Airedale NHS Foundation Trust
Board of Directors: 27 February 2013
Title: Briefing on the performance against the four hour standard for treatment in A&E
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Executive Summary

The performance against the 4 hour maximum wait in A&E is monitored internally daily, weekly and monthly by the Trust and performance reported quarterly to the regulator, Monitor. The Monitor compliance framework standard is to meet 95% in each quarter. The Trust exceeded the 95% of patients being treated or admitted within 4 hours for the first two quarters of the year. The performance has been 96.79% and 96.89% respectively.

However at the time of writing this report the Trust failed quarter three with a performance of 94.6% (50 breaches) and the Trust position for the fourth quarter is currently 93.9% following unprecedented activity levels. To achieve 95% by the end of quarter four the number of breaches allowed per day needs to be less than 5. So that the Board can understand the significant increase in demand and impact on beds occupancy details of activity rises mapped against bed occupancy rates and 4 hour standard breach position are included in the attached paper.

As predicted the Trust has also exceeded Monitors deminimus Clostridium difficile target. Both performance breaches incur a penalty point against Monitors compliance framework. This will result in the Trust having an amber/red governance rating for Quarter 3. This is the first time since the Foundation Trust was authorised that it has not secured a green governance rating.

In terms of impact on the governance risk rating, the following Monitor guidance states:

Failure of the A&E standard in any quarter leads to 1.0 penalty point being applied. In addition, Monitor may apply an automatic overall Red governance rating and escalate the Foundation Trust for consideration as to whether it is in breach of its Terms of Authorisation if;

- It fails the same standard for three consecutive quarters;
- It fails to meet the A&E target twice in any two quarters over a twelve month period and fails the indicator in a quarter during the subsequent nine month period or full year.

For the Medical Group, sustaining the required level of performance continues to be challenging. A 4 hour target action plan has been refreshed to reflect the latest developments including responding to the recommendation from the recent review by the intensive support team of the systems and processes in A&E. The plan focuses on the priorities of improvements namely A&E, Urgent Care and capacity, demand and organisational development.

In addition to the internal operational plan, Directors have been seeking improvements across the health and social care economy, as a system wide approach is reputed to secure improvements in flow and enhanced patient experience that we all aspire to.

The Trust Board is asked to receive and review the 4 hour performance action plan which has been updated since the last Trust Board meeting

Standard 4 hour maximum wait in A&E

The original standard was introduced in 2004 by the Department of Health for National Health Service acute hospitals in England, that at least 98% of patients attending an ED department must be seen, treated, admitted or discharged in under 4 hours.

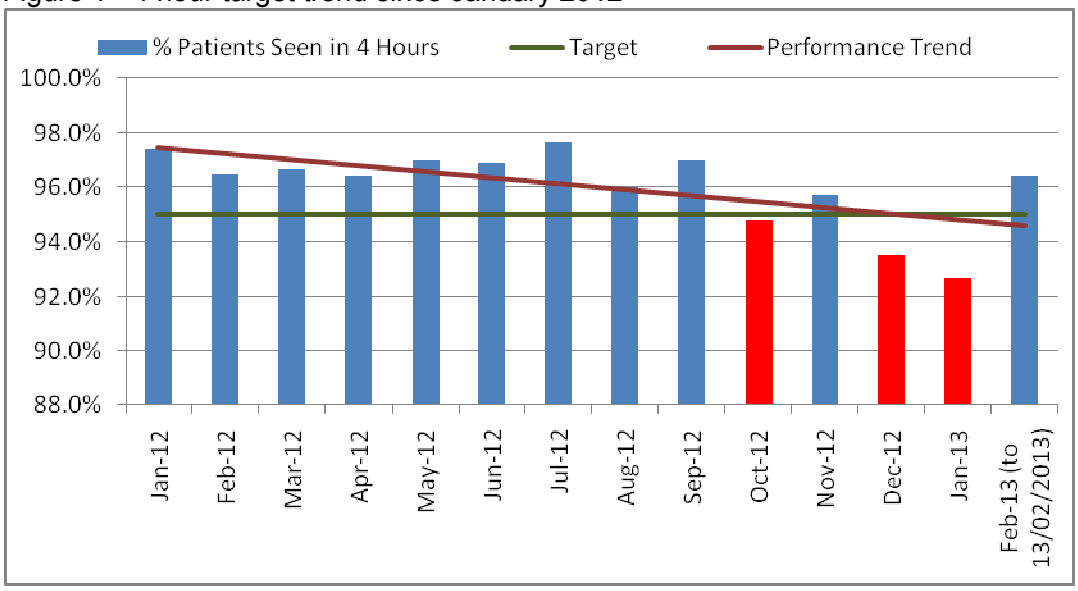
There is a generally held clinical view that the performance metric has driven improvements in care for patients as clearly no patient should wait for more than 4 hours to complete their care (with certain clinical exceptions).

The Department of Health amended the standard in 2010 and required each Foundation Trust to achieve 95% of patients attending A&E department to be seen, treated, admitted or discharged in under 4 hours. Internally, the Trust agreed that it would continue to strive to deliver against a 98% stretch target.

Historically, Airedale FT has consistently achieved a performance against the standard of 98%. Recent trends (figure 1) show that this performance has come under pressure and has been falling since October 2011 with a more significant fall from August 2012.

January's poor performance was exacerbated by one difficult weekend on the 5th January where we accumulated 88 breaches which created a difficult position at the start of quarter 4. Since the introduction of a focused action plan for A&E which includes the recommendations from the IST, February's performance has improved to above 96% as shown in Figure 1.

Figure 1 - 4 hour target trend since January 2012



The potential causes of a decrease in performance.

The following considerations have been declared to Monitor as reasons the decrease in performance and failure of the 4 Hour Trust target:

- A significant and unprecedented demand on the whole health system.
- The creation of additional escalation beds to accommodate an increased rate of admissions through January.
- Norovirus has been active on 4 wards across the Airedale Hospital site and has affected both the Castleburg and Curregate facilities for 2 weeks during Quarter 4. Unfortunately this created some delays in discharging patients as any patient being referred to a nursing home, community bed or residential care needed to be 48 hours clear from the virus prior to discharge which extended length of stays and increased bed occupancy in the month.

The following additional factors have also contributed to failure to achieve 95%

- Emergency admissions in quarter 3 were 20.3% higher than Q3 11/12. Emergency admission in January 2013 were 6% higher than in January 2012. This drop in the increase in admissions from the previous year was not matched by a decrease in bed occupancy because many of the patients occupying a bed in the early part of January were admitted before the beginning of the month. The reduction in admissions therefore did not help the flow out of A&E because occupancy levels were higher and bed holds still occurred.
- Emergency admissions from GPs were up 1.7% in January 2013 compared with January 2012. This is a significant change from Q3 where emergency Admissions from GPs were up by 44.2% compared to the same period last financial year.
- Emergency admissions via A&E were up 9.3% in quarter 3 compared with Q3 11/12. Emergency admissions via A&E were up 8.3% in January 2013 compared to January 2012. The conversion rate in January was 22.9% - a figure consistent with Q3 (23.1%) and historic levels for winter months.
- The flow of patients from A&E to the assessment unit and onto wards is delayed due to the mismatch of bed availability and peaks in demand.
- The doctors and nurses in A&E rotas no longer match the peaks in demand
- Lack of comprehensive senior review or assess to admit along the urgent care pathway.

Summary of prioritised areas being addressed and progress so far

A&E

- A review of the medical and nursing manpower / skill mix has been completed and from February the nursing manpower will be align to demand. Work is on-going to adjust the Consultant rota and this is being worked through with Clinical Director and his colleagues which will include a Business case for additional A&E Consultants to increase Consultant cover to midnight.

- A review of the nurse training and competency base has been completed and gaps are being addressed
- The Consultants are now more visible as shift leader and they now routinely undertake Rapid Assessment of stretcher cases and regular Board rounds to improve patient flow and patient management. The Consultants are also completing a Senior sign off for all patients requiring a medical admission to reduce an inappropriate hospital admission.
- Professional networks have been developed with other Hospitals to learn and adopt good practice as part of the intensive support teams intervention
- The practice of proactively streaming patients to LCD (Local Care Direct) Out of Hours continues and this is being monitored to ensure consistency especially during peak periods of demand.

Urgent Care

- Enhanced acute physician model and developing short stay pathways started at the end of January 2013. This includes 12 hour consultant cover on the Medical Assessment Unit, (MAU), acute physicians taking telephone calls for medical admissions, running daily urgent care clinics,
- Direct admissions for patients from A&E to surgical and orthopaedic beds commenced during the first week of February 2013
- Developing ambulatory care pathways to avoid admissions to hospital and attendances to A&E is currently in development with Dr Crossley leading the implementation
- To meet the increase in medical admissions there needed to be an increase in the size of the medical assessment and short stay functions. This reconfiguration was completed 14 February by relocating and combining the current MAU and short stay facilities.
- The review the use and location of a clinical decisions unit (CDU) has been included in the business case for A&E but we are unable to identify an immediate area for a CDU in the short term.

Organisational Development

In order to support the new ways of working and culture change required in the A&E Department the Trust will develop and implement an OD package focused around the central objective of providing the right care for patients. This package will consist of:

1) a programme of ‘practice development’ that will encourage staff to engage with best practice elsewhere within and outside the Trust and embed the ‘right care’ philosophy within the A&E team (consultants, nurses and managers);

2) the use of the ‘productive’ series to improve processes, systems and ways of working; and

3) team based coaching focused on the interpersonal relationships that need to exist and be developed within and between teams in the Department in order to deliver the right care for patients.

Elements 1 and 3 will be facilitated by external facilitators and arrangements have been made to provide this training development. There is a meeting Friday 22 February with the Head of HR, A&E Management and the external facilitator to agree dates. Element 2 will be facilitated by the Trust's Service Improvement Team and the first meeting was held 8th February 2013.

Adult Bed Base - Capacity and Demand

The trusts November to January A&E performance has been exacerbated by a shortage of beds due to the number of patients attending A&E and the number of direct to ward GP emergency admissions.

A&E attendances in Q3 have historically been below Q1 & Q2. 2012/13 has not followed this trend with attendances comparable to Q1 & Q2. Conversely, conversion rates from A&E to the wards are normally at their highest in Q3. The 2012/13 Q3 conversion rate of 23% is comparable with previous years (23% in 2010/11, 22.5% in 2011/12). The higher than expected A&E attendances combined with the usual high Q3 conversion rate has resulted in a significant increase in admission via A&E.

A&E attendances and admissions slowed in January however bed occupancy has increased due to patients admitted prior to the beginning of the month.

Figure 2 – emergency admissions via A&E.
Note FOT denotes Forecast Outturn

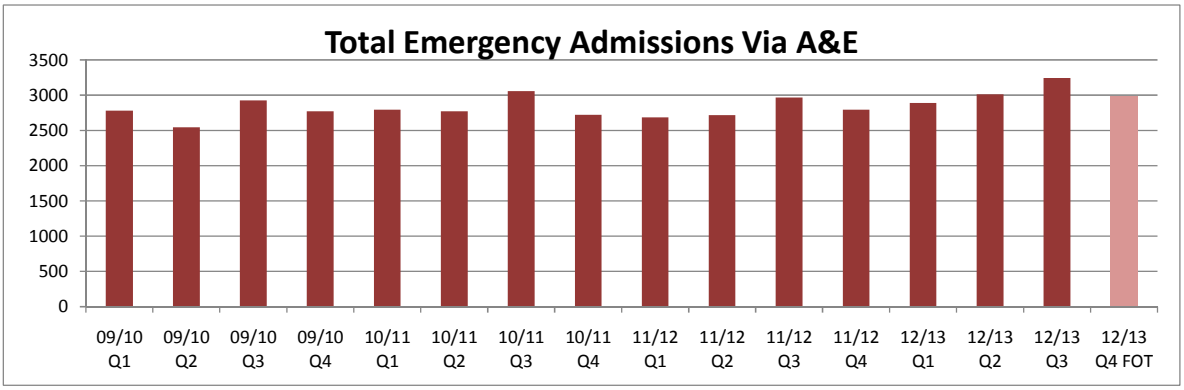
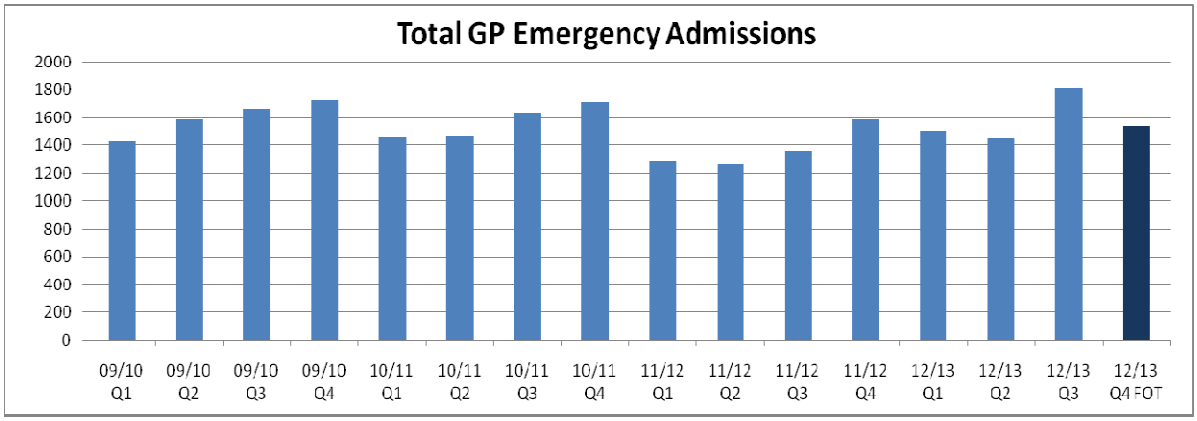


Figure 3 – emergency admissions direct from GP



The trust currently has 323 general adult acute beds available. This figure includes core beds on wards accepting emergency admissions and planned escalation beds provided to cope with winter pressures. The figure also includes 14 extra beds over and above the planned winter escalation beds. Paediatric and critical care beds are not included. The breakdown by ward is shown below:

Figure 4- Adult acute bed base.

Bed Type	Ward	Core Beds	Planned Escalation Beds	Additional Beds Due to Pressures – Flexed as required	Total Beds Available
Core Wards	Ward 1	20	10		30
	Ward 2	30			30
	Ward 5	27			27
	Ward 6	30			30
	Ward 7	30			30
	Ward 10	25	4		29
	Ward 13	25	5		30
	Ward 14	25	6		31
	Ward 15	27	3		30
	Ward 19	11	5		16
	CCU	7			7
Winter Ward	Ward 18		14		14
Ward 9 Escalation Beds	Ward 9		5		5
Ward 4 (previously closed)				14	
Total General Acute Beds		**257**	**52**	**14**	**323**

This bed base would have been sufficient to deal with activity levels in Q3 of 2011/12. The highest number of patients occupying a bed at noon in Q3 of 2011/12 was *295*.

Figure 5- Average adult bed utilisation.

	Bed Days Used - Adult General Acute Beds *	Available Bed Days - Based on 12/13 Winter Adult Bed Base (Excludes Ward 4)	% Utilisation
Q3 11/12	23886	28428	84.0%
Q3 12/13	26347	28428	92.7%
January 13	9730	9579	101.6%

** - Based on 12 noon snapshot*

In quarter of 12/13 there were over 300 patients admitted at 12 noon on 25 occasions (27% of the time). On 27% of days there have been less than 8 beds available in the Trust (based on the winter plan bed base). This level of demand has necessitated opening up additional beds on ward 4 and utilising a further 5 escalation beds in excess of the 5 illustrated within figure 4.

In January 2013 there were 28 occasions when there were over 300 patients at 12 noon (90% of the time). The trust does not currently have the ability to flex beds beyond those identified in figure 4. Due to the very high occupancy levels in January it was necessary to cancel some elective procedures in order to free up beds for emergency patients. Ward 4 was kept open until Friday 8th February and extra bank and agency staff were used to enable the total bed base to be staffed.

Operational Action plan

The current action plan with outstanding actions is shown in Appendix 1.
The plan is intended for frontline staff and will be delivered through the clinical leadership of CD, Senior Matron and A&E Unit Manager.

Our approach, of putting the patient at the centre, and through engaged and effective health economy wide clinical leadership is:

a) Managing systems, processes and clinicians in A&E.
b) Managing the **outflow** from A&E into the main hospital and bed availability.
c) Managing the **inflow of patients (demand)** by working very closely with primary care.

The Expected Outcomes of this work are:

- Improve patient safety
- Improve processes and flow
- Improve staff skillset and morale
- Enhance and create an effective team
- Improve capacity and demand

Deliverable:
Achievement of the Trust 4 hour target at 95%.

Monitoring and Progress

There continues to be considerable support and focus from all frontline and senior staff, management on-call and executives. In particular, the daily analysis of the 4 hour breaches continues. In addition, weekly Executive Assurance meetings have been established to provide support and gain assurance on all aspects of the delivery of the action plan from the multidisciplinary clinical teams that are implementing these. The general manager of the medical group has the responsibility for the daily performance management of the action plan. The clinical teams leading the two main areas of the action plan are:

A&E redesign: CD for A&E, Senior Matron, A&E Manager

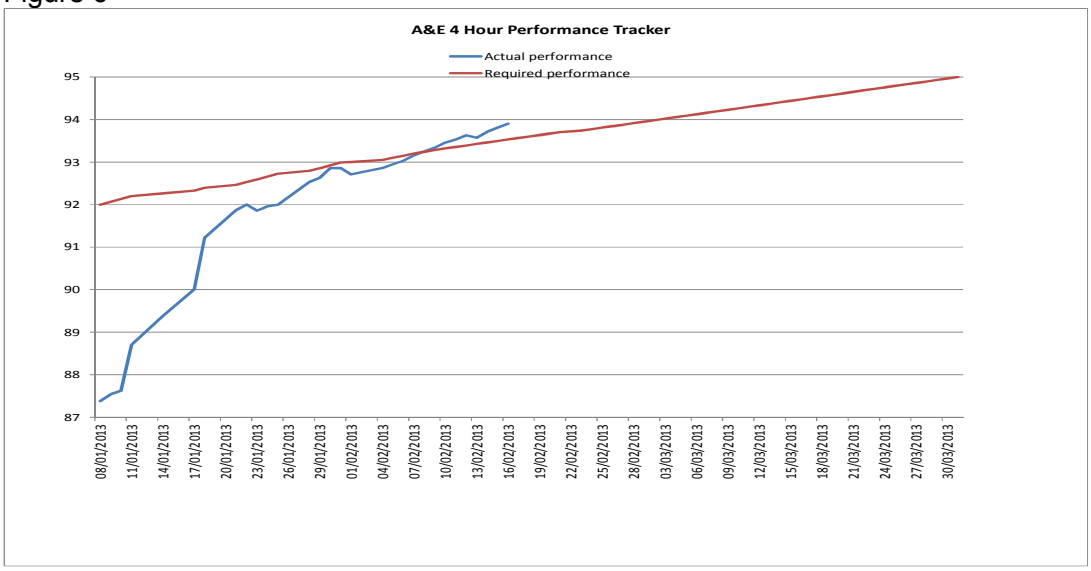
Urgent Care pathways: Clinical lead for urgent care pathways, Senior Matron, A&E Uit Manager, Matron for MAU.

The Executive Assurance Group consists of Director of Nursing, Director of Operations and Medical Director.

The Director of Operations continues to be the executive lead for the four hour target and the Medical Director is the executive lead for urgent care pathways.

The impact of the operational action plan has been a steady improvement in the 4 hour performance as outlined in figure 6. This shows the actual performance (in blue) is now above the required performance (in red) to achieve 95% by the end of Quarter 4. Should this trajectory continue the Trust would expect to be achieving 95% by the first week in March. However, it must be recognised that in order to achieve this we must be able to sustain a performance of 96.5% every day for the remainder of the quarter, (less than 5 breaches per day). This is something we have not been able to achieve in any period throughout 2012, so there remains the significant risk that the Trust may not achieve 95% in Quarter 4.

Figure 6



Appendix 1 – The Action Plan

Aim – complete a comprehensive review of Nursing and Medical workforce in the Emergency Department
Specific objectives – provide a competent and capable workforce, fully trained and competent in all aspects of providing emergency care, within the constraints of the present financial envelope.

Item	Focus	Recommendation (IST) / Local Action	Considerations	Achievable / Actions .	Deadline & Update	Owner	RAG
Workforce	ED	Adoption **of Advanced Nurse Practitioners** within department should be maximised to improve timely patient flow (IST) **PRIORITY**	The ACCT to add value in A&E by reviewing patients in A&E and assessing whether some patients could be treated in the department and then released into the care of ACCT to avoid an admission.	ACCT team having a greater presence within A&E	Mid Jan 2013 – Limited input during January although the team have planned a greater presence in the Department in February 2013 The team's input has prevented 1 to 2 patient admissions when they have worked. Their approach to proactively supporting treatment and care in the community is raising awareness in the Department that there are viable alternatives to a hospital admission.	Director of Nursing	Amber
			Development of ANPs within A&E	Training is on-going for 2 Band 7 nurses within the department to provide ANP cover.	This is a Masters based programme and the first Nurse is expected to be competent to practice is scheduled for November 2014.	Senior Matron for Medicine	Amber
Workforce	ED	**Shift pattern changes. PRIORITY** The activity within the unit in recent months has increased during the midweek afternoons which may be out of alignment with the staffing levels (Doctors and Nurses)	Recent analysis by GM to map demand with levels of medical and nurse staffing – some imbalance noted.	Consultant Rotas being reviewed Junior Doctor rota reviewed and revised January 2013. Contact has been made with the IST to arrange further input. We are developing a Business Case for extra Consultant Resource.	Completed December 2012 From March a new Consultant rota has been agreed which includes an extended finishing time.	Consultant	Amber

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				Implement new nursing rotas. Process agreed for sign off for rotas Jan 2013. Ongoing monitoring in place	End February 2013 Complete	Senior Matron for Medicine / ED Unit Manager	Green
				Contact made with procurement team for e-rostering. There is a framework in place for another provider and the details are being explored.	The procurement team will be creating a tender notice April 2013 and the first demonstration from a potential supplier is set for 8 March 2013		Amber
Workforce	ED	**Review of nurse access to training and professional development PRIORITY**	Opportunities exist within the A&E for nurses to participate in CPD to enhance skill set and raise standards	Nurses can attend in house ALS and ALTS courses or high fidelity simulation at BTHFT. A comprehensive training plan is being developed and this will be ready mid February 2013.	End February 2013 This is on track for completion before the end of the February 2013.	Senior Matron for Medicine	Amber
Workforce	ED	**Appointment of pharmacy MTO to aid drug restocking and release nurse leadership time.**	Top up stock and put away. Pharmacy Assistant Band 3 x 0.24 WTE @ £1.5k / 3 months.	Release Band 6/ 7 nursing staff time to be redirected to patient care, thus reducing the risk of breaching 4 hour target -Better organisation of stored medicines / regular checks of expiry dates / tighter stock control: reduce over ordering, req'd stock levels maintained	Completed December 2012	Chief pharmacist	Green
Workforce	ED	**Appointment of Senior Nurse Leader**	Enhanced professional leadership is absolutely essential – key appointment	Unsuccessful in November.	End February 2013 Update Senior Matron and General Manager are creating an option appraisal for an alternative longer term solution	Director of nursing/ Senior Matron	Amber
				Interim A&E unit manager in place to provide leadership along with senior matron for medicine	Completed January 2013		Green
Workforce	ED	**Extend opening hours of minor patients stream**	Reduce waiting times for first assessments in the evening to reduce the number of patients being handed over to the night	Temporarily enhancing Dr shift cover into the weekday evenings.	Completed December 2012.	CD for A&E	Green

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			team.				
Workforce	ED	**Review of junior doctor productivity and efficiency**	Evidence suggests a two-fold variation in JD throughput of patients (performance typical of junior staff elsewhere).	Data is collected and this is now shared with juniors to inform their development needs	Feb 2013 Complete. Data to be re-audited during next roster to see if variation has reduced. This report is now examined weekly and where variations are identified, these are discussed with those concerned and their supervisor.	CD & Unit Manager	Green
Workforce	ED	**OD development**	There is a need to improve team dynamics across all professional groups to improve process and efficiencies.	Develop team based coaching intervention to facilitate new ways of working and team working within A&E Department.	Feb 2013 Update, external facilitator LETB approached and the coaching will be in place by the end of February	NP	Amber

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Aim – Improve efficiencies and flow within the department by reviewing all processes. To enhance patient experience by implementing clinically safe pathways which are supported by the Organisation and external stakeholders. **Specific objectives –To deliver timely assessments to meet national and local performance targets, which include ambulance handover, time to initial assessment. To empower shift leaders to manage and direct their team by providing appropriate supervision and support through effective and timely decision making.**							
Item	Focus	**Recommendation (IST) / Local Action**	Considerations	Achievable / Actions	Deadline & Update	Owner	RAG
Process	ED	**Implementation of new front end adult clerking proforma**	Based on SystmOne adoption. Patients clerked in ED resulting in enhanced flow through system and fewer delays for patients and more accurate history taking.	New form devised and approved by CDs at SMLT in November 2012 which is anticipated to reduce clerking on MAU and increase clinical time for admissions	Completed Feb 2013	CD Urgent Care	Green
Process	ED	**Use of receptionist team to support shift leader with flow. management, completion of cards and handling telephone enquiries.**	The shift leader has the responsibility for managing flow during their shift and they would benefit from admin / ward clerk support to deal with telephone enquiries, chase patient flow and handle telephone enquiries at the nurses / doctors station.	Work with the receptionist / admin team to facilitate this support within 2 weeks.	End of march 2013 Update – sickness and vacancies within the admin team has meant a revised deadline to this action	Unit Manager	Amber
Process	ED	**Review clinical interface between senior nurses and doctors** **PRIORITY**	Shop floor relationships are seen as good, but opportunity exists for consultants and senior nurses to jointly lead on ED management issues and ownership of this plan	Review of interface to be part of IST support A variety of meetings are now established.	End Jan 2013	EMD DOO and DON	Green
Process	ED	**More effective utilisation of Local Care Direct**	Audit data shows that LCD see approximately 80% of refers from ED. Remaining 20% are not seen as LCD do not have capacity	2 recent meetings with CCG and LCD. Strong executive influencing of LCD position to provide sufficient capacity to see all ED referrals and ease early evening surge and weekend peaks.	March 2013	Medical director	Green

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Process	ED	**Effective use of Streaming to Primary Care & Pharmacy**	Royal Blackburn Hospitals are introducing streaming for patients presenting with Urgent care needs which will direct patients to Primary care / Pharmacy	The introduction of effective streaming could improve capacity and improve flow within the department. A link has been established to learn of the objectives of this scheme, support being given by commissioners and meeting being set to take this forward.	End March 2013 Update – meeting with Lynne Hollingsworth on 27th February to discuss proposal.	Unit manager & Matron	Amber
Process	ED	**Redistribution of CD workload to other A&E consultants whilst she is working on urgent care flow**	Medical Director has held 1:1s with all A&E consultants to explain proposed arrangements and attempt to understand concerns.	Dr Jennings acting as Interim Clinical Director whilst Dr Crossley is seconded to Urgent Care Flow role.	Completed Dec 2012	Medical Director & Director of Operations	Green
Process	ED	**Changes to Minors area**	Implement streaming to minors and majors and look to stop full Manchester triage	Undertake a review of present practice to be undertaken February 2013 to identify service improvements. Site visit to Bradford 1 Feb 2013 completed. This department does use Manchester triage but in a reduced form. Arrangements made for M Glover to work in Bradford A&E for a week in March. Once the training baseline has been completed for the nursing team this will determine future options.	March 2013	Unit manager & Matron	Amber
			The ENP manage the whole of the minors area, seeking guidance from the consultant based in the majors area	The ENPs already manage their own case load and actively treat patients within their capabilities. There is a Consultant presence to	Data is being prepared and the findings to be reviewed March 2013	Unit manager & Matron	Amber

Appendix 1 – The Action Plan

				aid decision / act as support to the ENPs but could the Consultant resource be better utilised elsewhere to allow the minors area to be ENP led? An audit will be completed to evidence the numbers of patients treated which are independent of Consultant input. (KW to arrange)			
			Implement see and treat after a managed trial	Undertake a review of present practice to be undertaken February 2013 to identify service improvements. Site visit to Bradford 1 Feb 2012 to explore their practice / Working party with commissioners based on East Lancs Urgent Care streaming.	March 2013	Unit manager & Matron	Amber
Process	ED	**Changes to Majors area PRIORITY**	The department looks to pilot RATS (rapid access and treatment)	Consultant assessment when patients arrive by Ambulance, improve decision making and planning of tests, diagnostics	January 2013	Clinical Director	Green
			Develop internal escalation with specific trigger points	Create robust triggers to unblock pressure points Review escalation plan KW / MG / MS	Mid March 2013 Update – working with band 7's to create a team approach to internal escalation which pulls information from all areas within A&E.	Unit manager	Amber
			Specific roles and responsibilities for staff on duty, eg stretcher side which will free the shift leader to concentrate on flow	Assigning tasks will improve continuity of patient care and working across the professional groups The shift leader now assigns the nursing team to work in specific	February 2013	Matron	Green

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				areas to create accountability for their patients. Daily check to be conducted by MS / KW			
Aim – To provide an environment for patients and staff which is fit for purpose and capable of meeting future demands. **Specific objectives –Ensure all available space is used appropriately for clinical care and associated support functions.**							
Item	Focus	**Recommendation (IST) / Local Action**	Considerations	Achievable / Actions	Deadline	Owner	RAG
Capital	ED	**The development of a new ED unit** to create a larger working area to deal with the increased activity especially at peak times.	The Strategic outline business case goes to November Board Work commences on 1st December on OBC	Improve capacity and demand	29th November March 2013	General Manager/ Head of estates	Amber

Appendix 1 – The Action Plan

1. ACTIONS TO BE TAKEN IN MAU & ON WARDS							
Item	**Focus**	**Recommendation (IST) / Local Action**	**Considerations**	**Achievable / Actions**	**Deadline**	**Owner**	**RAG**
Pathway	Flow	**Build senior clinical leadership to drive through pathway changes and foster consultant clinical engagement with flow changes.**	**Appointment of interim Clinical Director** with responsibility for flow and pathways for 4 months in the first instance.	The clinical engagement challenge is very considerable and key to effective management is sufficient clinical manager time and focus to drive though change.	Completed December 2012	Medical Director	Green
Pathway	Flow	**The relationship between emergency, acute and speciality medicine appears progressive with shared vision and objectives. (IST comment)**	**The internal professional standards** group has been established which will quickly present the issues and move to solving solutions within 2 meetings.		Review end February 2013. The acceptance of the internal professional standards is key to delivering flow and a gap analysis is being prepared to identify any gaps across the Trust.	Clinical Directors & Medical Director	Amber
Comms	Flow	Internal **Summit meeting** with CEO with Clinical Leads and Senior Management representatives. External **summit meeting** with CEO, social services and CCG	Number of workstreams as mentioned above have come from these summit meetings		Continuous	Clinical Director	Amber
Pathway	Flow	There should be an integrated and performance managed approach to **short stay.** (IST)	Short stay can be best achieved through a degree of segmentation of admitted patients into streams, namely short stay, sick specialty, sick general and complex.	Short stay ward area.	January 2013 – completed Ward 2 is now MAU and annex ward 3 is designated SS and ambulatory care/CAT (Clinical Assessment and Triage)	Clinical Directors and General Managers	Green

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Workforce	Flow	**Enhanced Consultant Physician presence on MAU**	Design rota for consultants to deliver 8am to 9pm consultant presence on MAU incorporating short stay, ambulatory clinics, GP call screening, telemedicine and assessment and Post Take Ward Rounds (PTWR)	Consultation process completed and rotas being designed	Anticipated rota start date early January 2013 Completed. NB Current rota is up and running without geriatricians. Meeting 26th Feb to resolve.	Clinical Directors	Green
Discharge Work	Flow	Ensure internal and external processes are contributing to the overall aim of reducing the length of stay and improving the patient experience.	Meeting has occurred between Airedale and social care. However Dr Foster benchmarking shows lower than expected readmissions. NHS benchmarking shows low LOS [2012 dataset].	Review nursing needs assessment process. Timely assessments by all health professionals.	Project completed in December .	Senior Matron	Green
Discharge	Flow	A full review of the discharge work stream will be undertaken by Senior Matron in Medicine		New action plan produced	January 2013 Completed and working across all areas.		Green

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1. ACTIONS TO BE TAKEN IN PARTNERSHIP WITH PRIMARY CARE							
Item	**Focus**	**Recommendation (IST) / Local Action**	**Considerations**	**Achievable / Actions**	**Deadline**	**Owner**	**RAG**
Comms	Flow	**Close working and influencing / supporting CCG leadership thinking**	Available data shows significant upward shift in referred GP activity thought secondary to behaviours: workload and case complexity / multimorbidity / over 85 year olds	CEO has chaired and directed 2 urgent care summits, sharing performance data at practice level with CCG AO and challenging higher than expected referral rates.	On-going	CEO	Amber
Comms	Flow	**Close working and influencing / supporting YORLMC leadership with performance data and trends**	Ditto above	EMD and DOO attended November YORLMC and shared upturn in GP activity. Encouraged GP providers to support FT and agree to triage back to primary care (see below)	On-going	Medical director	Amber
Comms	Flow	**Clarity of messaging with primary care through robust understanding of the A&E performance data and how individual GP practice referral rates.**	Highly complex analysis of trends – if CCG engagement is to be effective, data must lead to reliable conclusions when securing trust and confidence	Detailed analysis undertaken by information department at request of DOO shows themes and trends to explore with ED consultants and CCG.	First cut complete Nov 12 and send to CCG leaders on weekly basis	DOO and EMD	Amber
Pathway	Flow	**Developing ambulatory emergency care pathways with primary care**	Already underway but move to a basket of 20 conditions in the first instance. **Key aim is to reduce conversion rate by 2%.**	Link to TRANSFORM work and building on current DVT and cellulitis pathway. Good CCG engagement.	On-going. Update – a number of pathways are already introduced and being delivered by community (3) and ambulatory care on ward 3 CAT area. MC	Clinical Director for Urgent Care	Amber
Pathway	Flow	**Developing innovative approaches to primary care demand management – telemedicine access in high volume primary care settings**	High volume users of acute care identified and offered access to acute physician opinion remotely as an alternative to admission.	Technology in place. Work on new physician job plans on track for Jan 13.	On-going. Update – CAT are fielding the telemedicine calls.	Telemedicine lead	Amber

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Pathway	Flow	**Improving access to specialist acute medical opinion for primary care**	Access to acute physician by mobile phone to aid signposting and admission avoided. Also investigating role of **e- consultation.**	Similar concept to the effective and GP rated 'stroke line'.	January 2013 Completed for acute medicine	Clinical Director Urgent Care	Green
Pathway	Flow	**Telemedicine units in nursing homes**	Telemedicine units have been installed and workshops being held to increase uptake		Complete	Telemedicine lead	Green
Pathway	Flow	**Working with CCG and YAS to avoid Green 1 and 2 admissions (GP in hours pathways)**	Complex piece. Good evidence from South Coast Ambulance Trust that low category ambulance calls can be safely triaged to GP as an alternative to ED.	clinical joined leadership of YAS MD, EMD and CCG AO in hand.	On going. No update.	Medical director	Amber