

## Excellence in rural healthcare

<b>To:</b>	Trust Board
<b>From:</b>	Deputy Director of Operations, Urgent Care
<b>Date:</b>	25th March 2019
<b>Healthcare standard</b>	Urgent Care Constitutional Standards

<b>Title:</b>	ULHT Acute Performance Update for the Month of February 2019										
<b>Author/Responsible Director:</b>	Michelle Harris, Deputy Director of Operations, Urgent Care, Sarah Hall, Urgent Care Programme Manager/ Mark Brassington, Chief Operating Officer										
<b>Purpose of the report:</b>	To update the Trust Board on the performance of key standards related to Urgent and Emergency Care										
<b>The report is provided to the Board for:</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Decision</td> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="width: 50%; text-align: center;">Discussion</td> <td style="width: 5%; text-align: center;">X</td> </tr> <tr> <td style="text-align: center;">Assurance</td> <td style="text-align: center;">X</td> <td style="text-align: center;">Information</td> <td style="text-align: center;">X</td> </tr> </table>			Decision	<input type="checkbox"/>	Discussion	X	Assurance	X	Information	X
Decision	<input type="checkbox"/>	Discussion	X								
Assurance	X	Information	X								
<b>Summary/key points:</b>	<p>4 hour performance was 64.4% (ULHT+Streaming) February Outturn.                      Activity remains above plan and 17/18 activity levels                      Primary care streaming showed continued improvement at PHB. LCH is now beginning to see a continuous improvement.                      EMAS handover times deteriorated but 'batched' conveyances have continued to increase, with the biggest impact being seen at Lincoln County.                      Super-stranded patient numbers reduced closer to plan                      Transformation Steering Group now attended by regulators and partners signalling a move away from site specific meetings due to assurance of the transformation programme                      Programme governance now embedded                      Hierarchy of KPIs agreed with trajectories being developed over the next period                      Automated programme management reports and performance dashboard being developed                      PMO funding approved and recruitment has taken place. All key posts will be in place by 1<sup>st</sup> April 2019</p>										
<b>Recommendations:</b>	Trust Board asked to note the contents of the report										
<b>Strategic risk register</b>	<b>Performance KPIs year to date</b> As identified within the report										
<b>Resource implications (eg Financial, HR)</b>											
<b>Assurance implications</b>											

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<b>Patient and Public Involvement (PPI) implications</b>
<b>Equality impact</b>
<b>Information exempt from disclosure</b>
<b>Requirement for further review? Yes</b>

### ULHT Acute Performance Update for the Month of February 2019

Michelle Harris, Deputy Director of Operations – Urgent Care

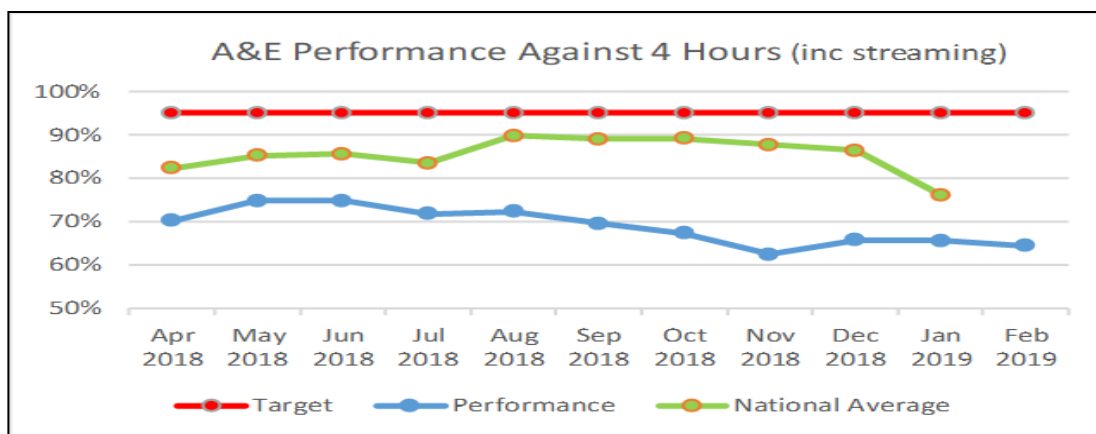
#### 1.0 Introduction & Purpose

This paper is a summary and narrative of key urgent care performance indicators at ULHT. It incorporates elements of internal performance reporting and is consistent (although more detailed) with information that will be published at ULHT Trust Board. The paper will identify what the performance is and why, present the agreed recovery trajectories and how, through the Urgent Care Transformation Programme, the Trust will demonstrate a continued improvement.

#### 2.0 A&E Performance

##### Trust performance against 4 Hours (based on Medway Data)

The trust achieved 64.40% against a trajectory of 81.22%. The ULHT Trust performance incorporates Lincoln County Hospital (LCH), Grantham District Hospital (GDH) and Pilgrim Hospital Boston (PHB) performance.

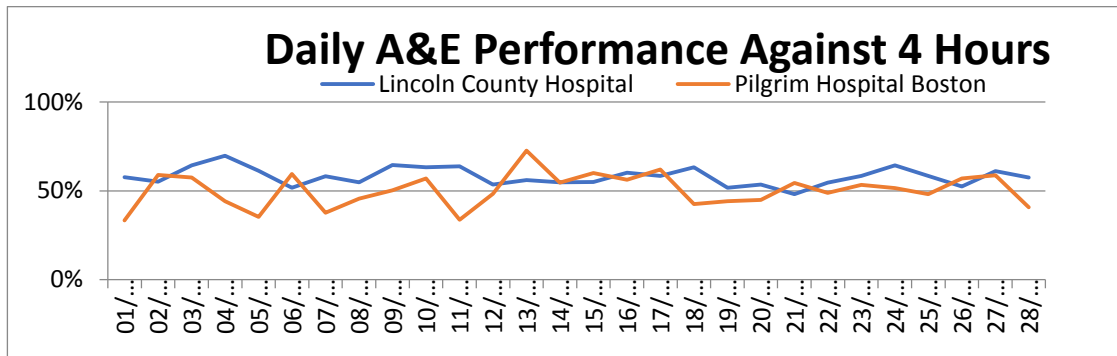


Overall monthly performance by site for February against AED 006 is as follows: LCH – 58.14%, PHB – 61.88% (combined) and GDH 92.57%. March month to date (as of 13/03/2019) is LCH – 66.44%, PHB – 76.05% (combined) and GDH 95.76%

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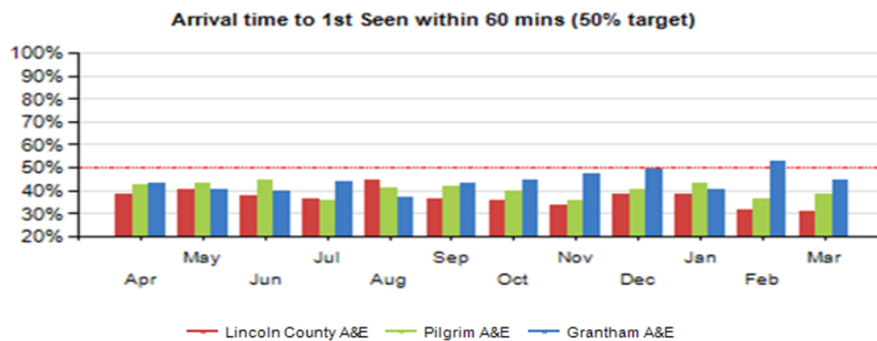
Daily Performance against 4 hours (Lincoln and Pilgrim)

Pilgrim)



The daily performance remains variable with performance at Lincoln County Hospital slightly better than at Pilgrim Hospital, although both were well below trajectory. The highest daily performance for Lincoln County Hospital was 69.75% (4/2/2019) and highest daily performance for Pilgrim Hospital was 80.23% (11/2/2019). The worst daily performance at LCH was experienced on 21/2/2019 and out turned at 48.07%. The worst daily performance at PHB was experienced on 11/2/2019 and out turned at 48.42%

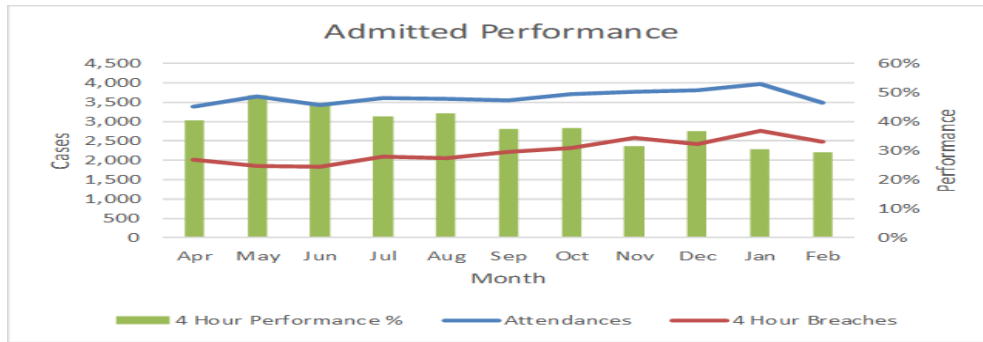
Time to First Assessment against 60 mins Target



Lincoln has seen a downward trend since January 2019. Pilgrim is showing minimal variation with shoots of improvement. Grantham hit the internal target for arrive time to 1<sup>st</sup> seen and is on track for March

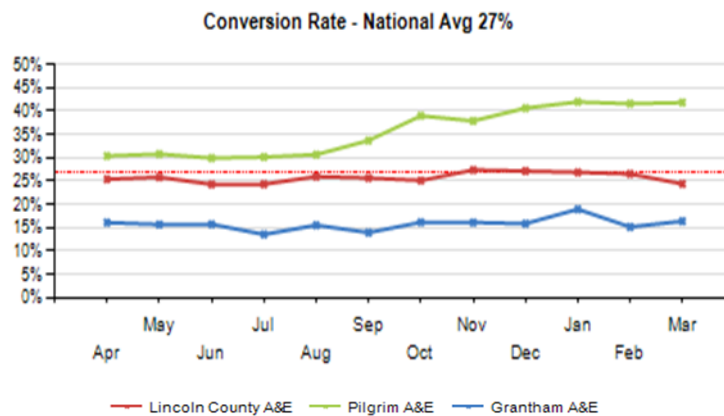
Admitted Performance

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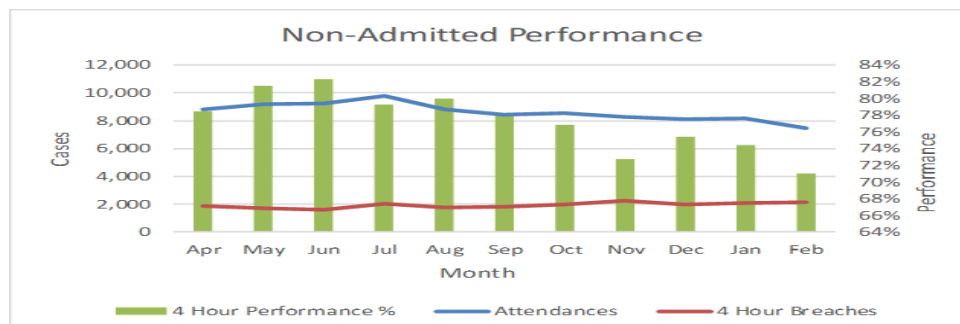
Breaches are showing an upward trend since June 2018. Attendances are showing an upward trend since September 2018. Over time performance is showing a 10% downward trend. There is a correlation between attendances, 4 hour breaches and 4 hour performance for admitted patients related to department crowding.

### Conversion Rates for Admitted Against National Average



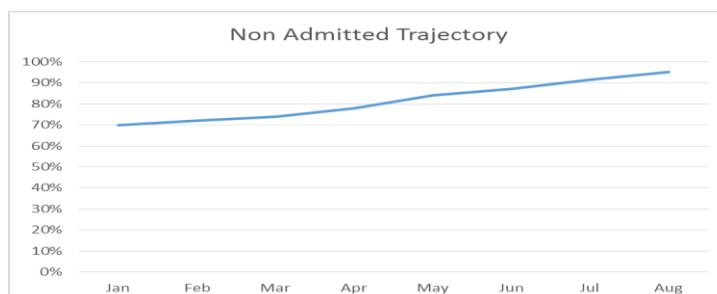
Lincoln are showing a stable conversion rate in line with the national average. Pilgrim have a higher than national average conversion rate with a marked increase September/October 2018 due to streaming numbers being excluded from our reported type 1 activity. Grantham have a below national average conversion rate that is stable

### Non Admitted Performance

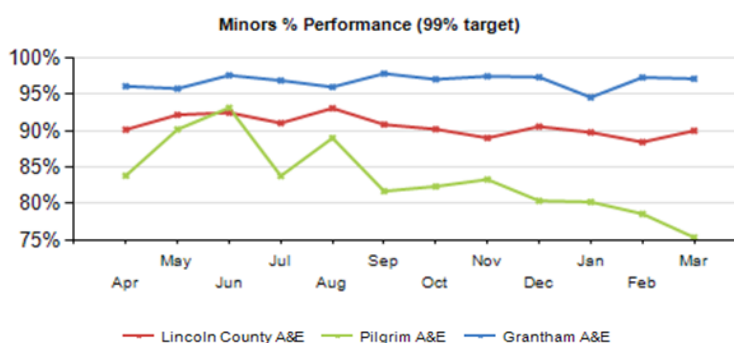


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Breaches fairly consistently around 2,000 per month, 500 per week or 71 per day across the 3 sites. Attendances have reduced over time from almost 10,000 in July 2018 to just under 8,000 in February 2019. Over time performance is showing a 10% decrease. There appears to be a correlation between attendances and performance. Below is the agreed improvement trajectory for non-admitted.



### Minors Performance

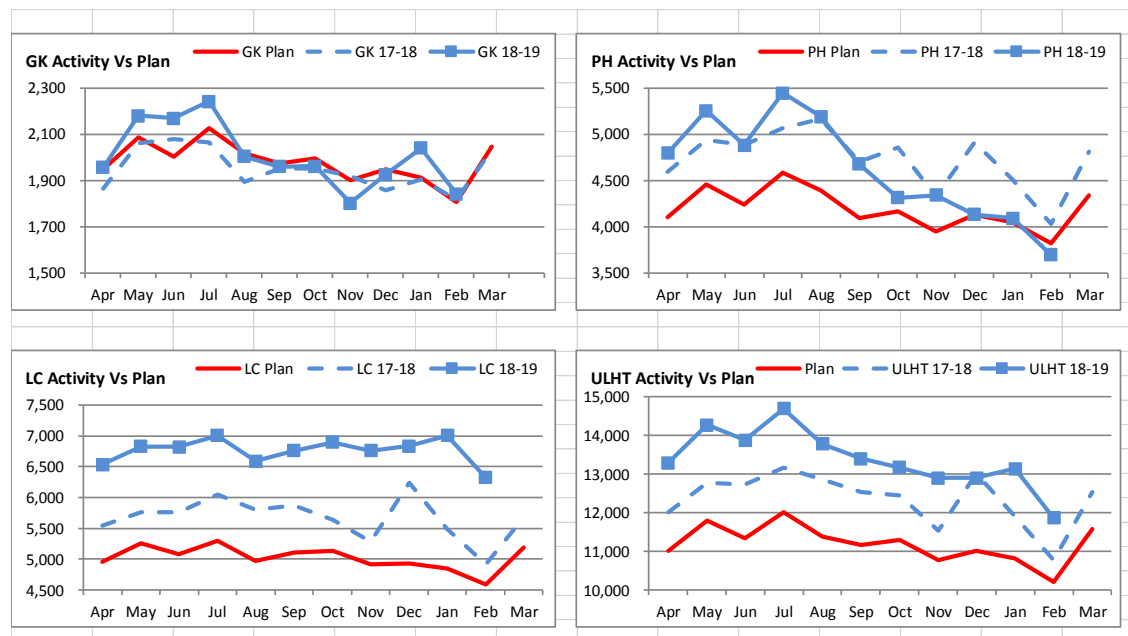


Performance in the minors stream for Lincoln demonstrates stable variation. Pilgrim performance is demonstrating a downward trend. The position at Pilgrim is being explored further and is thought to be due to a change to denominator and numerator for introduction of GP streaming. Grantham are performing consistently at, or above 95%

### 3.0 A&E Activity

ED attends remain above plan at Lincoln County Hospital (LCH). Although a downward trend is seen and Pilgrim Hospital Boston (PHB) is below plan for February. The reason for this shift is the removal of streaming from the activity figures. Attendances at Grantham are on plan for February.

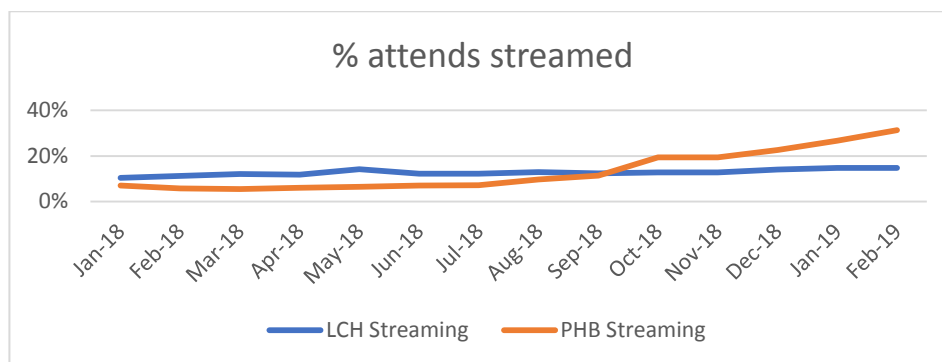
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The total activity for ULHT continues to remain above plan for February and year to date – 11,864 actual against the plan of 10,214. The 17/18 vs 18/19 and actual, Grantham and Pilgrim plan is more in line for February but has demonstrated an increased position overall. The change in position since the previous year is most reflected in the activity numbers at Lincoln County Hospital – actual 6,326 vs a 4,585 against 18/19 plan (February 2019).

### 4.0 Primary Care Streaming

ULHT set internal targets of 25% of all ED attendances at PHB and 20% at LCH. For February the total % of patients streamed was 31.3% at Pilgrim and 14.7% at Lincoln.



Between 1st and 25th Feb an average of 19% of walk-ins have been Streamed and completed at GP Streaming and completed at GP Streaming has been steadily increasing on both sites. Returned to A&E rate is currently 8.5% this equates to 1 in 5 patients. During February over a quarter of attendances during Streaming operational hours (0800-2300) were Streamed and completed at GP Streaming (26%). 29% of patients returned to A&E are returned to wait for speciality services or beds

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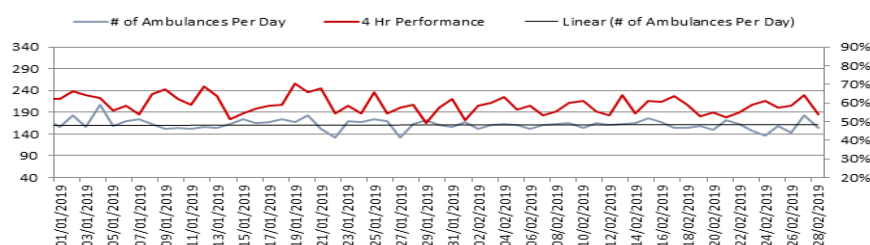
### 5.0 EMAS

System wide pressure has been noted during February. An increasing trend against EMAS demand/conveyances continue to be apparent at LCH. The overall numbers are only slightly up overall but 'batching' is causing both LCH and PHB issues with 'offload' capability.

EMAS ROM / DOM control now view pressure on the departments, County profile against demand, destination of demand and attempts manage that demand or 'forewarn' the acute site is being carried out more proactively. A revised hand over improvement trajectory has been put forward and the Trust awaits ratification by regulators/EMAS/ULHT.

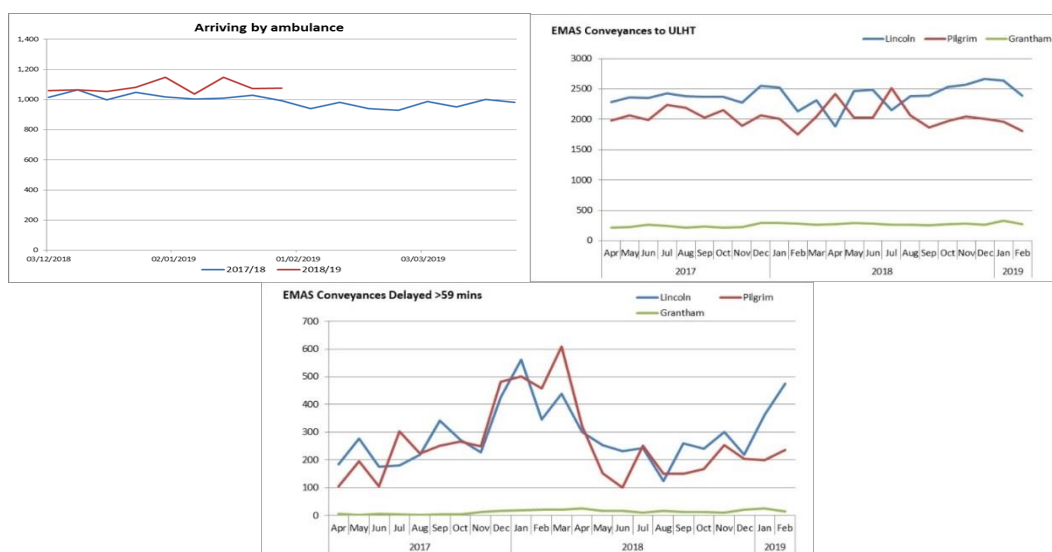
External opportunities include working with EMAS and CCG to establish community pathways to reduce conveyance into the trust including Early Intervention Vehicles, EMAS use of Hospital Avoidance Response Teams, access to transitional and palliative care beds and LIVES.

**Ambulance arrivals vs Type I 4-Hour Performance**



Conveyance saw a decline in February across LCH, PHB and GDH, but LCH are still experiencing higher conveyance. Grantham is fairly static.

There is a consistent theme at both LCH and PHB of issues with handover due to 'batched' arrivals but still more so at LCH currently.



There is a huge focus on reducing Ambulance handover times both in terms of patient safety and timely release of crews.

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The following table demonstrates the ambulance handover performance for ULHT year to date and number of conveyances. No hospitals are currently achieving zero AtH times greater than 120 minutes.

Month	Total	<15	>15<30	>30<60	>60	<15 %	>15<30 %	>30<60 %	>60 %
Apr	4570	1022	1704	1208	646	22.36%	37.29%	26.43%	14.14%
May	4783	1277	2079	1006	423	26.70%	43.47%	21.03%	8.84%
Jun	4644	1435	2069	825	322	30.90%	44.55%	17.76%	6.93%
Jul	4930	1530	1931	966	503	31.03%	39.17%	19.59%	10.20%
Aug	4701	1551	2023	836	291	32.99%	43.03%	17.78%	6.19%
Sep	4506	1443	1846	795	422	32.02%	40.97%	17.64%	9.37%
Oct	4779	1794	1737	829	419	37.54%	36.35%	17.35%	8.77%
Nov	4892	1523	1833	974	562	31.13%	37.47%	19.91%	11.49%
Dec	4935	1717	1909	866	443	34.79%	38.68%	17.55%	8.98%
Jan	4929	1710	1734	837	588	34.69%	35.18%	16.98%	11.93%
Feb	1764	518	554	342	350	29.37%	31.41%	19.39%	19.84%

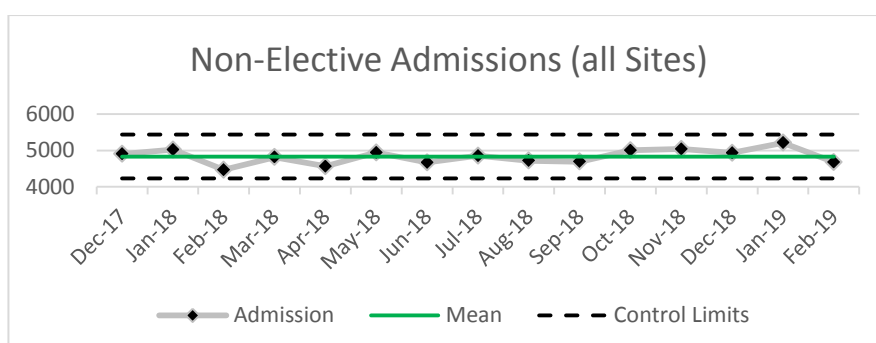
The following offers a trajectory for reducing ambulance handovers at Trust Level and applying a zero tolerance to AtH > 120 minutes.

2019												
Recovery Trajectory	March	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	AVG Improvement	Grand Total
Ambulance Handovers less than 15 minutes	30%	30%	35%	39%	42.00%	45.00%	51%	55%	58%	60%	52%	Improvement
Ambulance Handovers > 15 <30 minutes	40%	40%	46%	46%	48%	40%	41%	35%	38%	20%	39%	Improvement
Ambulance Handovers > 30 <60 minutes	23%	23%	13%	10%	6%	14%	8%	10%	4%	20%	12%	Improvement
Ambulance Handovers greater than 60 minutes	7%	7%	6%	5%	4%	1%	0%	0%	0%	0%	3%	Improvement
Ambulance Handovers greater than 120 minutes	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	Improvement

This is not in line with the centrally mandated improvement trajectory. The above suggested trajectory is being discussed by the Ambulance Handover Improvement Group, led by Pete Burnett and will be signed off by a joint EMAS/NHSe/NHSi and ULHT meeting planned for 18<sup>th</sup> April 2019..

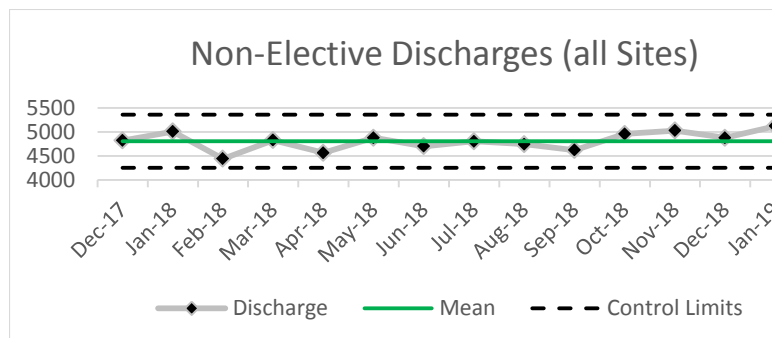
### 6.0 Non-Elective Admissions & discharges

Non Elective admissions saw a reduction in February from 5211 in January to 4680 in February (-531) but continues to experience an overall % increase against plan. Non Elective discharges also saw a reduction in February from 5121 in January to 4702 in February (-419). Occupancy remained well in excess of 92%, meaning that patients in ED requiring beds were held for long periods of time.





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Below is the 6 week rolling profile by Day of the Week



Friday - Sunday discharges shows improvement again in February. There remains variation between weekdays and weekend discharges with Mondays demonstrating a reduction over the last 2 weeks of February. This may be reflective of an increased LOS/acuity. A more detailed review is in train. Elective admissions are also variable due to increased site pressures. February experienced less on the day cancellations. The net effect on the overall admission and discharge totals during the week, and the reversing trend at weekends means that Mondays and Tuesdays have higher occupancy. The gradual recovery into the week, has a more focused approach on recovery and a more stable platform is being seen by Wednesday now rather than Thursday. The current MOL profile is significantly improved on this time last year.

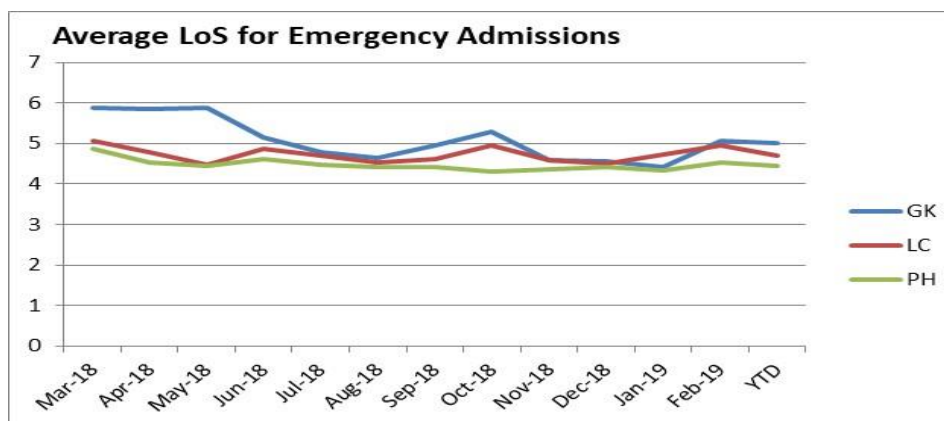
### Bed Occupancy

Average overall % Bed Occupancy for the Trust in February was 95.26% compare to 94.41% in January 2019.

LCH ranged from 94.36 – 100% = Average of 95.98%, PHB ranged from 97.93% - 101.51% = Average of 98.16% and GDH ranged from 74.53% - 88.24% = Average of 82.02%.

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### 7.0 LOS

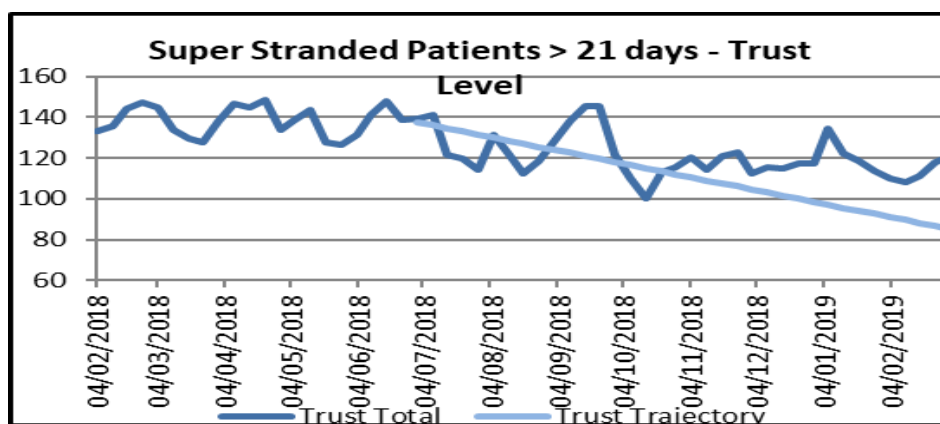


Length of Stay across the organisation is at 4.8 days for February and year to date 4.62 days. This is an increasing trend but can be attributed to acuity, dependency and an increased DTOC/MFFD position. This data includes all areas and does not distinguish between assessment areas and inpatient areas.

NEL Avera	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19 YTD	
CL	0	0	0	0	0	0	1	0	0	0	0	0	1	0.18
GK	5.82	5.89	5.86	5.87	5.15	4.8	4.64	4.96	5.3	4.6	4.56	4.41	5.07	5.02
LC	4.87	5.07	4.78	4.48	4.88	4.71	4.53	4.63	4.95	4.6	4.51	4.74	4.96	4.71
PH	4.5	4.86	4.52	4.44	4.63	4.49	4.43	4.41	4.32	4.36	4.42	4.34	4.54	4.45
ULHT	4.79	5.04	4.75	4.55	4.8	4.63	4.49	4.56	4.71	4.5	4.47	4.55	4.8	4.62

Over the year there has been a downward trend in the number of stranded patients on each site. Both Grantham and Pilgrim have seen improvements since the stranded patient reviews began.

The number of Super Stranded Patients had begun to reduce but over the last 3 months has seen slight increases. The organisation is above trajectory with the end of February number of Super Stranded Patients in the Trust at 107.9 against a trajectory of 86.6. The last 2 weeks have seen the % raise to an average 5.27%. The average % for February is 4.06% overall. The average year to date range is 2.82% - 4.38%



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Specific activities underway to improve overall LOS and capacity management are:

- Cohort DTOC into a dedicated area to promote a focused and timely pathway to discharge.
- R2G to concentrate on 3 – 7 day LOS.
- A partnership triumvirate agreement has been reached (ULHT, LCHS, LCC) to secure increased discharges and a ‘proof of concept pilot will commence in April and continue throughout Q1. The scope and Leadership has been agreed. The KPIs whilst still in development have been agreed. This will be part of Work stream 5 in the overarching Urgent Care Transformation Programme.

### 8.0 2019/20 Performance Trajectory

As part of planning for 2019/20 there is a requirement to submit delivery trajectories for next year. These are currently draft and await approval. The most recently submitted trajectories are as follows;

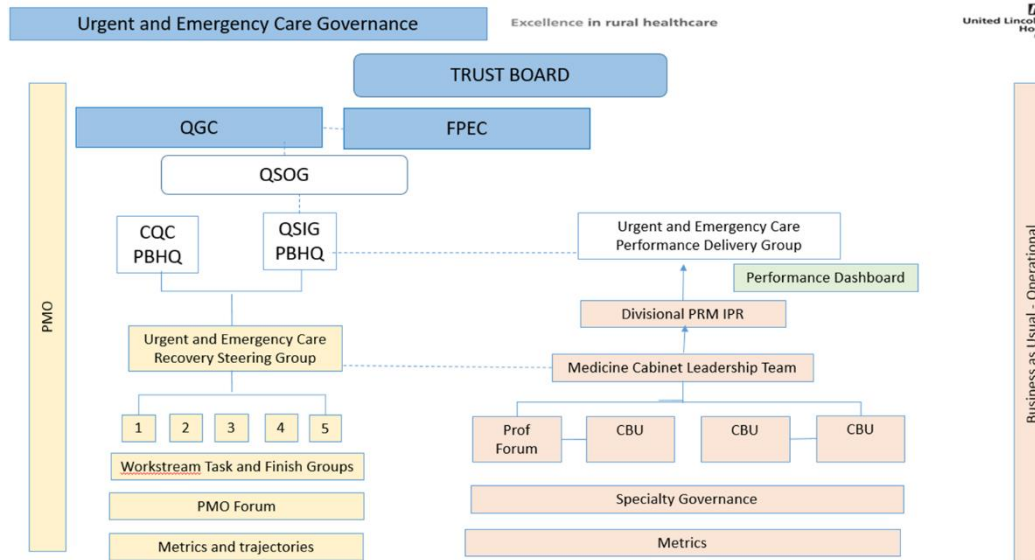
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	FY 19/20
ULHT Type 1	70.11%	72.00%	73.00%	75.00%	77.00%	79.00%	80.00%	80.00%	82.00%	82.00%	82.00%	82.00%	77.75%
ULHT + Streaming	72.40%	74.43%	75.13%	76.96%	79.07%	81.21%	82.25%	82.29%	84.24%	84.42%	84.65%	84.49%	80.14%
ULHT + Streaming & Type 3	81.27%	82.82%	83.23%	84.30%	85.87%	86.68%	87.49%	87.14%	88.51%	88.53%	88.57%	88.70%	86.03%

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### 9.0 Continuous Improvement Programme

#### Progress Update Board March 2019

The Urgent and Emergency Care (UEC) Continuous Improvement Programme has a well-defined and embedded governance structure which includes task and finish groups led by senior responsible officers (SROs) at an operational level, reporting to the Steering Group at Divisional level. The diagram below outlines the reporting governance structure for the UEC Improvement Programme. The Programme Steering Group is chaired by the Programme Director and project updates for each of the five work streams are presented at Steering Group meetings. Each workstream has a risk and issue log that is reviewed weekly at a PMO ‘check in’ meeting as well as at Programme Steering Group. The cornerstone of all of the work streams is the need to deliver safe care, developing and embedding a culture of safety across the emergency departments and wider organisation.



Steering Group is held fortnightly and at its last meeting was for the first time, attended by regulators and partners. This is significant because it signals a transition away from regulatory site meetings with Pilgrim Hospital to engagement in the Programme Steering group that is inclusive of Lincoln and Grantham. Having system partners and regulators at this meeting is really valuable and we are working well as a system looking at system based solutions.

Quality improvement methodology underpins the delivery of change for each of the workstreams with process mapping, appreciative enquiry and Plan, Do, Study, Act (PDSA) cycles being common tools within the improvement toolkit. The popular NHSI Programme ‘Quality Service Improvement and Redesign’ (QSIR) is the improvement methodology that the Trust has adopted as their preferred method of managing change and improvement in the Trust. We are fortunate that we have two

members of the PMO team who are ‘trained trainers’ in QSIR methodology and application.

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At a recent Delivery Group meeting, key performance indicators and a method of monitoring these were agreed by the Chief Operating Officer who is the Programme Executive Sponsor. The hierarchy of the KPIs is outlined below as trust level KPIs and workstream KPIs. We are currently determining the trajectories for these KPIs and building a dashboard to be able to track progress and performance.

The Trust level key performance indicators for the UEC Continuous Improvement Programme are as follows:

- 4-hour transit time (admitted and non-admitted pathways)
- Length of Stay (wards and ED)
- Bed Occupancy
- Workforce

At workstream level the KPIs have been agreed as follows :

Work stream	KPIs
QS04 Pilgrim EC1A Lincoln EC1B Grantham	<ul style="list-style-type: none"> <li>• Triage within 15 mins against trajectory</li> <li>• Ambulance handover times 30-60 mins and &gt;60 mins</li> <li>• Urgent care streaming</li> <li>• Time to be 1<sup>st</sup> seen (Q2)</li> <li>• Fill rate against establishment for medics and nurses</li> </ul>
EC2 Assessment Function	<ul style="list-style-type: none"> <li>• LoS in ED for patients &gt;70 years</li> <li>• Nos and percentages of patients navigated to urgent care and ambulatory care</li> </ul>
EC3 Site Function	<ul style="list-style-type: none"> <li>• 30% funded core beds available at 1600</li> <li>• No of patient moves after 2200 (quality indicator)</li> </ul>
EC4 Inpatient Ward Function and EC5 Discharge	<ul style="list-style-type: none"> <li>• All patients have a senior review before midday</li> <li>• All patients have an EDD</li> <li>• Number of stranded patients</li> <li>• Number of super stranded patients</li> <li>• % criteria led discharge</li> <li>• 7-day proactive discharge</li> </ul>

With the recent addition of a dedicated information analyst (3 days a week) to the programme, we are developing dashboards and systems to measure the impact of change, and how this impacts on performance. Some of the information to monitor progress is not currently available and where this is the case,

Agenda Item 9.2

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information reports are being developed. An automated programme management monitoring report and performance dashboard are being developed to support reporting against each of the workstreams, KPIs, and performance against trajectory. The images below provide an example of the work in progress to both monitor the programme, but also to report, KPIs, trajectories and performance.

		Trajectory												
Workstream 1: Emergency Department		Target with date	Baseline Period	Site	Baseline	Feb-19	Mar-19	reason for change	Apr-19	reason for change	May-19	reason for change	Jun-19	reason for change
4a	Ambulance Handover within 15 mins	60% by Apr 2020 (Local)	Q1 2018/19	Lincoln	32.0%	28.7%	30%		30%		35%		39%	
				Boston	19.0%	15.4%	30%		30%		35%		39%	
				Grantham			30%		30%		35%		39%	
4b	Ambulance Handover within 30 mins	96% by Nov 2019 (Local)	Q1 2018/19	Lincoln			70%		70%		81%		85%	
				Boston			70%		70%		81%		85%	
				Grantham			70%		70%		81%		85%	
4c	Ambulance Handover within 60 mins	100% by Sep 2019 (Local)	Q1 2018/19	Lincoln	88.5%	79.5%	93%		93%		94%		95%	
				Boston	91.1%	75.4%	93%		93%		94%		95%	
				Grantham			93%		93%		94%		95%	

Project Report Template														
Project Name: QS04 Pil ED		Use the pull down List to select the TAB, then click the Button below						Tue 19/03/2019 14:30						
Department:		Project Manager:		Change Stream		Completed		Total						
Project Completion Date:						No Date		Milestones						
						10		18						
						0		8						
						55.56%		100.00%						
						0.00%		44.44%						
						100.00%		100.00%						
Milestones														
Milestones	Description	Baseline	Finish Date	Completion Date	Completed	Total Tasks	KPIs							
QS4.1	Increase the level of assurance and monitoring of this plan to support successful delivery and sustainability	Nov-18	Jan-19		3	3								
					100.00%	100.00%								
Tasks														
Tasks	Description	Planned Finish Date	Actual Completion Date	KPI	Baseline	Target	Performance	Current						
QS4.1.1	A senior leadership assurance group (to include partners and CCG) oversee the delivery of the whole patient pathway and provide increased level of support for the delivery of this shared plan	Nov-18	Sep-18	T.B.C.	T.B.C.	T.B.C.	T.B.C.	T.B.C.						
QS4.1.2	There is a weekly Trust Clinical Leadership Emergency Care Board to ensure monitoring of plan and oversight of task and finish groups	Nov-18	Aug-18	T.B.C.	T.B.C.	T.B.C.	T.B.C.	T.B.C.						
QS4.1.3	There is monthly reporting of delivery of key milestones and actions from this patient flow programme to the local system A&E delivery board	Sep-18	Jan-19	T.B.C.	T.B.C.	T.B.C.	T.B.C.	T.B.C.						

The Executive Team have confirmed PMO funding resource and during the last couple of weeks, we have been recruiting to posts, and now have an improvement lead for Pilgrim and an improvement lead for Lincoln. We continue to have a trust wide lead for frailty and ambulatory care and the pace continues. From 1<sup>st</sup> April 2019 there will be a senior nurse in the team who will support the development of the clinical team and in particular continuing learning from patient cases. This has already started with a critical reflection case and shared lessons learnt with East Midlands Ambulance Service (EMAS). The lead nurse role will share critical reflections and learning pan Trust to support sustainable change.

Note: although data is currently reported for many of the metrics marked as 'TBC' below, the criteria/assumptions behind each metric are being validated to ensure figures used are appropriate and accurate before being included on reports.

WORKSTREAM 1 (Emergency Departments)					
Q4	Q1	Outcome			
January - March	April - June	KPI	Baseline	Ambition	
<ul style="list-style-type: none"> <li>○ Introduced new team working</li> <li>○ Redrafting all SoPs to provide evidenced based standard to audit</li> <li>○ Reviewed the role of the PHP</li> <li>○ Implemented triage training programme</li> <li>○ Introduced new children's pathway in ED</li> <li>○ Worked with LCHS to continue to improve GP streaming and identifying how further joint working will continue to improve non-admitted patient care pathway</li> <li>○ Increased the workforce levels in ED including triage nurses</li> <li>○ Introduced a quality audit of triage</li> <li>○ Successfully recruited HCAs</li> <li>○ Continued to deliver the medical workforce recruitment plan with all new SHOs now commenced in post in IAC PBH (Workstream 2)</li> <li>○ Introduced a new safety huddle process</li> <li>○ Introduced a new handover process</li> <li>○ Introduced a new clinical process for patients being handed over from EMAS</li> <li>○ Introduced an on-boarding programme for all new recruits</li> <li>○ Commenced a job plan review to provide the foundation for consistency</li> </ul>	<ul style="list-style-type: none"> <li>○ All SoPs will be ratified and an 'app' is being explored for easy access by staff</li> <li>○ Redesign the nurse in charge station to improve patient flow between PHP and RAT</li> <li>○ Introduce a new children's triage procedure and practice</li> <li>○ Introduce a 'fit to sit' area in the children's ward</li> <li>○ Develop model for an integrated minors, fit to sit, non-admitted pathway with LCHS that underpins and prepares for the UTC</li> <li>○ Introduce a nurse recruitment campaign</li> <li>○ Commence a new reporting schedule with NHSI which is shared with the CQC</li> <li>○ Implement new RAT timing system to monitor productivity</li> <li>○ Work with IP&amp;C team to roll out and refresh ANTT standard</li> <li>○ Introduce a shared learning process with EMAS to critically reflect on cases for continuous improvement</li> <li>○ Work collaboratively with the children's team to increase shared governance and learning</li> <li>○ Introduce a new ED clinical lead across the CBU and establish a new way of working as part of the TOM</li> <li>○ Introduce a workforce management model to ensure there is a correct medical workforce on duty to meet demand</li> <li>○ Work towards joint medical workforce rota</li> <li>○ Introduce new job plans to meet demand</li> </ul>	Ambulance handover within 15 mins	Lincoln 32%	60% by Dec 2019	
		Ambulance handover within 30 minutes	Boston 19%	TBC	TBC
		Ambulance handover within 60 minutes	Lincoln 88.5%		100% by Sept 2019
			Boston 91.1%		
		Triage within 15 minutes	Lincoln 79.8%		100% by Mar 2020
			Boston 58.9%		
			Grantham 64.8%		
		Triage within 30 minutes	TBC		TBC
		All Patients streamed out of ED	TBC		35%

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	and patient care need	Patients Streamed out of ED to GP	7.4%	25% by Mar 2020
		Medical staffing fill rate	TBC	TBC
		Nursing staffing fill rate	TBC	TBC



WORKSTREAM 2 (Assessment and Ambulatory)				
Q4	Q1	Outcome		
January - March	April - June	KPI	Baseline	Ambition
<ul style="list-style-type: none"> <li>○ Introduced a collaborative integrated frailty service at PBH and commenced a new model at LCH in partnership with ECIST</li> <li>○ Reviewed and refreshed the ambulatory pathway at PBH</li> <li>○ Reviewed the ambulatory care model at LCH</li> <li>○ Reviewed and increased capacity in PIU at PBH to enable increased capacity in ambulatory IAC</li> </ul>	<ul style="list-style-type: none"> <li>○ Introduce the integrated frailty model at LCH</li> <li>○ Introduce and establish a new clinical leader for frailty trust wide as part of the new TOM</li> <li>○ Introduce new ambulatory care model at LCH</li> <li>○ Introduce a Consultant connect model as part of the refreshed ambulatory pathway</li> <li>○ Reduce the number of patients in ED with a GP referral and ensure these patients are seen in the ambulatory care unit</li> <li>○ Review capacity and demand in the MIDU at LCH and assess how this service functions alongside ambulatory care to allow patients being re-directed</li> <li>○ Review and re-model MEAU</li> </ul>	<p>Nos and percentages of patients navigated to urgent care and ambulatory care</p> <p>Patients discharged within 11 hours of Arrival to Ambulatory Care</p>	<p>TBC</p> <p>Lincoln 99.3%</p> <p>Boston 53.3%</p>	<p>TBC</p> <p>TBC</p>

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WORKSTREAM 3 (Site Management and Flow)				
Q4	Q1	Outcome		
January - March	April - June	KPI	Baseline	Ambition
<ul style="list-style-type: none"> <li>○ Introduced a joined-up capacity meeting</li> <li>○ Review the escalation policy aimed at new practice that decongests the ED and reduced the risk of ambulance delays</li> </ul>	<ul style="list-style-type: none"> <li>○ Refresh the capacity report</li> <li>○ Full roll out of the escalation policy using the PDSA cycle</li> </ul>	30% funded core beds available at 1600  No of patient moves after 2200 (quality indicator)	TBC	100%
			TBC	TBC

WORKSTREAM 4 (Ward Processes)				
Q4	Q1	Outcome		
January - March	April - June	KPI	Baseline	Ambition
<ul style="list-style-type: none"> <li>○ Fully opened the new AMSS unit at PBH</li> <li>○ Introduced a DToC ward at LCH</li> <li>○ Commenced a bed modelling process</li> <li>○ Introduced the ECIST long stay patient reviews</li> </ul>	<ul style="list-style-type: none"> <li>○ Complete the bed modelling process and include the introduction of frailty ambulatory spaces and increased capacity for medical ambulatory and hot clinics</li> <li>○ Refresh SAFER and introduce early morning board rounds</li> <li>○ Refresh the Red to Green process</li> </ul>	All patients have a senior review before midday  All patients have an EDD  % criteria led discharge  7-day proactive discharge	TBC	100% by Mar 2020
			TBC	TBC
			TBC	TBC
			TBC	TBC

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WORKSTREAM 5 (Discharge)				
Q4	Q1	Outcome		
January - March	April - June	KPI	Baseline	Ambition
<ul style="list-style-type: none"> <li>Implemented a daily system wide meeting to manage capacity</li> </ul>	<ul style="list-style-type: none"> <li>Introduce an integrated discharge team and function in collaboration with LCHS colleagues</li> </ul>	Number of stranded patients  Number of super stranded patients	TBC  107	TBC  TBC

Programme Management				
Q4	Q1	Outcome		
January - March	April - June	KPI	Baseline	Ambition
<ul style="list-style-type: none"> <li>Set up of programme team</li> <li>Set up of the programme governance structure and reporting</li> <li>Set up of the steering group which includes regulators and partners</li> </ul>	<ul style="list-style-type: none"> <li>Agree all KPIs</li> <li>Establish the performance dashboard</li> <li>Establish the programme trajectories and associated KPIs and SPC charts</li> </ul>			

Agenda Item 9.2

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