorities

4.3 Appendix 2 provides an overview of the current position on the 3 workstreams that have been scheduled for completion by the end of March 2014. The first two are already in train and have detailed plans in place which are included in this document. The plan for 7 Day working is in the process of being developed and it is anticipated that this will be ready for implementation from end of June 2013. These workstreams are:

- Procurement of out-source GP function in the UCC (January 2014);
- Emergency Department consultant recruitment (December 2013);
- 7 Day Working (development phase completion June 2014. Implementation phase completion September 2014).

4.4 In addition the management of capacity/Winter planning will commence earlier than in previous years, with a view to having a fully worked up plan in place by September 2013 with implementation to cover the period October 2013 – March 2014. This is an operational plan which will evaluate the initiatives adopted in the current year to manage surges in demand, and which will align to the 13 workstreams as described in this document.

Longer term priorities

4.5 Finally, longer term goals include the realisation of Health for North East London aims by determining what the precise configuration of services will be across both QH as the 'hot' site and KGH as the 'cold' site. Ahead of this plans to redevelop the

Emergency Department as part of the development of the Urgent Care Centre on the Queen's hospital site is underway and scheduled for completion in December 2014.

- 4.6 In addition the role of the Clinical Decision Unit alluded to under the Ambulatory Care workstream, is seen as essential to the provision high quality care for appropriate patients in the right setting, thus avoiding unnecessary and inappropriate A&E attendances and admission to acute care. While this is being developed in partnership with NELFT and primary care, the project is dependent on securing suitable accommodation.
- 4.7 Other critical areas to be monitored closely will be the ongoing recruitment of emergency care consultants, Care of the Elderly consultants and acute physicians.
- 4.8 Other initiatives are expected to be identified and these will be developed as the Acute Reconfiguration Programme plan evolves.

5 Performance of the Emergency Department to March 2013

- 5.1 Appendix 3 contains information about the performance of the Emergency Department over the period to March 2013, based on the last reporting period to the public Board meeting.

6 Health & Wellbeing Board discussion

- 6.1 The information about the Emergency Care Improvement Plan is being presented to the Health & Wellbeing Board in recognition of the crucial part it plays in the overall health economy. Members of the Board are invited to comment on the progress and plans, and to suggest areas where there are greater opportunities for the whole health economy to support the Trust in its work on improving emergency care.
- 6.2 An Urgent Care Board is in the process of being established across the BHR health economy with the participation of the local authorities, clinical commissioning groups and the health trust. The intention is for this Board to lead the system-wide response and to streamline the multiple reporting processes in place to monitor BHRUT's improvement journey. A workshop was scheduled for Friday 24 May 2013, from which a verbal update will be available at the meeting.
- 6.3 Officers that are part of the discussions at that Board will note the comments of the Health & Wellbeing Board and reflect them in discussions as the Board and its workplan are shaped. A more formal update will be provided to a future meeting of the Health & Wellbeing Board.

7 Implications

7.1 Joint Strategic Needs Assessment

The 2012 JSNA contained a number of disparate references to urgent and emergency care, spread across a number of areas of analysis. In many respects, it has been superseded in any consideration of the specific issues about emergency care at BHRUT by the more comprehensive work undertaken by CQC. Future iterations of the JSNA would need to refer to this work.

7.2 Health & Wellbeing Strategy

Improvements in local health services, and emergency care in particular, are identified in the Health & Wellbeing Strategy and the considerable work described in these reports are major contributors to those priorities.

7.3 Promoting integration

The Health & Wellbeing Board's duty to promote integration will be discharged through consideration of the BHRUT-specific activities in the context of the wider health system. The establishment of the Urgent Care Board and related processes will be a further opportunity to ensure that integrated programmes of activity are pursued for the improvement of urgent and emergency care across this and neighbouring boroughs.

Appendix 1:
Emergency Care Improvement Plan:
Immediate Term Actions

Improving Patient Safety and Experience

Short Term Goals	Plan	Progress
Leadership	<ul style="list-style-type: none"> •Set a mission and expected outcome to improve patient experience. •Leadership behaviours/leadership charter. •OIC Nurse quality walk rounds at least 3 x per shift. •Define OIC nurse/co-ordinator roles to ensure flow is maximised. •Performance management of junior staff. •Introduce 'Give a star to a star'. •Clear escalation pathways that allow the department to respond to change. •Improve internal communications via SBAR and leadership charter. 	<ul style="list-style-type: none"> •New lead nurse started 7 May •OIC Quality rounds assurance rounds with lead nurse and matron overseeing •Give a star a star – started •Reviewing compliance against mandatory training and appraisals (which will lead to individual development plans)
Staffing.	<ul style="list-style-type: none"> •Review staffing establishment to ensure staff on duty match activity. •Strengthen roles and responsibilities. •Improve performance management of bank and agency staff. •Band 7s to lead sickness absence management. •Mentorship/preceptorship for band 5s and support for new starters. •Retention strategy to focus on junior grades of staff. 	<ul style="list-style-type: none"> •New lead nurse started 7 May •Revised staffing for short term •20 wte band 5 nurses recruited •All band 5 nurses accesses the preceptorship programme
Patient safety and experience.	<ul style="list-style-type: none"> •Increase uptake of patient survey to 15% of attendances. •Display 'friends and family' feedback in public places. •Implement 'the big 3' key areas of focus for the week. •OIC Nurse to include waiting room checks in her daily shift role. •Implement NHS Institute of Innovation 15 steps. •Define a process to identify vulnerable patients and expedite their assessment. •Introduce monthly 'you said we did' posters. •Create a set of '<i>always</i>' events. •Reduce medicines incidents via the introduction of a management plan. 	<ul style="list-style-type: none"> •Increasing survey numbers •Monthly focus on 3 key issues for improvement based on survey started •Focus on medication and medicines for May as one of the top 3 (feeling welcome and discharge) •You said we did posters in place •OIC waiting room regular review

Improving Staff Experience.

Short Term Goals	Plan	Progress
Improve communication to staff.	<ul style="list-style-type: none"> • Accessible service improvement communication in staff rooms. • Computers in staff rooms. • Purchase emergency care journals. • 4 positive messages of the week. • More frequent reception teams meetings. 	<p>Service communication is available in staff rooms and reception teams meetings occur monthly.</p> <p>All other actions are on trajectory for completion in May 2013.</p>
Ensure staff engagement in change/service improvement.	<ul style="list-style-type: none"> • Ask for volunteers on service improvement projects. • Monthly Q&A with senior members of the team. • Staff feedback book. • Align to the Trust Organisational (OD) Development Plan. • Major OD event planned for July 2013. 	<p>Staff feedback book in place.</p> <p>All other actions are on trajectory for completion in May 2013.</p>
Ensure consistent staffing levels.	<ul style="list-style-type: none"> • Overseas recruitment plan for ED Consultants. • Recruitment campaign for nursing. 	<p>Overseas recruitment plan is a medium term goal for delivery by December 2013.</p> <p>20 wte band 5 nurses recruited.</p>
Staff training and development.	<ul style="list-style-type: none"> • Appraisals and Personal Development Plans. • Ensure training and development takes places and minimise/limit cancellations. 	<p>Appraisals require attention to achieve 85% target.</p>
Monitoring improvements.	<ul style="list-style-type: none"> • Assess baseline from staff survey and reaudit in 3 months. • Retention rate/reduction in turnover. • Sickness absence rates. 	<p>Sickness absence rates were well below the Trust target in March 2013 at 2.6%.</p>



Improving Acute Medical Assessment Including Direct GP Access.

Short Term Goals

Plan

Progress

Ensure there is robust and effective medical leadership.	<ul style="list-style-type: none"> •The Clinical Director for Medicine has overarching responsibility for the MAU. •A consultant has been identified to lead MAU development. •A lead consultant has been identified for ambulatory care. 	The following doctors have assumed leadership roles: <ul style="list-style-type: none"> •Dr Andrew Deaner. •Dr. Aklak Choudhury. •Dr. Gurvinder Rull.
Developing the GP/Ambulatory Unit	<ul style="list-style-type: none"> •Set up unit on MAU commencing with 6 trolleys increasing to 12. •Implement additional nurse and medical staffing plan. •Communication with GPs. 	GP unit with 6 trolleys up and running since February. New staffing establishment for 12 trolleys approved and recruitment in process. Steady increase in GP referrals week on week – from 5 in first week to c. 30 currently.
Improve flow of patients through the medical assessment unit.	<ul style="list-style-type: none"> •Improve nursing transfer from ED to MAU by ensuring appropriate clinical pathways are followed and documentation is complete. •Improve communication between bed site team, MAU, and ED. •Redesign portering roster. •Relaunch TTAs system to facilitate discharge from MAU. 	08.30meeting between bed site team, MAU and ED nurses is resulting increased use of the GP/Ambulatory Unit for appropriate patents direct from ED. Patients remaining in the unit for more than 48 hours the week ending 28 th April 0.0%.
MAU medical assessment JONAH	<ul style="list-style-type: none"> •Implementation of MAU assessment JONAH, to include MAU and the Short Stay Elderly Unit. •3 month project with external support from QFI. 	Project commences 1 st June and finishes 31 st August 2013.

Improving Acute Medical Assessment including Direct GP Access Continued.

Short Term Goals

Plan

Progress

Admission avoidance.	<ul style="list-style-type: none"> •Allocation of patients under specialty in MAU to be medically managed by the appropriate specialty. •12 noon medical handover meetings. •Community Treatment Team to operate in MAU. •Post take admission avoidance resource folder available to nursing and medical staff. 	<ul style="list-style-type: none"> •Medical discharges out of hospital direct from MAU are increasing from 69 4 weeks ago to 115 currently.
Staff retention and recruitment.	<ul style="list-style-type: none"> •Dedicated MAU Manager in place •Recruitment campaign to increase nursing staff. •Recruitment of locum consultants x 3 wte. •Foundation of Nursing Studies working with the MAU nursing team to lift morale. 	<p>8 wte band 5 nurses recruited. 8 WTE to be recruited – next recruitment day May 26th 2 x Care of Elderly consultants recruited which will support MAU. Acute physician recruitment underway.</p>
Improving the current environment on MAU to ensure our patients remain in contact with the outside world.	<ul style="list-style-type: none"> •Installation of patient entertainment systems. •Installation of water fountains and Costa coffee machine. •Large screen TVs in communal areas. •Review of food served in MAU. 	<p>On trajectory for delivery Summer 2013.</p>



Improving Assessment for Frail Elders.

Short Term Goals	Plan	Progress
<p>7 day advice and liaison service.</p>	<ul style="list-style-type: none"> •Assessing medical and nursing staff requirements. •Redeployment of experienced care of elderly consultants. •Agree rota for 7 day working. •Recruitment to Clinical Nurse Specialist posts. •Plan for nursing support at weekends. •Junior doctor support for 7 day working. 	<p>On trajectory for delivery Summer 2013.</p>
<p>Establish a short stay elderly care ward. The clinical model to be further refined so that short stay brings an emphasis assessment.</p>	<ul style="list-style-type: none"> •Completion of Operational Policy. •Manpower requirements in place for nursing and medical staff. •Additional training for ward staff on rapid discharge. 	<p>Short Stay Unit opened April 2013.</p> <p>Average length of stay for this patient group has been reduced by 1.5 days.</p> <p>Further development of the assessment model will require 2 further wte Care of the Elderly consultants.</p>

Improving The Urgent Care Centre

Short Term Goals	Plan	Progress
Walk in, Streaming and GP 'see and treat'.	<ul style="list-style-type: none"> •Develop see and treat model. •Ensure all streamers understand process of redirection to primary and/or community care. •Primary care non- compliance with agreed redirection protocol to be followed up with commissioners. •Liaison with the Hurley Group to ensure GPs have the right skills for streaming and 'see and treat'. 	126 patients were streamed back to the community/primary care services week ending 5 th May, exceeding the 120 weekly target.
Ambulance flows into the UCC	<ul style="list-style-type: none"> •Provide LAS with an exclusion criteria. •Provide a self assessment guide for ambulance crews as they arrive at A&E so that they can make appropriate decisions regarding ambulance transfer. 	<p>Exclusion criteria in place and agreed, working with LAS to increase daily activity.</p> <p>Direct conveyances to the UCC are increasing gradually: 13.9% currently up from c. 5% since implementation of the exclusion criteria.</p>
Removing unnecessary process and delay within the UCC.	<ul style="list-style-type: none"> •LEAN methodology exercise to improve internal workings of UCC. •Re-establishment of roles and responsibilities. •Adjustment to infrastructure to aid patient flow. 	On trajectory for completion in the summer 2013.
Workforce skills, ROTAs and training.	<ul style="list-style-type: none"> •Review of staffing levels and development of minimum staffing establishment. •UCC improvement manager 	<p>Substantive recruitment in progress</p> <p>Manager in place</p>

Improving The Urgent Care Centre continued.

Short Term Goals	Plan	Progress
Performance data and performance management.	<ul style="list-style-type: none"> •Measures to improve data capture and reporting. •Pathway improvement: appropriate patient appropriate pathway •Dashboard analysis weekly. Reported at weekly Improving Emergency Care Programme Board, weekly Consultants meeting, and weekly ED Seniors meeting. 	Including adult and paediatric attendances, around 31% of patients who present at A&E are seen in the UCC. Less ambulance arrivals this figure is 41%.
Creating a UCC team with high aspirations.	<ul style="list-style-type: none"> •Establish robust chain of command with well understood thresholds for escalation. •Robust management of the 'shop floor'. •Engender a strong sense of shared purpose. 	On trajectory for delivery summer 2013.
Strengthening relationships with partner providers.	<ul style="list-style-type: none"> •Strengthen operational links with external partners. •Procurement process for out-source GP element to UCC. 	An increased number of patients redirected and data shared weekly with CCG's.
Clinical Governance and professional relationships with ED.	<ul style="list-style-type: none"> •Induction process for locums and contract staff. •Removing obstacles to a smooth referral process to specialties within BHRUT. 	<p>The UCC GPs can make direct referrals to specialties.</p> <p>External GPs can also refer direct to specialties.</p>



Improving The Emergency Department.

Short Term Goals	Plan	Progress
Extend and Improve RAT	<ul style="list-style-type: none"> •Increase RATING to from 17.00 to 22.00. •Review RATING area via LEAN methodology. 	<ul style="list-style-type: none"> •RAT hours extended on a number of days per week but unable to fill further until additional consultants/seniors recruited •RATING improvement to be implemented further by consultant lead in May.
Improve Communication from RAT to Majors	<ul style="list-style-type: none"> •Improve RAT documentation. •Improve availability of results. •Improve RAT to majors nurse handover. 	Completed.
Review role of Majors Co-ordinator/board nurse	<ul style="list-style-type: none"> •Trial admin role as board post. •Review and implement clear responsibilities of the senior nurse in charge. 	<ul style="list-style-type: none"> •Admin role trial commenced 22nd April. Due for evaluation week commencing 13th May.
Review all equipment in Majors and fixed equipment in Majors cubicles.	<ul style="list-style-type: none"> •Process for monitoring and checking equipment. •Stock control measures in place. 	Completed
Review staffing in Majors	<ul style="list-style-type: none"> •Recruitment campaign for band 5 nurses. •Review medical staffing and submit rota for EWTD testing. 	<ul style="list-style-type: none"> •20 wte band 5 nurses recruited. •EWTD testing completed.
Improve mental health reviews for patients in ED	<ul style="list-style-type: none"> •Monthly multi professional meeting to review progress regarding mental health, drugs, alcohol and police. •Review Whipps Cross in reach model. •Review top 20 reattenders for alcohol pathway 	<ul style="list-style-type: none"> •Monthly meetings with key operational partners are in place.

Improving The Emergency Department continued.

Short Term Goals

Plan

Progress

Locums and induction.	<ul style="list-style-type: none"> •Online induction for medical locums. •Useful contacts list. 	Completed.
Specialty input	<ul style="list-style-type: none"> •Ensure GPs refer directly to specialties. •Feedback to specialties their 'referral to review' performance. •Emergency Access Policy. 	<ul style="list-style-type: none"> •All patients who attend with a 'dear doctor letter' from their GP are referred direct to the relevant specialty.
Monitor improvements through better data and information.	<ul style="list-style-type: none"> •Recruitment of a dedicated information officer for ED. •Weekly analysis of A&E dashboard and taking forward key points of learning. 	<ul style="list-style-type: none"> •Information Officer commenced in post April 2013. •Weekly analysis reviewed at Programme Board.
Review Management Structure	<ul style="list-style-type: none"> •New Management team in place: Clinical Director, General Manager, Service Manager and Nursing Lead as of May 4th 	<ul style="list-style-type: none"> •Provide additional support following review at the end of May
Improve data capture	<ul style="list-style-type: none"> •Review of Symphony data system to ensure live data is captured – internal review completed. ED data steering group established 	System review by external consultants week of May 13th

Improving Paediatric Emergency Care.

Short Term Goals	Plan	Progress
Launch NICE guidelines for the management of common conditions.	<ul style="list-style-type: none"> •Review NICE Guidelines for 'FEVER' and implement •Review NICE Guidelines for 'HEAD INJURY' and implement •Review current guidelines for 'GASTROENTERITIS', 'BRONCHIOLITIS' and 'ASTHMA' to ensure current and up to date. •Ensure joined up pathways with 'outpatient' based services such as Diabetes Management and Seizure clinics. 	<ul style="list-style-type: none"> •In Progress •Target Completion July/August
Improve the timeliness of responses to the Paediatric ED by Speciality services.	<ul style="list-style-type: none"> •Establish a case review meeting when breaches of the internal 2 hour target occur •Review the current escalation protocols between clinical and managements teams •Increase Consultant Paediatrician presence within the ED 	<ul style="list-style-type: none"> •In Progress •Target Completion May
Review the Transfer Protocols and policy with CATS.	<ul style="list-style-type: none"> •Acutely ill children to be managed with a jointly owned and developed policy with CATS, internal teams and receiving hospitals •Development of parent education leaflet 	<ul style="list-style-type: none"> •In Progress •Target Completion May



Improving Paediatric Emergency Care continued.

Short Term Goals	Plan	Progress
Management of the Critically Ill child	<ul style="list-style-type: none"> •Review current policies and protocols to ensure 'fit for purpose' •Develop the Resuscitation area in Paeds ED •Create robust escalation protocol for 'backfilling' with routine paediatric staff to avoid consequential delays in the event of a 'crash' event •Review current staffing levels and internal support 'out of hours' 	<ul style="list-style-type: none"> •In Progress •Target Completion May
Patient environment	<ul style="list-style-type: none"> •To review the provision of play specialists within the ED to improve child experience and reduce anxiety •To develop a multi-functional SSPAU (Short Stay Paeds Assessment Unit) on Tropical Lagoon 	<ul style="list-style-type: none"> •In Progress •Target completion September
Clinical Pathways	<ul style="list-style-type: none"> •Establish a SSPAU on Tropical Lagoon to appropriate management children attending the ED. •Ensure robust links with Admission Avoidance strategies elsewhere in the organisation •Review CAMHS provision and 'Safeguarding' provision to ensure safe management of vulnerable children. 	<ul style="list-style-type: none"> •In Progress •Target completion September •In Progress •Target completion May

Surgical Assessment Unit including direct GP access.

Short Term Goals	Plan	Progress
Establish a Surgical Assessment Unit (SAU).	<ul style="list-style-type: none"> •Implementation of a 5 day 'hot clinic' (Monday to Friday). •Implementation a 7 day SAU two trolleys and clinic area on Ocean B. 	Clinic commenced on the 4 th February 2013.
Communication with GPs and transfer of appropriate patients from the Emergency Department.	<ul style="list-style-type: none"> •Improve nursing transfer from ED to SAU by ensuring appropriate clinical pathways are followed and documentation is complete. •Improve communication between bed site team, SAU, and ED. •Redesign portering roster. •Communication with GPs •SAU audit completed 	<p>Numbers of patients transferred from A&E to SAU on a weekly basis 40 – 60.</p> <p>Numbers of patients referred directly by GPs on a weekly basis 12 – 28.</p> <p>Weekly data shared with CCG's.</p> <p>Audit data shared with CCG quarterly.</p>

Surgical Assessment Unit including direct GP access.

Short Term Goals	Plan	Progress
Establish a Surgical Assessment Unit (SAU).	<ul style="list-style-type: none"> •Implementation of a 5 day 'hot clinic' (Monday to Friday). •Implementation a 7 day SAU two trolleys and clinic area on Ocean B. 	Clinic commenced on the 4 th February 2013.
Communication with GPs and transfer of appropriate patients from the Emergency Department.	<ul style="list-style-type: none"> •Improve nursing transfer from ED to SAU by ensuring appropriate clinical pathways are followed and documentation is complete. •Improve communication between bed site team, SAU, and ED. •Redesign portering roster. •Communication with GPs •SAU audit completed 	<p>Numbers of patients transferred from A&E to SAU on a weekly basis 40 – 60.</p> <p>Numbers of patients referred directly by GPs on a weekly basis 12 – 28.</p> <p>Weekly data shared with CCG's.</p> <p>Audit data shared with CCG quarterly.</p>
Plan future of the unit given need for relocation in 6 months.	<ul style="list-style-type: none"> •Plan in place for relocation by end June 2013. •Implementation phase June – September 2013 	On trajectory as per published timescales.

Improving Ambulatory Care

Short Term Goals

Plan

Progress

First fit pathway/acute headache.	<ul style="list-style-type: none"> •Review pathway with Neurological lead (Dr Wore). •Document and implement. 	On trajectory for delivery summer 2013.
Self harm pathway.	<ul style="list-style-type: none"> •Review pathway with ED lead 9 (Dr Hicks). •Document and implement. 	On trajectory for delivery summer 2013.
Rapid access chest pain.	<ul style="list-style-type: none"> •Review pathway with cardiology leads (Dr Deaner, Dr Salehi and GP). •Document and implement. 	On trajectory for delivery summer 2013.
COPD.	<ul style="list-style-type: none"> •Review pathway with respiratory lead (Dr Fowler). •Document and implement. 	On trajectory for delivery summer 2013.
Pulmonary Embolism.	<ul style="list-style-type: none"> •Audit of current pathway (Dr Rull) •Document and implement changes/lessons learned. 	On trajectory for delivery summer 2013.

Improving Ambulatory Care continued.

Short Term Goals	Plan	Progress
Renal Colic	<ul style="list-style-type: none"> •Review current pathway with Dr Andrew Bolero. •Document and implement changes. 	On trajectory for delivery summer 2013.
Cellulitis	<ul style="list-style-type: none"> •Review current pathway with NELFT. •New pathway commences 1st May. 	New pathway for Cellulitis in place and more patients being cared for in the community.
Business case for Clinical Decision Unit. (utilising current area allocated to Renal services)	<ul style="list-style-type: none"> •Establish operational model. •Draft Business case for discussion. •Sign off at Trust Executive Committee. •Implementation phase 	Medium term goal for completion September 2014.
GP Ambulatory Care	<ul style="list-style-type: none"> •Convert 8 agreed pathways into 'GP appropriate' pathways. •Document and implement. •Communicate to GPs. •Work with GP's on pathways. 	<p>On trajectory for delivery summer 2013.</p> <p>Referral details for GPs are posted on the website.</p> <p>Straight forward referral process for GPs in place.</p>
Nursing Home/Care Home outreach.	<ul style="list-style-type: none"> •Review nursing home data regarding A&E attendances and community input. •Multi agency workshop in summer 2013. •Establish proposal for reducing nursing home patients attendance in A&E. 	On trajectory for delivery summer 2013.



Care Planning and Discharge.

Short Term Goals	Plan	Progress
<p>Ward based discharge planning processes are fully effective and when present discharge plans are effectively executed.</p>	<ul style="list-style-type: none"> •All departments and disciplines are fully engaged with and keeping JONAH up to date. •Investment of 37 wte to strengthen leadership by ward sisters/CN's •Consultants and senior ward nurses lead board and ward rounds, ensuring that TTAs (EDS) are completed during that process. •Increase ward manager capacity to lead JONAH reviews and manage discharges as planned. •A protocol in place to ensure timely access to social workers. •Improve use of the discharge lounge and potering during peak periods. •Address issues of Locum access to key IT systems e.g. PAS. •OT process are refined to reduce likelihood of delays. •Develop policy and process to manage families who apply pressure to keep their relatives in an acute setting. 	<p>On trajectory for delivery by 21st July 2013. 37 posts agreed. Recruitment event and open day in June. Event facilitated in April to improve communication between bed/site team, MAU and the wards.</p> <p>Weekly meetings ongoing with key managers</p>
<p>The interfaces with local social care and community bed provision are clearly understood and operating effectively.</p>	<ul style="list-style-type: none"> •Daily communication with senior managers at NELFT and escalation of rehab patients delayed in the system. •Development of a policy and process that manages the discharge of patients to care/nursing homes as well as the restarting care packages. •Develop a clear, effective process for rehab referrals through collaboration between BHRUT therapies and NELFT community rehab services. •Address issues for healthy non weight bearing patients. 	<p>On trajectory for delivery by 21st July 3013.</p> <p>Additional community bed capacity provided until end of April.</p> <p>Community provision needs to be assured as capacity is not aligned to patient choice.</p>
<p>An effective performance framework linking overall performance with local (ward and department) level is in place.</p>	<ul style="list-style-type: none"> •Agreed set of ward metrics in place: •Performance manage with ward teams led by matrons. •Communicate the approach with the wider organisation (ADOs and GMs) 	<p>On trajectory for delivery by 21st July 3013.</p>

Appendix 2:
Emergency Care Improvement Plan:
Medium-Term Actions

Procurement of out-source GP function in the UCC.

Short/Medium Term Goals

Plan

Progress

<ul style="list-style-type: none"> •Service Specification 	<ul style="list-style-type: none"> •Develop service specification. 	On trajectory for delivery Summer 2013.
<ul style="list-style-type: none"> •Service Level Agreement. 	<ul style="list-style-type: none"> •Development of contractual arrangements with performance metrics and penalties for non-achievement of KPIs. 	On trajectory for delivery Summer 2013.
<ul style="list-style-type: none"> •Procurement process. 	<ul style="list-style-type: none"> •Invite expressions of interest on OJEU website. •Provide pre-qualifying questionnaire and Service Specification to prospective bidders. •Shortlist those to provide Intention to tender document.. •Selection process August/Sept. •Award contract October. •New provider commences operations January 2014. 	On trajectory for new provider to commence January 2014.

Emergency Department Consultant Recruitment

Medium Term Goals

Plan

Progress

























































































































Recruitment options	<ul style="list-style-type: none"> •Engage with an external agency to undertake executive search and international recruitment. •Advertise vacancies on NHS Jobs. 	Recruitment strategy in place and commenced.
Confirm established posts to be recruited to and displace agency	<ul style="list-style-type: none"> •7 ED consultants •15 middle grades •17 basic grades •1 consultant with special interest •2 clinical fellows 	Trajectory agreed to meet target
Implementation of revised, attractive, consultant roles.	<ul style="list-style-type: none"> •Develop creative 'joint' roles across ED and specialties e.g Critical Care. 	Job description for joint role for ED and critical care out to advert.
Selection process.	<ul style="list-style-type: none"> •Interview panel and selection process to be determined. •Anticipated to commence Summer 2013. 	Late Summer 2013 selection with start in post anticipated by December 2013.
Recruitment of Clinical Fellows	<ul style="list-style-type: none"> •Advertise posts 	Interviews May 23 rd 2013
Retention.	<ul style="list-style-type: none"> •Changes to clinical and managerial leadership. •New clinical and managerial team in place 	New Clinical Director commenced in 2 nd May 2013. New management and nurse lead in place May 2 nd

Appendix 3:
Performance information on
Emergency Department

To March 2013

Hospital **King George's Hospital**
 Reporting D... **27 Mar 2013**

 Within threshold
  Within 10% of threshold
  Outside threshold
  No threshold

	Metric	Threshold	Yesterday 26/3/2013	Snapshot last week 19/3/2013	Average 7-days wk ending 26/3/2013	Average 7-days 2012 wk ending 26/3/2012
System overall	% of patients treated & discharged in 4 hours	Above 95.0%	 95.4%	 72.9%	 91.9%	 92.3%
	Resus Breaches	Below 1.0	 2.0	 2.0	 1.6	 1.7
	Majors Breaches	Below 10.0	 4.0	 36.0	 10.0	 13.7
	UCC Breaches	Below 1.0	 0.0	 5.0	 0.3	 0.9
	Paeds Breaches	Below 1.0	 2.0	 5.0	 1.9	 0.7
	Other Breaches	Below 1.0	 0.0	 1.0	 0.3	 0.0
	Total Breaches	Below 14.0	 8.0	 49.0	 14.0	 17.0
Emergency Department	Total attendances	Below 200.0	 173.0	 181.0	 173.4	 219.7
	Arrival flow	Ambulance to ED as % of overall attendances	 28.3%	 32.6%	 27.3%	 23.8%
		Ambulances to ED	 49.0	 59.0	 47.4	 52.3
	Flows within ED/UCC	Ambulance to UCC as % of ambulances	 6.1%	 6.8%	 3.9%	 11.2%
		Numbers into majors (inc Triage; excl Resus)	 88.0	 84.0	 88.7	 92.7
		Numbers direct into minors	 42.0	 45.0	 38.0	 53.9
	Speed of care in ED	% of 1st clinical assess in ED <30mins	 91.3%	 85.6%	 93.7%	 83.2%
		% refer to specialities < 120mins	 89.7%	 51.9%	 77.9%	 67.3%
		% of specialist response < 60mins	 51.7%	 50.0%	 55.7%	 50.7%
		Average time spent in ED (admitted patients)	 222.0	 413.7	 250.3	 284.8
		Average time spent in ED (not admitted patients)	 148.9	 203.8	 169.5	 177.7
	Admissions	Total admissions from ED	 50.0	 50.0	 45.7	 56.7
		Admissions from ED as % of total attendances	 28.9%	 27.6%	 26.4%	 25.8%
	Total admissions that were Ambulance arrival	 27.0	 25.0	 22.4	 25.6	
Assesment & Wards	MAU	Direct MAU admits from GPs	 0.0	 0.0	 0.0	 0.0
		Average length of stay on transfer in MAU (days)	 0.0	 1.0	 0.9	 1.1
		Average length of stay on discharge in MAU (days)	 0.0	 1.2	 1.1	 1.3
		MAU transfers	 30.0	 15.0	 20.6	 20.6
		MAU discharges home	 0.0	 0.0	 0.0	 0.0
	Medical ward discharges	Total number of medical discharges (Med & CoE only)	 17.0	 21.0	 18.4	 17.9
		% of pre 11am discharges (Med & CoE only)	 5.9%	 4.8%	 7.0%	 8.0%
		Average active spell LOS (days; Med & CoE only)	 -	 -	 -	 -
		# of active patients >14days (Med & CoE only)	 0.0	 0.0	 0.0	 0.0



Emergency Care Pathway Dashboard

Hospital	King George's Hospital	Legend	Trend from the previous week (PW)	XX Last 7 days average Wed 20 Mar 2013 - Tue 26 Mar 2013	PW: Previous week average Wed 13 Mar 2013 - Tue 19 Mar 2013 SW: Six week average Wed 06 Feb 2013 - Tue 26 Mar 2013
Reporting Date	27 Mar 2013				

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Ash	3.3 PW:3.7 SW:3.2	0.0% PW:7.7% SW:7.1%	8.7% PW:15.4% SW:12.2%	- - PW:8.1 SW:8.1	16.3 PW:8.3 SW:11.5	- -
Elm	1.7 PW:1.6 SW:1.5	8.3% PW:18.2% SW:8.2%	16.7% PW:18.2% SW:12.3%	- - PW:11.0 SW:11.0	17.9 PW:18.5 SW:21.2	- -
Erica	0.9 PW:1.6 SW:1.0	0.0% PW:45.5% SW:18.8%	0.0% PW:9.1% SW:4.2%	- - PW:16.8 SW:16.8	4.0 PW:21.5 SW:17.6	- -
Fern	2.1 PW:1.6 SW:2.2	6.7% PW:9.1% SW:6.5%	20.0% PW:18.2% SW:9.3%	- - PW:11.0 SW:11.0	13.6 PW:27.1 SW:15.9	- -
Gardenia	3.3 PW:3.0 SW:3.6	4.3% PW:4.8% SW:5.1%	30.4% PW:14.3% SW:14.3%	- - PW:5.2 SW:5.2	8.7 PW:6.4 SW:6.2	- -
Gentian	3.6 PW:5.3 SW:5.2	12.0% PW:10.8% SW:11.5%	16.0% PW:2.7% SW:7.9%	- - PW:3.1 SW:3.1	7.6 PW:5.5 SW:7.0	- -
Holly	3.6 PW:2.9 SW:3.3	12.0% PW:5.0% SW:10.6%	8.0% PW:10.0% SW:8.8%	- - PW:7.5 SW:7.5	9.2 PW:9.6 SW:10.7	- -
Overall	18.4 PW:19.6 SW:19.9	7.0% PW:11.7% SW:9.0%	15.5% PW:10.9% SW:10.2%	- - PW:8.5 SW:8.5	11.2 PW:10.8 SW:10.8	- -

Hospital	King George's Hospital
Reporting Date	27 Mar 2013

Legend

  Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

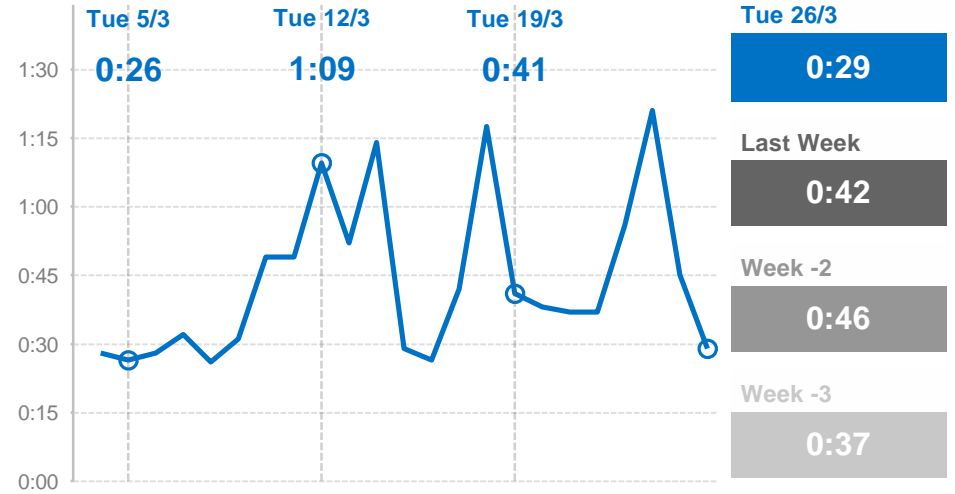
PW: Previous week average
 Wed 13 Mar 2013 - Tue 19 Mar 2013
 SW: Six week average
 Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Ash	PW:16.7% SW:16.7%					
Elm	PW:26.1% SW:26.1%					
Erica	PW:41.2% SW:41.2%					
Fern	PW:23.3% SW:23.3%					
Gardenia	PW:7.7% SW:7.7%					
Gentian	PW:0.0% SW:0.0%					
Holly	PW:11.5% SW:11.5%					
Overall	PW:16.8% SW:16.8%					

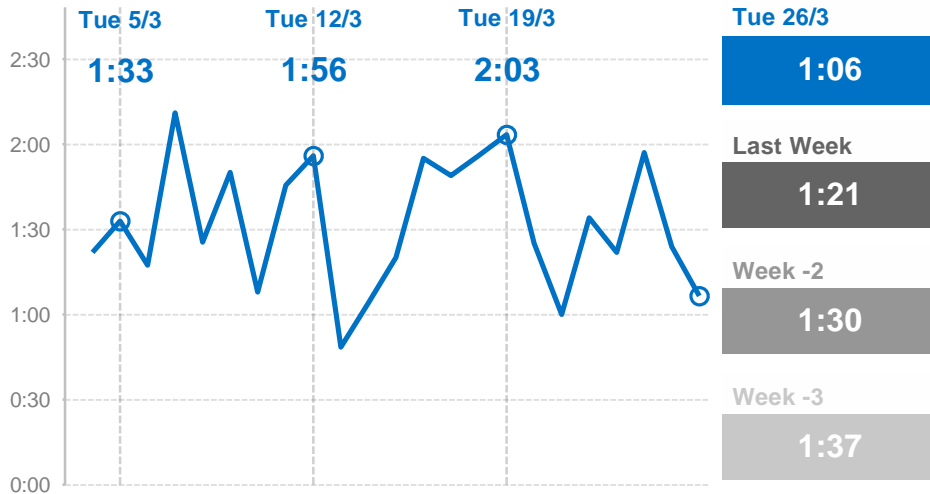
Hospital **King George's Hospital**
Reporting D... **27 Mar 2013**



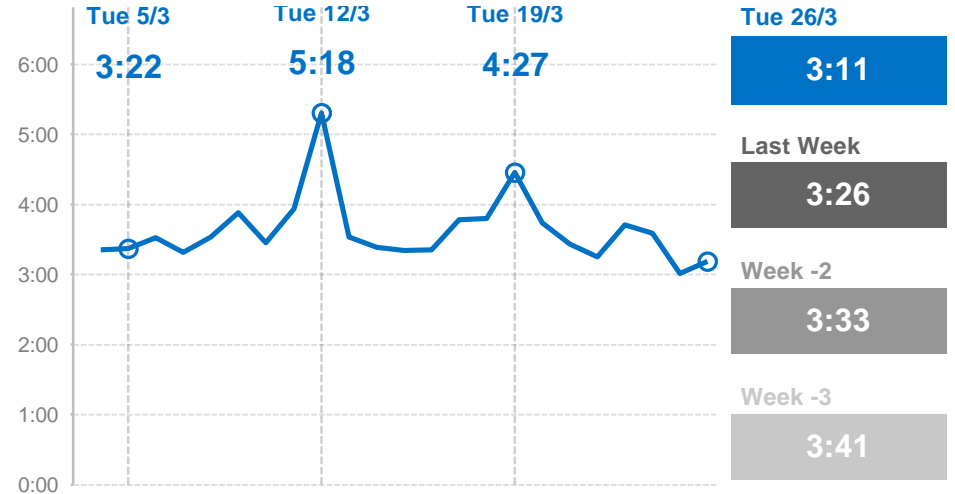
Median time between registration and seeing clinician (hours)



Median time between registration and request sent for investigations (hours)

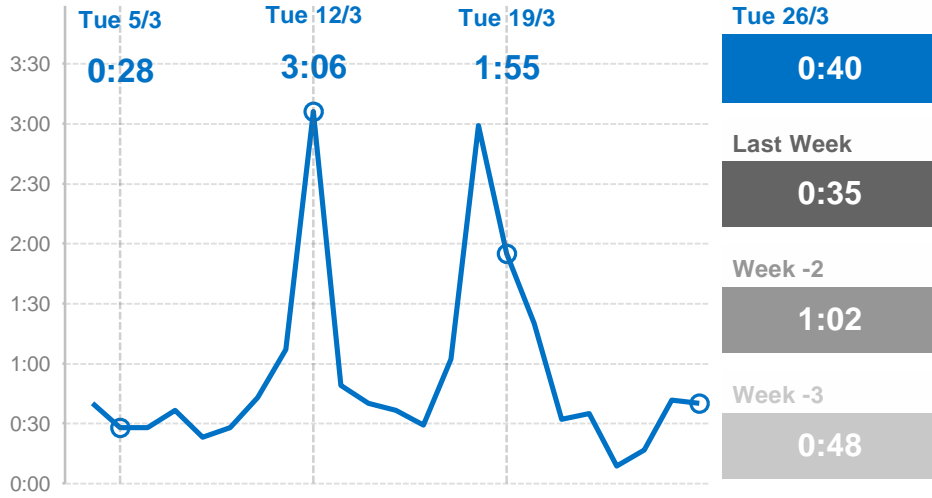


Median time between registration and referral to specialties (hours)

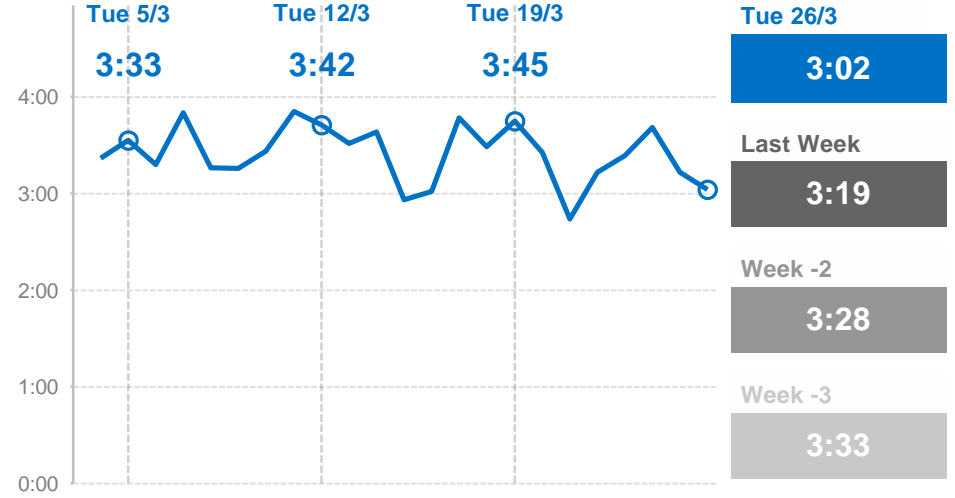


Median time between registration and request for bed (hours)

Hospital **King George's Hospital**
Reporting D... **27 Mar 2013**



Median time between bed request and left department (hours)







































































































































Median time spent in ED (hours)

Reattendance rate

Period	Reattendance rate
Last Month	11.7%
Previous Month	11.3%

Hospital **Queen's Hospital**
 Reporting D... **27 Mar 2013**

 Within threshold
 Within 10% of threshold
 Outside threshold
 No threshold

	Metric	Threshold	Yesterday 26/3/2013	Snapshot last week 19/3/2013	Average 7-days wk ending 26/3/2013	Average 7-days 2012 wk ending 26/3/2012	
System overall	% of patients treated & discharged in 4 hours	Above 95.0%	 80.9%	 72.7%	 81.8%	 86.4%	
	Resus Breaches	Below 2.0	 5.0	 12.0	 5.9	 3.6	
	Majors Breaches	Below 36.0	 51.0	 83.0	 47.1	 40.9	
	4 Hour Performance	UCC Breaches	Below 2.0	 2.0	 2.0	 5.0	 4.1
	Paeds Breaches	Below 1.0	 14.0	 15.0	 11.7	 9.1	
	Other Breaches	Below 1.0	 5.0	 9.0	 5.3	 1.3	
	Total Breaches	Below 42.0	 77.0	 121.0	 75.0	 59.0	
Emergency Department	Total attendances	Below 412.0	 404.0	 443.0	 412.9	 435.1	
	Arrival flow	Ambulance to ED as % of overall attendances	 31.7%	 28.9%	 28.5%	 27.8%	
		Ambulances to ED	 128.0	 128.0	 117.9	 120.9	
		Ambulance to UCC as % of ambulances	 16.4%	 14.8%	 14.2%	 7.1%	
	Flows within ED/UCC	Numbers into majors (inc Triage; excl Resus)	 123.0	 116.0	 127.4	 144.6	
		Numbers direct into UCC	 85.0	 114.0	 101.1	 97.9	
		Numbers treated in UCC(Adults & Paeds)	 87.0	 128.0	 116.6	 122.3	
		% of attending adults into UCC	 30.1%	 35.7%	 34.5%	 31.5%	
		Redirects to GP/Community (% of Walk-ins)	 3.3%	 0.3%	 3.1%	 3.3%	
	Speed of care in ED	% of 1st clinical assess in ED <30mins	 72.8%	 69.3%	 77.6%	 79.8%	
		% refer to specialties < 120mins	 64.4%	 59.3%	 69.0%	 70.5%	
		% of specialist response < 60mins	 50.0%	 36.3%	 51.5%	 55.2%	
		Average time spent in ED (admitted patients)	 344.0	 426.7	 342.1	 290.9	
		Average time spent in ED (not admitted patients)	 148.6	 181.3	 158.5	 167.9	
	Admissions	Total admissions from ED	 78.0	 99.0	 83.6	 100.7	
	Admissions from ED as % of total attendances	 19.3%	 22.3%	 20.2%	 23.1%		
	Total admissions that were Ambulance arrival	 47.0	 67.0	 48.0	 59.0		
Assessment & Wards	MAU	Direct MAU admits from GPs	 3.0	 2.0	 1.9	 0.4	
		Average length of stay on transfer in MAU (days)	 0.0	 0.7	 0.9	 0.8	
		Average length of stay on discharge in MAU (days)	 0.0	 1.2	 0.9	 0.8	
		MAU transfers	 33.0	 30.0	 28.7	 28.9	
		MAU discharges home	 15.0	 16.0	 17.6	 15.7	
	Medical ward discharges	Total number of medical discharges (Med & CoE only)	 45.0	 36.0	 32.3	 25.9	
		% of pre 11am discharges (Med & CoE only)	 6.7%	 8.3%	 10.6%	 8.8%	
		Average active spell LOS (days; Med & CoE only)	 -	 -	 -	 -	
	# of active patients >14days (Med & CoE only)	 0.0	 0.0	 0.0	 0.0		

Emergency Care Pathway Dashboard

Hospital	Queen's Hospital
Reporting Date	27 Mar 2013

Legend

Trend from the previous week (PW)



XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Bluebell A	2.9 PW:3.7 SW:3.5	25.0% PW:3.8% SW:11.2%	30.0% PW:7.7% SW:12.4%	-- -- PW:7.2 SW:7.2	11.4 PW:7.4 SW:10.0	-- -
Bluebell B	3.9 PW:3.1 SW:3.4	7.4% PW:13.6% SW:7.1%	11.1% PW:9.1% SW:13.1%	-- -- PW:11.0 SW:11.0	10.0 PW:12.7 SW:9.7	-- -
CCU	-- 3.0 PW:3.0 SW:2.9	4.8% PW:0.0% SW:9.0%	19.0% PW:14.3% SW:18.1%	-- -- PW:4.7 SW:4.7	4.7 PW:7.1 SW:5.5	-- -
Clementine A	3.6 PW:3.4 SW:3.3	4.0% PW:4.2% SW:9.1%	12.0% PW:16.7% SW:12.8%	-- -- PW:14.5 SW:14.5	8.4 PW:16.1 SW:9.8	-- -
Clementine B	3.4 PW:3.1 SW:3.6	0.0% PW:4.5% SW:6.9%	8.3% PW:4.5% SW:8.6%	-- -- PW:8.3 SW:8.3	10.6 PW:10.4 SW:9.5	-- -
Harvest A	2.3 PW:3.7 SW:2.7	18.8% PW:34.6% SW:20.3%	0.0% PW:23.1% SW:17.3%	-- -- PW:12.8 SW:12.8	18.0 PW:10.9 SW:12.3	-- -
Mandarin A	3.0 PW:3.9 SW:3.5	0.0% PW:11.1% SW:12.2%	14.3% PW:7.4% SW:14.5%	-- -- PW:8.5 SW:8.5	9.7 PW:9.9 SW:10.3	-- -
Sky A	5.7 PW:5.1 SW:3.6	22.5% PW:16.7% SW:19.7%	7.5% PW:19.4% SW:15.2%	-- -- PW:8.8 SW:8.8	6.8 PW:6.9 SW:8.9	-- -
Sunrise A	2.1 PW:3.7 SW:2.7	6.7% PW:7.7% SW:12.0%	6.7% PW:23.1% SW:14.3%	-- -- PW:11.2 SW:11.2	13.8 PW:9.2 SW:11.7	-- -
Sunrise B	-- 2.4 PW:2.4 SW:2.6	11.8% PW:0.0% SW:7.2%	11.8% PW:17.6% SW:8.8%	-- -- PW:8.0 SW:8.0	15.8 PW:11.4 SW:14.0	-- -
Overall	32.3 PW:35.3 SW:31.9	10.6% PW:10.5% SW:11.5%	11.9% PW:14.6% SW:13.4%	-- -- PW:9.7 SW:9.7	10.2 PW:10.0 SW:10.0	-- -

Hospital	Queen's Hospital
Reporting Date	27 Mar 2013

Legend

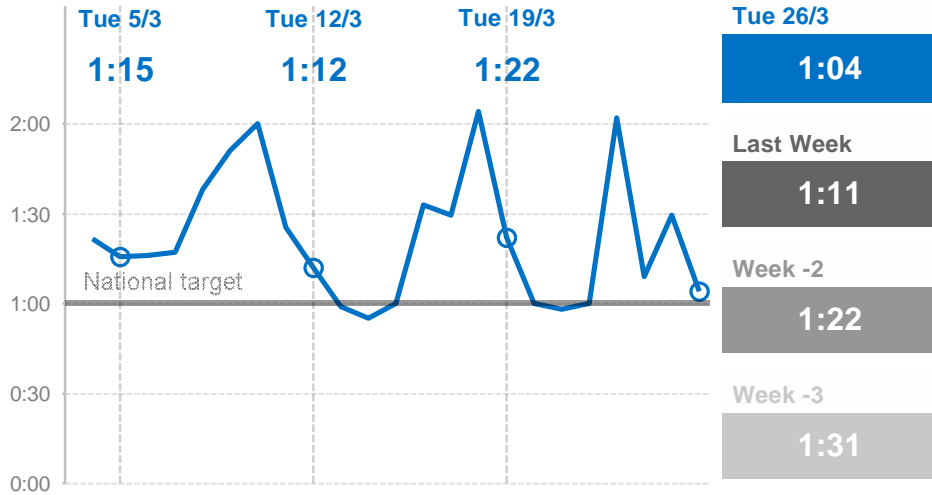
  Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

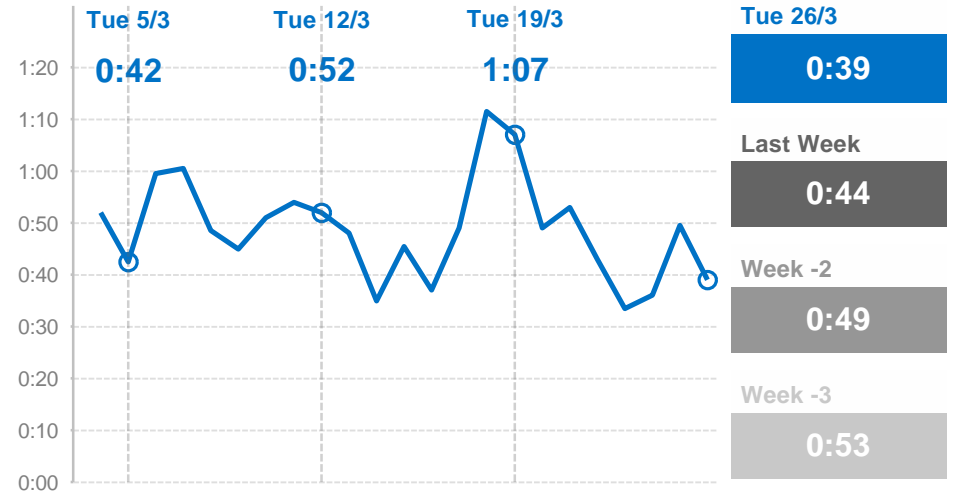
PW: Previous week average
 Wed 13 Mar 2013 - Tue 19 Mar 2013
 SW: Six week average
 Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Bluebell A	PW:6.9% SW:6.9%					
Bluebell B	PW:25.0% SW:25.0%					
CCU	PW:12.5% SW:12.5%					
Clementine A	PW:34.5% SW:34.5%					
Clementine B	PW:16.7% SW:16.7%					
Harvest A	PW:27.6% SW:27.6%					
Mandarin A	PW:17.2% SW:17.2%					
Sky A	PW:23.1% SW:23.1%					
Sunrise A	PW:34.5% SW:34.5%					
Sunrise B	PW:23.3% SW:23.3%					
Overall	PW:22.5% SW:22.5%					

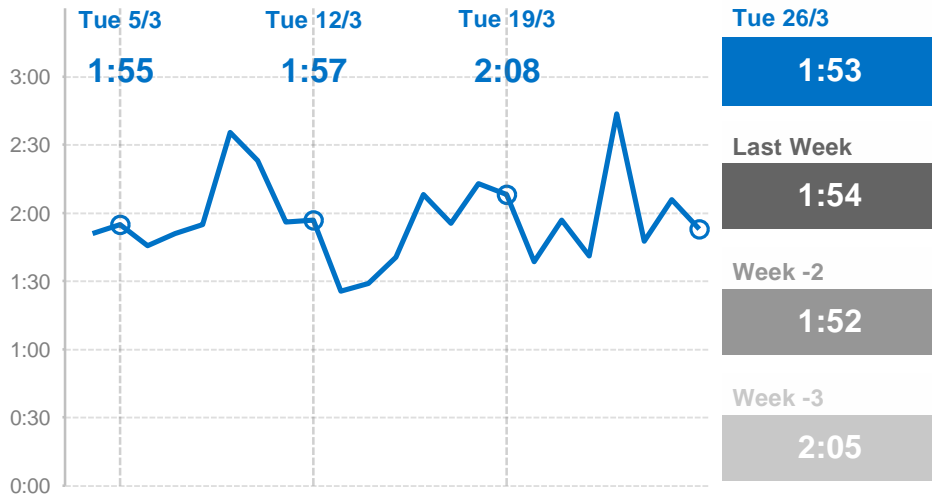
Hospital **Queen's Hospital**
Reporting D... **27 Mar 2013**



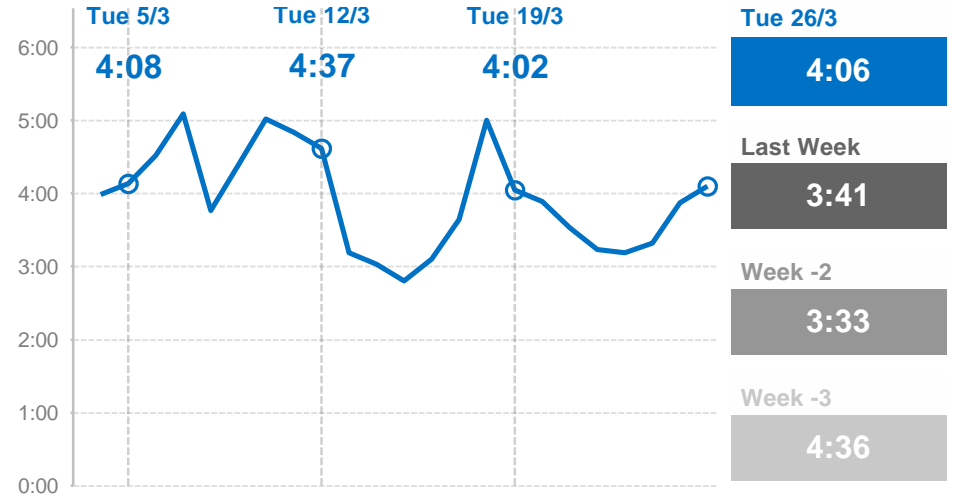
Median time between registration and seeing clinician (hours)



Median time between registration and request sent for investigations (hours)

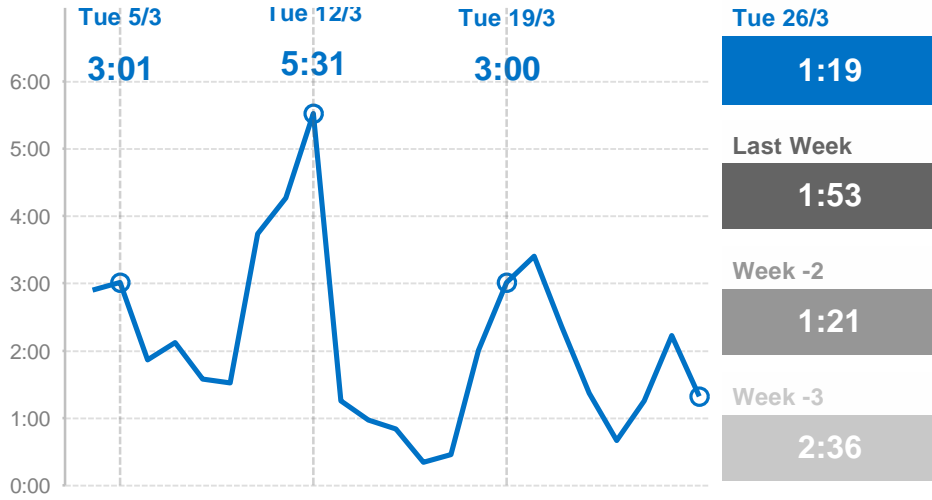


Median time between registration and referral to specialties (hours)

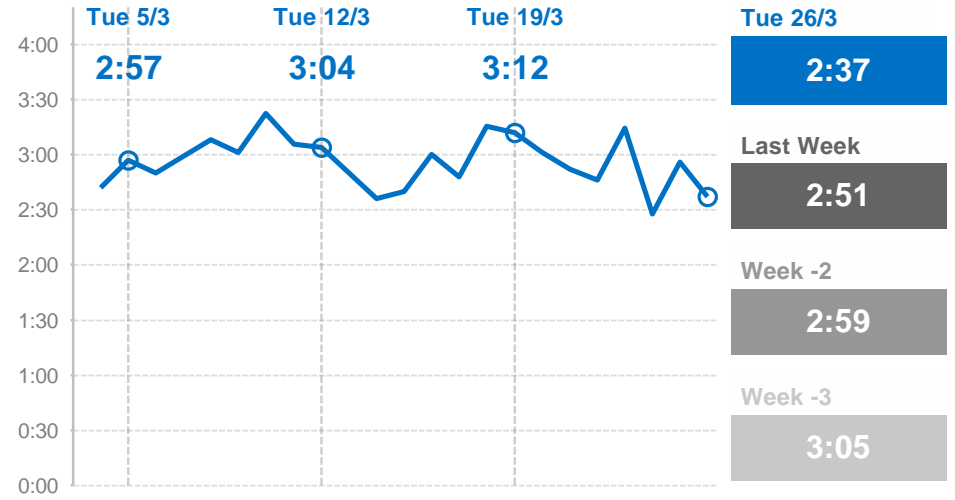


Median time between registration and request for bed (hours)

Hospital **Queen's Hospital**
Reporting D... **27 Mar 2013**



Median time between bed request and left department (hours)



Median time spent in ED (hours)

Reattendance rate

Last Month	Previous Month
14.4%	13.6%

Hospital **Trust (QH+KGH)**
 Reporting D... **27 Mar 2013**

Within threshold
 Within 10% of threshold
 Outside threshold
 No threshold

	Metric	Threshold	Yesterday 26/3/2013	Snapshot last week 19/3/2013	Average 7-days wk ending 26/3/2013	Average 7-days 2012 wk ending 26/3/2012
System overall	% of patients treated & discharged in 4 hours	Above 95.0%	85.3%	72.8%	84.8%	88.4%
	Resus Breaches	Below 3.0	7.0	14.0	7.4	5.3
	Majors Breaches	Below 46.0	55.0	119.0	57.1	54.6
	UCC Breaches	Below 3.0	2.0	7.0	5.3	5.0
	Paeds Breaches	Below 2.0	16.0	20.0	13.6	9.9
	Other Breaches	Below 2.0	5.0	10.0	5.6	1.3
	Total Breaches	Below 56.0	85.0	170.0	89.0	76.0
Emergency Department	Total attendances	Below 612.0	577.0	624.0	586.3	654.9
	Ambulance to ED as % of overall attendances	Below 25.0%	30.7%	30.0%	28.2%	26.4%
	Ambulances to ED	Below 180.0	177.0	187.0	165.3	173.1
	Ambulance to UCC as % of ambulances	Above 20.0%	13.6%	12.3%	11.2%	8.3%
	Numbers into majors (inc Triage; excl Resus)	Below 267.0	211.0	200.0	216.1	237.3
	Numbers direct into UCC/Minors (excl. KGH UCC)	Above 166.0	127.0	159.0	139.1	151.7
	Numbers treated in UCC(Adults & Paeds)	Above 160.0	87.0	128.0	116.6	122.3
	% of attending adults into UCC	Above 40.0%	30.1%	35.7%	34.5%	31.5%
	Redirects to GP/Community (% of Walk-ins)	Above 10.0%	3.3%	0.3%	3.1%	3.3%
	% of 1st clinical assess in ED <30mins	Above 80.0%	78.3%	74.0%	82.4%	80.9%
	% refer to specialties < 120mins	Above 80.0%	69.9%	56.9%	71.5%	69.3%
	% of specialist response < 60mins	Above 80.0%	50.4%	40.7%	52.7%	53.5%
	Average time spent in ED (admitted patients)	Below 180 Mins	296.3	422.4	309.6	288.7
	Average time spent in ED (not admitted patients)	Below 120 Mins	148.7	187.5	161.6	171.1
	Total admissions from ED	Below 170.0	128.0	149.0	129.3	157.4
	Admissions from ED as % of total attendances	Below 25.0%	22.2%	23.9%	22.1%	24.0%
	Total admissions that were Ambulance arrival	Below 90.0	74.0	92.0	70.4	84.6
Assessment & Wards	Direct MAU admits from GPs	Above 12.0	3.0	2.0	1.9	0.4
	Average length of stay on transfer in MAU (days)	Below 1.0 Days	0.0	0.8	0.9	0.9
	Average length of stay on discharge in MAU (days)	Below 2.0 Days	0.0	1.2	0.9	1.0
	MAU transfers	Above 55.0	63.0	45.0	49.3	49.4
	MAU discharges home	Above 49.0	15.0	16.0	17.6	15.7
	Total number of medical discharges (Med & CoE only)	Above 62.0	62.0	57.0	50.7	43.7
	% of pre 11am discharges (Med & CoE only)	Above 25.0%	6.5%	7.0%	9.3%	8.5%
	Average active spell LOS (days; Med & CoE only)	N/A(Days)	-	-	-	-
	# of active patients >14days (Med & CoE only)	N/A(Number)	0.0	0.0	0.0	0.0



Emergency Care Pathway Dashboard

Hospital	Trust (QH+KGH)	Legend	Trend from the previous week (PW)	XX Last 7 days average Wed 20 Mar 2013 - Tue 26 Mar 2013	PW: Previous week average Wed 13 Mar 2013 - Tue 19 Mar 2013 SW: Six week average Wed 06 Feb 2013 - Tue 26 Mar 2013
Reporting Date	27 Mar 2013				

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Ash	3.3 PW:3.7 SW:3.2	0.0% PW:7.7% SW:7.1%	8.7% PW:15.4% SW:12.2%	-- - PW:8.1 SW:8.1	16.3 PW:8.3 SW:11.5	-- -
Bluebell A	2.9 PW:3.7 SW:3.5	25.0% PW:3.8% SW:11.2%	30.0% PW:7.7% SW:12.4%	-- - PW:7.2 SW:7.2	11.4 PW:7.4 SW:10.0	-- -
Bluebell B	3.9 PW:3.1 SW:3.4	7.4% PW:13.6% SW:7.1%	11.1% PW:9.1% SW:13.1%	-- - PW:11.0 SW:11.0	10.0 PW:12.7 SW:9.7	-- -
CCU	-- 3.0 PW:3.0 SW:2.9	4.8% PW:0.0% SW:9.0%	19.0% PW:14.3% SW:18.1%	-- - PW:4.7 SW:4.7	4.7 PW:7.1 SW:5.5	-- -
Clementine A	3.6 PW:3.4 SW:3.3	4.0% PW:4.2% SW:9.1%	12.0% PW:16.7% SW:12.8%	-- - PW:14.5 SW:14.5	8.4 PW:16.1 SW:9.8	-- -
Clementine B	3.4 PW:3.1 SW:3.6	0.0% PW:4.5% SW:6.9%	8.3% PW:4.5% SW:8.6%	-- - PW:8.3 SW:8.3	10.6 PW:10.4 SW:9.5	-- -
Elm	1.7 PW:1.6 SW:1.5	8.3% PW:18.2% SW:8.2%	16.7% PW:18.2% SW:12.3%	-- - PW:11.0 SW:11.0	17.9 PW:18.5 SW:21.2	-- -
Erica	0.9 PW:1.6 SW:1.0	0.0% PW:45.5% SW:18.8%	0.0% PW:9.1% SW:4.2%	-- - PW:16.8 SW:16.8	4.0 PW:21.5 SW:17.6	-- -
Fern	2.1 PW:1.6 SW:2.2	6.7% PW:9.1% SW:6.5%	20.0% PW:18.2% SW:9.3%	-- - PW:11.0 SW:11.0	13.6 PW:27.1 SW:15.9	-- -
Gardenia	3.3 PW:3.0 SW:3.6	4.3% PW:4.8% SW:5.1%	30.4% PW:14.3% SW:14.3%	-- - PW:5.2 SW:5.2	8.7 PW:6.4 SW:6.2	-- -
Gentian	3.6 PW:5.3 SW:5.2	12.0% PW:10.8% SW:11.5%	16.0% PW:2.7% SW:7.9%	-- - PW:3.1 SW:3.1	7.6 PW:5.5 SW:7.0	-- -
Harvest A	2.3 PW:3.7 SW:2.7	18.8% PW:34.6% SW:20.3%	0.0% PW:23.1% SW:17.3%	-- - PW:12.8 SW:12.8	18.0 PW:10.9 SW:12.3	-- -
Holly	3.6 PW:2.9 SW:3.3	12.0% PW:5.0% SW:10.6%	8.0% PW:10.0% SW:8.8%	-- - PW:7.5 SW:7.5	9.2 PW:9.6 SW:10.7	-- -
Overall	50.7 PW:54.9 SW:51.7	9.3% PW:10.9% SW:10.5%	13.2% PW:13.3% SW:12.2%	-- - PW:9.2 SW:9.2	10.5 PW:10.3 SW:10.3	-- -

Hospital	Trust (QH+KGH)
Reporting Date	27 Mar 2013




















Legend

  Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013



PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Ash	PW:16.7% SW:16.7%					
Bluebell A	PW:6.9% SW:6.9%					
Bluebell B	PW:25.0% SW:25.0%					
CCU	PW:12.5% SW:12.5%					
Clementine A	PW:34.5% SW:34.5%					
Clementine B	PW:16.7% SW:16.7%					
Elm	PW:26.1% SW:26.1%					
Erica	PW:41.2% SW:41.2%					
Fern	PW:23.3% SW:23.3%					
Gardenia	PW:7.7% SW:7.7%					
Gentian	PW:0.0% SW:0.0%					
Harvest A	PW:27.6% SW:27.6%					
Holly	PW:11.5% SW:11.5%					
Overall	PW:20.3% SW:20.3%					

Hospital		Trust (QH+KGH)		Legend		Trend from the previous week (PW)		XX Last 7 days average		PW: Previous week average		SW: Six week average	
Reporting Date		27 Mar 2013						Wed 20 Mar 2013 - Tue 26 Mar 2013		Wed 13 Mar 2013 - Tue 19 Mar 2013		Wed 06 Feb 2013 - Tue 26 Mar 2013	
Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)		Average LOS on discharge (days)		Patients >14 days active (% of active patients)					
Mandarin A	 3.0 PW:3.9 SW:3.5	 0.0% PW:11.1% SW:12.2%	 14.3% PW:7.4% SW:14.5%	-	-	PW:8.5 SW:8.5	 9.7 PW:9.9 SW:10.3	-	-				
Sky A	 5.7 PW:5.1 SW:3.6	 22.5% PW:16.7% SW:19.7%	 7.5% PW:19.4% SW:15.2%	-	-	PW:8.8 SW:8.8	 6.8 PW:6.9 SW:8.9	-	-				
Sunrise A	 2.1 PW:3.7 SW:2.7	 6.7% PW:7.7% SW:12.0%	 6.7% PW:23.1% SW:14.3%	-	-	PW:11.2 SW:11.2	 13.8 PW:9.2 SW:11.7	-	-				
Sunrise B	- 2.4 PW:2.4 SW:2.6	 11.8% PW:0.0% SW:7.2%	 11.8% PW:17.6% SW:8.8%	-	-	PW:8.0 SW:8.0	 15.8 PW:11.4 SW:14.0	-	-				
Overall	 50.7 PW:54.9 SW:51.7	 9.3% PW:10.9% SW:10.5%	 13.2% PW:13.3% SW:12.2%	-	-	PW:9.2 SW:9.2	 10.5 PW:10.3 SW:10.3	-	-				

Hospital	Trust (QH+KGH)
Reporting Date	27 Mar 2013

Legend

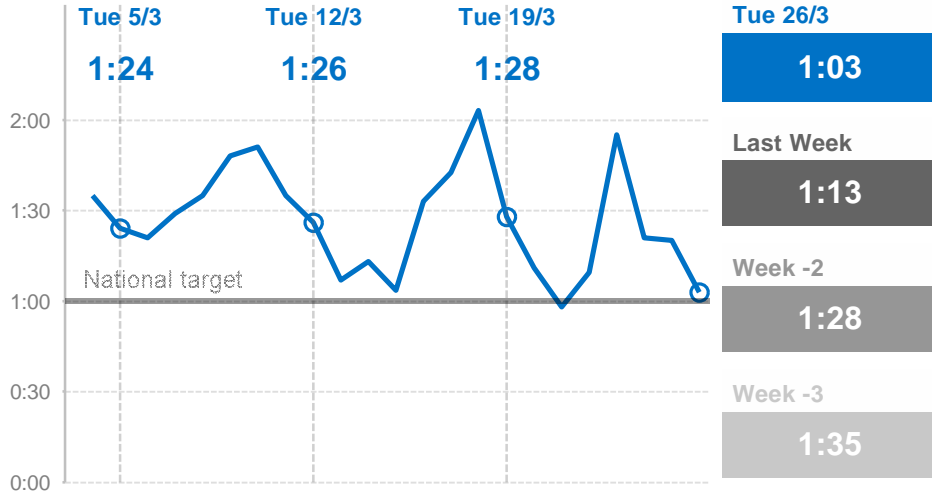
  Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Mandarin A	PW:17.2% SW:17.2%					
Sky A	PW:23.1% SW:23.1%					
Sunrise A	PW:34.5% SW:34.5%					
Sunrise B	PW:23.3% SW:23.3%					
Overall	PW:20.3% SW:20.3%					

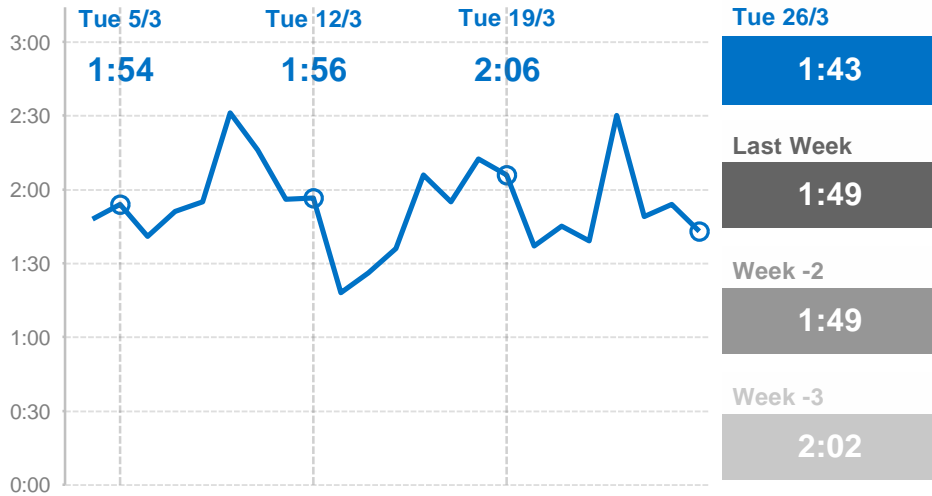
Hospital **Trust (QH+KGH)**
 Reporting D... **27 Mar 2013**



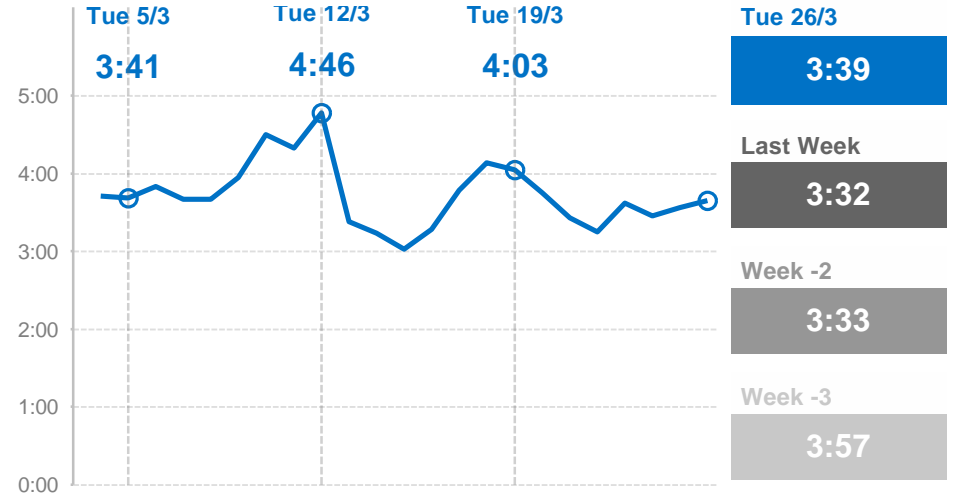
Median time between registration and seeing clinician (hours)



Median time between registration and request sent for investigations (hours)

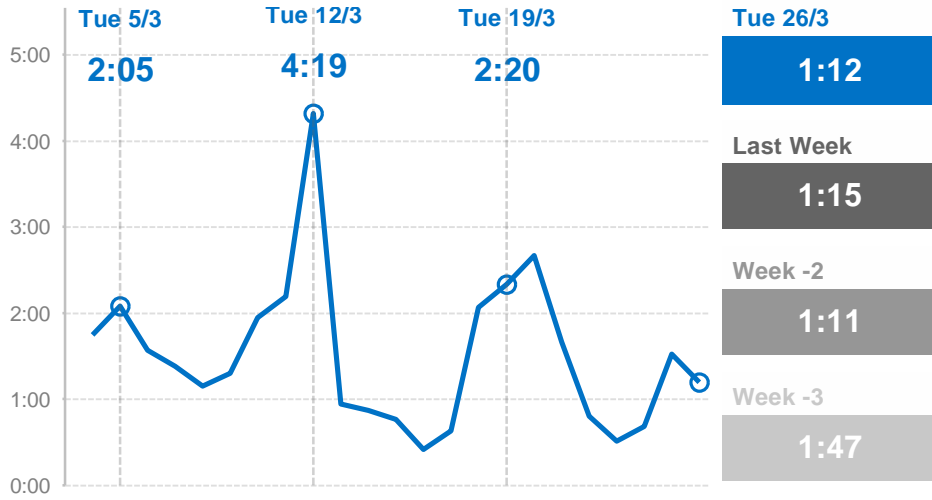


Median time between registration and referral to specialties (hours)

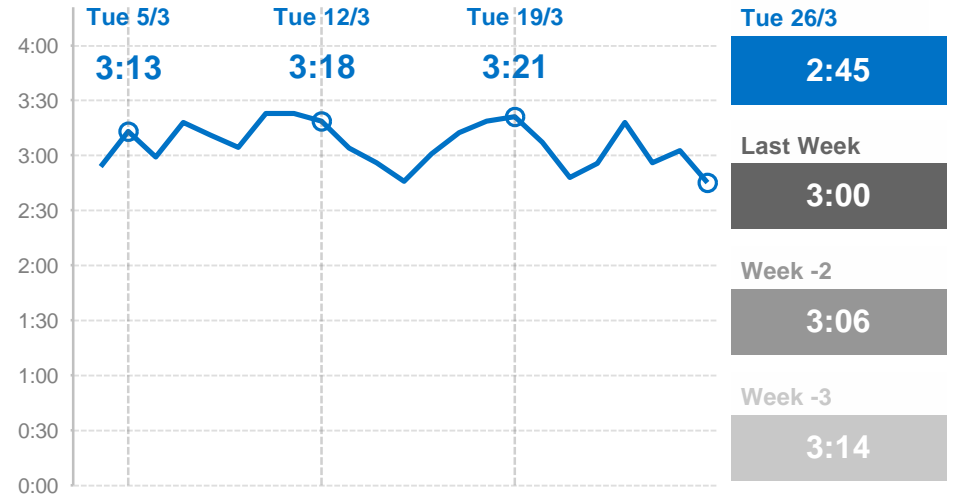


Median time between registration and request for bed (hours)

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Median time between bed request and left department (hours)



Median time spent in ED (hours)

Reattendance rate

Last Month	Previous Month
13.5%	12.9%